Hospice Referral Form

Brookestone Home Health & Hospice

Fax back to Brookestone Home Health & Hospice at: 308-210-3553. Please inlcude your cover sheet.
If you have a patient who might benefit from hospice services, please fill out this form and return it to Brookestone Home Health & Hospice. A hospice specialist will follow-up promptly.

REQUIRED INFORMATION

Patient Name: _____ Gender: ☐ M ☐ F DOB: _____

Patient's Address: _____ City: _____ State: _____ Zip: _____

Hospice Diagnosis: _____ SSN: _____

Attending Physician:_____ Patient's Ph. #: _____

Patient's Primary Contact Name:_____ Patient's Primary Contact #: _____

Who should we contact to discuss our services? ☐ Patient ☐ Patient's Primary Contact

Has Hospice been discussed with the patient/family? ☐ Yes ☐ No

Referral Contact Name:_____ Referral Contact Ph. #: _____

SUPPORTING INFORMATION

☐ Documents Attached to Fax ☐ Send a Representative to Collect Documents

If you have the following supporting documentation, please provide as appropriate.

- Patient Face Sheet (Demographics)
- Pathology Reports
- History and Physical
- Discharge Summary
- Last Visit Note
- Labs
- Medicare/Medicaid/Commercial Insurance Card
- Additional Information

Comments:

ORDERS

☐ Evaluate and Admit to Hospice Services

Please choose one box below:

☐ Hospice Medical Director to assume care of the patient.

☐ Dr. _____ will remain attending physician w/ hospice medical director to assist w/ sign & symptom mgt.

Additional Orders: _____

For Physicians: Please sign here to authorize us to evaluate and admit patient, if eligible.

Physician Signature:_____ Date: _____

Physican Name (Print): _____

Brookestone Home Health & Hospice

We look forward to serving you and your patients.

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