MJHS®
HOSPICE AND PALLIATIVE CARE

Referral Form

mjhsreferrals.org | Email: **hospicereferrals@mjhs.org**
Phone: **(212) 420-3370** | Fax: (718) 759-4618 / (212) 844-7605

Refer to: ☐ Hospice ☐ Palliative Care **Date:** ___ / ___ / ____

PATIENT INFORMATION

First Name _____
Last Name _____
Address _____ Apt/Flr ____
City _____ State _____ Zip _____
Home Phone _____
Date of Birth ____/____/____ Age _____
SSN _____
Religious Preference _____ _____
Race _____ Marital Status _____
Primary Language _____

CAREGIVER/HEALTH CARE PROXY INFORMATION

Caregiver _____
Relationship _____
Address _____ Apt/Flr ____
City _____ State _____ Zip _____
Home Phone _____
Cell Phone _____
Health Care Proxy _____
Relationship _____
Home Phone _____
Cell Phone _____

Insurance	**Policy Holder**	**Policy Number**	**Contact No.** (if available)

REFERRAL SOURCE/PHYSICIAN INFORMATION

Referral Source _____ Telephone _____
Address _____
Referring Physician _____ Telephone _____
Address _____ NPI _____
Primary Physician _____ Telephone _____
Address _____ NPI _____

CLINICAL INFORMATION

Diagnosis: _____ **Dx Known by:** ☐ Patient ☐ Family

Was this patient receiving hospice services before? ☐ YES ☐ NO Hospice's Company Name: _____

☐ **Evaluate and admit to hospice, if eligible** **Date:** ____/____/____
Diagnosis with prognosis of 6 months or less, if disease runs its normal course

Physician's Signature _____ Physician's Name _____

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