# Palliative Care Referral Form

## Demographics

| | |
|---|---|
| Patient name: | Date of birth (DOB): |
| Address: | Alternate contact name: |
| City, state, ZIP: | Alternate phone: |
| Phone: | Relationship: |
| Language/Ethnicity: ☐ M ☐ F | |
| Primary care physician (PCP)/attending physician: | Phone: |

## Insurance

| | |
|---|---|
| Member ID: | LOB: ☐ Medicare ☐ Medi-Cal ☐ Commercial ☐ PPO |
| Participating physician group (PPG): | PPG phone: |

## Evaluate and treat as indicated

**Reason for referral:**

- ☐ Pain management
- ☐ Disease management
- ☐ Functional decline
- ☐ Behavioral health
- ☐ Emotional support
- ☐ Socio-economic support
- ☐ Spiritual support
- ☐ Other _____

**Related diagnoses:**

- ☐ Cancer (specify): _____
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Heart/Congestive heart failure (CHF) (specify): _____
- ☐ Liver disease
- ☐ Renal (specify): _____
- ☐ GI condition (specify): _____
- ☐ AIDS
- ☐ Other _____

Would you be surprised if the member expired within 12 months? ☐ Yes ☐ No

Has the member had > 2 emergency room (ER) visits in the last 6 months? ☐ Yes ☐ No

Has the member had > 2 inpatient admits in the last 6 months? ☐ Yes ☐ No

Additional history: _____

_____

## Current location

☐ Home OR ☐ Hospital: _____ Room: _____

Estimated discharge date: _____

Skilled ☐ Yes ☐ No ☐ SNF/B+C/ALF: _____ Room: _____

## Send completed form to:

Fax to: 844-907-0436

A fax cover sheet must accompany all fax transmissions of protected health information. The cover sheet must be labeled "PROTECTED HEALTH INFORMATION."

Email to: careconnections@healthnet.com for the online form to download and complete. For questions, contact 916-935-2273 (CARE).

**For internal use only**

Referral source: _____ Phone: _____

☐ PCP ☐ Vendor ☐ PPG ☐ CM ☐ Other _____

Assigned vendor: _____



23-1034 (9/23)