Physician Certification for Pediatric Hospice Services
Immediate Attention Requested

Name of Patient: ☐ Male ☐ Female	Patient DOB:
Referring Physician:	Referring Physician Fax: Referring Physician Phone:
Hospice Diagnosis:	

- I (Referring physician) authorize Alive Hospice to assess and admit the patient to hospice care.
- We (Referring/Attending physician and Alive Hospice Medical Director) certify the patient's medical diagnosis to be a life-threatening/ limiting condition, and has a 50% chance of dying in 6 months.

Physician giving verbal order:	Nurse receiving verbal order/ Date of verbal order Read back completed: ______________(initials)

REFERRING PHYSICIAN SIGNATURE / Date

- For questions, call Alive Monarchs at 615/963-4828 (Pediatric Intake Specialist)
- For complete referral also include *patient demographic sheet* and *recent clinical notes*.

FAX TO ALIVE MONARCHS: 615-963-4807

~ Alive Hospice use only ~	Hospice P#:
Admitting nurse signature Date	Referral Date: Start of First 90 day benefit period:
Alive Physician giving verbal order: ☐ N/A written signature below	Nurse receiving verbal order/ Date of verbal order Read back completed: ______________(initials)
Alive Hospice Physician Signature Date	Clinical notes:
If appropriate: ☐ An Alive Hospice Pediatric Medical Director is acting as the attending physician.	
☐ PED-Home Care ☐Residence-PED ☐ StThomas-PED ☐ Skyline-Madison-PED	

FAH0070 9/4/08