Date: [Insert Date]

To: [Hospice Facility/Organization Name]
Attention: Admissions Department
Address: [Insert Address]

RE: Patient Transfer and Certification of Terminal Illness
Patient Name: [Insert Patient Name]
Date of Birth: [Insert Date of Birth]
Medical Record Number: [Insert MRN]

To Whom It May Concern,

I am writing to formally request the transfer of the above-named patient into your hospice program. Based on my clinical evaluation and the patient's current medical history, it is my professional opinion that the patient has a terminal prognosis.

Primary Diagnosis: [Insert Primary Terminal Diagnosis]
Secondary Diagnoses: [Insert Related Comorbidities]

Clinical Summary:
The patient has reached a stage in their illness where curative treatments are no longer effective or desired. Recent clinical findings include [insert brief summary of decline, e.g., weight loss, repeated hospitalizations, or organ failure]. I certify that this patient's life expectancy is six months or less, should the illness run its normal course.

Plan of Care:
The goals of care have been transitioned to comfort measures, symptom management, and quality of life. The patient and their legal representative, [Name of Representative], have been informed of the prognosis and have consented to hospice enrollment.

Transfer Details:
The patient is currently located at [Current Location/Hospital Unit] and is ready for transfer on [Date]. Please find the attached medical records, medication list, and signed Advance Directives.

If you require further clinical documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
Physician Name: [Insert Printed Name]
NPI Number: [Insert NPI Number]
Facility/Practice: [Insert Facility Name]