CAROLINA CARING

PHYSICIAN REFERRAL / CERTIFICATION FORM

Referral & Certification

Certification Period Dates		
Benefit Period____	Start:_____	End Date:_____

Patient: Last, First _____

Terminal Diagnosis: _____

Primary Physician: _____

- I request Hospice services to be provided by Carolina Caring.
- I certify that this patient is terminally ill with an expected prognosis of six months or less, if the terminal illness runs its normal course.
- I have discussed the disease process with the patient and family and to the best of my knowledge, they understand the terminal nature of the illness and the prognosis.
- I will accept responsibility for signing the death certificate.
- I am the patient's primary physician and agree to work with Carolina Caring to provide care to the patient.
- I certify that during the patient's enrollment in Carolina Caring all treatment interventions will be palliative and coordinated with me as primary physician.

Re-Election

☐ The patient is re-electing the Hospice Medicare/Medicaid Benefit after previously revoking for the following reason _____

_____

Acknowledgement

SIGNATURES/DATES

☐ Verbal order authorizing admission and certifying prognosis of six months or less

_____ _____
Staff Signature for Attending MD Verbal Order — Date

_____ _____
Attending Physician Signature — Date

_____
Staff Signature for Medical Director Verbal Order — received from:

_____ _____
Hospice Physician Name — Date

_____ _____
Carolina Caring Medical Director Signature (if re-election) — Date

Patient Name - Last, First	MR#