Please complete and return this form to FAX (215) 486-1253

HUMANITAS

HOSPICE • PALLIATIVE CARE

PHYSICAN ORDERS

☐ Evaluate and Admit to Hospice

please choose one box below:

☐ Hospice Medical Director to assume care of the patient.

☐ Dr. _____ will remain the attending physician.

☐ Dr. _____ will remain the attending physician with Hospice Medical Director to manage symptoms and after hours needs.

Physicians: please sign to authorize HUMANITAS HEALTH SERVICES to evaluate and admit the patient, if eligible for hospice.

Physician Signature:

_____

Physician Name (print):

_____

Date: _____

Patient Name: _____

DOB: _____ SSN: _____

Residence: ☐ Home ☐ Skilled Nursing ☐ Assisted Living ☐ Other

Phone Number: _____ Zip Code: _____

Does the patient have a caregiver? ☐ Yes ☐ No

Representative/Primary Caregiver: _____

Contact Phone Number: _____

Referral by Name: _____

Referred by Agency: _____

Referred by Phone Number: _____

Are patient/family aware of hospice referral? ☐ Yes ☐ No

☐ The following documents are attached (fax) to this referral:

- ☐ Patient Face Sheet
- ☐ History & Physical
- ☐ Labs
- ☐ Pathology Reports
- ☐ Discharge Summary
- ☐ Radiology Reports
- ☐ POA/Guardian Paperwork
- ☐ POLST / DNR / DNI / DNH
- ☐ Advance Directives / Living Will
- ☐ Medicare / Medicaid / Commercial Insurance Card

☐ Please have hospice representative pick up referral documents.

Patient has ☐ Medicare ☐ Medicaid ☐ Other Commercial Insurance

MBI: _____ MCD: _____

Insurance Company: _____

Policy Number: _____ Group Number: _____

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