Hospice Referral

Patient's name: ____ **DOB:** ____________________

Hospice diagnosis*:* ____

Primary care physician (if different than below)*:* ____

Date of last physician visit: ____________________

Insurance company: _________________________ *Policy number:* ___________________________

Date of hospitalization / facility discharge (if appropriate): ________________________

Allergies: ____

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Please send: ☐ H & P _______ *(please initial)* ☐ Recent progress notes _______ *(please initial)*

Hospice order: ____

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Physician's name (printed): _____________________________________ **Date:** ___________________

Physician's signature: ____

Please fax to 650.554.1018
along with patient's demographics, contact info,
insurance, and H&P/current office notes