Physician Information

1. This hospice patient ____________________ has been admitted for **HOSPICE RESPITE CARE**. (Name of Patient)

2. **HOSPICE RESPITE CARE** admissions are for the purpose of retaining a rest period for the caregiver. This admission is to be no longer than five (5) days in duration.

3. I acknowledge and will advise the facility nursing staff responsible for providing care to this patient that **HOSPICE RESPITE CARE** is intended to be an extension of home care. It is not necessary for admission laboratory or other diagnostic procedures to be done.

4. This patient has a Hospital DNR form: Yes______ No_____ 

5. The High Peaks Hospice (HPH) team that has been caring for this patient will continue to see the patient during hospitalization. The hospice RN case manager is: ________________________________ and can be reached at ________________________________ between the hours of 8 am and 4 pm.
   (Name of HPH Staff)  
   (Phone Number)  
   After 4 pm and before 8 am and on weekends/holidays call the After Hours nurse at 518-891-0606.

6. If the patient develops new symptoms requiring a change in medications or any diagnostic procedures, I will confer with the Hospice Head of Nursing (HON) or RN Case Manager to discuss the possibility of changing the patient’s status from **HOSPICE RESPITE CARE** to another Hospice classification.

I have read and acknowledge the above criteria for a **HOSPICE RESPITE CARE ADMISSION**.

Date____________________ Admitting Physician___________________________________