

**HOSPICE OF SANTA CRUZ COUNTY
ATTENDING PHYSICIAN CERTIFICATION**

To: _____ Fax: _____ Phone: _____
 From: ADMISSION DEPT Fax: 831- 430-9271 Phone: 831- 430-3093
 Regarding: _____ Terminal Dx: **CANCER** Date: _____

The above named patient/family has expressed an interest in Hospice services.. Medicare guidelines documentation of prognostic data. The prompts below are intended to make the process as convenient as possible.

Please confirm terminal dx: _____

Primary dx/site: _____
 Confirmed by: biopsy CT MRI _____

Metastatic disease/site: _____
 Confirmed by: biopsy CT MRI _____

	Yes	No
I support hospice care at this time	<input type="checkbox"/>	<input type="checkbox"/>
I will be pt's attending physician	<input type="checkbox"/>	<input type="checkbox"/>
I have discussed px with patient/family	<input type="checkbox"/>	<input type="checkbox"/>
I will sign the death certificate	<input type="checkbox"/>	<input type="checkbox"/>

Based on the information indicated above, the above named patient has a medical prognosis that life expectancy is 6 months or less, if the terminal illness runs its normal course.

 Telephone Order by Date

 Physician Signature Date