Rev. 07-13-2016; 05-09-2017

# HOSPARUS HEALTH

**ADMISSION & REFERRAL**

# Action Required
# Physician Signature Needed

**Please fax completed form to Hosparus Health Admission & Referral Office**

**Fax: 502-458-2246**

| **Patient Name:** | | | |
|---|---|---|---|
| **Patient DOB:** | | **Hosparus Health ID#:** | |
| **Patient Address:** | | **Patient Contact Phone Number:** | |

**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:**

☐ **I do not want to be attending.**

***I would like the Hosparus Health Medical Staff to follow as attending.***

**PROCEED TO BOTTOM FOR SIGNATURE AND DATE**

☐ **I want to be attending.**

**PLEASE READ AND CHECK THE REMAINING BOXES AS APPLICABLE, AND SIGN AND DATE**

☐ 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.

☐ **Yes** ☐ **No** ComfortPak Order

☐ **Yes** ☐ **No** Hosparus Health Symptom & Wound Management Protocols Authorized PRN

**PHYSICIAN SIGNATURE:** ______________________________

**Date:** ____________________ **Please Print Physician Name:** ______________________________


**Confidentiality Notice:**
This message is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient they are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.