

Palliative Care Referral Form

Fax: 877-926-5332

Phone: 877-868-2528

Intake@totalcare2u.com



PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____ Building #: _____ or Apartment #: _____

INSURANCE INFORMATION

Medicare #: _____ Secondary Insurance Carrier: _____

ID #: _____ Group # (if applicable): _____ Effective Date: _____

HOME HEALTH INFORMATION

Home Health Name: _____ Telephone: _____ Fax: _____ Email Address: _____

(If Different from HHA) Referral Name: _____ Fax: _____ Phone: _____

In the event the patient becomes appropriate for hospice care, you may optionally provide the name of a preferred hospice agency.

Hospice Agency Name: _____ Telephone: _____ Fax: _____

Email Address: _____

Qualifiers listed below are provided for guidance only and do not establish eligibility. All referrals are welcomed. Patients whose insurance is accepted and who reside within our service area will be scheduled for an initial physician evaluation, during which appropriateness for palliative care will be determined.

- Advanced chronic illness with functional decline (e.g., CHF, COPD, Dementia)
- Recent hospitalization with poor prognosis or high symptom burden
- Frequent ED visits or hospitalizations due to symptom crises
- Poorly controlled symptoms despite standard care
- Need for goals-of-care discussion, advance care planning, or hospice transition

Why is this patient being referred to palliative care:

NOTICE:

Referrals for palliative care must include needs beyond opioid or pain medication management alone. Patients seeking opioid management only, without broader palliative care needs, will not be appropriate for this program.

MEDICAL RECORDS MUST BE ATTACHED TO REFERRAL

EMAIL / FAX COMPLETED FORM AND MEDICAL RECORDS TO:

INTAKE@TOTALCARE2U.COM / 877-926-5332