



# HOSPARUS HEALTH

## ADMISSION & REFERRAL

### Action Required Physician Signature Needed

Please fax completed form to Hosparus Health Admission & Referral Office  
Fax: 812-945-4733

<b>Patient Name:</b>			
<b>Patient DOB:</b>		<b>Hosparus Health ID#:</b>	
<b>Patient Address:</b>		<b>Patient Contact Phone Number:</b>	

**PHYSICIAN ORDER:**

Assess and Admit to Hosparus Health Services (PHYSICIAN: Fax H&P and Demographics sheet)

Is patient currently receiving

**Chemo**     Yes     No     Not known

**Radiation**     Yes     No     Not known

If yes, please attach the chemo and/or radiation treatment plan for coverage determination.

ONE BOX MUST BE CHECKED:	
<input type="checkbox"/> <b><u>I do not want to be attending.</u></b>  <i>I would like the Hosparus Health Medical Staff to follow as attending.</i>  <b>PROCEED TO BOTTOM FOR SIGNATURE AND DATE</b>	<input type="checkbox"/> <b><u>I want to be attending.</u></b> <b>PLEASE READ AND CHECK THE REMAINING BOXES AS APPLICABLE, AND SIGN AND DATE</b> <input type="checkbox"/> Based on the patient's diagnosis and current condition, I expect this patient has a limited life expectancy of six (6) months or less, if the terminal illness runs its normal course, and hereby certify this patient as eligible for hospice care.  <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> ComfortPak Order  <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> Hosparus Health Symptom & Wound Management Protocols Authorized PRN

**PHYSICIAN SIGNATURE:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Please Print Physician Name:** \_\_\_\_\_

**Confidentiality Notice:**

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