Friends of Hospice of the Lakeway Area
421 N. High Street
Morristown, TN 37814
423-586-5284 (O) 423-586-5274 (Fax)
Please email form to:
fohserenityhouse@gmail.com

SERENITY HOUSE REFERRAL FORM

Date of Referral: _____ **Hospice Agency**: _____

Patient Name: _____

Date of Birth/Age: _____ **Sex:** ☐M F ☐ **County of Residence**: _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Primary Diagnosis: _____

Present location of patient: ☐ **Pt's own home** ☐ **Living with family/friend** ☐ **Hospital** ☐ **ALF** ☐ **NH** ☐ **Homeless** ☐ **Other**

Home Address or Hospital Name: _____

Name/phone# of person making referral: _____

Name of patient's primary contact: _____

Relationship to patient: _____**Phone Number**: _____

Reason for Referral:
_____ Patient has no primary caregiver and is no longer able to care for self
_____ Patient has declined to the point that family is no longer able to provide needed care
_____ Patient has good family support but desires an alternative place for end-of-life care

Does the patient have a DNRO? ☐ Yes ☐ No
Is the patient taking any medications other than for comfort/palliative care needs? ☐ Yes ☐ No
Is the patient's life expectancy three months or less? ☐ Yes ☐ No
Does patient have good family support? ☐ Yes ☐ No

What is the patient's approximate weight? _____ **Height** _____
What is the patient's ambulatory status? ☐ Independent ☐ Stand-by Assist ☐ Wheelchair ☐ Bedbound
What is the patient's cognitive status? ☐ Alert ☐ Oriented ☐ Confused ☐ Dementia ☐ Non-Responsive
What is the patient's nutritional status? ☐ Regular ☐ Soft ☐ Liquids Only
What is the patient's bowel/bladder needs? ☐ Continent ☐ Incontinent ☐ Catheter

Please give brief narrative re: patient's current situation and why placement is needed: _____

_____

_____

_____

Signature/Date of Person Completing Form: _____
Updated 1/6/26