Physician Order and Certification

HOSPICE OF MARION COUNTY
Feel Better. Live better.

PO Box 4860 * Ocala, FL 34478 * 352-873-7415

Patient Name:_____ Date:_____/_____/_____

Date of Birth:_____/_____/_____ SS#:_____-_____-_____

Physician Orders

Check the appropriate boxes

- ☐ Admit to Hospice Services/may initiate Standing Orders/Life expectancy is 6 months or less
- ☐ I will remain the attending physician.
- ☐ I will not be the attending physician and request Hospice Medical Director(s) to serve as attending physician.

*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 phone (352) 873-7415

H00114	Revision Date:8/06/14