Logo

Description automatically generated with low confidence

**ORDER TO EVAL AND TREAT PROVIDER FAX**

|  |  |
| --- | --- |
| **Patient Last Name:** | **Patient First Name:** |
| **Patient Phone Number:** | **Patient DOB:** |
| **Patient Address:** | |

Patient and or Personal Representative is aware of referral: \_X\_\_\_\_ YES \_\_\_\_\_ NO

**PROVIDER ORDER: OK TO EVAL AND TREAT FOR HOSPICE**

|  |
| --- |
| Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ |

From: Anna Dudzik

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