Referral Form

Evaluate for: ☐ Hospice (Advanced Serious Illness with life expectancy of 6 months or less)

☐ Palliative Care (Advanced Serious Illness with life expectancy 18 months or less)

☐ Pathways (telephonic support only)

Date: _______________ Name & Contact Number of Person Making Referral: ______________________

Referring Physician: ___________________________ Referring Organization: _______________________

Patient Name: ____ Date of Birth: ________________

Patient Address: ____ Phone: _____________________

Caregiver Name and Contact Number: ____

Relationship to Patient: ____________________________ CHOT should contact: ☐Patient ☐Caregiver

Primary Diagnosis: ☐COPD ☐CHF/Heart Disease ☐Cancer ☐Dementia ☐Other ____________

Primary Care Physician (Name/Phone number): ____

Specialist (Name/Phone number): ____

Is Home Health Care involved: ☐Yes ☐ No Agency: _________________________________

Please Check why you feel Patient is appropriate for Palliative Care or Hospice at this time?

☐Unexplained Weight Loss ☐Frequent Medication Changes ☐ Multiple Falls

☐Multiple/Recurring Infections ☐Increased Shortness of Breath ☐ Mental Status Changes

☐Frequent ER Visits/Hospitalizations ☐Other____

I authorize Community Healthcare of Texas to Evaluate and Treat the above-mentioned patient for Palliative Care or Hospice

____ ___________________

Physician Printed Name **Contact phone**

____ ___________________

Physician Signature (only required for Hospice) **Date**

<u>In order to expedite care and services for your patient, please send Face Sheet, Clinical Record, Medication List, completed Advanced Directive and last Physician H&P.</u>

Please email referral to: chotreferral@chot.org or fax to 800-958-4943

Patient/caregiver will be contacted within 2 hours to set up evaluation visit.