Consultants for Palliative Medicine

Referral Form
Referral Phone: 336-532-0100
Referral Fax: 336-532-0516

Patient Name: _____DOB: _____
Last First MI

Primary Diagnosis: _____

Referral is for Palliative Medicine:

❑ In Home

❑ Independent Living, Assisted Living, Memory Care, Skilled or Long Term Care Community

Are there any other service providers involved in the patient's care? ❑Yes❑No

If Yes (Explain): _____

Referral has been discussed with patient: ❑Yes❑No If other than patient:

(Specify): _____

Desired Response Time for Referral

❑ *High – (significant sudden changes, urgent needs, etc.)
*Contact to be made by palliative medicine team within 72 hours.
❑ Low - Contact to be made by palliative medicine team within 10 days.

Reason for Referral (Check all that apply)

Goals of Medical Treatment:
❑ Higher level of care needs
❑ Code Status
❑ Home Health vs. Hospice
❑ Discuss Continuing Aggressive Therapy vs. Initiating Comfort Care
❑ Other:

Change in Patient Status:
❑ Newly Diagnosed with Complex Medical Illness
❑ Recent Clinical Decline
❑ Disease Progression
❑ Multiple Hospital Admissions
❑ Other:

Symptom Management:
❑ Pain ❑ Shortness of Breath ❑ Constipation
❑ Nausea/Vomiting ❑ Anorexia
❑ Other:

Provider Name (Print): _____ **Date:** _____

Provider Signature: _____ **Date:** _____

Person Completing Referral: _____ **Phone:** _____

Please Fax:❑Demographics ❑Insurance Card ❑History & Physical ❑Office notes/Discharge summaries

For office use only:

Verbal order received from _____ in Dr. _____ office on _____
Date

_____ _____
Entered by (Nurse/NP Name and Credentials) Date

Revised 12-1-17