

Fax Referral

If this is a weekend referral, please call Patient Access at 530.902.3573.

Date of referral: _____ Phone number: _____

Person making referral: _____

Patient Name: _____		Date of birth: _____	
Diagnosis: _____			
Comorbidities: _____			
<i>Check all that apply:</i>			
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Increased weakness		
<input type="checkbox"/> Decreased LOC	<input type="checkbox"/> Increased assist with AOLs		
<input type="checkbox"/> Decreased Albumin	<input type="checkbox"/> 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: _____

Please fax this form with above mentioned documents to YoloCares at 530.758.9017.

Thank you