

## Referral for Hospice of San Joaquin

**In order to expedite this referral please provide the following information.  
 Fax to Hospice of San Joaquin @ (209) 922-0321  
 Referral Nurse Phone # (209) 922-0320**

<b>Patients Name:</b>		<b>Phone #:</b>	
<b>Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>SS #:</b>		<b>Date of Birth:</b>	
<b>Terminal Diagnosis:</b>		<b>ICD-9 Code:</b>	
<b>Insurance Info:</b>		<b>Insurance ID #:</b>	

**Allergies:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Other relevant information: Copy of most recent H & P.

<b>Current Problems:</b> Check all that apply			
Pain <input type="checkbox"/>	Skin <input type="checkbox"/>	Nutrition <input type="checkbox"/>	
Weakness <input type="checkbox"/>	Edema <input type="checkbox"/>	Respirations <input type="checkbox"/>	
Bowels <input type="checkbox"/>	Nausea <input type="checkbox"/>	Mental Status <input type="checkbox"/>	
Coping <input type="checkbox"/>	Insomnia <input type="checkbox"/>	Emotional <input type="checkbox"/>	

<b>Physician has discussed the following information with patient / family:</b>	
Diagnosis <input type="checkbox"/>	
Prognosis <input type="checkbox"/>	
Hospice Referral <input type="checkbox"/>	

<b>Code Status:</b> Full Code <input type="checkbox"/>	DNR <input type="checkbox"/>
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Prognosis is 6 months or less of life expectancy if terminal illness runs its normal course.

<b>Care setting:</b> Home <input type="checkbox"/>	Hospice House <input type="checkbox"/>	SNF <input type="checkbox"/>	RCFE <input type="checkbox"/>
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X: \_\_\_\_\_  
 Physicians Signature

X: \_\_\_\_\_  
 Date