Collabria Hospice

Fax to: Collabria Hospice 707.258.9088

REQUIRED INFORMATION

Patient Name: _____ Gender: M F DOB: _____

Patient's Address: _____

Person to Contact: _____ Phone Number: _____

SS#: _____ Insurance #: _____

Hospice Diagnosis: _____

Attending Physician: _____ Physician Phone Number: _____

Referral Contact Name: _____ Referral Contact Phone: _____

DOCUMENTATION NEEDED:

Please provide the following supporting documentation as appropriate:

- Patient face sheet/demographics
- History & Physical
- Discharge Summary
- Office & Consult Notes
- Labs/Radiology/Path Reports

Comments: _____

_____

_____

FOR PHYSICIAN ONLY:

Based on the patient's diagnosis and current condition, I expect this patient has a limited life expectancy of six (6) months or less, if the terminal illness runs its normal course, and hereby certify that this patient is eligible for hospice care. Please evaluate for admittance to hospice.

_____ _____

PHYSICIAN SIGNATURE DATE

_____

PHYSICIAN NAME (PRINT)