HOSPICE REFERRAL FORM



We are honored that you are referring one of your patients to us

here at **Bright Horizon Hospice**.

You may create a hospice referral by completing the simple form below and faxing to **(559) 443-0003**. Please remember to call to verify receipt of the fax transmission. A Bright Horizon Hospice representative will follow up with you once we initiate the referral.

If you require any assistance, or would like to provide additional details by phone, please contact us directly at (**559) 443-0303**.

**Start of Care Requested by: \_\_\_ / \_\_\_ / \_\_\_**

Any information shared will be protected in accordance with HIPAA and Bright Horizon Hospice’ Privacy Policy. Unless there is a specific request that we contact the patient directly a Bright Horizon Hospice representative will always contact the referring office prior to contacting the patient.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Referring (Primary) Physician: | | | | | Office Contact (name & #): | | | | |
| Patient: | | Phone: | | | | DOB: | | Referring Diagnosis: | |
| Full Address: | | | | | | | | | |
| Emergency Contact: | | | | Phone: | | | Relationship: | | |
| Insurance Type: | | | | Number: | | | | SSN: | |
| Does patient live alone? | Does another person need to be present during eval? (reason/contact): | | | | | | | | |
| Pertinent History (medical/surgical/social): | | | | | | | | | Allergies: |
| Prognosis:  3 months  6 months  Other (describe): | | | | | | | | | |
| Advance Directive Discussed? | | | Outcome: | | | | | | |
| Other requests or information: | | | | | | | | | |