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.** |

