Referral Fax Number:
336.690.5423

Referral Center Phone Number
336.790.3672

Number of Pages (including cover):_____

REFERRAL FAX FORM

Please fax this form, along with demographic sheet and recent office notes. If applicable, please include discharge summary, hospital palliative care notes, etc.

Name of person completing this referral: ____________________

Patient Name: ____________________

Date of Birth: ____/____/________ SSN: ________ — ________ — ________

Primary Diagnosis (required): ____________________

Community Provider Name (if different from referring provider): ____________________

____

Is the community provider aware of this referral? ☐ Yes ☐ No

Reason for consultation: Please check all boxes that apply.

☐ Advance care planning discussion

☐ Symptom management

☐ Determine goals of care for patient and family

☐ End-of-life decision making

☐ Other: ____________________

What are your concerns about this patient?

____

____

____

____________________	____________________	__________
Referring Provider Name (Print)	Referring Provider Signature (Required)	Date

getpalliative@authoracare.org