REFERRAL

Referral Fax 919-828-9514

Date: ______________________

Number of Pages to follow: ________

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

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: ______________

☐ 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

Granville

Orange

Durham

Franklin

Wake

Chatham

Johnston

Harnett

919.828.0890

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transitionslifecare.org

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