Hospice Brazos Valley

ADMISSION AND REFERRAL

Patient Name:		Patient DOB:	
Patient Address:		Patient Contact Phone # :	

ONE BOX MUST BE FILLED OUT AND PHYSICIAN SIGNITURE BELOW

Physician Order

Assess and Admit to Hospice Brazos Valley if appropriate, I would like to **turn over** total care to the Hospice Brazos Valley Medical Director as the attending physician.

Upon patient death, I would like to be notified:

- ☐ At time of death, even during night, weekends & holidays **OR**
- ☐ Next business day.
- ☐ I will sign the Death Certificate.

TORB Per: ______________________________
Physician Name

______________________________ ________ ________
Nurse receiving order Time Date

Physician Order

Assess and Admit to Hospice Brazos Valley if appropriate:

- ☐ I would like to **continue** as the attending physician for this patient while on Hospice Brazos Valley and wish to write all orders for care. **OR**
- ☐ I would like to **continue** as the attending physician for this patient while on Hospice Brazos Valley and have Hospice Brazos Valley Medical Director manage signs and symptoms.

Upon patient death, I would like to be notified:

- ☐ At time of death, even during night, weekends & holidays **OR**
- ☐ Next business day.
- ☐ I will sign the Death Certificate.

Certification of Terminal Illness: This patient has a terminal illness with a medical prognosis of six months or less to live, if the illness runs its normal course.

TORB Per: ______________________________
Physician Name

______________________________ ________ ________
Nurse receiving order Time Date

______________________________ ______________________________ ____________
Physician Signature Printed Name Date

**** PLEASE SIGN AND RETURN VIA FAX WITHIN 48 HOURS TO 979-822-0169****