

***** By completing this form you are authorizing Hospice of Westchester to contact the patient's physician**

PATIENT INFORMATION	
Patient Name	
Date of Birth	Social Security
Home Phone	Cell Phone #
Address	Apt/ Bldg #
City	Zip
Lives With	
Emergency Contact	
Relationship to Patient	
Contact Home Phone #	Contact Cell Phone #

PHYSICIAN INFORMATION	
Physician Name	
Telephone	Fax
Email:	
<input type="checkbox"/> Verbal Cert Obtained	Date: _____
HOW Signature: _____	

INSURANCE INFORMATION	
Insurance Company	
Insurance ID #	

No further aggressive treatment MD willing to sign death certificate MD willing to participate in plan of care/ order meds

I certify that the above beneficiary is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

***Attach: H&P/ Clinical note to this referral**

Terminal Diagnosis: _____

BRIEF NARRATIVE STATEMENT (review the individual's clinical circumstances and synthesize the medical information to provide clinical justification for admission to hospice services). **NOTE:** Dementia and failure to thrive are NOT hospice appropriate diagnoses.

Attestation: I confirm that I composed this narrative and it is based on my review of the patient's medical record and/or examination of the patient.

Name of Attending Physician

Signature of Attending Physician

Date

Gary Tatz

Name of Hospice Medical Director

Signature of Hospice Medical Director

Date

Effective Date of Certification: ___/___/___

Benefit Period from: ___/___/___ **to:** ___/___/___

PLEASE COMPLETE IMMEDIATELY AND FAX TO ALLOW FOR PROMPT EVALUATION OF YOUR PATIENT.
THANK YOU