Good Shepherd Hospice
Catholic Health Services
At the heart of health

PLEASE FAX REFERRALS TO:
631-465-6533

Questions? Please contact:
GSH CENTRAL INTAKE TEAM
631-465-6363
516-586-1420

Patient's Name:_____**Soc Sec #**_____
Address:_____
City:_____**Zip**:_____
Patient's Phone:_____
Emergency Contact Person Outside the home: (Name & Number)
_____

Date of Birth:_____ **Gender: Male Female**
Insurance Name:_____
Insurance Policy Number:_____

Hospice Diagnosis: Please include brief history of illness & advanced disease status indicators)_____
_____

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

Comorbid Medical Illnesses/ PMH:_____
_____

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

( ) **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

Referral Source Name: _____ Title:_____

Contact Number:_____ Date:_____