ResolutionCare Home-Based Palliative Care Referral Form V11.1.19

Referring To

Date of Referral:	**Phone:**	**Fax:**
Specialty: Palliative Care	707-442-5683	707-442-2006

Referring to Provider Name, Practice Name & Address:
ResolutionCare

Please Schedule:
☐ Urgent (appointment within 7 days)
☐ First Available with any Provider or specific provider listed_____
☐ Routine Appointment with Specific Provider listed:

Referring from Provider's Name: **Supervising MD (if applicable):**	**Phone:**	**Fax:**
Person Completing Referral:	**Practice Name:**	

Type of Referral

☐ Medical Consultation: (Evaluate and advise with recommendations for management and send back to PCP)
☐ Procedural/Diagnostic test: (Specialist to confirm need for and perform procedure/diagnostic test if deemed necessary)
☐ Procedural/Diagnostic testing with consult: (Same as above with addition of consulting with patient regarding results)
☐ Co-management: (I prefer to share the care for the referred condition(PCP lead, first call))
☐ Co-management: (Please assume principal care for the referred condition(Specialist assumes care, first call))
☐ Specialist to Specialist - Secondary Referral - **Send copy of this referral to patient's PCP**
☐ Other (designate):

Patient Information

Patient Name:		**If child, Parent:**
DOB:	**Address:**	**City/Zip**
Daytime Phone:	**Patient Insurance Type:** ☐ **Partnership** ☐ **PPO** ☐ **HMO** ☐ **Medicare** ☐ **Work Comp** ☐ **Other**	
Insurance Auth #:		☐ **Copy of card attached (Front & Back)**

Clinical Information

Reason for Referral (*Clinical Question*):

Required Documentation:
☒ Problem list ☒ Medications lists ☒ Allergies ☒ Recent labs ☒ Pertinent imaging reports
☐ Pre-work(See Specialist's Clinical Guidelines) ☒ Relevant clinical notes (do not include non relevant records)
☒ Other:

Reason for referral discussed with patient? ☒ Yes ☐ No: Explain

Referral Tracking (to be completed by Specialty Office)

Referral Tracking

Referral Received Date: (Fax back to Referring provider to acknowledge receipt of referral)

Request for additional information (please detail):

Appointment Scheduled with:	**Date & Time:** ☐ Referral deemed routine (not urgent)

☐ Patient Cancelled/No showed for appointment ☐ Patient will schedule at a later date
☐ Unable to contact patient ☐ Patient did not call for appt ☐ Other: