



— caring from the heart since 1984 —

Physician Evaluate and Treat Order

Patient Name:

Date of Birth:

PID#

Hospice RN to perform Initial Assessment and admit to hospice services.

I would like to maintain exclusive management of my patient's care with no assistance at this time. I will sign death certificate for my patient at time of death

I would like to continue as the Attending Physician regarding my patient's care, with the HeartsWay Medical Directors managing pain control and symptom management. HeartsWay Medical Directors to sign the Death Certificate and provide me correspondence and/or consult with me as needed.

I would like HeartsWay Hospice Medical Directors to assume care as the Attending Physician while under hospice care. HeartsWay Hospice Medical Directors to sign Death Certificate.

Physician Name *(Please Print)*:

Physician Signature:

Date:

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www.heartswayhospice.org