

# Hospice Referral Form

# Brookestone Home Health & Hospice

**Fax back to Brookestone Home Health & Hospice at: 308-210-3553. Please include 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.

<b>REQUIRED INFORMATION</b>	Patient Name: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> 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?	<input type="checkbox"/> Patient	<input type="checkbox"/> Patient's Primary Contact
	Has Hospice been discussed with the patient/family?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Referral Contact Name: _____	Referral Contact Ph. #: _____		
<b>SUPPORTING INFORMATION</b>	<input type="checkbox"/> Documents Attached to Fax <input type="checkbox"/> Send a Representative to Collect Documents		
	If you have the following supporting documentation, please provide as appropriate.		
	<ul style="list-style-type: none"><li>• Patient Face Sheet (Demographics)</li><li>• Pathology Reports</li><li>• History and Physical</li></ul>	<ul style="list-style-type: none"><li>• Discharge Summary</li><li>• Last Visit Note</li><li>• Labs</li></ul>	<ul style="list-style-type: none"><li>• Medicare/Medicaid/Commercial Insurance Card</li><li>• Additional Information</li></ul>
Comments: _____			
<b>ORDERS</b>	<input type="checkbox"/> Evaluate and Admit to Hospice Services		
	<b>Please choose one box below:</b>		
	<input type="checkbox"/> Hospice Medical Director to assume care of the patient.		
	<input type="checkbox"/> Dr. _____ will remain attending physician w/ hospice medical director to assist w/ sign & symptom mgt.		
Additional Orders: _____			
<b>For Physicians: Please sign here to authorize us to evaluate and admit patient, if eligible.</b>			
Physician Signature: _____		Date: _____	
Physician Name (Print): _____			



**We look forward to serving you and your patients.**

507 West Ave, Holdrege, NE 68949  
Office: 308-995-4375 // Fax: 308-210-3553

NOTICE: The attached communication contains privileged and confidential information. If you are not the intended recipient, DO NOT read, copy, or disseminate this communication. Non-intended recipients are hereby placed on notice that any unauthorized disclosure, duplication, distribution, or taking of any action in reliance on the contents of these materials is expressly prohibited. If you have received this communication in error, please destroy all pages and contact the sender or the Brookestone Home Health & Hospice office at 308-995-4375.