



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

Name* _____ Referral Source* _____

Phone Number* _____ Email _____

Provider Information

Name of Referring Provider* _____ ☐ MD ☐ PA ☐ NP
Select one of the above

Phone Number, if different: _____

Patient Clinical Information

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

Reason for Hospice Referral _____

Patient Contact Information

Name* _____ Date of Birth* _____

Gender* _____ Phone Number* _____ Email _____

Type of residence where care will be delivered

☐ Home ☐ Nursing Home ☐ Assisted Living ☐ Group Home ☐ Other _____

Address _____ City _____ Zip _____

Optional: Home Phone Number/Landline _____

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 Number _____

Relationship to Patient _____

If available, please send supporting documentation for an expedited referral:

- | | |
|--|--|
| ☐ Patient Face Sheet | ☐ Last 2-3 Office Visit Notes |
| ☐ Palliative Provider Notes | ☐ Most Recent Labs or Reports (i.e. Echo, Pathology, MRI, etc.) |
| ☐ History & Physical | ☐ Demographic sheet and insurance information |

Provider Signature* _____ **Date*** _____

We can admit your patient and start care at any time. Our team is available 24/7 to support you.