



Supportive (Palliative) Care Referral

Phone: 1-530-621-7820 Fax: 530-622-7032

Patient's Name: _____ **DOB:** _____

Diagnosis: _____

Primary Care Physician: _____

I understand that the patient referenced above must have a **qualifying diagnosis**. Consultation services may be provided by a Board Certified Palliative Medicine Physician or a Board Certified Nurse Practitioner during Supportive Care services. Please admit to **Supportive (Palliative) Care**. If you feel your patient requires hospice care, please call 1-530-621-7820.

_____ **Date:** _____
Print Referral Provider Name Provider Signature

THANK YOU FOR REFERRING YOUR PATIENT TO SUPPORTIVE (PALLIATIVE) CARE

Upon completion, please fax this form, along with records requested below, to:

Fax: 530-622-7032

Primary point of contact and phone number for scheduling: _____

Patient demographic sheet

History & Physical

Copy of insurance card

Diagnostic reports (CT, MRI, PET scan, lab tests, biopsy, x-ray, etc.)

Social Services notes

Physician progress notes

Height/Weight

Other: _____

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