Pathway Hospice
...guiding you down life's path

PLEASE FAX : 803.391.3194
QUESTIONS CALL: 803.391.3146

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: ____

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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 evauation.*