HOSPICE FAX REFERRAL FORM

PROVIDENCE Health & Services

PROVIDENCE HOSPICE OF SEATTLE	PROVIDENCE HOSPICE AND HOMECARE OF SNOHOMISH	PROVIDENCE SOUND HOME-CARE AND HOSPICE
Phone: 206-749-7701 800-221-8022 Fax: 206-320-7333	Phone: 425-261-4801 800-221-8022 Fax: 425-261-4725	Phone: 360-493-4650 800-221-8022 Fax: 360-493-4659

Please call our Access Services office to confirm our receipt of your fax.
Please use a cover sheet.

TODAY'S DATE ___/___/___ MD OFFICE CONTACT NAME _____ PHONE # ( ) _____

FAX # ( ) _____

REFERRAL INFORMATION

PATIENT'S NAME _____ _____ _____
Last First MI

DOB _____/_____/_____ SOCIAL SECURITY NUMBER (if available) _____ - _____ - _____

LANGUAGE PT SPEAKS _____ (if not English)

INTERPRETOR NEEDED: YES NO If no, **name & phone** of person who speaks English: _____, ( ) ____-_____

IS PATIENT COMPETENT TO SIGN CONSENT FOR HOSPICE CARE: YES NO **IF NO, LIST NAME OF DPOA ON NEXT LINE**

NEXT OF KIN NAME _____ RELATIONSHIP _____

HOME # _____ WORK #_____ CELL # _____

HOSPICE DIAGNOSIS _____

ATTENDING PHYSICIAN (FOR HOSPICE CARE) **_____ PHONE # _____**

Please fax the following information with this referral form (if available) :

- ☐ Face Sheet (including name, address, insurance info)
- ☐ Copy of current medication list
- ☐ Recent H&P
- ☐ Hospital D/C Summary or recent office visit notes (to describe the patient's current clinical condition)
- ☐ Copy of physician's order for hospice care