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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: _____