Pathway Hospice
...guiding you down life's path

PLEASE FAX FORM TO
803.391.3194

For Questions call: 803.391.3146

Date: ________________

Number of pages to follow: ________________

PHYSICIAN'S ORDER FORM FOR HOSPICE SERVICES

Patient: ______________________________ *Primary Diagnosis:* ____________________

Facility Name (if applicable): ____

Facility Telephone: _________________________ *Facility Fax:* ______________________

Physician's Name: ______________________________ *Phone:* ____________________

Name of Person Completing this Referral: ____

FAX IN:

- ☐ This sheet was signed by a physician
- ☐ H&P / Hospital Discharge Summary
- ☐ Demographic Sheet / Face Sheet
  (include DOB, SS#, insurance information, responsible party)
- ☐ Medication List

☐ **Pathway Hospice to evaluate and treat if appropriate**
(please check box)

Physician: ________________________________ *Date:* ________________
SIGNATURE

Certification of Terminal Illness (page 2) can be signed by physician and faxed along with this referral OR faxed after the evaluation.