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: _____

23-1033 (9/23)