Pathways Hospice®
Community Care for Northern Colorado

REFERRAL / ORDER FORM

Pathways Supportive Services

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**

==========

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!