Sutter Health
Sutter Care at Home

HOSPICE ORDER FORM

Fax (866) 652-9179
Phone (866) 652-9178

Thank you for referring to Sutter Care at Home Hospice. By sending this form and the supporting documentation you are assisting us in providing a more caring, efficient and timely response for your referral. Our goal is to be at your patient's home to admit them to service within 4 hours of receipt.

Patient Information

Patient Name | Sex ☐ M ☐ F | D.O.B. | Patient's Phone

Please fax a copy of demographic, medication and H&P sheet with orders.
If data not available, please complete demographic information below.

Address | City | State | Zip | Social Security Number

_____ _____ - _____ - _____

Medicare #_____ Private Ins. _____ Grp# _____

Referring MD _____ Following MD _____

MD Phone _____ MD Phone _____

Emergency Contact: _____ Contact Phone: _____

Orders

Terminal Diagnosis: Is patient able to sign their consents? ☐ Yes ☐ No

Resuscitation Order : ☐ Code ☐ No Code Date: POLST? ☐ Yes ☐ No Date:

Admission orders

X - EVALUATE AND ADMIT TO HOSPICE IF APPROPRIATE

X - I CERTIFY THAT THE PATIENT'S PROGNOSIS IS SIX MONTHS OR LESS IF THE DISEASE RUNS ITS NORMAL COURSE

X - YES, I WILL CONTINUE TO PARTICIPATE IN MY PATIENT'S CARE WHILE S/HE IS RECEIVING HOSPICE SERVICES

If you <u>do not</u> wish to participate in your patient's care while receiving hospice services, please check the box and initial below:

☐ _____ **NO, PLEASE HAVE THE SCAH MEDICAL DIRECTOR MANAGE DAY TO DAY ORDERS WHILE MY PATIENT IS RECEIVING HOSPICE SERVICES.**

Physician Information

Print Name of Ordering MD | Phone# | Fax#

X _____ X _____

MD Signature Date