KANAWHA DIVISION
1606 Kanawha Boulevard West
Charleston, WV 25387

HOSPICE REFERRAL REQUEST

For Assisted Living Facility Residents

Patient Name: _____ DOB _____

1. I certify that this patient is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course. Please assess for admission to Hospice.
2. Hospice nurse may initiate LTC HospiceCare Standing Orders.
3. I authorize the Hospice Nurse to act as my agent when ordering approved medications.
4. I agree to sign hospice orders and death certificate.

If, for any reason, patient does not meet Hospice admission criteria at this time, will you approve a Palliative Care consult? Yes _____ No _____

CHECK ONE OF THE FOLLOWING:

_____ I prefer to have the Hospice Medical Director prescribe medications for end-of-life symptom management.

_____ I prefer to continue to prescribe medications & manage the patient's end-of-life symptoms.

Physician Signature _____ Date_____

Physician's Printed Name _____

If you have any questions, please call 1-304-768-8523 or 1-800-560-8523.

These forms must be returned prior to assessment.

Please upload this form when submitting the Online Referral Form
OR
FAX to 1-304-941-1916 or EMAIL to OnlineReferral@hospicecarewv.org