Pathway Hospice

...guiding you down life's path

PLEASE FAX FORM TO

803.391.3194

For Questions call: 803.391.3146

ATTENDING PHYSICIAN'S CERTIFICATION OF TERMINAL ILLNESS

Date: _____

Patient Name: _____ *MR#* _____

Physician Name: _____

☐ *I will continue to serve as this patient's attending physician. If I am unavailable, I give permission for orders for this patient to be obtained from a Pathway Hospice Physician/NP or an alternate physician/NP in my practice.*

☐ *I would like a Pathway Hospice physician/NP to serve as the patient's attending physician.*

A Pathway Hospice nurse or physician may release the body to a funeral home or crematorium at the time of death.

I certify to the best of my medical knowledge that this patient is terminally ill with a life expectancy of six (6) months or less if the terminal illness runs it normal course. I understand that Medicare requires that physician employees of Pathway Hospice may write orders for this patient to address unmet general medical needs.

Physician: _____ *Date:* _____

SIGNATURE