

## Physician Referral Fax Form for Mission Hospice & Home Care

Fax to: (650)554-1018

Call: (650)554-1000

Hours: 8:00 A.M. – 5:00 P.M., Monday – Friday

Requested Start-of-Care Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient's Primary Physician (if applicable): \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Name: (Last Name, First Name, MI): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ | Gender: Male \_\_\_ Female \_\_\_ | Social Security # \_\_\_\_\_

Marital Status: Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Divorced \_\_\_ Unknown \_\_\_

Resuscitation Order: Full Code \_\_\_ DNR \_\_\_ Date: \_\_\_\_\_

Medicare # \_\_\_\_\_ or Medi-Cal # \_\_\_\_\_ or

Private Insurance \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber \_\_\_\_\_

Primary Hospice DX (and date): \_\_\_\_\_

Secondary DXs (and date): \_\_\_\_\_

Surgery/Procedures (and date) – if applicable: \_\_\_\_\_

The current medical condition(s) that the clinician needs to assess and treat: \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: NKDA \_\_\_ Other: \_\_\_\_\_

Orders: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE FAX PERTINENT HISTORY AND PHYSICAL

We will call you back within two hours of receiving this form to confirm the referral. Please call us at (650)554-1000 if you do not hear from us within that time or regarding any questions. To make a referral after hours, please call (650)554-1000 and ask to speak to the administrator on call.