

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

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| **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  No  Additional 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](mailto:hcohen@libertana.com) and [palliative@libertana.com](mailto: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: |