DIGNIFIED DECISIONS
END OF LIFE CARE PROGRAM

PHYSICIAN CERTIFICATION OF TERMINAL ILLNESS — ORDER TO ADMIT TO HOSPICE

PATIENT NAME (PLEASE PRINT):		
ADDRESS:		
TELEPHONE:	MEMBER ID#:	
PHYSICIAN NAME (PLEASE PRINT)	LICENSE #	NPI
ADDRESS		
PHONE	FAX	

☐ I will continue as the attending physician for this patient.

☐ I prefer the Hospice physician act as the attending physician for this patient.

I certify that this individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course and request the above-named individual be admitted for hospice services.

Physician Signature ____________________ Today's Date ____________

CLINICAL INFORMATION FOR HOSPICE ADMIT

Diagnosis:	Secondary Diagnosis:
Other Health Conditions:	Additional Current Clinically Relevant Information:

COMPLEX CASE MANAGEMENT

Patient has:

☐ Ventilator

☐ BIPAP

☐ Implanted devices (Peg, Tracheostomy, mediport, pacemaker, stents, catheters).

Please specify: ____________________

The patient is receiving:

☐ IV therapy. Please specify: ____________________

☐ IV antibiotics. Please specify: ____________________

☐ Radiation therapy. Site/Duration: ____________________

☐ Chemotherapy. Drugs/Duration: ____________________

☐ Hormonal therapy. Drugs/Duration: ____________________

There is a plan for:

☐ Surgical procedures. Please specify: ____________________

☐ Further diagnostic testing. Please specify: ____________________

☐ Other support therapies or invasive procedures: ____________________

PLEASE COMPLETE ALL INFORMATION ON THIS FORM. SIGN and fax to 1-212-510-5265.

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