YOUR LOCAL CHOICE FOR LIFE CHANGING SERVICE

Hospice
Referral Form

Park Point Healthcare LLC
DBA Pasco/SW Hospice
2208 E Main St
Cortez, CO 81321
Phone: (970) 565-6833
Fax: (970) 564-8057

Patient Name:		Gender:	DOB:	SSN:

FAX

To refer your patient for Hospice Care, please fax the following documents:

- ☐ Referral Form
- ☐ Copy of Insurance Cards
- ☐ Demographic Sheet
- ☐ Most Recent Visit Note
- ☐ Current H&P
- ☐ Copy of MDPOA, Proxy/Legal Guardian

Street Address:			Apt:
City:		Zip:	Phone:
Emergency Contact:			Phone:
Medicare #:			Effective Date:
Medicaid #:			Effective Date:
Commercial Ins:		Group ID:	Plan:
Referring MD:		***NPI:**	**Phone:**
Terminal Diagnosis:			
Other Relevant Medical Co-Morbidities:			
Previous Hospice?			
If yes, Agency Name?		Benefit Period Entering?	F2F Needed? YES ☐ NO ☐

SERVICE REQUEST

- ☐ Informational Meeting Only
- ☐ Urgent Admission
- ☐ Admit Per Patient Preference
- ☐ Other: ____

CONTACT

Contact me by: We will be happy to provide regular updates regarding your patient's status/care if you wish. We will call you for new orders and changes in the patient's condition. If we are unable to reach you for urgent matters, we will contact our Medical Director as needed.

☐ **Phone:** ____________________ ☐ **Fax:** ____________________

☐ **I would like to continue overseeing this patient's care as the Attending Physician. *NPI required above!**

☐ **I would like for a Pasco/SW Hospice Medical Director to oversee this patients' care.**

Based on the patient's diagnosis and current condition, I expect that this patient has a limited life expectancy of six (6) months or less if the terminal illness runs its normal course. I hereby certify that this patient is eligible for hospice care. Please evaluate for admission to hospice.

Printed Physician Name:	*Physician Signature:*	*Date:*

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