Referral Form

This form can be completed as a self-referral or by a health-care professional, family member, caregiver or friend.

Referral Information

Name of person to receive hospice support: _____ Date of Referral: _____

Age/DOB: _____ Language: _____

Email: _____ Phone: _____

Physical Home Address: _____

Current Location of person (circle one): Home Address / Hospital / Long Term Care Facility / Other

Address if different than above: _____

If Known:

Home Health Nurse: _____ Phone Number: _____

Physician Name: _____ Phone Number: _____

Referral Source (if not a self-referral)

Name and Relationship to person:

_____

Phone number: _____ Email Address: _____

Type of Support Requested

Palliative and/or end-of-life hospice support: _____ Grief Support: _____

Is this person aware of this referral? Yes _____ No _____

If not, please briefly explain why not: _____

_____

Who should we contact regarding this referral?

The person directly _____ The person making the referral _____ Other _____

If other please provide full name and contact information:

_____

_____

Is there any other information you would like to share?

_____

_____

_____

_____

Initial here to declare the information provided is accurate & complete _____

Your Signature

_____

Scan & send to
elkvalleyhospice@gmail.com

Submissions will be directed to the Volunteer Coordinator through the confidential Elk Valley Hospice email account (elkvalleyhospice@gmail.com). This inbox is checked regularly however, if this referral is urgent and time sensitive or contact hasn't been made within 72 hours, please call us at 250-423-4453 ext 38109 and our goal is to return your call within 24 hours.