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 _____

Email _____

We may use this contact information to communicate important updates about patients admitted to VNS Health Hospice Care.

**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)

_____

Submit Referral Form