Referral Orders and Physician Certification of Terminal Illness

Patient Name_____ Date of Birth_____

Terminal Diagnosis_____

Certification Statement:

I certify that the above named 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 progression. 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 will provide me with updated information on my patient's condition as necessary. If I am the primary care physician, I further certify that I am a member of the hospice interdisciplinary team and am responsible for the medical direction of my patient's care.

Referral Orders:

1. Admit to hospice care.
2. Continue current medications
3. Other orders:

_____

_____

_____

_____

Referring Physician signature_____ Date: _____

Printed Physician Name_____

PHYSICIAN AGREEMENT AND PREFERENCE

Patient Name_____HOSA #_____ Date of Birth_____

If I choose to remain the attending physician, I understand the following:

- I am a member of the hospice interdisciplinary team (IDT) and am responsible for the medical direction of my patient's care.
- The other members of the hospice IDT which includes the hospice's Medical Director, Registered Nurse, Licensed Social Worker and a chaplain will update me on my patient's condition as necessary.
- If my patient elects to use the Hospice Medicare and/or Medicaid benefit that ANY hospital admission must be with the knowledge of Hospice of San Angelo (HOSA).
- Once the patient elects to use their benefit for hospice care, the hospice 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 Hospice Medicare and/or Medicaid benefit at the time curative treatment is elected.

Please indicate your preference as the Attending Physican below:

☐ I would like the HOSA Medical Director to assume ALL DUTIES AS ATTENDING PHYSICIAN.

☐ I would like to continue duties as attending physician AND allow the HOSA Medical Director to write orders for hospice related issues including pain and symptom control.

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

Attending/ Referring Physician Signature _____Date _____

Printed Physician Name _____

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

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