PARAGON
HEALTHCARE

HOSPICE ORDER FORM

Phone: 866.972.5888 | Fax: 866.491.5888

Patient Name: ______________________ DOB: __________ Sex: ☐ M ☐ F

Delivery Address: ______________________ Patient SSN: __________

City: __________ State: ______ Zip: ______ Phone: __________

☐ *Demographics Attached*

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK

Primary Insurance: ______________________ Phone: __________

Policy Number: __________ Group Number: __________

Secondary Insurance: ______________________ Phone: __________

Policy Number: __________ Group Number: __________

MEDICAL INFORMATION

Hospice Diagnosis: ______________________

Treating Diagnosis: ______________________

Height: ______ Weight: ______ Allergies: ______________________

Line/Access: ______________________ # Lumens: __________

Ordering Physician: ______________________ Phone: __________

HOSPICE ORDERS - *Please attach DEA triplicate for all pain management orders if applicable*

HOSPICE INFORMATION

Hospice Agency: ______________________

Person Submitting Order Signature: ______________________ Date: __________

Print Name: ______________________

Call Back Number: ______________________

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately. If you have received this document in error and then destroy this document immediately.

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