VNS Health

Hospice Referral Form

Please complete this form and send via fax or email:
Fax: 212-290-1825 | Email: HospiceReferral@vnshealth.org
Need to speak to a VNS Health team member? Call **212-609-1900**

All fields marked with an asterisk (*) are required.

Referral Contact Information

Contact Name* ______________________ Referral Source* ______________________

Phone* ______________________ Email ______________________

Patient Clinical Information*

Has patient and/or family been informed about the hospice referral?* ☐ Yes ☐ No

Proposed Terminal Diagnosis ______________________

Reason for Hospice Referral* ______________________

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To expedite referral, please send supporting documentation:

☐ Patient Face Sheet ☐ History & Physical ☐ Last 2-3 Office Visit Notes

☐ Palliative Provider Notes ☐ Most Recent Labs or Reports (i.e. Echo, Pathology, MRI, etc.)

Patient Contact Information

Patient Name* ______________________ DOB* __________ Gender* __________

Phone* ______________________ Email ______________________

Please send demographic sheet and insurance information or complete below.

Type of residence where care will be delivered*

☐ Home ☐ Nursing Home ☐ Assisted Living ☐ Group Home ☐ Other ______________________

Address ______________________ City ______________________ Zip __________

Phone ______________________

Will the patient be the primary point of contact throughout treatment?* ☐ Yes ☐ No

If no, please provide information of primary point of contact below.

Name ______________________ Phone ______________________

Relationship to Patient ______________________

Payor Information*

Complete all that apply

☐ Medicare No. ______________________ ☐ Other Carrier ______________________ ☐ Charity Care

☐ Medicaid No. ______________________ Policy Number ______________________

Provider Information

Name of Ordering Provider* ______________________ ☐ MD ☐ PA ☐ NP

Select one of the above

Phone* ______________________

If patient consents, will the provider follow this patient for hospice?* ☐ Yes ☐ No

☐ Order for Hospice Evaluation and Treatment

Based on my clinical expertise, I certify that this patient has a terminal illness with a prognosis of six (6) months or less if the disease follows its typical course.

Provider Signature ______________________ Date ______________________