

Piedmont Palliative Care Services

a program of Hospice of the Piedmont

REFERRAL FAX: 336.889.3450

Referral Department Phone: 336.889.8446

Date: _____

Number of pages (including cover sheet): _____

NO CALL REQUIRED.
Please fax this sheet, along with H&P and demographic sheet for this order.

Please Print Legibly

Name of person completing this referral: _____

Patient Name: _____

Primary Diagnosis: _____
(Required)

Physician Name: _____

Physician Phone: _____ Physician Fax: _____

Order for Consultation by Piedmont Palliative Care Services. Please check all boxes that apply:

- Pain and symptom management
- Determine goals of care for patient and family
- End of life decision making
- Patient and family support
- Other: _____

Fax Palliative Care order on chart

What are your concerns about this patient?
