Palliative Care Referral Form

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Total Care 2 U
Care is our specialty. Our priority is you.

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

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