

**PALLIATIVE CARE CONSULTATION SERVICE**

Phone: (585) 273-1154 Fax: (585) 275-7403  
Strong Ambulatory Care Facility, 3rd Floor, Suite B

(For Office Use Only) <b>Appointment Information</b>
Date: _____
Time: _____
Insurance: _____
Referral #: _____

**PALLIATIVE CARE CONSULTATION REQUEST FORM**

**REFERRAL:**

Patient Name: \_\_\_\_\_ Date of Referral: \_\_\_\_\_  
Med. Rec. # \_\_\_\_\_ DOB: \_\_\_\_\_  
Referring MD: \_\_\_\_\_ Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_  
Family Contact: \_\_\_\_\_  
Primary Diagnosis: \_\_\_\_\_

**Type of Referral:**

Outpatient Consult       Home-based Consult

**URGENCY OF CONSULT:**

Very Urgent (Please call 273-1154 to make special arrangements )  
 First available appointment (1-3 weeks)

**MAIN REASON FOR CONSULT:**

Pain and symptom management       Goals of Treatment       Other  
 Patient and family support       Primary Care at home

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PRESCRIBING PREFERENCES:**

If changes in symptom-relieving medications are recommended, would you prefer:

Palliative Care to make recommendations, but primary team to do all prescribing  
 Palliative Care to make appropriate medication changes, provide scripts, and send primary team a note  
 Palliative Care to take primary responsibility for managing symptoms until stable  
 Would appreciate a phone call to discuss proposed recommendations. Phone: \_\_\_\_\_ Pager: \_\_\_\_\_

**Additional Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_