



HOSPICE REFERRAL

Referring Facility: _____ Referring Date: _____

PATIENT INFO

Patient Name: _____ DOB: _____ Sex: Male Female
Address: _____
City: _____ State _____ Zip: _____ Phone: _____
DPOA: Yes No DPOA Contact: _____ Contact #: _____ Relationship: _____

COVID-19 SCREENING

Has the patient or your facility been exposed to positive COVID-19 cases in the last 14 days? Yes No

PRIMARY INSURANCE

Payer: Medicare MBI # _____
 Medicaid Provider One # _____
 Insurance: _____ Policy # _____

PHYSICIAN INFO

Primary/Referring MD for Hospice Order: _____ MD Phone #: _____

Will Referring MD continue as patient's Hospice Attending MD? Yes No

If no, name of patient's Hospice Attending MD (if known): _____ MD Phone #: _____

DOCUMENTATION NEEDED

- History & Physical
- Progress Notes
- Reason for hospice (*can be embedded in progress notes or noted below*)
- Nursing Notes
- CTI (**Certification of Terminal Illness**) → Verbal CTI accepted (*please see below for signatures*)
- Copy of DPOA (*if applicable*)
- Copy of POLST (*if applicable*)

*** Please fax the documentation needed, completed referral form, and hospice order including diagnosis to 206-805-1931.**

HOSPICE ORDER/REFERRAL

I am referring this patient to hospice with the following recommended terminal diagnosis: _____

CTI (CERTIFICATION OF TERMINAL ILLNESS)

I certify that the patient's prognosis is six months or less if the condition takes its normal course.

PHYSICIAN SIGNATURE

Print Physician Name _____ Physician Signature: _____ Date: _____

VERBAL CTI

Signature/Credential of Clinician receiving verbal CTI from Physician: _____
Name of Contact Person: _____ On behalf of Dr. _____ Date: _____