HOSPICE OF ORLEANS
Phone 585-589-0809
Fax 585-589-5304

HOSPICE REFERRAL

PHYSICIAN SIGNING HOME CARE ORDERS

PHYSICIAN NAME	DATE
ADDRESS	
CITY STATE ZIP	
TELEPHONE # ( )	FAX ( )
NPI #	LICENSE #
OFFICE CONTACT	TELEPHONE #

PATIENT INFORMATION

LAST NAME	FIRST NAME	
Sex ☐ Male ☐ Female	TELEPHONE #1	TELEPHONE #2
SERVICE ADDRESS		APT/BLDG#
CITY	STATE	ZIP
DATE OF BIRTH	SOCIAL SECURITY	
LANGUAGE SPOKEN BY PATIENT		
MENTAL HEALTH STATUS: ☐Oriented ☐Forgetful ☐Confused		
LIVES WITH ☐Caregiver ☐Family ☐Alone		
EMERGENCY CONTACT/RELATIONSHIP		
CONTACT TELEPHONE # DAY	EVENING	

INSURANCE INFORMATION

MEDICARE #	MEDICAID #
COMMERCIAL INSURANCE CARRIER	
POLICY #	

PRIMARY REASON FOR HOSPICE

Prognosis of less than 6 months

End Stage DX:

1. _____
2. _____
3. _____

***Mandatory attach the following:**

1. Last office note
2. Current list of meds
3. History & Physical
4. Certificate of Terminal Illness (CTI)

☐ **Home Hospice Services**
RN, SW, HHA, Volunteer,
Pastoral Care

☐ **Inpatient at Martin Linsin Residence**
- ☐ Pain/symptom management
- ☐ End of life care

Additional Information: _____

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