



Hospice Physician Order and Certification

PO Box 4860 * Ocala, FL 34478 * 352-873-7415

Patient Name: _____ DOB: ____/____/____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone:(____) _____ SS#: _____ - _____ - _____ DNR in place: Yes No

Allergies: _____

Next of Kin: _____ Relationship: _____ Phone:(____) _____

Medicare#: _____ Medicaid#: _____

Other Insurance: Name: _____

Policy Number: _____ Phone Number:(____) _____

Physician Order

Physician order for Hospice of Marion County, Inc. intervention

“Asterisk” items are **standing orders and will be activated when physician signs below. Draw a single line through asterisk(s), plus sentence line(s) and initial if physician doesn’t want standing order(s).

“Boxed” items **must** be marked below to be ordered by the physician.

- ** Hospice RN to do consult.
- ** Hospice RN assessment if applicable.
- ** Hospice to admit patient to hospice if applicable.
- Discharge patient when hospice arrangements are made.
- Contact physician for discharge orders.
- Contact physician if hospice not applicable.

Hospice Certification

Hospice Benefit period ____/____/____ to ____/____/____

Check the appropriate boxes

- I will remain the attending physician.
 - I will not be the attending physician and request Hospice Medical Director(s) to serve as attending physician.
 - Hospice Medical Directors may cover PRN.
 - Allow formulary therapeutic equivalent substitution for symptom management
- May place the following kits in home (**RN will call for orders prior to use**)
- General Hospice Heartbeats Seizure Inspirations
 - May initiate Standing Orders

***Please fax medical records for proof of diagnosis and continuity of care to (352) 873-7445**

Diagnosis: _____

This patient is considered terminally ill and has a life expectancy of 6 months or less, if the terminal illness runs its normal course. Admit to Hospice Services.

Physician Print Name _____

Physician Signature _____ Date ____/____/____

Hospice Medical Director Signature _____ Date ____/____/____

Please fax to Admissions (352) 873-7445 or phone (352) 873-7415

Within 24 Hours per Federal Statutes

(CMA Manual System, Publ 100-2, Medicare Benefit Policy Manual, Chapter 9, Sections 20.2.142 CFR Part 418.22)

I Notified Hospice of Marion County at ____:____ am/pm on ____/____/____