Community
PALLIATIVE CARE
of Hospice of North Idaho

REFERRAL FORM

Patient information

Last name:_____ First name:_____ Middle initial:_____

Date of birth:_____ Phone:_____

Contact person:_____ Relationship:_____ Phone:_____

Schedule appointments with: ☐ Patient ☐ Contact person

Provider information:

Primary care physician (PCP):_____ Phone:_____

Referring provider if different from PCP:_____ Phone:_____

Reason For Consult:

☐ Complex Symptom Management (specify) _____ ☐ Goals of Care Discussion

☐ Code Status Review ☐ Advanced Care Planning (completion of POST and Advanced Directives)

☐ High Risk Care Transition - High symptom burden/risk for impending decompensation/rehospitalization

☐ Pre-hospice Consultation ☐ Patient/family chronic illness-related counseling with social worker

☐ Chronic Illness or dementia education/caregiver support ☐ Other (specify in comments)

Primary Diagnosis:_____

CPC provides expert multidisciplinary palliative care consultation through comprehensive management of complex symptoms for those with life-limiting illness. Chronic pain management NOT associated with life-limiting illness should be referred to a pain management clinic. Untreated/undiagnosed psychiatric illness requires evaluation by a behavioral health specialist.

Comments:_____

_____

Consultation Type:

☐ Co-management/shared care (care recommendations sent to referring office)

☐ Assume primary palliative management (palliative orders written by CPC)

Comments:_____

Acuity Level of Referral:

☐ Routine (within 2-6 weeks)

☐ Urgent (within 2 weeks)

Physician/NP/PA Signature: _____ Date: _____

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