Pathway Hospice

...guiding you down life's path

PLEASE FAX TO: 864.312.6812
QUESTIONS CALL : 864.312.6825

Date: _____

ATTENDING'S CERTIFICATION OF TERMINAL ILLNESS

Patient Name: _____ **DOB:** _____ **MR#** _____

Physician Name: _____

☐ **I will continue to serve as this patient's Attending Physician. If I am unavailable, I give permission for orders for this patient to be obtained from a Pathway Hospice Physician/NP or an alternate Physician/NP in my practice.**

☐ **I would like a Pathway Hospice Physician/NP to serve as the patient's Attending Physician.**

A Pathway Hospice nurse or physician may release the body to a funeral home or crematorium at the time of death.

I certify to the best of my medical knowledge that this patient is terminally ill with a life expectancy of six (6) months or less if the terminal illness runs its normal course. I understand that Medicare requires that physician employees of Pathway Hospice may write orders for this patient to address unmet general medical needs.

Physician: _____ **Date:** _____
SIGNATURE