Doctor's Hospice of Idaho

Hospice Referral/Admission

Physician: _____

Patient Name: _____ DOB: _____

Evaluate and Admit to Hospice if appropriate for Diagnosis: _____

I certify that the patient is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course

_____ _____

Physician Signature Date

I would like to follow patient on Hospice: _____

I am requesting to have Hospice Medical Director to follow patient on Hospice: _____

Hospice Office Use Only:

Verbal Order given to: _____

Please attach a copy of Patient's Face Sheet, History & Physical

Phone: 208-985-2260

Fax: 208-985-2261