PATIENT INFORMATION

Name _______________________________________________ DOB _________________

Phone _________________________________________________

Medicare/Medicaid or Insurance # _______________________________________________

Diagnosis ________________________________________________


I authorize the use of telehealth and telecommunications as necessary and appropriate for this patient's treatment

Hospice Evaluation and admit to hospice if Appropriate

If admitted, and patient chooses, I wish to remain the patient's primary attending physician

If admitted, and patient chooses, have ____________________________________________
or the local medical director serve as attending


PHYSICIAN SIGNATURE: ____________________________ DATE: ________________

PLEASE PRINT NAME: __________________________________________

Face Sheet, MAR, H&P attached.

Last updated 4.9.20