VNS Health

Hospice Referral Form

Tel: **212-609-1900** Fax: **212-290-1825**

Hospice online referral: **vnshealth.org/hospicereferral**

URGENT ☐ within 24 hours priority collaboration **SC#** _____ **Case#** _____

REFERRAL SOURCE

Date/Time of Referral _____ Referrer _____ Tel # _____

Source: Hospital/SNF (Name/Unit #) _____

☐ MD ☐ PT/FAM ☐ Other Adult Care Team # _____ MRN # _____

PATIENT INFORMATION

Patient Name _____ Gender ☐ M ☐ F Language Spoken _____

Address _____ Tel # _____

_____

DOB _____ Age _____ SS # _____ Marital Status ☐ Married ☐ Single

Lives ☐ Alone ☐ with Family ☐ with Spouse ☐ with FES ☐ in SNF/ALF/ALP ☐ Divorced ☐ Widowed

Primary Contact _____ Primary Tel # _____

Relationship _____ Language _____

Address _____ Email _____

_____

Health Care Proxy / Surrogate _____ Primary Tel # _____

Relationship _____ Language _____

Address _____ Email _____

_____

CLINICAL

Terminal Dx _____ Dx _____

IV _____ Mediport Access _____ Allergies _____

INSURANCE

Primary Insurance _____ # _____ Verified ☐ Pending ☐ Done

Other Insurance _____ # _____ Auth # _____

Insurance Contact Person _____ Tel # _____ Auth. Period _____

PHYSICIAN

Primary MD _____ License # _____

Mailing Address _____ Tel # _____ Fax # _____

_____

Is MD willing to continue providing care to the patient while on hospice? ☐ Yes ☐ No

HOSPICE REFERRAL / VERBAL ORDER

☐ I am referring this patient for hospice care. Patient competent to sign consents? ☐ Yes ☐ No

Physician Signature _____ NPI # _____ Date _____

OTHER

Patient/Family aware of Hospice referral? ☐ Yes ☐ No Patient served in the military? ☐ Yes ☐ No

COMMENTS "Why Hospice Now?" Describe patient decline that precipitated Hospice (comment below)

_____

_____