

PATIENT REFERRAL FORM



DATE: _____
TO: **INTAKE DEPARTMENT** (Hospice of San Joaquin)
INTAKE FAX: **(209) 922-0321**
INTAKE PHONE **(209) 922-0320**
PAGES: _____ (Including Coversheet)
FROM: _____
ORGANIZATION: _____
FAX NUMBER: _____
PHONE NUMBER: _____

PATIENT & PHYSICIAN INFORMATION

PATIENT NAME: _____
DATE OF BIRTH: _____
SSN: _____
PRIMARY CARE PHYSICIAN: _____

(PCP will follow patient while on hospice services)

SELECT TYPE OF CARE: **Admit Patient for "Home Care"**
 Admit patient to Hospice House

(Note: Hospice of San Joaquin's physician will follow patient at Hospice House, upon request. Primary Care Physician will sign death certificate.)

PHYSICIAN NAME: _____

Please include the following documents:

- Demographics**
- Insurance**
- Terminal Diagnosis**
- H & P**
- Family Contact Information**
- CXR**

By signing this Patient Referral Form, the physician states that the patient has a prognosis of 6 month's or less, if the patient's disease process runs its normal course, and understands that no further curable treatments will be administered. The PCP will be responsible for signing orders, plan of care and death certificate.

Upon receipt of this REFERRAL request, Hospice of San Joaquin will contact the patient and family to schedule an assessment.

Physician Signature

Date