enhabit
Home Health & Hospice

Hospice referral form

Date: _____ Time: _____

Referral source: _____ Phone: _____

Referring physician: _____ Phone: _____

REFERRAL INFORMATION

Patient name: _____

Patient address: _____

Is the patient in a facility? ○ Yes ○ No If 'Yes,' name of facility: _____

Medicare #/Beneficiary Identifier (MBI): _____

DOB: _____ Diagnosis: _____

PCG/Relationship: _____ Phone: _____

Please include face sheet, H&P, med list, and any progress/lab/hospitalization notes.

HOSPICE ORDERS

_____

_____

_____

I authorize Enhabit Home Health & Hospice to evaluate the patient listed above and admit to hospice if indicated.

Physician signature: _____

Physician name (print): _____ Date: _____

Nurse practitioner signature: _____

Nurse practitioner name (print): _____ Date: _____

We will contact you within 30 minutes of receiving this form to confirm the referral. Please call if you do not hear from us within that time, or with any questions.