



# REFERRAL

## Referral Fax 919-828-9514

Phone: 919-828-0890 (Ask for Access Department)

Date: \_\_\_\_\_

Number of Pages to follow: \_\_\_\_\_

### FAX IN:

- This sheet signed by physician
- H&P / FL2 / Hospital discharge summary
- Demographic Sheet / Face Sheet (include DOB, SS#, insurance information, responsible party)
- Office visit notes within the last 90 days
- ICD-10 codes

Name of person completing this referral: \_\_\_\_\_

Patient: \_\_\_\_\_ Primary Diagnosis: \_\_\_\_\_

Physician (print): \_\_\_\_\_

\*Signature required below

Physician Telephone: \_\_\_\_\_ Physician Fax: \_\_\_\_\_

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Order for Consultation for **Transitions PalliativeCare**

Please check all boxes that apply.

- Symptom management
- Advance care planning/decision making
- Determine goals of care for patient and family
- Patient and family support

Describe reason for referral to Transitions PalliativeCare:

\_\_\_\_\_

\_\_\_\_\_

Do you want recommendations only  Yes  No

Do you want recommendations and have the Transitions PalliativeCare provider write orders?

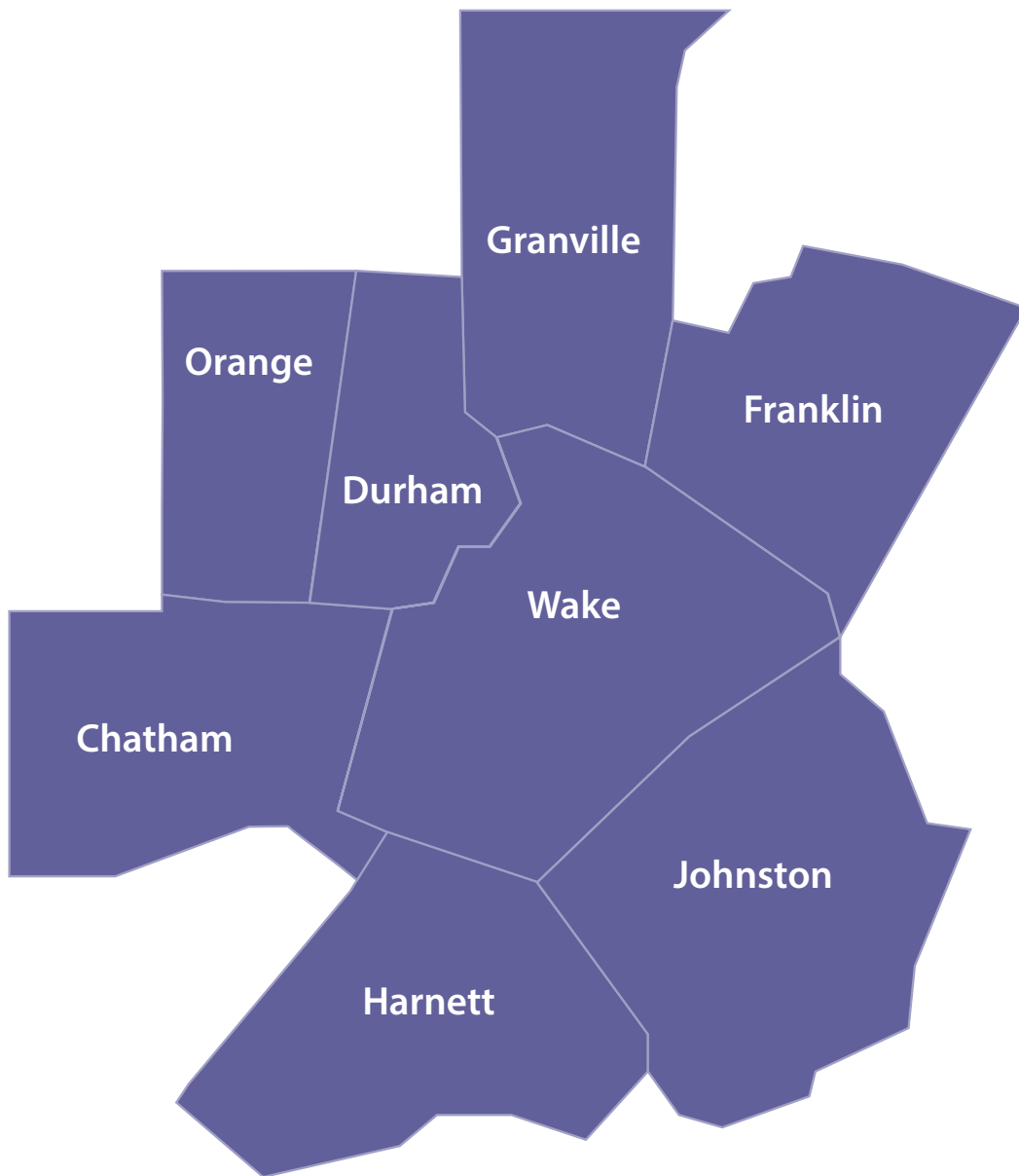
Yes  No

What is the best way to communicate findings of the consult:

phone number \_\_\_\_\_

fax number \_\_\_\_\_

# Coverage Area For Care



919.828.0890  
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[transitionslifecare.org](http://transitionslifecare.org)