



**Mission
Hospice**

Affiliated with By the Bay Health

Hospice Referral Request from Physician

To: Mission Hospice Admissions Team Date: _____ No. of pages (incl. cover): _____

From: _____ Phone: _____ Fax: _____

Re: Hospice Referral Referring Physician: ☐

Services Requested:

☐ Informational Meeting Only ☐ Admit per Patient Preference ☐ Urgent Admission

☐ Other: _____

Please complete this form and fax to the number below

Phone: 650.554.1000

Fax 650.554.1001

Patient Name: _____

Social Security No.: _____ Date of Birth: _____

1. Terminal Diagnosis: _____

2. Please include the following:

- ☐ Face Sheet/Demographics (include family contact)
- ☐ Recent History and Physical (and last MD visit note)
- ☐ Any pertinent consultation reports
- ☐ Copy of Payer/Insurance Card (unless information included on face sheet)

3. I want to be (please choose one):

- ☐ **Consulting MD:** I understand all orders will be sent to the Hospice Physician. I am available for consultation as needed for my patient(s).
- ☐ **Attending MD:** I will sign the initial Plan of Care and Certification of Terminal Illness as required by the patient's insurance, in addition to all orders regarding my patient.
I understand that the BTBH Hospice Physician may be called in my absence.

Additional comments: _____

☐ Make this an ongoing preference for all my patients.

4. Based on the patient's diagnosis and current condition, I expect this patient has a limited life expectancy of six (6) months or less, if the terminal illness runs its normal course, and hereby certify that this patient is eligible for hospice care.

Physician Signature

Date

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