Hope Palliative Care Center
an affiliate of Hope Hospice & Palliative Care Rhode Island

Referral Form

Please fax an automated referral form or complete the information below and fax to (401) 383-2961. Please include the following:

- Copy of note from last office visit
- Discharge summary from hospitalizations in the last six months

Check off one (or more) of the following indicators for referral:

___ Symptom management of a life-limiting illness related to diagnosis or treatment
___ Goals of care for life-limiting illness
___ Advanced care planning

Please note: The Hope Palliative Care Center would not be suitable for patients whose primary needs relate to non-cancer related chronic pain.

Patient's Name: _____ Patient DOB: _____

Patient's Address: _____

Home Phone: _____ Cell Phone: _____

Insurance: _____ Policy #: _____

Referring MD Name: _____ MD Phone #: _____

Referring MD Fax #: _____ PCP (If Different): _____

Current Diagnosis/ Diagnoses: _____

_____

Current Medications: _____

_____

Known Allergies: _____