Referral Date: _____

St. Mary's Hospice Services, Inc.

Physician Referral Form

Patient Name: _____ DOB: _____

Address: _____ Phone #: _____

City: _____ Zip: _____ SSN: _____ Gender: ☐ M ☐ F

Current Patient Location: _____ Allergies: _____

Primary Insurance: _____ Policy #: _____

Suggested Terminal Diagnosis: _____

Co-morbid conditions: _____

Family Contact: _____ Relationship: _____

Family Address: _____ Phone #: _____

If your patient is found appropriate for hospice services, St. Mary's will provide care in accordance with your patients' needs and may include the services of a Skilled Nurse, Therapy, HHA, Social Worker, Chaplain, Volunteer, DME, medical supplies and/or medications as they relate to the patient's terminal condition. It is a pleasure for us to work with you in providing excellent end-of-life care to your patients. Should you have any questions please don't hesitate to call us.

Please select:

☐ I have attached/provided the patient's medical record supporting the patient's condition, related and co-morbid diagnoses, and related tests and treatments.

AND

☐ I will sign the initial plan of care as well as orders for care. OR

☐ I prefer Hospice Medical Director to take over patient care for Hospice.

I certify this patient is terminally ill with a life expectance of six (6) months or less if the patient condition runs its expected course. I am giving a written order to St. Mary's Hospice Services, Inc. to assess and admit if appropriate.

Physician's Name: _____ Phone #:_____ Fax #:_____

Physician Address: _____

Physician's Signature: _____ Date: _____

Hospice Medical Director Signature: _____ Date: _____

3180 E. Shields Ave #105A, Fresno, CA 93726 Phone: 559-222-1291 **Fax: 559-222-1293**