By the Bay Health

Pediatric Palliative Care Referral

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: _____