Hospice of Westchester

HOSPICE REFERRAL FORM

Fax to: (914) 559-3092
Phone: (914) 682-1484
1025 Westchester Ave., Ste. 200, White Plains, NY 10604
www.hospiceofwestchester.org

PATIENT INFORMATION	
Patient Name	
Date of Birth	Social Security
Home Phone	Cell Phone #
Address	Apt/ Bldg #
City	Zip
Lives With	
Emergency Contact	
Relationship to Patient	
Contact Home Phone #	Contact Cell Phone #

PHYSICIAN INFORMATION	
Physician Name	
Telephone	Fax
Email:	
Verbal Cert Obtained	Date:
HOW Signature:	

INSURANCE INFORMATION
Insurance Company
Insurance ID #

No further aggressive treatment ☐ MD willing to sign death certificate ☐ MD willing to participate in plan of care/ order meds ☐

I certify that the above beneficiary is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

Terminal Diagnosis: ______________________________

*Attach: H&P/ Clinical note to this referral

BRIEF NARRATIVE STATEMENT (review the individual's clinical circumstances and synthesize the medical information to provide clinical justification for admission to hospice services). **NOTE:** Dementia and failure to thrive are NOT hospice appropriate diagnoses.

Attestation: I confirm that I composed this narrative and it is based on my review of the patient's medical record and/or examination of the patient.

______________________	______________________	________
Name of Attending Physician	Signature of Attending Physician	Date
_Gary Tatz_______________	______________________	________
Name of Hospice Medical Director	Signature of Hospice Medical Director	Date

Effective Date of Certification: ________

Benefit Period from: ________ **to:** ________

PLEASE COMPLETE IMMEDIATELY AND FAX TO ALLOW FOR PROMPT EVALUATION OF YOUR PATIENT.
THANK YOU