WILSHIRE HOSPICE

Requested Start of Care Date (on or before):

/ /

Patient Name: _____

Phone: _____

Gender: ☐ Male ☐ Female

MEDICARE #: _____

FROM:

Doctor/Facility: _____

Contact Name: _____

Date: _____

Fax#: _____

Phone#: _____

Total # of Pages: _____

Reason for Hospice referral: _____

Diagnosis: _____

☐ Evaluate and Admit as appropriate

☐ I will follow my patient as Attending Physician while they are on Hospice care.

☐ Pt is a DNR _____

Other Orders/Special Needs:

_____

_____

_____

Signature: _____ Date: _____

Printed Name: _____

Form completed by: _____ Date: _____

Please attach these essentials:

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

FAX TO: (805) 782-8614 **TELEPHONE**: (805) 782-8608

THANK YOU FOR YOUR REFERRAL!