PALLIATIVE CARE SERVICES
Provided by Hospice of Humboldt

Referral to Palliative Care Services

3327 Timber Fall Court • Eureka, CA 95503 • Phone (707) 267-9880 • Fax (707) 445-2204

Please complete this form and return by **fax to (707) 445-2204**
If you have any questions please do not hesitate to call us at (707) 267-9880

If a POLST or Advanced Directive has been completed please attach to referral

Provider making referral: _____ Date of referral: _____

Patient's name: _____ Patient's DOB: _____

Patient's Best Contact Number (and name of contact if not patient): _____

Diagnosis: _____

Please tell us what has been discussed with the patient and about the primary concerns.

SECTIONS BELOW MUST BE COMPLETED TO ACCEPT REFERRAL

☐ Patient has terminal prognosis of one (1) year or less.
☐ Patient (or family if patient is incapacitated) has been told about terminal prognosis of one (1) year, has given permission for the referral, and understands what a Palliative Care Services referral means.

Date of discussion: _____ By whom: _____

Discussion Notes: _____

_____

☐ The patient is currently experiencing unmanaged pain or other symptoms. Please explain:

☐ Describe the current or anticipated therapies or other treatments:

We appreciate your referral and hope to assist your patient during this critical time in their life.

Referral to Palliative Care Services	Created by: Palliative Care Administrative Assistant	Date Created: 02/28/2022
Responsible Director: Director of Patient Care Services	E signature of Director:	Last Review/Revision: 09/22/2023