



A Program of Hospice of Santa Cruz County

The Mary & Richard Solari
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Concurrent Care for Children Referral

To : \_\_\_\_\_ From: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Address: \_\_\_\_\_

Legal Guardian: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Language: \_\_\_\_\_ Primary Dx: \_\_\_\_\_

Insurance(s) (Private/Medi-cal/CCS): \_\_\_\_\_

Current Medical Needs (Pain/Respiratory Mgt /Artificial Food & Fluids/Wound Care/IV's/Special Instructions):

Known current DME in use or Needed:

The patient / patient's representative has identified me as his / her attending physician.

Based on my clinical judgement regarding the normal course of this patient's illness, I certify this patient is suffering from a terminal illness and could be within the last six months of their life.

Recent Medical Records Attached: Yes \_\_\_\_\_ No \_\_\_\_\_

I have discussed prognosis with the patient / family: Yes \_\_\_\_\_ No \_\_\_\_\_

I will sign the death certificate: Yes \_\_\_\_\_ No \_\_\_\_\_

Please anticipate a call from our Concurrent Care for Children team to confirm whether or not your patient has been admitted to our Concurrent Care Program. If admitted, the RN will obtain your authorization to implement the Plan of Care and consent to treat.

Physician Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

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