

STEIN HOSPICE REFERRAL/INQUIRY FORM

REFERRAL DATE: _____

CALLER/REFERRAL SOURCE: _____

PHONE #: _____

PATIENT NAME: _____

PHONE #: _____

HOME ADDRESS: _____

DC DATE: _____

CURRENT LOCATION: _____

CITY/STATE/ZIP: _____

SKILLED? IF YES, WHY: _____

SS#: _____ DOB/AGE: _____ MARITAL STATUS: _____ SEX: _____

SPOUSE/CAREGIVER: _____ PHONE #: (H): _____ (W): _____

OTHER FAMILY/CAREGIVERS: _____

PREVIOUS HOSPICE INVOLVEMENT? ____Y ____N IF YES, ENTERING WHAT BENEFIT PERIOD? _____

IS PATIENT ABLE TO SIGN FOR THEMSELVES: ____Y ____N

DOES THIS PATIENT HAVE A LEGAL GUARDIAN: ____Y ____N

PROGNOSIS KNOWN BY: ____ PATIENT ____ FAMILY COMMENTS: _____

ALLERGIES/SENSITIVITIES TO MEDICATIONS: _____

PALLIATIVE CHEMO/RADIATION/OTHER: _____

APPROPRIATENESS FROM PHYSICIAN: ____ YES ____ NO/NEED TO CALL

ORDERING PHYSICIAN: _____ PHONE #: _____

ATTENDING PHYSICIAN: _____ PHONE #: _____

OTHER PHYSICIAN(S): _____

PRIMARY DX: _____ DATE OF DIAGNOSIS: _____

SECONDARY DX: _____ OTHER DX: _____

PRIMARY INSURANCE/POLICY #: _____ PHONE #: _____

SECONDARY INSURANCE/POLICY #: _____ PHONE#: _____

IF NSG FACILITY PT, HOW IS ROOM&BOARD PAID? ____ Private Pay ____ Medicaid, #: _____

IS PATIENT SKILLED? ____ YES ____ NO

Comments: