

SHORE REGIONAL PALLIATIVE CARE REFERRAL FORM

Please use this form to provide as much information as possible about your patient being referred to the Shore Regional Palliative Care Outpatient Office and send by fax, **410-822-2534**. If you have any questions, call **410-820-4434**.

REFERRING PROVIDER

PRIMARY CARE PROVIDER

OFFICE CONTACT

OFFICE CONTACT

PATIENT INFORMATION:

NAME (FIRST LAST)

DATE OF BIRTH (MM/DD/YYYY)

REASON/S FOR REFERRAL (please check all that apply):

- Pain Management
- Dyspnea/cough
- Depression
- Anxiety
- Diarrhea/constipation
- Insomnia
- Fatigue
- Nausea/vomiting
- Failure to thrive
- Loss of appetite
- Illness understanding and expectations
- Complex treatment decisions and advanced care planning for health care
- Frequent ED visits/hospital admissions due to disease progression
- Goals of care discussion
- Strategies for coping with serious/advanced illness
- Other (please describe):

CHRONIC/SERIOUS HEALTH CONDITION (please check all that apply):

- Cardiac disease
- Chronic kidney disease
- Chronic lung disease
- Cancer
- Other (please describe):

DEGREE OF URGENCY:

- Routine
- Urgent
- Comments, if any:

FOR THE PATIENT:

Your Palliative Care consult appointment is scheduled for:

(DAY, DATE AND TIME)

at UM Shore Medical Pavilion at Easton
500 Cadmus Lane, Suite 209
Easton, MD 21601

Please call **410-820-4434** if you have any questions or need to reschedule.