PHYSICIANS ORDER

DATE: _____ TIME: _____

PATIENT: _____PHONE:_____

ATTENDING PHYCISIAN: _____MEDI. DIRECTOR: _____

HOSPICE EVALUATION AND ADMISSION

HOSPICE PHYSICIAN TO FOLLOW FOR SYMPTOMS MANAGEMENT OR

ATTENDING TO FOLLOW FOR SYMPTOM MANAGEMENT (FILL OUT BELOW)

NAME: _____

PHONE: _____ FAX: _____

Verbal Order Taken By: _____ Date: _____

I certify that this patient is under my care, to the best of my medical knowledge given the data available, has a life expectancy of six (6) months or less if the disease runs its normal course. I authorize hospice care on the basis of the Plan of Care contained in the record and received by the physician.