ALLEVIATE HOSPICE CARE INC.
13098 Borden Ave Sylmar, CA 91342
Phone: (818) 433-4558 * Fax: (818) 452-3833
E mail: alleviatehospicecareinc@gmail.com

CHANGE IN ATTENDING PHYSICIAN

_____ who elected hospice services
(Name of Patient/Representative)

on _____ designated **Dr.** _____ as my chosen
(Date of Admission)

Attending physician to provide my Hospice care effective _____
(Date of Change)

The physician I have chosen to serve as my attending physician is,

Name of the Doctor:
_____

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(Return to Office)

PATIENT NAME: _____ **DATE:** _____

SIGNATURE: _____

HOSPICE REPRESENTATIVE: _____