

# Hospice Referral Form

# Brookestone Home Health & Hospice

**Fax back to Brookestone Home Health & Hospice at: 308-221-2288. 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><li>• Discharge Summary</li><li>• Last Visit Note</li><li>• Labs</li><li>• Medicare/Medicaid/Commercial Insurance Card</li><li>• Additional Information</li></ul>		
<b>ORDERS</b>	Comments: _____		
	<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.**

904 Parkview Court, North Platte, NE 69101  
308-221-2288 phone / fax

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