CORPORE SANO
Home Health & Hospice

Five-Star Quality Rated
Centers for Medicare and Medicaid Services

Hospice Certification Order / Certificate of Terminal Illness

Patient's Name _____ D.O.B. _____

Insurance _____ SSN _____

Is the patient competent to sign Consent for Hospice Care? ☐ YES ☐ NO If No, please list DPOA

Next of Kin/ DPOA Name: _____ Relationship: _____

Services Requested

☐ Hospice Evaluation /Admission ☐ Specific Order/Other_____

TERMINAL DIAGNOSIS: _____

Comorbidities: ☐ CHF ☐ DM ☐ COPD ☐ Ischemic heart disease ☐ Pain ☐ Neoplasia ☐ CVA ☐ ALS ☐ Parkinson's ☐ Alzheimer's

☐ Renal Failure ☐ Liver Disease ☐ Cancer ☐ Dementia ☐ Other_____

Certification Statement

Benefit Period: ___ 1st ___2nd **(90 days)** _____-_____

Based on our clinical judgment regarding the normal course of this patient's illness, We certify that this patient is suffering from _____(a terminal illness) with a life expectancy of six (6) months or less.

Certifying Physician Narrative Statement: (Review the individual's clinical circumstances and medical information to provide clinical justification for admission to hospice services.)

_____

_____

_____

_____

I hereby certify that I composed this narrative based on my review of the patient's medical record or my examination of this patient.

Attending Physician Printed Name _____ **Phone** _____

Attending Physician Signature _____ **Date of Signature** ____/____/_____

Verbal Certification taken by: _____ Date of VO/VC____/____/_____

Medical Director Signature_____ **Date of Signature** ____/____/_____

Verbal Certification taken by: _____ Date of VO/VC____/____/_____