SYMPONIA HOSPICE
We Are Compassion

PRIMARY CERTIFICATION

Admitting Diagnosis: _____ ID-9 Code: _____

Patient Name: _____ Record#: _____

Start of Care: _____ Attending Physician: _____

- I hereby certify to the best of my ability within the realm of current medical records, that the prognosis indicates a life expectancy of six months or less, provided the disease continues on its normal course of progression.

- Clinical information and other documentation support the terminal condition and co-morbidities.

Verbal order received by: _____

Yes ☐ No ☐ I will turn over care to the Hospice Medical Physician to manage all medical certification, pain control, and symptom management for all diagnoses.

Signature: _____ Date: _____