



Pediatric Palliative Care Consultation Request

Our palliative care consult service works in collaboration with primary and/or specialty providers caring for children/adolescents with life-limiting condition, **regardless of life expectancy**, by providing pain & symptom management. A physician or nurse practitioner will provide the consultation and will report back suggestions for care needs to the referring provider.

Name of Patient: <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient DOB:
Consult received from <u>name and title</u> of referring physician:	Referrals Fax:
	Referrals Phone:
	Referrals NPI #:
Chronic/Life Limiting Diagnosis:	
Symptom(s) to be addressed by Pediatric Palliative Care Team:	
<input type="checkbox"/> Request end-of-life/"transition to hospice" discussion	
Please indicate your assessment of the following: 1 = Completely disagree 5 = Completely agree	
The patient has a realistic understanding of his/her disease-process. 1 2 3 4 5 n/a	
The primary caregiver(s) has/have a realistic understanding of the patient's disease-process. 1 2 3 4 5	
Person giving verbal consult request:	
<input type="checkbox"/> n/a written request received	Alive staff receiving consult request/ Date of request Read back completed: _____ (initials)

SIGNATURE of referral source / Date

- For questions, call Alive Monarchs at 615-963-4828
- For complete referral also include *patient demographic sheet (to include patient address, insurance)* and *recent clinical notes*.

FAX TO ALIVE MONARCHS: 615-963-4807

~ Alive Hospice use only ~	R#:
Consult triaged to:	Referral Date:
	Patient seen: