Request for Hospice Order

Please sign and fax back if in agreement

Patient First Name Last Name
Date of Birth Date

Order: Hospice to evaluate; if hospice Medical Director determines patient is eligible for hospice, admit to hospice.
If patient/family choice; are you willing to be the attending practitioner for hospice services? (circle one) YES / NO
Referring Practitioner First Name Last Name

Signature

Date
Date

Goshen HomeCare & Hospice Intake Department
Phone: 574-364-2495
Fax: 574-364-2835
GHHIntake@goshenhealth.com