CHAPTERS
HEALTH®
Palliative Care

Outpatient Palliative Care Referral

For more information, call 813-871-8200.
(Fax or email completed form to 813-357-5501 or PalliativeCareReferrals@chaptershealth.org.)

PATIENT LOCATION: ❒ Home ❒ ALF

PATIENT TYPE: ❒ Adult ❒ Pediatric

PATIENT INFORMATION:

Name: _____ DOB: _____ Sex: ❒ M ❒ F

Caregiver/Responsible Party: _____ Ph: _____

Pt/ALF Phone: (H) _____ (C) _____ (W) _____

Home/ALF Address: _____

City: _____ State: _____ ZIP: _____

Diagnosis (Dx)/ICD-10: _____

INSURANCE (PAYOR) INFORMATION:

Primary Insurance Name: _____

ID#: _____ Group #: _____ Phone: _____

Secondary Insurance Name: _____

ID#: _____ Group #: _____ Phone: _____

REFERRAL SOURCE INFORMATION:

Referring Physician/Provider: _____

Phone: _____ Fax: _____

PATIENT PCP INFORMATION:

Primary Care Physician Name: _____

Phone: _____ Fax: _____

ATTACH TO THIS FORM:

Please note: If all records listed below are not attached, the referral process will be delayed.

❒ **Demographics/Face Sheet**
❒ **Medical Records**

Professional Relations Representative: _____

Territory: ❒ GSH ❒ HOK ❒ HPH ❒ LPH

Thank you for choosing Chapters Health Palliative Care.