Family Palliative Care

# Palliative Care Referral Form

Referral Name: _____ Ph:_____

Referral Date: _____ Time: _____

Facility: _____

**Fax to 260.589.2595**

**Please provide any related documentation as listed below. Thank you.**

| | | | |
|---|---|---|---|
| Facility face sheet | X-ray, MRI, CT scan reports | Cardiology reports | Medication profile |
| Insurance documentation | Labs | Last office visit note | Treatment plan |

| | |
|---|---|
| **Demographics** | Patient Name:_____ Date of Birth: _____<br>Address:_____ SSN:_____ □ M □ F<br>City, State, Zip:_____ Alt. Contact Name:_____<br>Phone: _____ Alt. Contact Phone:_____<br>Relationship:_____<br>If in Facility: Facility:_____ Room:_____ Discharge Date:_____<br>Patient skilled? □ No □ Yes Skilled Benefit End Date:_____ |
| **Evaluate and Treat as Indicated** | **Reason for referral:**<br>□ Pain<br>□ Nausea & Vomiting<br>□ Anxiety<br>□ Behaviors<br>□ Constipation<br>□ Diarrhea<br>**Related Diagnoses:**<br>□ Cancer: (specify)_____<br>□ COPD<br>□ Heart: (specify)_____<br>□ Lupus<br>□ Dementia: (specify)_____<br>□ Injury: (specify)_____<br>□ Other: (specify)_____ |
| **Referring Provider** | Referring MD/NP/PA: _____ Phone #:_____<br>Relationship to patient: □ PCP □ Hospitalist □ Specialist Fax #: _____<br>Attending Physician:_____ Phone #:_____<br>Specialist:_____ Phone #:_____ |
| **Evaluation Location** | □ Palliative Care Office □ Hospital _____ Room #_____<br>□ Home □ NF_____ Room #_____ Skilled □ Y □ N |
| **Payer Information** | Primary Insurance:_____ Insurance #: _____<br>Insurance Phone:_____ Insured Member:_____<br>Social Security #:_____<br>(If different than patient)<br>Secondary Insurance:_____ Insurance #: _____<br>Insurance Phone:_____ Insured Member:_____<br>Social Security #:_____<br>(If different than patient)<br>**(May provide information or attach face sheet/copy of card)** |