

To submit completed form, Please fax to (831) 430-9271 or email to intake@hospicesantacruz.org

REFERRAL FORM

HOSPICE OF SANTA	

Demographics		
Patient Name:	Alternate contact name/relationship:	
Address:	Alternate contact number:	
City, State, ZIP:	Primary Care Physician:	
Telephone:	Contact Number:	
Language Preference:	Specialists/Other MDs:	
Date of Birth (DOB):	Contact Number:	

Referral Source Name/Title: Fax: Reason for Referral (check all that apply) Symptom Management Pain – Cancer or non Cancer related COPD Anxiety/Depression Bowel Management Dyspnea Nausea/Vomiting Existential Distress Primary Diagnosis Cancer – Type COPD CHF COPD CHF Liver Disease Renal Documents provided with referral (please attach the following):								
Reason for Referral (check all that apply) Symptom Management Pain – Cancer or non Cancer related Anxiety/Depression Bowel Management Dyspnea Nausea/Vomiting Existential Distress Fax: Cancer – Type COPD CHF Liver Disease Renal Documents provided with referral (please attach the following):	Patient Needs							
Reason for Referral (check all that apply) Symptom Management Pain – Cancer or non Cancer related Anxiety/Depression Bowel Management Dyspnea Nausea/Vomiting Existential Distress Primary Diagnosis Other: CANCER – Type COPD CHF Liver Disease Renal Documents provided with referral (please attach the following):	Referral Source Name/Title:	Phone Number:						
Symptom Management Pain – Cancer or non Cancer related Anxiety/Depression Bowel Management Dyspnea Nausea/Vomiting Existential Distress Cancer – Type COPD CHF Liver Disease Renal Documents provided with referral (please attach the following):	Email:	Fax:						
□ Pain – Cancer or non Cancer related □ Anxiety/Depression □ Bowel Management □ Dyspnea □ Nausea/Vomiting □ Existential Distress □ Documents provided with referral (please attach the following):	Reason for Referral (check all that apply)	Primary Diagnosis						
Anxiety/Depression Bowel Management Dyspnea Nausea/Vomiting Existential Distress CHF Liver Disease Renal Documents provided with referral (please attach the following):	Symptom Management	Cancer – Type Other:						
□ Bowel Management □ Dyspnea □ Nausea/Vomiting □ Existential Distress □ Documents provided with referral (please attach the following):	☐ Pain – Cancer or non Cancer related	COPD						
□ Dyspnea Renal □ Nausea/Vomiting □ Existential Distress □ Documents provided with referral (please attach the following):	☐ Anxiety/Depression	CHF						
□ Nausea/Vomiting □ Existential Distress □ Documents provided with referral (please attach the following):	☐ Bowel Management	Liver Disease						
☐ Existential Distress	□ Dyspnea	Renal						
Existential Distress (please attach the following):	□ Nausea/Vomiting	Description of the description o						
□ Other	☐ Existential Distress	•						
	□ Other							
High Risk Factors Authorization form	High Risk Factors							
☐ Med Non Compliance Demographics	☐ Med Non Compliance	Patient ID/insurance cards H&P/medical records/POLST/AHD Labs/imaging/diagnostics						
□ Low health literacy	☐ Low Health Literacy							
☐ Frequently Missed Appointments	☐ Frequently Missed Appointments							
Frequent Hospitalizations of ED visits	☐ Frequent Hospitalizations or ED Visits							
Other:	□ Other	Other:						
Other Support Needs Insurance	Other Support Needs	Insurance						
Conflict Management within the circle of patient,	 Conflict Management within the circle of patient, 	Nadiore Nadi CAL MadiMadi						
family, and health care team Medicare Medi-CAL MediMedi	family, and health care team	Medicare Medi-CAL MediMedi						
☐ Goals of Treatment Other:	☐ Goals of Treatment	Other:						
☐ Advance Care Planning Needs ———————————————————————————————————	☐ Advance Care Planning Needs							
Other Member ID:	□ Other	Member ID:						

Other				
Has your patient had 2 or more ED visits within the last 6 months?	Yes	No		
Has your patient had two or more admissions to the hospital within the last 6 months?	Yes	No		
Would you be surprised if your patient died within the next 12 months?	Yes	No		