



HOME CARE SERVICES-PALLIATIVE CARE

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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: \_\_\_\_\_