

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.

Print Referral Provider Name

Provider Signature

Date:

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:_____

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