LIGHTHOUSE HOSPICE GROUP

GUIDANCE THROUGH LIFE'S TRANSITIONS

[ ] Hospice Consult, Education, and Admit if appropriate

[ ] PLEASE CHECK IF THE FAMILY HAS BEEN NOTIFIED ABOUT HOSPICE REFERRAL

Referring Physician:	Patient Name:
Physician's Office Phone:	Patient's Address: Patient's Phone:
Physician's Office Fax:	DOB: SSN:
Referring Hospice Diagnosis/Codes:	Insurance Info: [ ] Medicare ID#: [ ] Medicaid ID#: [ ] Private Pay Insurance Name and ID#:
Alert and Oriented, and able to sign for self [ ] Contact POA, not able to sign for self [ ]	POA/Caregiver's Name: Address: Phone:

[ ] Please attach the following documentation when faxing order:

1. face sheet/demographics
2. labs
3. history and physical
4. discharge summary
5. Most recent visit notes
6. copy of Medicare/Medicaid or private insurance card
7. copy of patient's Social Security card

Physician, please sign here to authorize Lighthouse Hospice Group to evaluate and treat the patient if appropriate.

Physician's Signature: _____ Date: _____

Physician's Name (PRINT): _____

Lighthouse Hospice Group

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