**A.**dvanced **I.**llness **M.**anagement

**Palliative Care Referral Form**

4277 Middle Settlement Rd., New Hartford, NY 13413 Tel: 315-735-6484 Fax: 315-624-0416

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

Facility face sheet Labs, X-rays, 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ € M € F  Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Alt. Contact name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt. Contact Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Health Care Proxy € Y € N If yes, name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Power of Attorney € Y € N If yes, name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Special Needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Evaluate and Treat as Indicated** | Reason for referral: Primary Diagnoses:  € Pain Comorbidities:  € Gastrointestinal (N, V, D, C)  € Neurological  € Psychosocial  € Dyspnea  € Functional  € Spiritual  € Advanced Care planning (HCP, MOLST) |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (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.** |