Hope Hospice
6377 Clark Ave., Ste. 100
Dublin, CA 94568
HopeHospice.com
Office: (925) 829-8770
FAX: (925) 829-0117

Hospice Referral Form

PATIENT INFORMATION

Patient name ______________________________ DOB ________________

Contact person and relationship to patient ______________________________

Phone: ________________ Medicare/insurance number ______________________

DIAGNOSIS DETAILS

Diagnosis ______________________________

Special orders ______________________________

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Along with this completed form, please provide the following by **FAX to (925) 829-0117**.

❒ Face sheet ❒ H&P, if recent ❒ List of current medications ❒ Recent labs

PHYSICIAN INFORMATION

Physician name (print) ______________________________

Signature ______________________________ Date ________________

I assume medical oversight for the duration of this patient's hospice care. ❒ YES ❒ NO

If No, oversight will divert to Hope Hospice MD.

NOTICE: This fax may contain confidential Protected Health Information (PHI). Hope Hospice, Inc., is required by the U.S. Department of Health and Human Services' Health Insurance Portability and Accountability Act (HIPAA) to adhere to administrative, technical, and physical safeguards to ensure integrity and confidentiality and protect against any reasonably anticipated threats to, or hazards of, such information or any reasonably anticipated unauthorized uses or disclosure by your office, employees, or officers. This fax is intended for use by the individual or entity to whom it is addressed. If you are not the intended recipient, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify our Privacy Officer immediately at (925) 829-8770.