crossroads HEALTHCARE AT HOME
*an Impact company*

# HOSPICE REFERRAL FORM

**Vallejo Branch**
127 Hospital drive, Vallejo, CA 94589
**Tel:** 707-554-4003
**Fax:** 707-554-4043

## Patient Demographics

Patient Name: *(Last Name, First):*

_____

Patient Date of Birth:

_____/_____/_____

Patient Address:

_____

_____

Patient Telephone:

(_____) _____-_____

Patient's Sex:

☐ Male ☐ Female

Patient SSN: _____ - _____ - _____

Patient Allergies: _____

Person to Contact to Schedule Hospice Evaluation / Admission

Name: _____ Relationship: _____

Tel: (_____) _____-_____

## Primary Payer Information

☐ **Medicare**: _____

☐ **Medi-Cal**: _____

☐ **HMO/Commercial Insurance**

Health Plan: _____

Policy #: _____

## Hospice Orders

☒ **Evaluate and if appropriate, admit to Hospice**

***Please include a copy of last progress/visit note, medication list and past medical history, along with this completed form***

## Diagnosis

**Primary Diagnosis or Condition for which patient is being referred to service(s):**

_____

_____

## Referring Provider Signature

Referring Provider Signature: _____ Date: _____/_____ /_____

Print Name of Referring Provider: _____ (indicate MD, DPM, DO, NP or PA)

Tel: (_____) _____-_____ Fax: (_____) _____-_____

**FAX COMPLETED FORM TO: 415-682-2112 OR EMAIL TO: eFAX@CROSSROADSHH.COM**