SSM HOSPICE REFERRAL FORM

☐ SSM Home Care of St. Louis
☐ SSM Home Care of Mid-Missouri
☐ SSM Home Care of NW Missouri
☐ SSM Home Care at St. Mary's Good Samaritan
☐ SSM Home Care of Oklahoma
☐ SSM Hospice
☐ SSM Hospice of NW Missouri
☐ SSM Hospice of The Good Samaritan
☐ SSM Infusion
☐ SSM Home Care Private Duty In-Home

Facility _____ Room # _____ CM: _____

☐ Info Only ☐ Priority 1 – Imminent death, severe needs, admit ASAP ☐ Priority 2 – no new/severe needs, admit next 2 days

Patient Name: _____
Last *First* *MI*

Address: _____
City *State* *Zip* *Phone*

DOB	Age	Sex	Marital Status	SSN

Primary Caregiver	Relationship
Address	
Home Phone	Other
Additional Contact	Phone

Meeting Date: _____

Meeting Time: _____

Referred by: _____
Date

Referring MD: _____

Terminal Dx: _____

PCP: _____

MD to Follow: _____

Admission Date: _____

Requested	Obtained	
☐	☐	Most Recent Hospital / ER Stay
☐	☐	H & P
☐	☐	Discharge Summary
☐	☐	Labs / X-rays
☐	☐	Medication List
☐	☐	Other test R/T Terminal DX
☐	☐	Order for Hospice
☐	☐	Adv. Directive/POA

Primary Payer

Medicare _____

Medicaid _____

Private Ins ID# _____

Co-morbidities affecting terminal DX: _____

_____

Other pertinent information: _____

_____

_____