

**ORDER TO EVAL AND TREAT PROVIDER FAX**

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| --- | --- |
| **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**

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

From: Anna Dudzik

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