Palliative Care Referral Form

Fax: 877-926-5332
Phone: 877-868-2528
Intake@totalcare2u.com

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

PATIENT INFORMATION

Patient Name: _____ DOB:___/___/____

Address:_____ Building #____or Apartment #:____City:_____State:____Zip:_____

Phone: _____

HOME HEALTH INFORMATION

Home Health Name: _____ Telephone: _____ Fax: _____

Email Address:_____

(IF Different from HHA) Referral Name:_____ Fax #:_____ Phone #:_____

INSURANCE INFORMATION

Medicare #: _____ Secondary Insurance Carrier: _____

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

CRITERIA FOR PALLIATIVE CARE REFERRAL **(select ALL that apply)**

☐ 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

Reason for visit (what needs to be addressed): _____

Trigger for referral (why now): _____

EXCLUSION CRITERIA: *Patients referred for any of the exclusion criteria listed below will not qualify for the TC2U Palliative Care program.*

- Primary chronic pain syndromes without life-limiting illness
- Patients seeking opioid management without broader palliative needs
- Stable patients with well-managed symptoms and no goals-of-care needs
- Primary psychiatric or addiction treatment needs

Please do not refer patients for chronic pain syndromes needing opiate pain medication

PLEASE ATTACH MEDICAL RECORDS TO THIS REFERRAL

EMAIL COMPLETED REFERRAL TO: INTAKE@TOTALCARE2U.COM

OR

FAX COMPLETED FORM TO: 877-926-5332