



Friends of Hospice of the Lakeway Area
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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 of person making referral: _____

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?

Is the patient taking any medications other than for comfort/palliative care needs?

Is the patient's life expectancy three months or less?

Does patient have good family support?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> 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: _____

