



## Order to Eval & Treat Provider Fax

<b>Patient Last Name:</b>	<b>Patient First Name:</b>
<b>Patient Phone Number:</b>	<b>Patient Date of Birth:</b>
<b>Patient Address:</b>	

Patient and or Personal Representative is aware of referral:  Yes  No

### PROVIDER ORDER: OK TO EVAL AND TREAT FOR HOSPICE

Diagnosis: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

From: Tammy Johnston APRN, AGNP-C  
Minnesota Hospice  
17645 Juniper Path Ste 155  
Lakeville MN, 55044  
P: 952-898-1022

**Confidentiality Notice:** *The information contained in this facsimile message may be privileged and confidential and is intended only for the use of the individual(s) or entity above who have been specifically authorized to receive it. If the reader is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone, and return all the pages to the address shown above.*