Transitional & Palliative Care Services

A PROGRAM OF HOSPICE OF SANTA CRUZ COUNTY

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

REFERRAL FORM

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:**

Patient Needs

Referral Source Name/Title:	**Phone Number:**
Email:	**Fax:**

Reason for Referral (check all that apply)

Symptom Management
- ☐ Pain – Cancer or non Cancer related
- ☐ Anxiety/Depression
- ☐ Bowel Management
- ☐ Dyspnea
- ☐ Nausea/Vomiting
- ☐ Existential Distress
- ☐ Other _____

High Risk Factors
- ☐ Med Non Compliance
- ☐ Low Health Literacy
- ☐ Frequently Missed Appointments
- ☐ Frequent Hospitalizations or ED Visits
- ☐ Other _____

Other Support Needs
- ☐ Conflict Management within the circle of patient, family, and health care team
- ☐ Goals of Treatment
- ☐ Advance Care Planning Needs
- ☐ Other _____

Primary Diagnosis

Cancer – Type COPD CHF Liver Disease Renal	Other:

Documents provided with referral (please attach the following):

Authorization form
Demographics
Patient ID/insurance cards
H&P/medical records/POLST/AHD
Labs/imaging/diagnostics
Other:

Insurance

Medicare   Medi-CAL   MediMedi

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

Additional questions?	**phone** (831) 430-3030 **fax** (831) 430-9271 www.hospicesantacruz.org/transitional-palliative-care/