Hospice *of* New York

Serving Manhattan, the Bronx, Brooklyn Queens and Nassau

Referral to Hospice

Phones: 718-472-1999 / 516-222-1211 Fax: 718-472-4570

Patient Information

Last Name First Name MI

Street Address Apt. #

City State Zip

Home Phone ___-___-___

Cell Phone ___-___-___

Insurance: Medicare☐ Medicaid ☐

Other ☐ (specify) ___

Policy # ___

Date of Birth ___/___/___

Social Security # ___-___-___

Marital Status: Married☐ Single☐ Widowed☐ Domestic Partners ☐

Ethnicity: Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Other ☐

Religion: ___ Sex: M☐ F☐

Check those items that the patient has:

Health Care Proxy ☐ DNR ☐ Power of Attorney ☐

Living Will/Advanced Directives ☐

Patient Location:

Home ☐ Hospital ☐ SNF ☐ ALF ☐

Facility Name ___

Contact Person / Proxy / Designee

Last Name First Name MI

Relationship to Patient ___

Street Address Apt. #

City State Zip

Home Phone ___-___-___

Cell Phone ___-___-___

Medical Information

Primary Dx: ___

If cancer, primary site: ___

Metastases site(s) if any: ___

Allergies: ___ NKDA ☐

Clinical information attached:

Labs ☐ Medical Record ☐ H&P ☐ Face Sheet ☐

Referral Source

Last Name First Name MI

Hospital / SNF / Agency

e-mail ___

Office Phone ___-___-___

Cell Phone ___-___-___

Fax ___-___-___

Referring Physician Information

Last Name First Name MI

Street Address Apt. #

City State Zip

Office Phone ___-___-___

Cell Phone ___-___-___

Fax ___-___-___

NPI# ___ UPIN# ___

Specialty: ___ License # ___

Community Physician: ___

Office phone ___-___-___

Please Indicate: (check ONE)

☐ I will continue as the primary physician

If I am not available, the hospice physician may write orders

☐ I refer this patient to the hospice designated physician

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