

**LIBERTANA CARE PARTNERS-Palliative Care Referral Form**

|  |  |
| --- | --- |
|  **Demographics** |    Patient Name: Date of Birth: \_Address: Alt. Contact Name: \_City, State, Zip: Alt. Contact Number: \_Phone: Relationship:  Language/Ethnicity: [ ]  M [ ]  F  PCP/Attending Physician: \_\_\_\_\_\_ Phone:   |
|  **Insurance** |  Member ID#: LOB: [ ] Medi-Cal Fee for Service [ ] Medi-Cal Managed Care Medi-Cal Managed Care Plan (if applicable) ­­­­­­­­­­­­­­­­­­­­­  Other Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  **Referring****Physician Information** |   Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_ Fax: \_\_ Specialty: \_\_\_\_\_\_\_ |
| **Evaluate and****Treat as****Indicated** |  **Primary Diagnosis Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Reason for referral: Related Diagnoses:** [ ]  Pain Management [ ]  Cancer (specify): \_[ ]  Disease Management [ ]  COPD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Functional Decline [ ]  Heart/CHF (specify):  [ ]  Behavioral Health [ ]  Liver Disease [ ]  Emotional Support [ ]  Renal (specify): [ ]  Socio-Economic Support [ ]  GI (specify): [ ]  Spiritual Support [ ] Neurological(specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Other: [ ] Other (specify): Would you be surprised if the member expired within 12 months? [ ]  Yes [ ]  No Has the member had >2 ER visits in the last 6 months? [ ]  Yes [ ]  No Has the member had >2 inpatient admits in the last 6 months? [ ]  Yes [ ]  No Would you be surprised if the member is hospitalized in the next 6 months? [ ]  Yes [ ]  NoAdditional History:  \*\*Please Attach HISTORY & PHYSICAL with Referral  |
| **Current****Location** | Home [ ]  [ ]  Hospital: Room #: Skilled [ ]  Yes [ ] No [ ]  SNF/B+C/ALF: Room #:   |
| **Send Completed Form to:** | hcohen@libertana.com and palliative@libertana.com  Phone for questions: (818) 902 5000 Fax#: (818) 902 5008 |
| **For Internal Use Only:** |  Referral Source: Phone #:  [ ]  PCP [ ]  Vendor [ ]  PPG [ ] CM [ ]  Other: \_ Assigned Vendor:  |