

AMERICAN CARE

A Hospice Company

Hospice Evaluation Form

Date ___/___/___

Patients Name _____ M ___ F ___ DOB _____

Patients Address _____

Contact person to arrange evaluation (circle one) Patient Caregiver

Patients contact number () _____

Primary Caregiver name and number _____

Hospice Diagnoses _____

Attending Physician _____ NPI _____

Ref. contact name _____ Contact Number _____

Is patient aware of terminal prognosis (circle one) Yes No

Reason for hospice _____

Evaluate for hospice admission and admit if appropriate

Please choose one of the options below:

If admitted to hospice, I agree to be the patient's attending physician if requested by patient or authorized representative

OR

If the patient is admitted to hospice, I decline to serve as the patient's attending physician if chosen to do so.

Dr. _____ (print name)

Dr. _____ (signature)

Contact number () _____