Hope Hospice
Affiliated with By the Bay Health

Home-Based Palliative Care Referral-Adult

Please complete this form and return toll-free to:

Fax: (925) 829-0868

If uncertain of eligibility or if you have palliative care referral questions, please call the By the Bay Health Palliative Care Intake Line at (925) 829-8770, available Monday-Friday 8:30 a.m.-5:00 p.m.

PATIENT INFORMATION *(If information is on attached Face Sheet, feel free to write "see Face Sheet")*

Last Name:_____ First Name:_____ DOB:_____

Phone (home):_____ Mobile:_____

Address:_____ City:_____ Zip:_____

Place of Service: ❑ Home ❑ Facility _____ ❑ Other _____

Insurance:_____ Subscriber ID:_____

Surrogate Decision Maker Name (if applicable):_____

Phone Number:_____ Email Address:_____

Primary Care Provider Name:_____ Phone Number:_____

REASON FOR REFERRAL

- ❑ Symptom Management (chronic/persistent and requiring long-term management)
  Please list symptoms: _____
- ❑ Assessment and/or discussion about hospice eligibility and transition planning
- ❑ Advance care planning (POLST and/or Advanced Directive completion)
- ❑ Goals of Care conversation facilitation
- ❑ Emotional/Social Challenges arising from the serious illness
- ❑ Complex care coordination & healthcare navigation support
- ❑ Other: _____

Primary Diagnosis:

- ❑ Cancer ❑ CHF ❑ COPD ❑ Liver Disease ❑ Renal Disease
- ❑ Advanced Dementia
- ❑ Other medical issue (specify): _____

REFERRAL INFORMATION

Person Making Referral:_____ Relationship to Patient:_____

Phone:_____ Email:_____

INSTRUCTIONS

Please include:

- ❑ Face Sheet/Demographics (include family contact)
- ❑ Recent History and Physical (and last MD visit note)
- ❑ Any pertinent consultation reports
- ❑ Copy of Payer/Insurance Card *(unless information is included on face sheet)*