



# WILSHIRE

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## HOSPICE

**Requested Start of Care Date (on or before):**

**FROM:**

/  /

Doctor/Facility: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Date: \_\_\_\_\_

Gender:  Male  Female

Fax#: \_\_\_\_\_

Phone#: \_\_\_\_\_

MEDICARE #: \_\_\_\_\_

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!**