Tranquil Care HOSPICE

3250 Ocean Park Blvd., Suite 120
Santa Monica, Ca 90405
Tel: (310) 264-8431
Facsimile: (310)829-6032

REQUEST FOR HOSPICE SERVICES

Requested Start of Care Date (on or before):

[/ /]

Gender: D Male D Female

FROM:
Doctor/Facility: _____
Address_____
Fax#_____
Phone#:_____
Contact Name:_____
Total# of Pages: _____

Patient Name: _____DOB_____
Address: _____
Phone:_____ Medicare #_____
Family Contact:_____ Relationship_____Phone:_____
Gender: ❒ Male ❒ Female
Medical Information/Reason for referral:_____

PHYSICIAN ORDER FOR HOSPICE SERVICES

Diagnosis: I certify that this patient has a terminal diagnosis with a prognosis of 6 months or less if the disease runs its normal course.

❒ Cancer: Type: _____ ❒CHF ❒ IHD ❒ Alzheimer's disease

❒ Dementia ❒ General Debility ❒ Renal Failure ❒ End Stage Liver Disease

❒ Other_____

_____Evaluate and Admit to Hospice Services if appropriate
_____Education Meeting with patient and family
_____I will follow my patient as attending while they are on Hospice care
_____Pt is a DNR

Other orders/SpecialNeeds:_____

Printed Name of Physician:_____

Signature of Physician_____Date:_____

Form completed by: _____ Date:_____

Please attach these essentials:

***FACE SHEET *Copy of Insurance Card * Med List *H & P**

FAX TO: (310) 829-6032 **TELEPHONE**: (310) 264-8413

THANK YOU FOR YOUR REFERRAL!

Revised 1/18/16

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