LENITY HOSPICE
KINDNESS • GENTLENESS • HUMANITY

4920 E Yale Avenue
FRESNO, CA 93727-1517
PHONE: (559) 825-0606 **FAX:** (855) 536-4893

REFERRAL/PHYSICIAN'S ORDER

Patient name: _____ D.O.B: _____

Address: _____ SSN: _____

Contact phone: _____ Contact e-mail: _____

Patient representative (if applicable): _____ Relationship: _____

Primary Health Insurance: ☐ Medicare ☐ Medi-Cal ☐ Other: _____

Member ID: _____ Group: _____

EVALUATION / ADMIT INFORMATION

Ordering Physician (printed name): _____

Alternate Contact / Office Contact (printed name): _____

Contact Phone: _____ Fax: _____

☒ Please evaluate for Hospice and admit as appropriate.

☒ Reason for evaluation/admission: _____.

Attending Physician's order for Hospice Services and Certification of Terminal illness:

☒ I certify that this patient is under my care and to the best of my medical knowledge, given the data available, that this patient is terminally ill with the expectancy of six months or less if the terminal illness runs its normal course.

☐ Terminal Diagnosis: _____

Physician's Signature: _____ Date: _____

☐ *I wish to follow the patient and be contacted directly for all orders and changes in condition. Should the need arise for a change in the current plan of care the Hospice Physician can be designated in my absence. I wish to sign the Death Certificate. The Hospice Physician may follow and support pain and symptom management.*

☐ *I do not wish to follow patient and/or sign the death certificate. Please assign hospice medical director to follow.*

PLEASE ATTACH THE FOLLOWING DOCUMENTS WITH THIS REFERRAL:

- Demographics
- History & Physical
- Last office visit
- Insurance card