Ionia Area Hospice

PHYSICIAN CERTIFICATION OF TERMINAL ILLNESS

Patient Name: _____ **Chart #:** _____

1. Patient Certification – *Please provide a diagnosis, narrative, and complete signature section*.

I certify that the patient named above has the following life limiting diagnosis which, if it follows its expected course, will have a prognosis of six months or less. Please admit this patient to hospice.

_____

(Terminal Diagnosis)

Federal guidelines require a brief narrative supporting the diagnosis above:

_____

_____

_____

Attending/Certifying Physician Signature: _____ **Date:** _____

Attending/Certifying Physician Printed Name: _____

2. Designate a Physician

I designate the following responsibility for patient care as follows (choose one)

- ❑ Hospice of Lansing/Ionia Area Hospice Medical Director
- ❑ I will manage this patient's care. If I am unavailable, please contact:

  Physician Name and Phone #: _____
- ❑ I have arranged for the following Physician(s) to assume care for the patient

  Physician Name and Phone #: _____

3. Death Certificate will be signed by (choose one):

❑ Medical Director ❑ Myself ❑ Physician named above

Please fax back to 517-882-8822

Thank you in advance for your assistance. We appreciate your continued partnership.

5/16

FOR IN OFFICE USE
Benefit Period _____
Dates _____ to _____