healthcare california
an Impact company

Physician's Referral Form Hospice

Phone :(559) 243-9990 Fax: (559) 243-9994 Email: referrals@healthcal.com

Patient Name:_____**DOB**:_____

MBI/Medicare:_____**Primary Ins**:_____

Patient Location:

☐ **Home** ☐ **Facility** _____

Eval Need:

☐ **ASAP** ☐ **STAT** ☐ **Info Visit Only**

Please attach most recent progress notes, demographics, H&P, Med list and Labs

Hospice Services

Hospice DX:_____HealthCare California Hospice to Eval/Admit

☐ In consultation with the patient, I prefer to remain the attending physician and will sign all physician orders and remain in open communication with the HealthCare California Hospice Team.

☐ In consultation with the patient, I prefer to remain the attending physician with the Hospice Medical Director to provide symptom management.

☐ In consultation with the patient, I prefer to relinquish my role as the attending physician. Pursuant to consultation with the patient, the Hospice Medical Director will take over as the attending physician.

Referring Physician Signature:_____**Date**:_____