CMC-Embrace Hospice House

Referral Form for Hospice House Admission

Includes GIP, Residential/Routine, & Respite Levels of Care

175 Village Center Blvd., Myrtle Beach, SC 29579 | (843) 353-6228 (Office) | (843) 742-5105 (Fax)

Please send this completed form and required documentation via e-mail to the Hospice House Administrative Team at:
HospiceHouseAdmissions@cmc-sc.com

Security Code: _____ (*Hospice House Staff Use Only)*

1. Hospice Provider Name: _____
2. Patient Full Name: _____
3. Attending Physician Name: _____
4. Patient D.O.B.: _____ *(mm/dd/yyyy)*
5. Level of Care Requested: ☐ GIP ☐ Respite ☐ Residential (Private) ☐ Residential (Semi-Priv.)
6. Arrival Date: _____ *(mm/dd/yyyy)* Arrival Time: _____ ☐ AM ☐ PM
7. Departure Date: _____ *(mm/dd/yyyy)* Depart Time: _____ ☐ AM ☐ PM
8. Emergency Contact Name: _____ Relationship to Patient: _____

   Emergency Contact Address: _____

   _____

   Emergency Contact Phone: _____ E-Mail: _____
9. Primary Hospice Contact Name: _____ Title: _____

   Primary Hospice Contact Phone: _____ E-Mail: _____
10. Funeral Home: _____
11. Diagnosis (Primary): _____ Benefit Period: _____
12. Symptom to Manage *(GIP only)*: _____
13. Discharge Plan *(GIP, Respite only)*: ☐Home/Other Facility Placement ☐Residential (Priv.) ☐Residential (Semi-Priv.)
14. Activity Level: _____
15. Code Status *(GIP & Residential cannot be full code)* ☐ DNR ☐ Full Code
16. Veteran: ☐ Yes ☐ No ☐ Spouse Branch: _____ Years/War: _____
17. Please include all of the following documentation along with this completed form to submit a complete referral. Incomplete referrals will be filed for 14 days and then discarded. In the event of a waitlist, we will notify you of tentative approval, but may require updated notes and/or additional documentation.

    ☐ Hospice Benefit Election Form (*Required in house **prior** to patient arrival to Hospice House)*
    ☐ POA Paperwork (if applicable)
    ☐ Order to Admit with Level of Care
    ☐ Facesheet / Demographics Sheet (*Name, DOB, SSN, Address, Phone #, and Payor source required)*
    ☐ DNR *(if applicable)*
    ☐ Medication Record *(unless listed on following page under #22)*
    ☐ Last Two (2) Nurses' Notes and/or Hospital Records
    ☐ Most Recent Certification *(if already under hospice benefit)*
    ☐ Plan of Care

18. Medical Equipment Needed *(please check all that may apply)*: ☐ O2 Concentrator ☐ Portable O2 Setup

Liter Flow: _____ ☐ PRN (or) ☐ Continuous ☐ Nasal Canula (or) ☐ Face Mask

☐ Wheelchair ☐ Transport Chair ☐ Walker ☐ Bedside Commode ☐ Shower Chair

Other(s): _____

_____

**Please note that standard DME typed above may be supplied by CMC-Embrace Hospice House; however, items not approved above may not be available through the Hospice House, including but not limited to tube feeding pumps, Alternating Pressure Mattresses, or PCA pumps. The Hospice Provider will be required to provide said items. For questions or concerns, please contact Administration at the information listed above.*

19. Diet: ☐ Does not require special dietary alternatives ☐ NPO ☐ Puree ☐ As Tolerated

Alternative Meals will be provided based on the following dietary choices (check all that apply):

☐ Vegetarian (with eggs) ☐ Vegetarian (without eggs)
☐ Vegan (plant-based) ☐ Vegan (raw) ☐ Other: _____
☐ No Pork ☐ No Beef ☐ No Fish

We also accommodate the following medically-necessary dietary needs (check all that apply):

☐ Lactose Intolerant (non-dairy) ☐ Gluten Intolerant (non-Gluten) ☐ Diabetic ☐ Low Sodium

Food Allergies (these are the 8 most common food allergies: check all that apply):

☐ Milk ☐ Eggs ☐ Peanuts ☐ Tree Nuts ☐ Fish ☐ Shellfish ☐ Soy ☐ Wheat ☐ Corn ☐ Yeast

Any Other Food Allergies: _____

20. Wound Care Orders *(if applicable)*: _____

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21. Medications *(please include Medication Record OR list all Medications below)*:

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