PalliativeCare Center

Consulting & Education

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Community Palliative Care Referral Form

Please fax any related documentation as listed below:

□Demographics (Face Sheet) □Insurance Cards □Last 2 office visit notes □Medication profile

Demographics	Patient Name:_____ Date of Birth:_____ Address:_____ City, State, Zip: _____ Phone:_____or _____ □ Male □ Female Alt. Contact Name:_____ Alt. Contact Phone:_____ Relationship:_____ Patient SSN:_____
Treatment Plan	**Reason for referral:** □Pain □Anxiety/Depression □Goal Clarification □Dyspnea □Advanced Care Planning □Other(specify) _____ **Related Diagnoses:** □Cancer (specify)_____ □Lung disease (specify)_____ □Heart disease (specify)_____ □Dementia_____ □ ALS_____ □ Other_____ □ Evaluate and Treat **OR** □ Recommendations Only
Referral Source	Referral Source:_____Phone:_____ Fax:_____ Relationship to patient: □PCP □Hospitalist □Specialist □Other_____ PCP:_____ Phone:_____
Request Status	□ Priority-(acute symptom palliation) Patient will be seen as soon as possible. □Non-Urgent- (discussions of treatment goals, advanced care planning, non-acute symptom management) Patient will be seen within two weeks.

Provider Signature:_____ Date: _____ Time: _____

Our role is to support you in caring for your patient on an outpatient basis by providing education and symptom management for improved quality of life.