Referral Form

Serenity Supportive Care is focused on equipping physicians, care providers, facilities and patients with another strategic partner in the continuum of care. Call us today for more information!

Serenity Supportive Care
— AN ADDUS HOMECARE COMPANY —

p: 503.980.4334 • f: 971.200.2431
www.serenityhospice.org

Referral Information

Today's Date _____/_____/_____

Patient Name _____ DOB _____/_____/_____

Referral Source _____ Referral Contact Info _____

Attending Physician _____ Phone Number _____

Patient Medicare # _____ Patient Medicaid #_____

Patient Information

Responsible party name & relationship (POA, next of kin, caregiver): _____

Patient/Responsible Party contact info: _____

Is the patient in a facility? ☐ Yes ☐ No Name of facility _____

Previous Hospice patient? ☐ Yes ☐ No Skilled Bed? ☐ Yes ☐ No Home Health? ☐ Yes ☐ No

Is the patient and/or responsible party aware of the need for supportive care? ☐ Yes ☐ No

Reason patient is being referred to supportive care (describe recent changes in condition, hospitalizations, etc)

_____

_____

PHYSICIAN SUPPORTIVE CARE ORDER

Primary Diagnosis: _____

"I authorize Serenity Supportive Care to evaluate the patient listed above and admit to the supportive care program if indicated"

_____
Physician Signature

_____ _____/_____/_____
Print Physician Name Date

Please Include

- Face Sheet - Demographic
- History & Physical
- POLST
- Medication List
- Visit notes related to serious illness (as appropriate)
- Relevant progress/lab/hospitalization notes

Comments:_____

Total number of pages, include cover sheet: _____

FAX TO: 971.200.2431