Date:		Ohio Living Palliative Medicine **Phone: 844.312.7479** **Fax: 419.948.4047**	**Internal Use Only**
Program Requested	☐ Palliative Care ☐ Hospice Is Patient currently on HH services? ☐ Yes ☐ No		**Territory:**
			Liaison:
Primary Decision Maker:			**Nurse Practitioner:**
			SS#:

Palliative Diagnosis		**Comorbidities**		**Reason for Palliative Care/ Symptom Management:**
Reason for Referral		**Client Agrees with Referral?** ☐ Yes ☐ No ☐ Unknown		

Last Name		**First Name**		**Middle Initial:**	
DOB		**Gender:**		**Patient Phone**	
Current Location	☐ Private Home ☐ Asst. Living ☐ Nursing Home ☐ Hospital: Discharge Date: _____ Other:				
Patient Address		**City**		**Zip Code**	
Alternative Contact		**Relation**		**Phone**	

Referral Information

Referred By	Physician/Family/LTC: Information			**Referring Contact Phone**	
				Provider Fax	
PCP Name		**Phone**		<u>Primary Care Physician Prefers Palliative:</u> ☐ Consultative Agreement ☐ Collaborative Agreement	
Payor:	☐ Medicare ☐ Medicaid ☐ Medicare Advantage ☐ Insurance ☐ VA ☐ Other				
MBI #		**INS Name**		**INS #**	
Medicaid #					

Patient and Diagnosis Related Information

Anticipated Prognosis	☐ < 3 months ☐ < 6 months ☐ < 12 months ☐ Unknown ☐ Other_____
Attachments to this Referral	☐ Clinical/ progress notes ☐ Lab results ☐ Diagnostic procedures ☐ X-ray/CT/PET/MRI reports ☐ Medication List ☐ DNR ☐ Living will ☐ Last Home Health Note or MD Progress e ☐ Other