Hospice Referral/Order Form

Artemis Hospice & Home Health
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Patient Last Name: **First Name:**	**Referral Source:** **Follow as attending physician? yes/no**
Patient Address: **The patient is currently:** ☐ **Home** ☐ **In-Hospital** ☐ **Other_____** **Does the patient live alone? yes/no**	**Physician name:** **Physician phone number:** **Physician address:**
Patient Phone Number:	**Referral Date:**
DOB: **Age:** **Gender:** **Marital Status:**	**Insurance Name and policy number:**
Race: **Religion:** **Primary Language:** **Does patient speak/understand English? yes/no**	**Additional Information: (Labs, etc)**
Diagnosis: **Allergies:**	**Co-morbidities:**
Primary Caregiver: **Relationship:** **Address and phone number:**	**POA:** **Relationship:** **Address and phone number:**

Evaluate for hospice services

I certify that the above patient is terminally ill and has a life expectancy of six months or less if the terminal illness runs its normal course. I have reviewed the patient's clinical information and considered the primary terminal diagnosis, related diagnosis, current subjective and objective medical findings, current medication and treatment orders and information about management of unrelated conditions in making this determination. I authorize Artemis Hospice & Home Health LLC to evaluate and treat the above-mentioned patient for hospice.

I would like Artemis Hospice & Home Health's Medical Director to manage symptoms. Yes/no

Verbal Order (if applicable)

Date:

Physician Name/Signature

Date:

***Please attach face sheet, insurance card, clinical record, labs, medication list, advanced directive, last physician H & P, hospital D/C summary. ***