Hospice Evaluation Form

Date___/___/____ Office/Facility Name_____

Patients Name_____M___ F___ DOB_____

Patients Address_____

Medicare/Medi-Cal, Ins._____SS#_____

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

☐ 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 ( )_____

THANK YOU FOR CHOOSING AMERICAN CARE HOSPICE!