HOSPARUS HEALTH

ADMISSION & REFERRAL

Action Required
Physician Signature Needed

Please fax completed form to Hosparus Health Admission & Referral Office

Fax: 502-458-2246

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:** _____