

HOSPICE REFERRAL FORM

(Please indicate branch below)

 Providence Portland Metro Hospice

P: 503-215-CARE (2273)
F: 503. 215-8274

 Providence Hospice of the Gorge

Hood River P: 541.387.6449 F: 541.386.6700
The Dalles P: 541.296.3228 F: 541.386.6700

Please attach:

- | | |
|---|---|
| <ul style="list-style-type: none"> • Face sheet or patient demographics • Most Recent Progress Note • POLST form, if completed | <ul style="list-style-type: none"> • Most Recent History & Physical • All diagnostics/imaging/labs related to hospice diagnosis |
|---|---|

*If you prefer to call in your referral, or if this is an urgent request, please call branch office at phone listed above.
Thank you for choosing Providence Hospice.*

PATIENT NAME:	DOB: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F
PRIMARY DIAGNOSIS TO HOSPICE:	PRIMARY CONTACT FOR ORDERS/UPDATES:
REFERRING PROVIDER:	ATTENDING PROVIDER:
Phone: _____	Phone: _____
<input type="checkbox"/> I authorize use of Providence Hospice Admission Orders for this patient.	
<input type="checkbox"/> I would like the hospice medical staff to manage medications and symptoms related to the hospice diagnosis and end of life symptoms. I will continue to be responsible for all other medications.	
○ OR	
<input type="checkbox"/> I will be responsible for all medications.	
I understand that hospice nurses and pharmacists will contact a Hospice Medical Staff member if hospice cannot reach me or my covering provider is unwilling or uncomfortable authorizing CII or other needed medications. Hospice Medical Staff will provide consultation and recommendations as indicated by changes in clinical status.	
Comments:	

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