Hospice of the Central Peninsula
P.O. Box 2584
Soldotna, AK 99669
Email: hospice@acsalaska.net
Phone: 907-262-0453
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REFERRAL FOR HOSPICE SERVICES

Referral by (circle) Physician Self Family Friend

Client Information:

Client Name: _____ Date of Birth: _____

Address: _____

Phone: _____

Referred by: _____

Client Liaison Name/Phone: _____

To Be Completed and Signed by Physician if applicable

Diagnosis _____

Is the patient prognosis 12 months or less? Yes No

Is a responsible person available to provide necessary home care? Yes No

Physician's orders for Hospice care

Hospice will provide clinical staff and trained volunteers for emotional and respite support for client and their family.

Anticipatory grief and bereavement services will be offered to the family.

In accordance with stated life expectancy and acceptance of hospice service, CPR will not be performed or initiated by hospice personnel.

_____

Physician Name (printed please)

_____

Physician Signature *Date*

jmn/april2017