Pathway Hospice

...guiding you down life's path

# PLEASE FAX FORM TO
# 864.312.6812

For Questions call: 864.312.6825

*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.