Consultation for Hospice Care

Tel. 888-771-9099
Fax 801-771-0200

Patient Name (If approp.): ______________________________
Diagnosis: ______________________________
Location: ______________________________
Hospice Representative: ______________________________ **Date**:______________

Patient <u>is</u> eligible for hospice services based on the following criteria:

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Recommendations:
(1) Notify attending physician of appropriateness for an order.
(2) Talk with the patient and family.
(3) Contact Legacy HealthCare to support you and the patient/family.

Patient <u>is not</u> eligible for hospice services based on the following criteria:

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Recommendations:
(1) Notify attending physician if necessary.
(2) Continue to observe patient for any changes or declines.
(3) Utilize our educational materials to further your knowledge.
(4) Let us know how we can support you in any way.

Hospice Signature: ______________________________ Title: ____________________

Referral Source: ______________________________ Title: ____________________