



HOSPARUS HEALTH

ADMISSION & REFERRAL

Action Required Physician Signature Needed

Please fax completed form to Hosparus Health Admission & Referral Office

Fax: 270-789-4248

Patient Name:			
Patient DOB:		Hosparus Health ID#:	
Patient Address:			Patient Contact Phone Number:

PHYSICIAN ORDER:

Assess and Admit to Hosparus Health Services (PHYSICIAN: Fax H&P and Demographics sheet)

Is patient currently receiving

Chemo Yes No Not known

Radiation Yes No Not known

If yes, please attach the chemo and/or radiation treatment plan for coverage determination.

ONE BOX MUST BE CHECKED:	
<input type="checkbox"/> <u>I do not want to be attending.</u> <i>I would like the Hosparus Health Medical Staff to follow as attending.</i> PROCEED TO BOTTOM FOR SIGNATURE AND DATE	<input type="checkbox"/> <u>I want to be attending.</u> PLEASE READ AND CHECK THE REMAINING BOXES AS APPLICABLE, AND SIGN AND DATE <input type="checkbox"/> Based on the patient's diagnosis and current condition, I expect this patient has a limited life expectancy of six (6) months or less, if the terminal illness runs its normal course, and hereby certify this patient as eligible for hospice care. <input type="checkbox"/> Yes <input type="checkbox"/> No ComfortPak Order <input type="checkbox"/> Yes <input type="checkbox"/> No Hosparus Health Symptom & Wound Management Protocols Authorized PRN

PHYSICIAN SIGNATURE: _____

Date: _____ **Please Print Physician Name:** _____

Confidentiality Notice:

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