



Referral Orders and Admission Certification

Hospice of San Angelo

Patient Name: _____

Physician: _____

Diagnosis: _____

PHYSICIAN CERTIFICATION:

I certify that my patient, _____ is terminally ill and, to the best of my medical judgment, has a prognosis of six (6) months or less to live, providing the illness follows the expected natural progressions. I have informed my patient and/or family that the goal of hospice care is palliative rather than curative, and that at this time no further curative treatment is planned. I understand that the Medical Director and/or Hospice Physician will also certify my patient's terminal illness and will review the plan of treatment for hospice home/nursing home/in-patient care as it relates to the terminal diagnosis. I understand that the hospice nurse will provide me with updated information on my patient's condition as necessary. I further certify that as the attending physician, I am a member of the hospice interdisciplinary team and am responsible for the medical direction of my patient's care.

PHYSICIAN AGREEMENT WITH HOSPICE OF SAN ANGELO, INC.

I further understand that if my patient elects to use the **MEDICARE** and/or **MEDICAID BENEFIT** that **ANY HOSPITAL ADMISSION MUST BE THROUGH THE KNOWLEDGE OF HOSPICE OF SAN ANGELO.** Once the patient elects to use their benefit for hospice care, then Hospice of San Angelo becomes financially responsible for **ALL TREATMENT RELATED TO THEIR TERMINAL DIAGNOSIS.** The patient always has the choice to decline hospice care if the decision is reached to pursue curative rather than palliative care. The patient may elect to cancel their **MEDICARE** and/or **MEDICAID BENEFIT** at the time curative treatment is elected.

1. Admit to Hospice Care
2. Continue current medications.
3. Hospice Medical Director, Dr. Peter Chang, may: Please Check Appropriate Box or Boxes

YES NO

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Assume duties of attending physician

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Write orders for pain and symptom control and hospice related issues

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Assume care for hospice related issues.

Attending Physician _____ Date _____