Catholic Health
Good Shepherd Hospice

PLEASE FAX REFERRALS TO:
631-465-6533

Questions? Please contact:
GSH INTAKE TEAM
631-465-6363

Patient's Name: _____
Address: _____
City: _____ **Zip**:_____
Patient's Phone: _____
Date of Birth: _____ **Gender: Male Female Marital Status: S M D W**
Emergency Contact Person Outside the home: (Name & Number)
_____
Health Care Proxy-Name: _____
_____
Medicare #:_____
Other Insurance Name: _____ **Insurance Policy#**:_____
Secondary Insurance Name: _____ Policy #_____
Hospice Diagnosis: Reason for Referral-Please include brief history of illness & advanced disease status indicators
_____
_____

Information on patient's recent physical / functional decline: _____
_____
( ) Weight loss ( ) Decline in ADLs ( ) Pain ( ) Dyspnea ( ) Delerium / Agitation
( ) Worsening Cognitive impairment ( ) Infections

( )Wound Care ( ) Tubes ( ) IV access ( )Injections ( ) Chemotherapy ( )Radiation
( )Procedures –please explain ( ) Treatments- please explain ( )Blood transfusions ( ) Paracentesis
( ) Other_____
_____

Comorbid Medical Illnesses/ PMH: _____
_____

Ht: Wt: Pharmacy: COVID Vax O2 Pets Smoking

( ) Pertinent Labs (Albumin, BUN and Cr, HGB, Hct, etc.) ( ) Medication list

Is Patient aware of Dx and Hospice referral: ( ) YES ( ) NO
If no, who is aware_____

Name of referring Physician: _____
Phone: _____
( ) MD is aware and agreeable to Referral ( ) MD will CERTIFY and follow

Referral Source Name: _____ Title: _____

Contact Number: _____ Date: _____