PHONE 325-658-6524 FAX 325-658-8895

Hospice of San Angelo

Referral Orders and Admission Certification

Patient Name: _____

Physician: _____

Diagnosis: _____

PHYSICIAN CERTIFICATION:

I certify that my patient, _____ is terminally ill and, to the best of my medical judgment, has a prognosis of six (6) months or less to live, providing the illness follows the expected natural progressions. I have informed my patient and/or family that the goal of hospice care is palliative rather than curative, and that at this time no further curative treatment is planned. I understand that the Medical Director and/or Hospice Physician will also certify my patient's terminal illness and will review the plan of treatment for hospice home/nursing home/in-patient care as it relates to the terminal diagnosis. I understand that the hospice nurse will provide me with updated information on my patent's condition as necessary. I further certify that as the attending physician, I am a member of the hospice interdisciplinary team and am responsible for the medical direction of my patient's care.

PHYSICIAN AGREEMENT WITH HOSPICE OF SAN ANGELO, INC.

I further understand that if my patient elects to use the **MEDICARE** and/or **MEDICAID BENEFIT** that **ANY HOSPITAL ADMISSION MUST BE WITH THE KNOWLEDGE OF HOSPICE OF SAN ANGELO.** Once the patient elects to use their benefit for hospice care, then Hospice of San Angelo becomes financially responsible for **ALL TREATMENT RELATED TO THEIR TERMINAL DIAGNOSIS.** The patient always has the choice to decline hospice care if the decision is reached to pursue curative rather than palliative care. The patient may elect to cancel their **MEDICARE and/or MEDICAID BENEFIT** at the time curative treatment is elected.

** Admit to hospice care.

** Continue current medications.

Please indicate your ONE preference below:

☐ I would like **Hospice of San Angelo** Medical Director**, Dr. Peter Chang** to assume **ALL duties as attending physician.**

☐ **I would like to continue duties as attending physician *AND*** allow Dr. Peter Chang to write orders for hospice related issues; including pain/symptom control.

☐ **I** would like to continue ***ALL*** duties as ***ATTENDING PHYSICIAN.***

Attending/Referring Physician _____ **Date**_____

Printed Physician Name _____

***** RETURN TO HOSPICE OF SAN ANGELO AT FAX # 325-658-8895 *****