YoloCares
1909 Galileo Ct, Ste. A
Davis CA, 95618
530-758-5566

Fax Referral

Please fax this form with above mentioned documents to YoloCares at **530-758-9017**.

Date of referral: _____ Phone number: _____

Person making referral: _____

Patient Name: _____ Date of birth: _____

Diagnosis: _____

Comorbidities: _____

Check all that apply:

- ❑ Weight loss
- ❑ Decreased LOC
- ❑ Decreased Albumin
- ❑ Increased weakness
- ❑ Increased assist with AOLs
- ❑ Other: _____

Evidence of decline: _____

Patient's Primary Contact: _____ Phone: _____

Please include:

- ❑ Written order for palliative or hospice care—YoloCares RN to evaluate
- ❑ Patient's face sheet/demographics including Social Security Number, Medicare Number and/or Medi-cal Number
- ❑ POLST form (if available)
- ❑ Most current H & P, past six months of MD office visits, any hospital discharge summaries for the past year, last 2-3 months of laboratory results and imaging studies related to hospice diagnosis

Physician Name: _____

Physician Signature: _____

- ❑ I will be the patient's attending physician while on hospice, signing CTIs and death certificate.

Physician's Office Contact: _____

Office phone number: _____ Fax number: _____

If this is a weekend referral, please **call** Patient Access at 530-902-3573.

Thank you