Karen Ann Quinlan Memorial Foundation

Hospice Medical Director CERTIFICATION OF TERMINAL ILLNESS
90 Day Certification

Patient Name: _____ **Certification period:**_____**thru** _____

NDOC#: _____ **MR#:**_____

Start of Care Date:_____

Terminal Diagnosis: _____

Medications **NOT RELATED** to Hospice diagnosis (es): **Reason**

_____ _____

_____ _____

_____ _____

_____ _____

PERSON WHO SAFELY ADMINISTERS MEDICATIONS_____

☐ **Medication profile reviewed - above/attached**

In my professional opinion, the above-named patient has a medical prognosis such that his or her life expectancy is six (6) months or less if the terminal illness runs its normal course, and hospice services are reasonable and necessary to the palliation and management of the terminal illness and related conditions.

MD Narrative: To include history of disease progression to date and effect of co-morbid conditions.

_____

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_____

_____

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_____

Based on these finding, it is my clinical judgment that this patient's prognosis is for a life expectancy of six months or less if the disease runs the normal course. By signing my signature, I attest that I composed the above narrative based on my review of the medical record, and the result of the Face to Face encounter, if applicable, documented above.

Printed Hospice Physician Name:_____

Physician Signature:_____**Date:** _____

Faxed to Attending Physician _____ on _____ by _____ (optional)