

Advanced Illness Care Referral Form

Referral Guidelines and Process

1. Insurance accepted: (Jackson Care Connect OHP and/or CareOregon Advantage)
 2. Fax Referral Form and order to (503) 416-1323 or call 541-566-7004 for assistance
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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
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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:

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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 (541)566-7004.