KANAWHA DIVISION
1606 Kanawha Boulevard,West
Charleston, WV 25387

GREENBRIER DIVISION
1265 Maplewood Avenue
Lewisburg, WV 24901

HOSPICE REFERRAL REQUEST

Patient Name: _____ DOB _____

Contact Name: _____ Contact Number _____

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.**

- I agree to serve as the patient's attending physician.
- HospiceCare nurse may initiate HospiceCare Standing Orders.
- HospiceCare nurse may consult me for medical needs not addressed within the HospiceCare Standing Orders.
- I agree to sign hospice orders and death certificate.

OR

_____ **I prefer to have the HospiceCare Medical Director prescribe medications, and provide end-of-life care, for this patient.**

- I agree to the HospiceCare Medical Director managing the care of this patient.
- HospiceCare will update me on significant changes: i.e. patient's death or improvement or discharge from hospice services.
- The HospiceCare 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 you have any questions, please call 1-304-768-8523 or 1-800-560-8523.
Please upload this form when submitting the Online Referral Form
OR
FAX to 1-304-941-1922 or EMAIL to OnlineReferral@hospicecarewv.org