HOSPICE REFERRAL FORM

PROVIDENCE Home Services

Date: _____ Time: _____ Total # of Pages: _____

Please indicate branch below:

☐ Portland metro service area	Phone: 503-215-2273	Referral Fax: 503-215-8274
☐ Clark County service area	Phone: 360-369-6109	Referral Fax: 503-215-8274
☐ Hood River service area	Phone: 541-387-6449	Referral Fax: 541-386-6700
☐ The Dalles service area	Phone: 541-296-3228	Referral Fax: 541-386-6700
☐ Southern OR service area	Phone: 541-732-6500	Referral Fax: 541-732-6503

Please attach:

- Face sheet or patient demographics
- Most recent History & Physical
- Most recent progress notes
- All diagnostics/imaging/labs related to hospice diagnosis
- POLST form, if completed

For urgent requests, or if you prefer to call in your referral, please call a branch office at the phone number listed above. Thank you for choosing Providence Hospice.

PATIENT NAME:	**DOB:** **SEX: M F**
PRIMARY DIAGNOSIS TO HOSPICE:	**PRIMARY CONTACT FOR ORDERS/UPDATES:**
REFERRING PROVIDER **Name (Print): _____ Phone: _____** **Signature: _____**	
☐ I authorize use of Providence Hospice Admission Orders for this patient.	
☐ I would like the hospice medical staff to manage medications and symptoms related to the hospice diagnosis and end of life symptoms. I will continue to be responsible for all other medications. OR ☐ I will be responsible for all medications. I understand that hospice nurses and pharmacists will contact a Hospice Medical Staff member if hospice cannot reach me or my covering provider is unwilling or uncomfortable authorizing CII or other needed medications. Hospice Medical Staff will provide consultation and recommendations as indicated by changes in clinical status.	
COMMENTS:	