

HOSPICE SERVICES

of Massachusetts

HOSPICE REFERRAL FORM

Thank you for considering Hospice Services of Massachusetts to partner with you in the care of your patients. We appreciate the trust that you place in us and will respond to your referral promptly. Together we can determine the next steps for hospice care for the patients that you refer.

Making a referral is simple:

- Either phone our office (Toll free 866 991-0049 or 877 500-4133) or
- Complete and fax the following information for any patient that you believe needs hospice care. If it is easier to include copies of documentation that is requested below, please feel free to fax the documentation rather than completing all sections. (Faxes are replied to on the same business day if received by 4:30 PM; if making a referral after 4:30 PM or on a weekend/holiday please call the toll free number.)

Date: ____/____/____ Time: _____

Patient Name: _____

Address: _____ City: _____ Zip: _____

Phone#: (____) _____ Location: Home Hospital SNF Other: _____

Your name: _____ Phone: _____

What prompts your referral today? _____

Patient/family is aware of referral? YES NO

CLINICAL INFORMATION:

Primary Diagnosis _____

Attending Physician _____ Phone: _____

Physician aware of referral? YES NO

PAYSOURCE INFORMATION: please attach any available information about payer source

Other information or special requests:

Main Office:

577 Main Street, Wareham, MA 02571
Phone: (508) 291-0049 or (866) 991-0049
Facsimile: (508) 291-8009

Branch Office:

391 Broadway Street, Everett, MA 02149
Phone: (617) 381-7015 or (877)500-4133
Facsimile: (617) 381-7579