One Good Hospice, Inc.
3148 W. Willow Ave, Clovis Ca 93612
Office: (559)388-8633
Fax: (559)878-4029

Patient Referral Form

Thank you for your referral to One Good Hospice, Inc. To ensure promptness of services to your patient, please provide the information listed below. Intake and admission services are performed 7 days a week.

If you have any questions, please contact (559)878-4029

Please send the following information
• **Demographics with current address** (Face sheets with address accepted) • Copy of insurance card, front & back (If available) • Copy of Medicare Card (MBI) • **Current Height:** _____ and **Weight:** _____ • Last hospital H7P (if available) or last (3) Doctor visit notes • Recent labs: Liver Function Test, Albumin, Creatinine, CBC, Lytes, Cultures, Blood Gases, PT, INR • Pathology Reports (if applicable) • Surgical Reports (if applicable) • Other Information to Support Terminal Diagnosis

Patient Name: _____ **DOB:** _____

Terminal Diagnosis: _____

Secondary Diagnosis: _____

Contact Name: _____ **Relationship:** _____ **Phone:** _____

Please Complete This Section

☐ I will follow this patient while on hospice and I will continue to see patient for Certifications needed for patient's eligibility for Hospice. (Face to Face & (CTI) Certification of terminal Illness) as well as sign death certification.

☐ I would prefer the One Good Hospice Medical Director follow this patient while on hospice.

Is the patient aware of the referral for Hospice Services? Yes ____ No ____

*I certify that the patient referenced above is terminally ill with a life expectancy of 6 months or less if the terminal illness runs its normal course. Please admit patient to One Good Hospice, Inc.

(Signature below will act as verbal (CTI) Certification of terminal Illness.)

_____ _____ Date: _____

Physician's Printed Name Physician's Signature