

To: _____ From: _____

Fax: _____ Pathway's Fax (970) 663-1180

Pathway's Admission Phone (970) 292-2388 Date: _____

Patient Name: _____ DOB: _____

Hospice Referral **Palliative Care Referral** **Both**

By requesting both services if a patient is not appropriate for hospice then we can pursue Palliative Care

Please provide the following documentation if available:

- Face Sheet
- Current Medication List
- Applicable Labs
- History and Physical including most recent weight along with weight from 6 months ago
- Most recent Physician/NP note
- MPOA/Advanced Directives/5 WISHES

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Referral for Palliative Care: (Please check appropriate reason(s) below)

- Pain (unacceptable level of pain or other distress for more than 24hrs)
- Shortness of breath (unrelieved by current treatment regimen)
- Severe anxiety/restlessness
- Constipation
- Significant change in mental status
- Appetite or eating problems associated with an advanced illness
- Difficult behaviors related to Dementia
- Multiple ER/admissions to the hospital (3 or more within 12 months)
- Patient and/or family having difficulty coping with the stress of their illness and need support
- Patient and/or family needs guidance with complex medical decision-making
- Other _____

Pathways Palliative Care has permission to prescribe and/or change medications related to symptom management and to notify the primary physician of changes. YES NO

Physician Name Printed: _____

Physician Signature: _____ Date: _____

IS THIS AN URGENT REFERRAL? YES NO

After the Initial Consultation how would you prefer to be updated Phone or Fax

From all of us at Pathways Hospice We Thank You!

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