Referral Fax 919-209-5150

For questions call Access Department: 919-209-5100

Name of person completing this referral:____

Patient: ____

Primary Diagnosis:____

Facility Name (print):____

Facility Telephone: Facility Fax:____

Physician's name:____
Required

Date:____________________________________

Number of Pages to follow:

FAX IN:

☐ This sheet signed by physician
☐ H&P / Hospital discharge summary
☐ Demographic Sheet / Face Sheet (include DOB, SS#, insurance information, responsible party)
☐ Medication list
☐ **Hospice Evaluation – Johnston Home Care and Hospice/ SECU Hospice Care** (please check box)

Physician Signature Date____

Certification of Terminal Illness can be signed by physician and faxed along with this referral.

FOR QUESTIONS CALL: 919-209-5100

PLEASE FAX TO 919-209-5150

ATTENDING PHYSICIAN'S ORDER FOR HOSPICE SERVICE AND CERTIFICATION OF TERMINAL ILLNESS

Date:___________________________________

Patient Name____: **I.D. #**______________________
LAST FIRST MI

Physician Name: ____

☐ I will continue to serve as this patient's attending physician. If I am unavailable, I give permission for orders for this patient to be obtained from a Johnston Hospice Care physician or an alternate physician in my practice.

☐ I would like a Johnston Hospice Care physician to serve as the patient's attending physician.

I certify to the best of my medical knowledge that this patient is terminally ill with a life expectancy of six (6) months or less if the terminal illness runs its normal course. I understand that Medicare requires that physician employees of Johnston Hospice Care may write orders for this patient to address unmet general medical needs.

Physician:____ **Date:**__________________________________
SIGNATURE