VNH
VISITING NURSE and HOSPICE
for VERMONT and NEW HAMPSHIRE
A Dartmouth-Hitchcock Affiliate

Hospice Patient Referral Form

(Please fill out completely. If PCP is a PA/NP/ARNP *please include covering MD*)

Please fax each unique patient referral independently

Patient Name: _____ ***DOB:**_____

PHYSICAL Address (no PO boxes): _____

Mailing Address_____

Phone # for PATIENT: *Home:*_____

Emergency Contact Name & Phone #:_____

Discharging Facility/Physician:_____

Name &Title of Person Making Referral:_____**Phone#:**_____

Primary Diagnoses:_____

MD who will Sign Care Plan & Orders:_____**Phone#:**_____

Primary Care MD only:_____**Phone#:**_____

Referral Date: _____ **Start of Care Date:** _____

***Insurance Company:**	***Policy #:**

Requested services:

☐ **Hospice Admission** ☐ **Hospice Informational**

ALSO INCLUDE:

☐ **PATIENT DEMOGRAPHICS-** ☐ **UPDATED MED LIST-** ☐ **DC SUMMARY**

☐ **RECENT HISTORY&PHYSICAL-** ☐ **OFFICE NOTES--** ☐ **SIGNED MD ORDERS**

THANK YOU FOR CHOOSING VNH

Admissions/Referrals: phone: (800) 575-5162/ fax: (603) 298-0465
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