Hospice Referral Form
Fax: 434-572-6211
Phone: 434-572-0063
Email: hospice@firstcare.biz

Date:_____ No. of page (incl.cover):_____

From:_____ Phone:_____Fax:_____

Referring Physician:_____

Services Requested:

- ☐ Informational Meeting Only
- ☐ Admit Per Patient Preference
- ☐ Urgent Admission
- ☐ Other_____

Patient Name:_____DOB: _____

1. Terminal Diagnosis: _____
2. Please include the following:
   - ☐ Face Sheet/Demographics (include family contact)
   - ☐ Recent History and Physical (and last MD visit note)
   - ☐ Clinical findings supporting life expectancy of 6 months or less
   - ☐ Any pertinent consultation reports
   - ☐ Copy of Payer/Insurance Card (unless information included on face sheet)
3. I want to be (please choose one):
   - ☐ Referral MD; I understand all orders will be sent to the Hospice Physician. I am available for consultation as needed for my patient(s).
   - ☐ Attending MD; I will sign the initial Plan of Care as required by the patient's insurance, in addition to all orders regarding my patient. I understand that the 1st Care At Home Hospice Physician may be called in my absence.

******Steps 4 & 5 need to be completed only if "Attending MD" is checked***

Additional comments: _____

4. Certification of Terminal Illness must be included.
   - ➢ "Patient has a life expectancy of 6 months or less if the illness is left to run its natural course."
5. Include statement (attestation) directly above MD signature:
   - ➢ "The physician composed the narrative based on his or her review of the patient's medical record or if applicable his/her exam of the patient.

Attending/Referring Physician Signature: _____
Date: _____