

Home Health & Hospice, Intake and Referral Department	
Phone:	(802) 860-4400
Fax:	(802) 860-4464
Mondays – Fridays:	8 am – 5 pm
Weekends & Holidays	7 am – 3 pm



Please complete the required patient information below to begin the referral process for Home Hospice Services or McClure Miller Respite House admission. The supplemental information requested below will help expedite the determination of hospice eligibility. Your patient does not need to be homebound or require specific skilled nursing to qualify for hospice. Once admitted to hospice, your patient will automatically be assessed for care from all hospice disciplines, including care from our Medical Director and Skilled Nursing, Social Work, Spiritual Care, Volunteer Services, Licensed Nursing Assistance, and Bereavement support.

Required Patient Information

Referral Date:

Patient Legal Name:

Patient Date of Birth:

Patient Preferred Name and Pronouns:

Patient Legal Sex:

Preferred Name of Primary Contact for Patient:

Relationship to Patient:

Primary Contact Phone Number:

Primary Contact Spoken Language:

Address or location of patient's residence or location care is requested:

Name of Referring Provider:

Phone:

What is the primary diagnosis and any concurrent conditions that are related to this hospice referral?

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Renal Failure
<input type="checkbox"/> Alzheimer's or other Dementia		<input type="checkbox"/> ALS/MS	<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Other (please describe):				

What is the urgency of this referral?

Evaluate & start care per findings Offer start of care within 24 hours Start care per patient preference

Optional: Please provide any additional information you think we should know to evaluate your patient for hospice eligibility (i.e., weight loss, declining functional status, frequent hospitalizations or emergency room visits).

Please attach relevant medical records including face sheet, medication list, and most recent provider note.

Signature of ordering provider: