SKYLAND PALLIATIVE MEDICINE

Advanced Illness Management Referral Form

Sylva FAMILY PRACTICE

Fax Referrals to 828/586-5162 or Call us at 828/399-9537

Patient Name:_____ ☐ M ☐ F DOB____/____/_____

Address:_____ SSN:_____

City, State, Zip:_____ Phone: (___)_____-_____

Alt. Contact Name: _____ Alt. Contact Ph:(___)_____-_____

Relationship to patient:_____

Referring MD/NP/PA: _____ Phone #:(___)_____-_____

Relationship to patient: ☐ PCP ☐ Hospitalist ☐ Specialist Fax #: (____)_____-_____

Reason for referral: Discussion of goals of care/ Decision support related to

☐ Cancer: (specify)_____ ☐ Chronic Lung Disease (specify)_____

☐ Cardiac Disease: (specify)_____ ☐ POTS ☐Dementia(specify)_____

☐ Lupus ☐ Ehlers Danlos ☐ Other: _____

Associated Symptoms Related to Serious Illness:

☐ Pain ☐ Nausea & Vomiting ☐ Anxiety ☐ Poor Sleep ☐ Constipation ☐ Diarrhea Other_____

****Note: We generally do not accept patients for chronic pain management outside of chronic serious illness.****

Evaluation Location:

☐ AIM Office Visit ☐ Harris Hospital Consult ☐ Swain Hospital Consult ☐ SNF_____ Room #___

Payer Information: (May provide information or attach Face Sheet/copy of card)

Primary Insurance:_____ Insurance #: _____

Insurance Phone:_____ Insured Member:_____

Secondary Insurance:_____ Insurance #: _____

Insurance Phone:_____ Insured Member:_____

Please provide last note, and any related documentation as listed below. Thank you!

Demographic face sheet X-ray MRI CT scan reports Cardiology reports Medication profile

Insurance documentation Labs Last office visit note Treatment plan