**HOSPICE REFERRAL FORM**

Person Making Referral, Title Date of Referral

 ( )

Assigned Team and Assigned Hospice Nurse Hospice Nurse Phone

( )

Fax Hospice Nurse E-Mail

 Patient Name & Family Contact Name Date of Birth Gender

Patient’s Address & Apt or Lot Number

**TX**

City State Zip

 ( ) ( )

Patient Phone Family Contact/Alternate Phone

Hospice Diagnosis DNR Status

Please include the following information:

Face-sheet & copy of DNR Current Insurance Information Medication Care Pack

Reason for High Risk Revocation Critical Comments regarding hospice placement

These documents help us establish patient demographics, the names of the patient’s physicians, a comprehensive medical history, what medications the patient’s will be sent home with in an effort to provide a continuum of care for the patient, should our continued services be required.

Please fax: **(817) 632-0530**

Or e-mail to: **chpreferral@medstar911.org**