Seward Area Hospice

PO Box 1331 Seward, Alaska 99664 Email: info@sewardareahospice.org Phone: (907)224-3051

REFERRAL FOR HOSPICE SERVICES

Referral by (circle) Physician NP PA Family Friend Self

***Client Information*:**

Client Name: _____ Date of Birth: _____

Address: _____

Phone: _____

Referred by: _____

Client Liaison Name/Phone: _____

To Be Completed and Signed by Physician/ Nurse Practitioner if applicable

Diagnoses _____

Is the clients' life expectancy: 6 months or less?

Is a responsible person available to provide necessary home care? Yes No

Is a DNR in effect? Yes No (If yes, please provide a copy)

Does the client have a MOLST Form or Comfort One (If yes, please provide a copy)

Physician/Nurse Practitioner Orders for Hospice Care

Hospice will provide staff and trained volunteers for emotional and respite support for the client and his or her family/caregivers.

Anticipatory grief and bereavement services will be offered to the family/caregivers.

_____

Physician / Nurse Practitioner Name (printed please)

_____

Physician / Nurse Practitioner Signature ***Date***