Patient's Name	
Start of Care Date	____/____/____
Today's Date	____/____/____
Hospice Representative	

Communication Preferences

We would like to communicate with you appropriately as frequently as you wish. To help us do this, please select your desired level of communication and provide your contact information. We will keep this as part of our records and use it as a reference for your communication preferences.

Check if you wish to be contacted	Occurrence
☑	Change in medication/plan of care
☑	Change in level of care
☑	Change in condition
☑	Change in visit schedule/frequency
☐	After every nursing visit
☐	After supervisory visits
☐	Weekly care conference - Please circle one: (phone/in-person)
☐	Monthly care conference - Please circle one: (phone/in-person)
☐	After care conference occurs between hospice and ALF or SNF
☐	After hospice IDG meetings
☐	If there is a missed or declined visit
☐	Before/after Physician visit
☐	Change in IDG team member
☐	New benefit period begins
☐	Other:

Contact Information & Preferred Method of Contact	
Family/DPOA Name	
Mailing Address	
E-mail Address	
Phone #	
Alternate Phone #	
Preferred Method of Contact (Please select one for each time)	Daytime: Call / Text / E-mail Evening: Call / Text / E-mail