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HOSPICE REFERRAL FORM

blize HEALTHCARE
your home health family

Patient Name		Height	Weight	Date of Birth	Sex ☐ M ☐ F
Patient Address					
Patient Phone	Alternate Patient Phone	DPOA/Primary Contact Name		DPOA/Primary Contact Phone	
Medicare #	Medical #	Secondary Insurance		Social Security #	

☐ Evaluate for Hospice and Admit Patient Location: ☐ Home ☐ RCFE ☐ SNF ☐ ALF

DME: ☐ Wheelchair ☐ Hospital Bed ☐ Oxygen ☐ Hoyer Lift ☐ Other: _____

DNR: ☐ YES Advanced Directive: ☐ YES ☐ NO

PHYSICIAN'S CERTIFICATION FOR MEDICARE HOSPICE BENEFIT

1. I certify that this patient is terminally ill with a life expectancy of six (6) months or less if the terminal runs its normal course. I have reviewed the patient's clinical information and considered the primary terminal condition, related diagnoses, current subjective and objective medical findings, current medication and treatment orders and information about management of unrelated conditions in making this determination.

2. The following medical disease or terminal diagnosis is the primary reason for hospice care:

   ☐ Cancer ☐ COPD ☐ End Stage Heart Disease ☐ Alzheimer's / Dementia ☐ Stroke / CVA ☐ End-Stage Renal Disease

   ☐ Failure to Thrive ☐ General Debility ☐ Other: _____

3. Co-Morbidities for Hospice Appropriateness are:

   ☐ Multiple ER visits or hospitalization, or emergency room visits more than once in the past six (6) months

   ☐ Multiple medications

   ☐ Increasing shortness of breath even while resting

   ☐ Multiple falls or several falls over the last six (6) months

   ☐ Increased assistance with ADLs

   ☐ Skin integrity/breakdown or starting to spend most of the day in chair or bed

   ☐ Recurrent/multiple infections

   ☐ Weight loss or weight loss with a noticeable difference in the way clothes fit

   ☐ Altered mental status

   ☐ Started feeling weaker or more tired than usual

   ☐ Been making more frequent phone calls to physician's office

   ☐ Other: _____

Choose One: ☐ I DO want to follow this patient ☐ I DO NOT wish to follow this patient; please have hospice medical director follow

Referring Physician		NPI #
Physician Address	Physician Phone #	Physician Fax #
Physician Signature		Date