HOSPICE HOUSE
& Support Care of Williamsburg
4445 Powhatan Parkway, Williamsburg VA 23188 · telephone: 757-253-1220 · fax: 757-253-2599 · www.williamsburghospice.org

HOSPICE HOUSE REFERRAL INFORMATION

CONFIDENTIAL

****TOP LINE & BOTTOM LINES IN GREEN TO BE COMPLETED BY HOSPICE HOUSE STAFF ONLY****

Upon completion, please fax this form to Hospice House Clinical Director, Brenda Stout: 757-253-2599 or send via email to: clinicaldirector@williamsburghospice.org

HH INFO	GUEST NAME (First, Last):	ADMIT DATE:	ROOM #: Select	FILE #:
REFERRAL INFO	REFERRAL DATE:	REFERRAL SOURCE (Name):	REFERRAL SOURCE PHONE:	REFERRAL SOURCE FAX:
	DISCHARGE FACILITY NAME:		REFERRAL SOURCE EMAIL:	
DEMOGRAPHIC INFORMATION	PATIENT NAME: (Last, First MI)	PATIENT DOB:	PATIENT AGE:	PATIENT GENDER: Select
	PATIENT SS#:	PATIENT RACE: Select	PATIENT HOME PHONE:	PATIENT CELL PHONE:
	PATIENT ADDRESS: (Street)	CITY:	STATE: ZIP:	COUNTY:
	NOK/POA: (Name: First & Last)	NOK/POA PHONE:	NOK ADDRESS:	STATE: ZIP:
	SECOND CONTACT/NOK:	PHONE:	ADDRESS:	STATE: ZIP:
	NOK/POA EMAIL:		SECOND CONTACT/NOK EMAIL:	
CLINICAL INFORMATION	DIAGNOSIS:	PATIENT HEIGHT:	PATIENT WEIGHT:	SPIRITUAL AFFILIATION:
	PHYSICIAN:	PHYSICIAN PHONE:	HOSPICE PROVIDER:	HOSPICE AGENCY PHONE:
	PATIENT ALLERGIES (List):			
	CURRENT COMPLICATIONS:	PLEASE DESCRIBE:		
	DOES THE PATIENT HAVE WOUNDS? Y/N Select	IF YES, PLEASE DESCRIBE:		
	DOES THE PATIENT HAVE ANY INFECTIONS? Y/N Select	IF YES, PLEASE DESCRIBE:		
	DOES THE PATIENT HAVE ANY BROKEN BONES/FRACTURES? Y/N	IF YES, PLEASE DESCRIBE: Select		
	DOES THE PATIENT HAVE AN NG TUBE OR PEG TUBE? Y/N Select	DOES THE PATIENT HAVE OR NEED O2? Y/N Select	DOES THE PATIENT HAVE A DNR? Y/N Select	PREFERRED FUNERAL HOME:

HOSPICE HOUSE CLINICIAN ASSESSMENT	REFERRAL MEETS DISEASE SPECIFIC INDICATORS FOR ADMISSION:			
	DISEASE INDICATORS MET: Check all that apply.	☐ ACUTE STROKE/COMA ☐ AMYOTROPHIC LATERAL SCLEROSIS ☐ CANCER ☐ CHRONIC STROKE/COMA	☐ DEMENTIA ☐ HEART DISEASE ☐ HIV ☐ LIVER DISEASE	☐ PULMONARY DISEASE ☐ RENAL DISEASE
	REASON(S) REFERRAL DOES NOT QUALIFY FOR ADMISSION:			
	DATE BED OFFERED TO PATIENT:	DATE PATIENT ADMITTED TO HH:	REASON(S) REFERRAL WAS NOT ADMITTED:	
	DOD:	TIME:	PRONOUNCING RN:	