



Your Experienced Nonprofit Community Partner  
Offering Guidance Through Life's Transitions

**Northland Hospice & Palliative Care (dba) Vista Hospice**  
**452 N. Switzer Canyon Dr., Ste. A, Flagstaff, AZ 86001**  
**Office: 928.779.1227 Fax: 928.779.5884**  
[www.vistahospice.org](http://www.vistahospice.org)

### FAST TRACK HOSPICE REFERRAL

Do you have a patient or know someone who might benefit from hospice services? If so, please complete and return this form; a representative will follow up promptly.

#### REQUIRED INFORMATION (Please Print)

Patient Name: \_\_\_\_\_ Gender:  Male  Female DOB: \_\_\_\_\_  
 Patient's Address: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_  
 Hospice Diagnosis: \_\_\_\_\_  
 Attending Physician/PCP: \_\_\_\_\_

#### SUPPORTING INFORMATION

Should you have any of the following supporting documentation, please provide as appropriate:

- Patient face sheet (demographics)
- History & physical
- Last visit note
- Current medication list
- Labs
- Discharge summary
- Medicare/Medicaid/Insurance card
- Other supporting medical information

Comments: \_\_\_\_\_  
 \_\_\_\_\_

#### EVALUATION

Physicians please sign & date to authorize **Vista Hospice** to evaluate and admit patient if eligible:

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Physician Name (Please Print): \_\_\_\_\_

Do you wish to follow this patient while on hospice?  Yes  No

#### MEDICAL DIRECTOR FOLLOW-UP/ POST-PHYSICIAN SIGNATURE

Medical Director Approval for Admission:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### Confidentiality Statement

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