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:** ☐ Pain Management ☐ Disease Management ☐ Functional Decline ☐ Behavioral Health ☐ Emotional Support ☐ Socio-Economic Support ☐ Spiritual Support ☐ Other:___________________________ **Related Diagnoses:** ☐ Cancer (specify):______________________________ ☐ COPD: ____ ☐ Heart/CHF (specify): __________________________ ☐ Liver Disease ☐ Renal (specify):_______________________________ ☐ GI (specify):__________________________________ ☐Neurological(specify)__________________________ ☐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 and palliative@libertana.com Phone for questions: (818) 902 5000 Fax#: (818) 902 5008
For Internal Use Only:	Referral Source:_____________________________Phone #:_________________________________ ☐ PCP ☐ Vendor ☐ P P G ☐ C M ☐ Other:____ Assigned Vendor:____