Seward Area Hospice
PO BOX 1331
Seward AK 99664
907 224 3051
info@sewardareahospice.org

Referral for Hospice or Palliative Care

Client Information:

Name _____ DOB _____

Address _____ Phone _____

Family/Caregiver Name _____ Phone _____

Referred by

Name _____ Relationship to client _____ Phone _____

Client Diagnosis _____

Anticipated life expectancy

6 months or less _____ Hospice 12 months or less _____ Palliative Care

The following is in place: DNR POLST

The client needs information about Advanced Directives: Yes No

Medical Provider

I understand there is no charge to the client/family for services of Seward Area Hospice.
I understand Seward Area Hospice is a state licensed volunteer Hospice.
I understand that Seward Area Hospice has trained volunteers, per availability, to assist in supporting the client/family.
I understand the Seward Area Hospice Nurse Educator will develop a Plan of Care based on the assessment and needs/wishes of the client/family.
I understand the Plan of Care will be signed by the client/family, Seward Area Hospice Nurse Educator and the Medical Provider.
I understand the Seward Area Hospice Nurse Educator will contact the Medical Provider after the client/family signs the Informed Consent for Services.

Medical Provider Signature **Date**

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If Medical Provider is PA-C, required to have NP/MD co-signature