

Refer a Patient



Madrona Hospice
Care and comfort in your loved one's time of need

HOSPICE REFERRAL FORM FAX 480-219-8283

REFERRAL INFORMATION			
Referred By:	Telephone:	Date:	
Patient Name (First, MI, Last):			
Home Address:	City	Zip	Home Phone #:
DOB:		English primary language? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary Family/Caregiver contact:		Relationship:	
Telephone/Home:			
PATIENT INFORMATION			
Hospice Diagnosis:		Co-morbidities:	
Patients History and Physical identify terminal diagnosis and change in condition is attached. <input checked="" type="checkbox"/> Yes		Does Attending Physician want Hospice Physician to Follow? <input type="checkbox"/> Yes <input type="checkbox"/> No	
INSURANCE INFORMATION	PRIMARY: <input type="checkbox"/> Medicare <input type="checkbox"/> AHCCCS <input type="checkbox"/> Other:		
Medicare#:	Social Security #		
ORDER TO EVALUATE AND TREAT			
<input checked="" type="checkbox"/> The above noted patient is <u>considered to be</u> terminally ill and has a life expectancy of six (6) months or less, if the terminal illness runs its normal course. <input checked="" type="checkbox"/> Physician Order for Madrona Hospice to Evaluate and Treat the <u>above named</u> patient			
_____		_____	
Physician Signature		Date	
<small>THIS COMMUNICATION IS INTENDED FOR THE USE OF THE PERSON OR ENTITY TO WHOM IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED AND CONFIDENTIAL, THE DISCLOSURE OF WHICH IS GOVERNED BY APPLICABLE LAW. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, OR THE EMPLOYEE OR AGENT RESPONSIBLE FOR DELIVERING IT TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION, OR COPYING OF THE INFORMATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS MESSAGE IN ERROR, PLEASE NOTIFY SENDER IMMEDIATELY.</small>			