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 ju _____

Reason for Hospice Referral* _____

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 _____

Email or Fax to Submit Form