REFERRAL FORM

Patient name:_____ Birth date: _____

Patient location:_____

Terminal diagnosis: _____

- ☐ Evaluated (patient and/or family are aware of terminal diagnosis and prognosis)
- ☐ Admit, if appropriate

The Hospice Family Care medical director monitors all patients as required by regulation. In addition, our medical director can offer the following:
(Please indicate which level of involvement you prefer)

- ☐ The attending physician (you) will continue to manage patient and complete all paperwork.
  The medical director will be called only if the attending physician or covering physician is unavailable.
- ☐ Medical director will assume the role of attending physician.
  The referring physician (you) will be kept informed of major changes.
- ☐ Attending physician and medical director will work in collaboration.
  The medical director may make minor changes, but the attending physician (you) will make major decisions regarding patient care. Medical director may adjust pain and other symptom medication and help with paperwork. If needed, the medical director may visit patient.

Physician name (printed): _____

Physician signature: _____

Date: _____

Phone: _____

Hospice Family Care

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