Intake Department
Phone 619-667-1900
Fax 619-740-8584
HospiceIntake@sharp.com

REFERRAL FORM

☐ **TRANSITIONS** ☐ **HOSPICE** ☐ **DUAL - HOSPICE & TRANSITIONS**

Patient Information		
Name (please print)		
Patient Sex	☐ Male ☐ Female DOB: ______________________	
Telephone	Home: Mobile:	
Address		
City/Zip Code		
Contact Person	Relationship to Patient: _________________	
Contact Telephone	Home: Mobile:	
Diagnosis	☐ CHF ☐ COPD ☐ Dementia ☐ Cirrhosis ☐ Frailty ☐ Renal Failure ☐ Motor Neuron Disease ☐ Oncology - Dx: ____________________________ ☐ Other: ___________________________________	
Other Care Providers	☐ Home Health ☐ Outpatient Rehab ☐ Other: _______________	Agency Name: ____________________ Contact: _________________________ Phone: __________________________
Additional Comments		

HOSPICE: Are you willing to follow your patient while on hospice if patient/family selects you as the attending physician? ☐ **Yes**, willing to follow ☐ **No**, hospice provider to follow

TRANSITIONS: Only PCP can follow patient while on Transitions Program

PHYSICIAN ORDER

Name (please print)	
Telephone	
M.D. Signature	
Referral received by: ____________________	☐ Verbal Order ☐ Telephone Order