NCH north country healthcare | Weeks Medical Center

Palliative Care
Lancaster/Colebrook, NH
P (603) 788-5762 F (603)788-5238

Palliative Care Referral Form

Referring Provider:_____ Phone #:_____

Patient Information

Name:_____ DOB:_____

Address: _____ Phone: _____

Does the patient have an Advance Directive, POLST, DNR (check all that apply)?

___ Advance Directive ___Guardian

___POLST ___DNR ___Activated Decision Maker (Guardian, Surrogate, DPOAHC)

___Other (please explain): _____

Primary Contact (if not patient, name and relationship):_____

Primary Contact Phone Number: _____

Primary Diagnosis (check one) *Patient must have a serious illness to qualify for services

___Advanced Cancer ___Dementia

___COPD or Other Respiratory Disease (advanced, life limiting) ___ESRD

___CHF ___Advanced Liver Disease ___Stroke ___Parkinsons

___Other (please explain) _____

Reason for Referral (check all that apply)

___Complex symptom burden ___Goals of care discussion

___Frequent hospitalizations ___Frequent emergency room visits

___Counseling or support ___Advanced care planning

___Difficulty coping ___Care Coordination

Is patient able to physically come to Lancaster or Colebrook offices (circle)? *yes *No

Any additional information we should know?_____

Please include:

*Most recent office notes and/or discharge summary

*Advanced directives if on file

*Activation of DPOA if applicable

**Patient must be able to attend an in-person visit at the Lancaster or Colebrook office. Subsequent visits can be provided via telehealth if needed.