# Palliative Care Referral Form

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| **Demographics** | Patient name:_____ Date of birth:_____<br>Address:_____ Alt. contact name:_____<br>City, state, ZIP:_____ Alt. contact number: _____<br>Phone:_____ Relationship:_____<br>Language/ethnicity:_____ ☐ M ☐ F<br>PCP/attending physician:_____ Phone: _____ |
| **Insurance** | Member ID#: _____ LOB: ☐Medi-Cal<br>PPG:_____ PPG contact number: _____ |
| **Evaluate and treat as indicated** | **Reason for referral:**<br>☐ Pain management<br>☐ Disease management<br>☐ Functional decline<br>☐ Behavioral health<br>☐ Emotional support<br>☐ Socio-economic support<br>☐ Spiritual support<br>☐ Other:_____<br>**Related diagnoses:**<br>☐ Cancer (specify):_____<br>☐ COPD<br>☐ Heart/CHF(specify): _____<br>☐ Liver disease<br>☐ Renal (specify):_____<br>☐ GI (specify):_____<br>☐ AIDS<br>☐ Other (specify):_____<br>Would you be surprised if the member expired within 12 months? ☐ Yes ☐ No<br>Has the member had more than two emergency room visits in the last six months? ☐ Yes ☐ No<br>Has the member had more than two inpatient admissions in the last six months? ☐ Yes ☐ No<br>Additional history:_____ |
| **Current location** | Home ☐ ☐ Hospital:_____ Room #: _____ Est D/C date: _____<br>Skilled ☐ Yes ☐No ☐ SNF/B+C/ALF: _____ Room #: _____ |
| **Send completed form to:** | cindy.tatu@healthnet.com, stephanie.m.espinoza@centene.com and gabriele.pierce@healthnet.com<br>Phone for questions: (949) 677-9154 Fax#: 1-800-677-4156 |
| **For internal use only:** | Referral source:_____Phone #:_____<br>☐ PCP ☐ Vendor ☐ P P G ☐ C M ☐ Other: _____<br>Assigned vendor:_____ |