



Home-Based Palliative Care Referral-Adult

Please complete this form and return toll-free to:

Fax: (415) 813.2017

If uncertain of eligibility or if you have palliative care referral questions, please call the By the Bay Health Palliative Care Intake Line at (415) 444.9210, available Monday-Friday 8:30 a.m.-5:00 p.m.

PATIENT INFORMATION *(If information is on attached Face Sheet, feel free to write "see Face Sheet")*

Last Name: _____ First Name: _____ DOB: _____

Phone (home): _____ Mobile: _____

Address: _____ City: _____ Zip: _____

Place of Service: ☐ Home ☐ Facility _____ ☐ Other _____

Insurance: _____ Subscriber ID: _____

Surrogate Decision Maker Name (if applicable): _____

Phone Number: _____ Email Address: _____

Primary Care Provider Name: _____ Phone Number: _____

REASON FOR REFERRAL

- ☐ Symptom Management (chronic/persistent and requiring long-term management)

Please list symptoms: _____

- ☐ Assessment and/or discussion about hospice eligibility and transition planning

- ☐ Advance care planning (POLST and/or Advanced Directive completion)

- ☐ Goals of Care conversation facilitation

- ☐ Emotional/Social Challenges arising from the serious illness

- ☐ Complex care coordination & healthcare navigation support

- ☐ Other: _____

Primary Diagnosis:

- ☐ Cancer ☐ CHF ☐ COPD ☐ Liver Disease ☐ Renal Disease

- ☐ Advanced Dementia

- ☐ Other medical issue (specify): _____

REFERRAL INFORMATION

Person Making Referral: _____ Relationship to Patient: _____

Phone: _____ Email: _____

INSTRUCTIONS

Please include:

- ☐ Face Sheet/Demographics (include family contact)

- ☐ Recent History and Physical (and last MD visit note)

- ☐ Any pertinent consultation reports

- ☐ Copy of Payer/Insurance Card *(unless information is included on face sheet)*

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