Hospice
and Palliative Care of Greensboro

HPCG Referral Fax 336.478.2541

To confirm receipt of fax, call the HPCG Referral Center: 336.621.7575

Date:________________

Patient Name:____

Date of Birth:______/______/______ **SSN:**____________________

Physician Order for: *(check appropriate boxes)*

❒ HPCG staff to assess prognosis and eligibility for admission to HPCG. Admit if eligible.
❒ This patient is considered terminally ill and has a life expectancy of six months or less, if the terminal illness runs its normal course.

Reason(s) for Referral: *(check appropriate boxes)*

❒ Symptom management ❒ Frequent ED/Hospital visits ❒ Caregiver concern ❒ Functional decline ❒ Weight loss
Additionalcomments:____

Physician Order Requests:

Attending: *(circle one)* I will / will not continue to serve as this patient's attending physician.

Symptom Co-Management/Menu of Services: *(please check one)*

❒ I prefer the HPCG physician be involved comprehensively in this patient's symptom management on an ongoing basis; this includes prescribing medicines and if necessary, making visits.
❒ I prefer the HPCG physician be involved on a limited basis with this patient, restricted to regulatory requirements for certification, re-certification, overseeing the hospice plan of careand in emergencies.

Previous Hospice Patient?

❒Yes ______________________ ❒No
(where)

Home Health Vendors Currently Involved?

❒Yes ______________________ ❒No
(who)
❒Home Care ❒Therapies ❒DME

Fax these medical records (if applicable) with this sheet for proof of diagnosis/continuity of care to 336.478.2541

Terminal Illness:____

1. Demographic/patient information form.
   - Contacts.
   - Reimbursement information.
2. Medical problem list.
3. Medication list.
4. Current wt. Wts. last six to 12 months.
5. Recent labs including CBC, CMET (for albumin).
6. CXR, CT scan, MRIs, bone scan, PET scan, ultrasound reports.
7. Two-D Echo, cardiac cath records including EF (most recent).
8. Recent office visit notes.
9. Treatment plan/chemo and/or radiation therapy plans.
10. List of ongoing cafe/procedures at day hospital.
11. PFTs/ABG records, oxygen requirements, pulse oxygenation.
12. Tube feeding, TPN, IV fluid needs.
13. Skin care needs, VAC system.
14. Code status and goals of care (possibly verbal).

______________________	______________________	___/___/___	___:___ a.m. p.m.
Referring Physician Name (print)	**Physician Signature** (required)	**Date**	**Time**

HPCG Referral Center: Monday-Friday 8:30 a.m. - 5 p.m. 336.621.7575
For emergency needs after business hours and on weekends, call 336.621.8800.