Pike County Health Department
Home Health & Hospice

HOSPICE FAX REFERRAL FORM

Please fax form to 573-324-5517

TODAY'S DATE ___/___/___ **MD OFFICE CONTACT NAME** _____ **PHONE #** (___)_____

FAX # (___) _____

REFERRAL INFORMATION

PATIENT'S NAME _____
Last First M

DOB _____/_____/_____ **SOCIAL SECURITY NUMBER (if available)** ___-___ _____ _____

LANGUAGE PT SPEAKS _____ **(If not English)**

INTERPRETOR NEEDED: YES NO If no, **name & phone** of person who speaks English: _____) ____-_____

IS PATIENT COMPETENT TO SIGN CONSENT FOR HOSPICE CARE: YES NO **IF NO, LIST NAME OF DPOA ON NEXT LINE**

NEXT OF KIN NAME _____ **RELATIONSHIP** _____

HOME# _____ **WORK #** _____ **CELL #** _____

HOSPICEDIAGNOSIS _____

ATTENDING PHYSICIAN (FOR HOSPICE CARE) _____ **PHONE #** _____

Please fax the following information with this referral form (if available) :

Face Sheet (including name, address, insurance info)
- □ Copy of current medication list
- □ Recent H&P
- □ Hospital D/C Summary or recent office visit notes (to describe the patient's current clinical condition)
- □ Copy of physician's order for hospice care