SPRINGHILL
HOME HEALTH & HOSPICE

Order for Hospice Services

Patient Name: _____

Hospice Diagnosis: _____

Physician Name: _____

Phone Number: _____ Fax Number: _____

_____

Physician Signature/Date

OR

V.O:_____

Physician Name/RN Name/RN Signature/Date

Please indicate one of the following:

- ☐ **I wish to continue to follow care if the patient is appropriate for hospice.**
- ☐ **I wish for the hospice medical director to follow care if the patient is appropriate for hospice.**
- ☐ **I wish to be contacted prior to the patient's admission to hospice.**

Please include:

- **Face Sheet (including DOB, SSN, address, & contact information)**
- **H&P**
- **Labs/Diagnostics, if applicable**
- **Office Visit Notes, if applicable**

DME/Special Needs:_____

Mobile Office:
Phone: (251) 725-1268
Fax: (251) 725-0070

Baldwin Office:
Phone: (251) 626-5895
Fax: (251) 626-0665