CHRISTUS®
Palliative Care
St. Frances Cabrini
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Palliative Care Consult Order

☐ Demographic Sheet Attached

Patient name: _____

Patient Phone: _____ Patient Email: _____

Patient address: _____

DOB: _____ SSN: _____

Caregiver name: _____ Phone: _____

Referring Physician/NPP: _____ Phone: _____

Patient Primary Care Physician: _____ Phone: _____

Primary diagnosis: _____

Secondary diagnosis: _____

REASON FOR REFERRAL *(please check all that apply)*

☐ Transition to comfort/hospice education

☐ Symptom management:

☐ Pain ☐ Nausea ☐ Anxiety ☐ Depression ☐ Diarrhea ☐ Insomnia

☐ Dyspnea ☐ Vomiting ☐ Delirium ☐ Constipation ☐ Fatigue

☐ Goals of care

☐ Disease trajectory understanding

☐ Prognostic awareness

☐ Complex decision-making

☐ Coping w/ serious illness/diagnosis

☐ Advance Care planning/code status

☐ Other _____

PALLIATIVE CARE CONSULT TO ASSESS, EVALUATE, RECOMMEND AND/OR ESTABLISH PLAN OF CARE:

_____ Physician/NPP make recommendations only

_____ Physician/NPP may write orders. Will update patients referring/primary care physician

PLEASE PROVIDE IF DEMOGRAPHIC SHEET NOT AVAILABLE:

Medicare#: _____ Medicare Supplement#: _____

Other Insurance Name: _____ Contract#: _____

Insurance Contact#: _____

Name: _____ Phone: _____ Fax: _____

Physician Signature: _____ Date: _____