



**VISITING NURSE SERVICE
&
HOSPICE OF SUFFOLK**

HOSPICE REFERRAL FORM

Phone: 631.930.9375 Fax Referral: 631.912.1114

Please download additional forms at: visitingnurseservice.org

PHYSICIAN SIGNING HOME CARE ORDERS		PRIMARY REASON FOR HOSPICE	
PHYSICIAN NAME		DATE	
ADDRESS			
CITY		STATE	ZIP
TELEPHONE #	FAX		
()	()		
NPI #	LICENSE #		
OFFICE CONTACT	TELEPHONE #		
PATIENT INFORMATION			
LAST NAME		FIRST NAME	
Sex	<input type="checkbox"/> Male	TELEPHONE #1	TELEPHONE #2
	<input type="checkbox"/> Female		
SERVICE ADDRESS			APT/BLDG#
CITY		STATE	ZIP
DATE OF BIRTH		SOCIAL SECURITY	
LANGUAGE SPOKEN BY PATIENT			
MENTAL HEALTH STATUS:			
<input type="checkbox"/> Oriented <input type="checkbox"/> Forgetful <input type="checkbox"/> Confused			
LIVES WITH <input type="checkbox"/> Caregiver <input type="checkbox"/> Family <input type="checkbox"/> Alone			
EMERGENCY CONTACT/RELATIONSHIP			
CONTACT TELEPHONE #			
DAY		EVENING	
INSURANCE INFORMATION			
MEDICARE #		MEDICAID #	
COMMERCIAL INSURANCE CARRIER			
POLICY #			
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)			
<input type="checkbox"/> Home Hospice Services RN, MSW, HHA, Volunteer, Pastoral Care, Nutritionist, Acupuncture			
<input type="checkbox"/> Inpatient at Hospice House <input type="checkbox"/> Pain/symptom management <input type="checkbox"/> End of life care			
<input type="checkbox"/> Respite at inpatient facility			
Additional Information: _____			

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)**
