



CONTINUUM HOSPICE CARE REFERRAL FORM © 2009

PLEASE COMPLETE AS MUCH INFORMATION AS POSSIBLE TO MAKE A PHONE REFERRAL TO FAX A REFERRAL
1-212-420-3370 **1-212-844-7605**
 REVIEW PATIENT FOR (SELECT ONE):
 IPU @ BETH ISRAEL-4K (GIP) | ZICKLIN RESIDENCE
 HOME HOSPICE | SNF -PRI SENT TO _____
REFERRAL SOURCE: _____
TELEPHONE #: _____ **DATE:** ____/____/____

PATIENT'S INFORMATION		
LAST NAME		FIRST NAME
SEX: MALE FEMALE	TELEPHONE #1	
RELIGION	TELEPHONE #2	
ADDRESS		APT./STE. #
CITY	STATE	ZIP
DATE OF BIRTH		SOCIAL SECURITY #
LANGUAGE	ETHNICITY	MARITAL STATUS
MENTAL HEALTH STATUS: <input type="checkbox"/> Alert & Oriented <input type="checkbox"/> Forgetful <input type="checkbox"/> Confused <input type="checkbox"/> Lethargic		PT LIVES WITH: <input type="checkbox"/> Caregiver <input type="checkbox"/> Family <input type="checkbox"/> Alone <input type="checkbox"/> Nursing Home
PT'S CURRENT LOCATION: <input type="checkbox"/> RH <input type="checkbox"/> SL <input type="checkbox"/> LICH <input type="checkbox"/> KHD <input type="checkbox"/> BI <input type="checkbox"/> HOME OTHER / RM #: _____		
EMERGENCY CONTACT/RELATIONSHIP:		
ADDRESS:		
PHONE: _____ ALT PHONE: _____		

REVIEW ASSESSMENT
HOSPICE DIAGNOSIS: _____
Cancer Mets: _____
Heart Disease (EF) _____
Dementia/Alzheimer's (Fast) _____
Liver Disease (INR >1.5) _____
Pulmonary Disease FEV>30%, O2 sats>88%, Dyspnea at rest _____
Other DX: _____
Comorbidities: _____
Other PMH: _____
PO Intake: <input type="checkbox"/> Fair <input type="checkbox"/> None <input type="checkbox"/> _____
Karnofsky/Palliative Performance Scale: _____
Recent infections: <input type="checkbox"/> Contact Precaution: _____ <input type="checkbox"/> Isolation: _____

REQUIREMENTS FOR IN-PATIENT UNIT
<input type="checkbox"/> SYMPTOM CONTROL: <input type="checkbox"/> SEIZURES <input type="checkbox"/> CONFUSION AGITATION <input type="checkbox"/> NAUSEA AND VOMITING, INTRACTABLE <input type="checkbox"/> PAIN, UNCONTROLLED TO DATE <input type="checkbox"/> RESPIRATORY DISTRESS <input type="checkbox"/> OTHER: _____
<input type="checkbox"/> MEDICATION REGIMEN IS COMPLEX: <input type="checkbox"/> PCA: _____ <input type="checkbox"/> IV ANTIBIOTICS: _____ <input type="checkbox"/> OTHER: _____
<input type="checkbox"/> OTHER: <input type="checkbox"/> COMPLEX AIRWAY MANAGEMENT <input type="checkbox"/> SURGICAL PROCEDURE: _____ <input type="checkbox"/> WOUND CARE, COMPLEX <input type="checkbox"/> ANXIETY; ACUTE, REQUIRES INTENSIVE SUPERVISION AND MEDICAL MANAGEMENT <input type="checkbox"/> SUICIDE WATCH <input type="checkbox"/> PATIENT IS ACTIVELY DYING AND HOSPITAL IS LOCATION PREFERRED BY PATIENT
<input type="checkbox"/> END OF LIFE CARE (< 1 WEEK)

ALLERGIES
PLEASE LIST:

PHYSICIAN SIGNING HOSPICE CARE ORDERS	
PHYSICIAN'S NAME	
TELEPHONE #	FAX #
NPI #	LICENSE #
OFFICE CONTACT PERSON	
PHYSICIAN SIGNATURE (below)	DATE
I certify that this individual's prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course	
<input type="checkbox"/> MD will continue to follow pt <input type="checkbox"/> MD wants hospice MD to follow	

COMPLEX TREATMENTS
* VENT? <input type="checkbox"/> Yes <input type="checkbox"/> No BIPAP? <input type="checkbox"/> Yes <input type="checkbox"/> No Settings: _____
PEG tube? <input type="checkbox"/> Yes <input type="checkbox"/> No Other Device: _____
Is pt receiving Chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name/Duration/Cycle: _____
Is pt receiving Radiation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Duration/Site: _____
* ATTENDING MUST SPEAK TO HOSPICE MD ON ALL VENT PTS

INSURANCE INFORMATION	
<input type="checkbox"/> MEDICARE # <input type="checkbox"/> PVT PAY	<input type="checkbox"/> MEDICAID#
<input type="checkbox"/> PRIVATE INS. POLICY #	<input type="checkbox"/> MCD. PENDING
APP. SENT: ____/____/____	

ADVANCED DIRECTIVES
<input type="checkbox"/> DNR <input type="checkbox"/> DNI <input type="checkbox"/> HCP/Agent <input type="checkbox"/> Living Will
GAIT / AMBULATORY STATUS ACTIVITIES
<input type="checkbox"/> Bed bound <input type="checkbox"/> Up as tolerated <input type="checkbox"/> Activity as tolerated
<input type="checkbox"/> Walker <input type="checkbox"/> Bed to Chair <input type="checkbox"/> Non-Ambulatory
DISPOSITION
<input type="checkbox"/> Eligible for GIP-Approved by HMD/Designee
<input type="checkbox"/> Transfer to another facility @ RHC LOC <input type="checkbox"/> Transfer Home
<input type="checkbox"/> Eligible for Zicklin Residence <input type="checkbox"/> Request Clinicals (H+P, Summary)