

**HOSPICE FAX REFERRAL FORM**



<b>PROVIDENCE HOSPICE OF SEATTLE</b>	<b>PROVIDENCE HOSPICE AND HOMECARE OF SNOHOMISH</b>	<b>PROVIDENCE SOUND HOME-CARE AND HOSPICE</b>
Phone: 206-749-7701 800-221-8022	Phone: 425-261-4801 800-221-8022	Phone: 360-493-4650 800-221-8022
Fax: 206-320-7333	Fax: 425-261-4725	Fax: 360-493-4659

**Please call our Access Services office to confirm our receipt of your fax.  
Please use a cover sheet.**

TODAY'S DATE \_\_\_/\_\_\_/\_\_\_ MD OFFICE CONTACT NAME \_\_\_\_\_ PHONE # ( ) \_\_\_\_\_  
FAX # ( ) \_\_\_\_\_

**REFERRAL INFORMATION**

PATIENT'S NAME \_\_\_\_\_  
Last First MI

DOB \_\_\_/\_\_\_/\_\_\_ SOCIAL SECURITY NUMBER (if available) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

LANGUAGE PT SPEAKS \_\_\_\_\_ (if not English)

INTERPRETOR NEEDED: YES NO If no, name & phone of person who speaks English: \_\_\_\_\_, ( ) \_\_\_\_\_ - \_\_\_\_\_

IS PATIENT COMPETENT TO SIGN CONSENT FOR HOSPICE CARE: YES NO IF NO, LIST NAME OF DPOA ON NEXT LINE

NEXT OF KIN NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

HOME # \_\_\_\_\_ WORK # \_\_\_\_\_ CELL # \_\_\_\_\_

HOSPICE DIAGNOSIS \_\_\_\_\_

ATTENDING PHYSICIAN (FOR HOSPICE CARE) \_\_\_\_\_ PHONE # \_\_\_\_\_

**Please fax the following information with this referral form (if available) :**

- Face Sheet (including name, address, insurance info)
- Copy of current medication list
- Recent H&P
- Hospital D/C Summary or recent office visit notes (to describe the patient's current clinical condition)
- Copy of physician's order for hospice care

*Privileged and Confidential Communication:* The information contained in this facsimile is privileged, confidential and otherwise exempt from disclosure and is intended solely for the use between the referral source and Providence Health and Services. If you have received this facsimile in error, please call 800-221-8022 immediately.