

# Palliative Care Referral Form

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

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