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

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: _____

_____

_____

_____

_____

_____

VISITING NURSE SERVICE AND HOSPICE OF SUFFOLK, INC.

CERTIFICATION OF TERMINAL ILLNESS

Patient Name: _____

Date of Birth: _____

Referring/ Attending Physician: _____

Diagnosis: _____

Certification Statement for Initial 90 Day Period

Certification Period: _____ - _____
(From MM/DD/YY) (Through MM/DD/YY)

In my clinical judgement this patient has a life expectancy of 6 months or less if the terminal illness runs its normal course.

_____ _____
Referring/ Attending Physician's Signature *Date (MM/DD/YY)*

NOTE - FOR OFFICE USE ONLY:

In my clinical judgement this patient has a life expectancy of 6 months or less if the terminal illness runs its normal course. Hospice physician, please use the space below to write a brief narrative explanation, after reviewing the individual's clinical circumstances and synthesizing the medical information, to provide a clinical justification for admission to hospice services.

Hospice Physician's Narrative:

_____

_____

_____

_____

_____

_____

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

_____ _____
Hospice Physician's Printed Name *Date (MM/DD/YY)*

_____
Hospice Physician's Signature