Fax Referral

*If this is a **weekend** referral, please call Patient Access at 530-902-3573*

Date of Referral: _____ Phone Number: _____

Person Making Referral: _____

Patient Name_____ Date of Birth_____

Hospice Diagnosis_____

Primary contact for Patient_____ Phone Number_____

Please Include:

[ ] Written order for Hospice
[ ] Patient's face sheet/demographics including Social Security Number, Medicare Number and/or Medi-cal Number
[ ] POLST form (if available)
[ ] Most current H & P, past six months of MD office visits, any hospital discharge summaries for the past year, last 2-3 months of Laboratory results and Imaging studies related to hospice diagnosis

Physician Name Printed_____

Physician Signature_____

[ ] I will be the patient's attending physician while on hospice, signing CTIs and Death certificate

Physician office Contact_____

Office phone number_____ Fax number_____

Please Fax this form with above mentioned documents to Yolo Hospice at 530-758-9017

Thank you

YH Fax Referral/WIP/Intake 08/29/20017