Physician Order and Certification

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.

***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: 9/17