Snowline Health

Palliative Care Referral Phone:
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 palliative care services. Please admit to **Palliative Care**. If you feel your patient requires hospice care, please call 530-621-7820.

_____ _____ **Date:** _____

Print Referral Provider Name **Provider Signature**

THANK YOU FOR REFERRING YOUR PATIENT TO SNOWLINE 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: _____