MinnesotaHospice
THE GOLD STANDARD of Care

Order to Eval & Treat Provider Fax

Patient Last Name:	**Patient First Name:**
Patient Phone Number:	**Patient Date of Birth:**
Patient Address:	

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