Hospice
& Palliative Care Center
Of Alamance-Caswell

Phone: ***336-532-0100***
Fax: ***336-532-0516***
www.hospiceac.org

Hospice Referral - Patient Information

Patient Name: _____ DOB: _____
Last *First* *MI*

Primary Diagnosis: _____ Secondary Diagnosis: _____

Other Comorbidities: _____

Patient Height: _____ Patient Weight: _____

Referral has been discussed with *(CHECK ALL THAT APPLY)*:

☐ Patient ☐ Primary Caregiver ☐ Family

Referral is for Hospice *(CHECK ONE)*:

☐ In-Home

☐ Independent Living, ALF, Memory Care, Skilled or LTC Community
Name of Community (If known): _____

☐ Hospice Home
**Requires prognosis of 2 weeks or less life expectancy*

Physician's Order for Hospice Services & Certification of Terminal Illness

Statement of Certification of Terminal Illness: I certify that this patient is under my care and to the best of my medical knowledge, given the data available, that this patient is terminally ill with a life expectancy of six (6) months or less if the terminal illness runs its normal course.

Hospice Attending Election *(CHECK ONE)*:

☐ I will not serve as the patient's attending physician.

☐ I will continue to serve as this patient's attending physician. If I am unavailable, I give permission for orders for this patient to be obtained from a Hospice physician/NP or an alternate physician/NP in my practice.

_____ _____
Person Making Referral Phone

_____ _____
Referring Provider (MD, DO, NP) - ***Signature*** Date

_____ _____
Referring/Supervising Provider - ***Print Name*** Date

_____ _____
Supervising Provider (For Referring NP) - ***Signature*** Date

Please Fax: - Demographics - Insurance Card - History & Physical - Last office note