alivia supportive care

REFERRAL FORM

Fax to 904.407.8131

Recent Hospitalization?

Hospital: _____

Referral Date: _____

Referral Source: Name _____ Phone _____

Patient Location (please circle one): Home Hospital PCP Specialist LTC/SNF ALF CPC

If facility, please identify: _____

Patient Name (Last, First, MI)	Phone	DOB	Patient Social Security # (if available)
Home Address	City	Zip	Male / Female (circle one)

Primary Contact Person (If not Patient) Relationship

Mobile Phone # _____

_____ _____ Home Phone #_____

Is this the designated health care decision maker? Yes No Does patient have decisional capacity? Yes No

Primary Care Physician	Referring Provider (if not PCP)
Name:	Name:
Phone #:	Phone #:

Reason for Referral: (circle any that apply) ☐ Pain ☐ Other Symptoms ☐ Goals of Care ☐ Advance Care Planning

Other:

Medical Diagnoses/ ICD 10 Code:

Insurance Carrier: _____ Secondary Carrier _____

Insured Name: _____

Policy # _____ Issuer #_____ Policy # _____

To provide the best care possible, please fax the below items to **904.407.8131** so we may prepare for the initial consultation.

_____ Face Sheet
_____ History and Physical
_____ Current Medication List
_____ Most Recent Discharge Summary (if applicable)
_____ Three (3) Most Recent Office Visit Notes
_____ Relevant Consult Reports
_____ Relevant Test Results

The Alivia Supportive Care team provides an Advanced Registered Nurse Practioner (ARNP), specialized in palliative medicine, which will provide goals of care discussions, education about disease progression, advanced care planning, assessment of pain and symptoms with follow up care coordination, and emotional support for patient and caregivers.

Please fax the above items to **Alivia Supportive Care at 904.407.8131**. The team will contact your patient to schedule an in home visit to assess your patient's needs. We look forward to continued collaboration with you in the ongoing care of your patient.

1/31/2023