VISITING NURSE SERVICE & HOSPICE OF SUFFOLK, INC.

Phone (631) 261 -7200 - Fax (631) 912-1114

HOSPICE REFERRAL

PHYSICIAN SIGNING HOME CARE ORDERS

PHYSICIAN NAME	DATE
ADDRESS	
CITY STATE ZIP	
TELEPHONE # ( )	FAX ( )
NPI #	LICENSE #
OFFICE CONTACT	TELEPHONE #

PATIENT INFORMATION

LAST NAME	FIRST NAME	
Sex ☐ Male ☐ Female	TELEPHONE #1	TELEPHONE #2
SERVICE ADDRESS		APT/BLDG#
CITY	STATE	ZIP
DATE OF BIRTH	SOCIAL SECURITY	
LANGUAGE SPOKEN BY PATIENT		
MENTAL HEALTH STATUS: ☐Oriented ☐Forgetful ☐Confused		
LIVES WITH ☐Caregiver ☐Family ☐Alone		
EMERGENCY CONTACT/RELATIONSHIP		
CONTACT TELEPHONE # DAY	EVENING	

INSURANCE INFORMATION

MEDICARE #	MEDICAID #
COMMERCIAL INSURANCE CARRIER	
POLICY #	

PRIMARY REASON FOR HOSPICE

Prognosis of less than 6 months

End Stage DX:

1. _____
2. _____
3. _____

***Mandatory attach the following:**

1. Last office note
2. Current list of meds
3. History & Physical
4. Certificate of Terminal Illness (CTI)

☐ **Home Hospice Services**
RN, MSW, HHA, Volunteer,
Pastoral Care, Nutritionist, Acupuncture

☐ **Inpatient at Hospice House**
- ☐ Pain/symptom management
- ☐ End of life care

☐ **Respite at inpatient facility**

Additional Information: _____

_____

_____

_____

_____

_____

1/7/14 mbroussa:acowles: certifiedhomehealthcarereferral(chha)

VISITING NURSE SERVICE & HOSPICE OF SUFFOLK, INC.

CERTIFICATION OF TERMINAL ILLNESS

PATIENT NAME _____

DATE OF BIRTH _____

PHYSICIAN NAME _____

DIAGNOSIS _____

The Medical Director/Nurse Practitioner of the Visiting Nurse Service & Hospice of Suffolk will assume responsibility for care of the above-named patient when the patient is admitted to the Hospice House of the Visiting Nurse Service & Hospice of Suffolk.

Certification Statement for Initial 90 Day Period

Based on the following findings, but recognizing that it is scientifically impossible to predict the exact life expectancy of any patient, and recognizing that this certification is required to obtain Medicare for insurance benefits, I am prepared to state that this patient has life expectancy of 6 months or less if the terminal illness runs its normal course.

IMPORTANT: Medicare regulations require that, as the referring physician, you prepare a brief narrative based on your examination of the patient or of his or her medical records explaining the clinical findings that support a life expectancy of six months or less. Please use the space provided below for the supporting narrative.

_____

_____

_____

_____ _____

Referring Physician Signature Date

Medical Director's Notes:

_____

_____

_____

_____ _____

Hospice Medical Director Signature Date

Attestation: By signing above, I attest that I composed the narrative based upon my review of the patient's medical record or my examination of the patient.

Verbal Order from Referring Physician (include date) _____

_____

Patient:

VISITING NURSE SERVICE & HOSPICE OF SUFFOLK, INC.

ADDENDUM

Additional Information: _____