A.dvanced I.llness M.anagement

**Palliative Care Referral Form**

4277 Middle Settlement Rd, New Hartford, NY 13413 Tel: 315-735-6484

**Fax to 315-624-0416**

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

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| Facility face sheet | Labs, X-ray, MRI, CT scan reports | Specialist office note | Medication profile |
| Physician order | Last PCP wellness visit and office visit | Advanced Care Directives | Treatment plan |

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| --- | --- |
| **Demographics** | Patient Name: Date of Birth: Home Address: SSN: □ M □ F City, State, Zip: Patient phone: Alt. Contact name:: Alt. Contact Phone:  Special needs: Relationship: |
| **Evaluate and Treat as Indicated** | **Reason for referral: Primary Diagnoses:**   * Pain * Gastrointestinal (N, V, D, C) * Neurological * Psychosocial Comorbidities: * Dyspnea * Functional * Spiritual * Advanced Care planning (HCP, Molst) * Patient is Homebound or needs assistive devices to leave the home |
| **Referring Provider** | Referring MD/NP/PA: Phone #: Relationship to patient: □ PCP □ Hospitalist □ Specialist Fax #: Attending Physician: Phone #: Specialist: \_ Phone #: |
| **Evaluation Location** | * Physician Office □ Hospital Room # Discharge Date: * Home □ NF Room # Skilled □ Y □ N |
| **Payer Information** | Primary Insurance: Insurance #: Insurance Phone: Insured Member:  Secondary Insurance: Insurance #: Insurance Phone: Insured Member:  Social Security #: (If different than patient)  **(May provide information or attach face sheet/copy of card)**  **To facilitate the process, please fax medical records and insurance info.** |

