Partners IN HOME CARE | BRINGING HEALTHCARE HOME

Palliative Care Referral

Patient Demographics

Name	DOB	Language
		English: ______ Other: __________ Needs Interpreter: Yes No

Referring Information *(*) indicated required field*

Referring Provider	*Patient Aware of Referral	*Type of Referral
○ Patient is self- referral	○ Yes, patient aware of referral ○ No, patient is unaware of referral	○ NP Consult ○ Co-Management of Care

*Referral Reason	*Patient has life-threatening Illness	Specific PMH

○ Symptom Management:
  ○ Pain
  ○ Dyspnea
  ○ Depression/ anxiety
  ○ Diarrhea/ constipation
  ○ Fatigue/ insomnia
  ○ Nausea/ vomiting/ anorexia
○ Illness understanding.
○ Treatment decisions
○ Coping w/ life threatening illness
○ Advance care planning
○ Complex disposition needs
○ Psychiatric illness
○ Medication non-adherence
○ Substance abuse
○ Frequent ED/ hospital visits
	○ Cancer- GI
	○ Cancer- Thoracic
	○ Cancer- Head and Neck
	○ Cancer- GU
	○ Cancer- Breast
	○ Cancer- other
	  ○ Specify: __________
	○ Non-cancer COPD
	○ Non-cancer Cardiac Disease
	○ Other:
	  ○ Specify: __________
		○ Medication non-adherence
		○ Substance abuse
		○ Not applicable
		*Requested Urgency
		○ Routine
		○ Within 1-2 weeks
		○ 24-72 Hours
		○ Patient self-referral
		*Requested Location
		Patient Adress, or SNF/ALF Location Missoula City Locations Accepted at this time

Additional comments and patient accommodations and specific needs:

Provider Signature: **Date:**

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