



Please complete this form and return to:

**Fax: (415) 813.2017**

**Pediatric Palliative Intake Phone: (415) 444.9210**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone (home): \_\_\_\_\_ Mobile: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Insurance Coverage: \_\_\_\_\_

**PARENT / GUARDIAN INFORMATION**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

**REFERRAL**

- Pediatric Palliative Care focuses on care coordination, pain and symptom management, family training, anticipatory grief and bereavement support, and quality of life for those facing serious illness and their families.
- If uncertain regarding eligibility or if you have pediatric palliative care referral questions, please call By the Bay Health at (415) 444.9210.

**REFERRING DIAGNOSES/REASON FOR REFERRAL:**

**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*)

**REFERRAL INFORMATION**

***Please evaluate for admittance to home based pediatric palliative care.***

Referring Provider Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Referring Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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