HospiceCare
Comfort. Dignity. Peace.
KANAWHA DIVISION
1606 Kanawha Boulevard West
Charleston, WV 25387

HOSPICE REFERRAL REQUEST

Patient Name: _____ DOB _____

I certify that the above patient is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

CHECK ONE ONLY:

_____ **I prefer to continue to prescribe medications & manage the patient's end-of-life care---*Attending Physician*.**

- Hospice nurse may initiate HospiceCare Standing Orders.
- Hospice nurse may consult me for medical needs not addressed on the Standing Orders.
- I agree to sign hospice orders and death certificate.

OR

_____ **I prefer to have the Hospice Medical Director prescribe medications and provide end-of-life care management—*Attending Physician with Hospice Medical Director to Manage Care.***

- Hospice will update me on significant changes: i.e. patient's death or improvement and discharge from hospice.
- Medical Director will sign 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 _____

Provider Signature _____ Date_____

Provider's Printed Name _____

(If Provider is a Resident, Attending Physician Signature_____)

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 1-304-941-1922 or EMAIL to OnlineReferral@hospicecarewv.org