forest park
HEALTHCARE AT HOME
an Impact company

Fax: 971.415.0110
Tel: 971.415.0100

HOSPICE REFERRAL FORM

PATIENT INFORMATION

Patient Name: ______________________________ DOB: __________

Phone: ______________________________

Medicare/Medicaid or Insurance #: ____________________

Diagnosis: ____

____

☐ I authorize the use of telehealth and telecommunications as necessary and appropriate for this patient's treatment.

☐ Hospice Evaluation and admit to hospice if appropriate

☐ If admitted, and patient chooses, I wish to remain the patient's primary attending physician

☐ If admitted, and patient chooses, have ____________________ or the local medical director serve as attending

Physician Signature: ______________________________ Date: __________

Please Print Name: ______________________________

☐ Face Sheet, MAR, H&P attached.