Physician Order and Certification

Policy IDT/A 0101
Attachment A

PO Box 4860, Ocala, FL 34478 | (352) 873-7415

Patient Name: ____ Date:_____/_____/_____

Date of Birth:_____/_____/_____ SS#:________-_______-_________

Physician Orders

Check the appropriate boxes.

- ☐ I will remain the attending physician if chosen by the patient or representative. Admit to hospice services/may initiate standing orders/life expectancy is 6 months or less.
- ☐ I will not be the attending physician and request Hospice of Marion Medical Director(s) to serve as attending physician.
- ☐ This is a referral to consult and admit if eligible, at which time the Hospice of Marion Medical Director will manage care.

*Please fax medical records for proof of diagnosis and continuity of care to (352) 873-7445

Diagnosis: ____

Hospice Certification

Hospice Benefit period from ____/____/____ to ____/____/____

This patient is considered terminally ill and has a life expectancy of 6 months or less, if the terminal illness runs its normal course.

☐ Verbal certification obtained from:____
Print Physician Name

By:____ ____/____/____
HMC Staff Signature Date

_______________________________ _____/_____/_____
Physician Signature Date

Please fax to Admissions (352) 873-7445 or call (352) 873-7415