Advanced Illness Care
Referral Form

Referral Guidelines and Process

1. **Insurance accepted: (Columbia Pacific OHP and/or CareOregon Advantage)**
2. **Fax Referral Form and order to (503) 416-1323 or call 971-202-5504 for assistance**

Referral Contact Information

Name of person completing form:_____ Date:_____

Phone #:_____ Email Address:_____

Referral from: ☐ Health Plan ☐ Hospital ☐ Clinic, Name:_____

Please include the following information with referral:

- Recent clinician chart/case notes and labs & recent admission H&P/discharge summary and order for palliative care

Patient Information

Patient Name: _____ DOB:_____

SS#_____ Phone #:_____ Insurance ID#_____

Alternative Contact Name:_____ Relationship:_____

Alt Phone #_____ ☐ POA/Guardian: _____ ☐ Other: _____

Interpreter Needed: ☐ No ☐ Yes, Language: _____

Patient address:_____

Referral Information

Reason for Referral:

Primary Diagnosis:

_____

Is the patient aware of their diagnosis and prognosis: ☐ Yes ☐ No ☐ Unknown

Psychosocial/Safety concerns:

Please include any information that will help with outreach and support of this patient:

Housecall Providers
Part of the CareOregon Family

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Columbia Pacific CCO

Care Team Information:

PCP: _____ Phone # _____

Clinic: _____ PCP is aware of referral? ☐ Yes ☐ No

Specialist: _____ Phone # _____

Clinic: _____ Specialist is aware of referral? ☐ Yes ☐ No

Provider Order

☐ Order in Epic ☐ Order included with referral

☐ Order for community-based palliative care: _____

(Provider Signature)

***OHA rules now require a provider order for Medicaid patients needing community-based palliative care**

If you are uncertain of eligibility or if you have any questions, please call (971) 202-5504.