

HOSPICE REFERRAL FORM



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

Please indicate branch below:

- | | | |
|--|---------------------|----------------------------|
| <input type="checkbox"/> Portland metro service area | Phone: 503-215-2273 | Referral Fax: 503-215-8274 |
| <input type="checkbox"/> Clark County service area | Phone: 360-369-6109 | Referral Fax: 503-215-8274 |
| <input type="checkbox"/> Hood River service area | Phone: 541-387-6449 | Referral Fax: 541-386-6700 |
| <input type="checkbox"/> The Dalles service area | Phone: 541-296-3228 | Referral Fax: 541-386-6700 |
| <input type="checkbox"/> 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: _____	
<input type="checkbox"/> I authorize use of Providence Hospice Admission Orders for this patient.	
<input type="checkbox"/> 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 <input type="checkbox"/> 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:	

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