Health Services of the Pacific – Hospice
415 Chalan San Antonio PMB 101-357
Tamuning, GU 96913
Ph. (671) 647-5356 * Fax (671) 649-0404
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☐ Admit Date
☐ Reassess Time
Case Manager:

Medical Record #:

HOSPICE REFERRAL/INTAKE

☐ HP ☐ HME

Disaster Code:

Name: *(Last, First, M.I.)*			Phone #:	
Mailing Address:			Residential Address:	
SSN:	Date of Birth:	AGE:	SEX: M F	RACE:
Marital Status: S M D W	Emergency Contact:		Relation:	Phone#:
Primary Insurance: Medicare Part A **(only)**			Effective Date:	
Primary Caregiver(s): Contact Number(s):			Person(s) with Power of Attorney: Contact Number(s):	
Referring Physician: Contact Number(s): Fax No.			Address:	

Referring Terminal Diagnosis: Is Patient aware of diagnosis? ☐ Yes ☐ No Is Patient on DNR Status? ☐ Yes ☐ No

Medical History (brief summary)

Referral Orders: ☐ Hospice Program Evaluation ☐ Hospice Care

☐ Other: _____

Diabetic: ☐ Yes ☐ No Ht: Wt:

Medications:

Referral taken by:

Date:

Allergies:

Diet:

Language spoken:

I authorize Health Services of the Pacific – Hospice to provide hospice care for my patient. The patient is under my care and requires hospice care under the Medicare Hospice Program. Patient will continue to be managed by me through the Plan of Care and will be re-evaluated in 90 days.

I authorize the Hospice Medical Director (Dr. Peter Brooks) to work with me in the care of my patient.
[Initial]

Case reviewed, _____, and in my professional opinion, _____
[Date of Review] [Patient Name]
is termanilly ill with a prognosis of six (6) months or less. As such he/she is eligible for the services of Health Services of the Pacific-Hospice (HSP-Hospice).

Verbal Order/Read Back: MD _____

RN/PT Print and Sign: _____ **Date:** _____

Physician Print and Sign: _____ **Date:** _____

Hospice Medical Director Print and Sign: _____ **Date:** _____