

Please fax back this form, recent history and physical, including lab and test results, to **904.407.6090**, or call **904.407.6500**.

PHYSICIAN ORDER/CERTIFICATION FORM

Patient's Name:	SSN#:	Sex: ___M___F	DOB:
Patient Phone #:	Next of Kin or Healthcare Surrogate:		Healthcare Surrogate Phone #:
Admission Date:	Certification Period beginning _____ to _____.		

Is patient/family aware of hospice referral? YES NO

Terminal Diagnosis: _____

Coexisting Diagnoses: _____

Based on the patient's diagnosis and current condition, I certify that this patient is terminally ill with a life expectancy of **six (6) months or less** if the disease continues to take its usual course and I hereby certify this patient as appropriate for hospice care.

Does attending physician desire to: (please check ONLY one)

- Remain the attending physician and for a Community Hospice Medical Director to provide pain and symptom management?**
- Turn over complete care of the patient to a Community Hospice Medical Director?**
- Retain complete management of patient's care?**

PLEASE NOTE: In the event my patient requires transfer to a Community Hospice inpatient center, I understand the Community Hospice Medical Director will assume care.

Verbal certification received from:

Attending Physician's Signature

Attending Physician

Printed Name

by Community Hospice Nurse

Date

Date

I have reviewed the patient's terminal diagnosis, other health conditions and clinically relevant information supporting all diagnoses, and I certify that this patient is appropriate for hospice care.

Verbal certification received from:

Community Hospice Medical Director's Signature

Community Hospice Medical Director

Printed Name

by Community Hospice Nurse

Date

Date

Patient Name: _____
 Team: _____
 Patient #: _____