Pioneer Hospice of NJ

Hospice Referral Form

14 S Center St, Orange, NJ 07050 | Phone: 862-520-4151 | Secure Fax: 862-520-1866 | PioneerHospiceOfNJ.com

Please fax completed form and available clinical records to 862-520-1866. For urgent hospice needs, call 862-520-4151.

CONFIDENTIAL HEALTHCARE INFORMATION: This form may contain protected health information. Send by secure fax or other HIPAA-compliant transmission method. Do not submit this form through the public website contact form. If received in error, notify the sender and delete or destroy the information.

1. Referral Source

Referral date/time: _____

Urgency: [ ] Today [ ] Within 24 hours [ ] Routine

Facility/agency/office: _____

Unit/department: _____

Contact name/title: _____

Best callback: _____

Phone: _____

Fax: _____

Secure email: _____

2. Patient Information

Patient name: _____

DOB: _____

MRN/account #: _____

Current location: [ ] Home [ ] Hospital [ ] SNF/LTC [ ] ALF [ ] Other: _____

Room/unit: _____

Planned discharge date/time: _____

Patient phone: _____

Primary language: _____

Interpreter needed: [ ] Yes [ ] No

Responsible party/POA: _____

Relationship: _____

Phone: _____

3. Physician / Diagnosis / Eligibility Information

Primary/attending physician: _____

Phone: _____

Fax: _____

Will physician continue as attending? [ ] Yes [ ] No [ ] Unknown

NPI if known: _____

Physician group: _____

Physician aware of referral? [ ] Yes [ ] No [ ] Unknown

Prognosis of 6 months or less if illness runs its normal course? [ ] Yes [ ] No [ ] Unknown

4. Reason for Hospice Evaluation / Clinical Indicators

[ ] Functional decline / increased ADL dependence

[ ] Weight loss / decreased intake

[ ] Recurrent infections or hospitalizations

[ ] Worsening dyspnea / oxygen needs

[ ] Pain or other difficult symptoms

[ ] Wounds / skin breakdown

[ ] Cognitive decline / dementia progression

[ ] Falls / safety concerns

[ ] Dysphagia / aspiration risk

[ ] Terminal cancer diagnosis

[ ] Caregiver exhaustion / unsafe home situation

[ ] Other: _____

5. Current Clinical / Care Information

Code status: [ ] Full Code [ ] DNR [ ] Unknown

Advance directive/MOLST/POLST available? [ ] Yes [ ] No

Pioneer Hospice of NJ - Hospice Referral Form (continued)

6. Payor / Insurance Information

Insurance/plan name: _____ **Member/ID #:** _____
Subscriber name if different: _____ **Group #:** _____

7. Records Requested With Referral

[ ] Face sheet / demographics
[ ] Current medication list
[ ] Insurance cards / payor info
[ ] H&P or recent physician note
[ ] Recent labs / imaging if relevant
[ ] Advance directive / DNR / MOLST if available
[ ] Recent progress notes
[ ] Discharge summary or plan
[ ] Recent therapy or nursing notes

8. Communication and Scheduling

Best phone number for scheduling: _____

Best time to call: _____

9. Optional Physician / Practitioner Order

This section may be completed when the referral source wants the form to serve as an order to evaluate. Hospice eligibility, election, and certification are completed according to applicable payer and Medicare requirements.

Physician/practitioner name: _____

NPI: _____

Signature: _____

Date/time: _____

10. Pioneer Hospice of NJ Intake Use Only

Referral received by: _____ **Date/time received:** _____
Assigned to: _____ **Initial contact date/time:** _____

Important: Submitting this referral form does not itself elect the hospice benefit, guarantee hospice eligibility, or replace required physician certification, consent/election, plan-of-care, or payer requirements.