



...guiding you down life's path

PLEASE FAX : 864.312.6812
QUESTIONS CALL: 864.312.6825

Date:
Number of Pages to follow:

PHYSICIAN'S/NP ORDER FORM FOR HOSPICE SERVICES

Patient: DOB: Primary Diagnosis:
Facility Name (if applicable):
Facility Telephone: Facility Fax:
Physician's name: Phone:
Name of person completing this referral:
Special Comments:

FAX IN:

- This sheet signed by physician
H&P / Hospital discharge summary
Demographic Sheet / Face Sheet (include DOB, SS#, insurance information, responsible party)
Medication list
Physician Signed CTI form
Pathway Hospice to evaluate and treat if appropriate (please check box)

Physician Signature Date

Certification of Terminal Illness (page 2) can be signed by Physician and faxed along with this referral or faxed after the evaluation.