PHYSICIAN INITIAL CERTIFICATION AND ORDER TO ADMIT

Please evaluate and admit ____________________________________ for hospice services.
(Patient's Name)

I certify that this patient has a life expectancy of six (6) months or less if the terminal illness runs its normal course.

In accordance with your patient's wishes, please indicate the extent to which you will be involved in the direct care of the patient after admission to Hospice of the Golden Isles:

☐ I assign my patient's overall care to the Hospice Medical Director as attending physician.

☐ I am willing to continue as attending physician for my patient. (**Please select one below**):

- ☐ I wish to be contacted directly for all order changes.
- ☐ I wish to have the Hospice Medical Director serve as a consultant for pain and symptom management. (Recommendations will be made by the Medical Director and you will be contacted for orders and Rx.)
- ☐ I wish to have the Hospice Medical Director manage all pain & symptom orders.

☐ I wish to sign the Death Certificate. In my absence, the Hospice physician may sign the Death Certificate.

Verbal Order received by _________________________ _____________________
Nurse's Name Date

______________________________________ _____________________
Attending Physician's Signature (REQUIRED) Date (REQUIRED)

____
Attending Physician's Printed Name

Please fax to Hospice of the Golden Isles 912-265-6100

1692 Glynco Parkway * Brunswick, GA 31525

Phone 912-265-4735 *866-275-6801

www.hospice.me

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