FAX

EvergreenHealth
HOME HEALTH & HOSPICE CARE

EvergreenHealth Hospice Referral **(Includes Attending Hospice Provider Signature - CTI)**

To: EvergreenHealth Hospice Intake

Fax #: (425) 899-1033	Phone #: (425) 899-3300	
From:	Facility:	Date:
Fax #:	Phone #:	# of Pages:

Patient Name (Last, First): _____ DOB: _____

Hospice Service Address: _____

Primary Insurance Type/#: _____ MC #: _____

Primary Hospice Dx: _____ Other Dx: _____

DPOA/Guardian Name: _____ Phone: _____

Please attach as much of the following documentation as possible:

- ☐ Patient Demographic Sheet
- ☐ Latest Visit Note (MD/PA/ARNP)
- ☐ History & Physical
- ☐ Current Meds/Orders
- ☐ POLST Form
- ☐ Weight Summary
  (ideally previous 6-month weight hx)
- ☐ Other nursing notes/helpful info

Certification of Terminal Illness (To be signed by Hospice Attending MD)

By signing below, you are confirming that you are providing the Verbal Certification of Terminal Illness for the patient and agreeing to act as the patient's attending hospice provider.

It is my clinical judgement that it is more likely than not that this patient has a prognosis of 6 months or less, should the terminal illness run its usual course.

MD Name: _____

Signature: _____

Date: _____