HOSPARUS HEALTH

ADMISSION & REFERRAL

Action Required
Physician Signature Needed

Please fax completed form to Hosparus Health Admission & Referral Office

Fax: 270-901-0843

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:

☐ **I do not want to be attending.**

I would like the Hosparus Health Medical Staff to follow as attending.

PROCEED TO BOTTOM FOR SIGNATURE AND DATE

☐ **I want to be attending.**

PLEASE READ AND CHECK THE REMAINING BOXES AS APPLICABLE, AND SIGN AND DATE

☐ 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.

☐ **Yes** ☐ **No** ComfortPak Order

☐ **Yes** ☐ **No** Hosparus Health Symptom & Wound Management Protocols Authorized PRN

PHYSICIAN SIGNATURE: _____

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

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