

FAX TRANSMITTAL



(PLEASE PRINT)

FROM:	DATE
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PATIENT NAME

TO: ACCESS DEPARTMENT
Tidewell Hospice

FAX TO: 941-894-1780
8 PAGES (including cover)

The following is a list of documents contained in the consent package. Please print and complete forms as instructed. Place name of patient where applicable. Use check off below to verify all completed forms.

For questions call: 941-894-1777

- CONSENT FOR CARE** – Sign and Date/Witness Sign and Date
(Tidewell will enter start date at time of admission)
- HOSPICE MEDICARE BENEFIT ELECTION FORM** – Sign and Date/Witness Sign and Date.
(Tidewell will enter start date at time of admission)
- AGENCY FOR HEALTH CARE ADMINISTRATION** – Sign – Do NOT DATE
(Tidewell will enter election date at time of admission)
- ADVANCE DIRECTIVES PATIENT ACKNOWLEDGEMENT** – Complete but do NOT sign.
- MEDICARE SECONDARY PAYER QUESTIONNAIRE** – Complete and include insurance information if known on question 11
- DO NOT RESUSCITATE ORDER** – Sign and print
- TIDEWELL TRICARE/CHAMPUS BENEFIT ELECTION FORM**
Military Insurance – Complete only if applicable, Sign and Date/Witness Sign and Date.
(Tidewell will enter start date at time of admission)

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Tidewell Hospice's mission is to provide the highest quality of care that embraces a comprehensive continuum of services for patients and families dealing with advanced illness.