Hospice Rapid Referral Form

Patient Name _____ DOB _____

Primary contact Person _____

Best contact phone number for Patient or Family _____

Lives in: ❍ Boise ❍ Caldwell ❍ Eagle ❍ Emmett ❍ Kuna ❍ Meridian ❍ Nampa

I Certify that this patient has a terminal diagnosis of _____ and has 6 months or less to live if disease runs its normal course.

Clinical team admit patient within: ❍ 1 hour ❍ 2 hours ❍ 4 hours ❍ Call to schedule non-emergent admission

Please tell us your preference in regards to contact and orders.

❍ Contact me for all orders. They will be signed either by myself or my covering Physician/PA/NP.

❍ Contact me for initial plan of care. Hospice medical director may cover all orders related to terminal illness.

❍ Transfer care to Keystone Medical Director. I will be available for consults as needed for continuity of care.

DME needed immediately: ❍ Hospital Bed ❍ Walker ❍ Wheel Chair ❍ Bed side commode ❍ Oxygen

Special considerations: ❍ Wounds ❍ Significant pain ❍ Central Line Access ❍ Psycho-social concerns

Complementary Medicine: ❍ Massage Therapy ❍ Acupuncture ❍ Reiki ❍ Aroma Therapy ❍ Cranial Sacral

_____

MD/DO signature

Keystone hospice

1159 E Iron Eagle Dr., Ste 170H, Eagle, ID 83616
P: 208.996.8181 • F: 208.228.5233

We Honor Veterans