



**Willamette
Vital Health**

Previously known as Willamette Valley Hospice

Intake: 503.779.2303 Fax: 503.779.2304

**EXPERIENCE.
AT YOUR SIDE.**

Provider Referral Form to Admit to Hospice Care

Medically Eligible Criteria: _____

Please indicate if willing to Attend:

- I will not be the attending physician and designate the WVH physician to act on my behalf
- I will serve as the attending physician and provide or arrange 24/7 hospice-related medical coverage while the patient is on hospice services.

I hereby certify that this patient is terminally ill with a life expectancy of six months or less if the terminal illness runs its natural course.

Medical Provider's Signature: _____ Date: _____

Please include the following:

- Physician Admitting Orders; Demographic or Face Sheet;
- Last 6 months notes including vitals, labs, scans, imaging and H & P;
- Medication list or MAR;
- Any other diagnostic testing.

Patient Name: _____ Date of Birth: _____

Contact Name: _____ Phone: _____

Contact Relationship: _____

Diagnosis: _____ SSN: _____

Insurer: _____ Policy #: _____

Medical Provider's Name: _____ Phone: _____

Does the contact know to expect our call? Yes No

Is there confirmed or suspected Tuberculosis? Yes (Date of positive test and/or treatment) _____ No

Thank you for your referral! We will contact your office with an update of patient status.

For urgent patient referral, our on-call nurse is available 24/7 at 503.588.3600

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