PALLIATIVE ASSESSMENT TOOL (PAT)
Referral Tool & Palliative Evaluation Order

Does your patient have one or more serious illnesses such as: (Including but not limited to) • Cancer • Congestive Heart Failure (CHF) • COPD, emphysema, lung disease • Kidney Failure • Liver Failure • Neurological Disease (ALS, Parkinson's Disease, Dementia)	Yes	No
Does your patient have s/s that make it difficult to be as active as they would like to be? or impact their quality of life? • Pain or discomfort • Shortness of breath • Fatigue • Anxiety • Depression • Lack of appetite • Nausea	Yes	No
Has our patient recently experienced difficulty with side effects from treatment? • eating problems due to a serious illness • frequent emergency room visits • 3 or more admissions to the hospital within last 12 months for same symptoms	Yes	No
Does your patient need help with: • emotional support • spiritual or religious support	Yes	No
Does your patient need help with: • knowing what to expect from an illness • knowing what programs and resources are available • making medical decisions about treatment choices/options • matching patient goals and values of their medical care • understanding the pros and cons of treatments	Yes	No
Additional Notes:		
If you have answered **"Yes" to 3 or more** questions, your patient may benefit from Community Palliative Care Program. **Patient Name: _____ DOB___/___/___** **Name and Title of Person Referring:_____Date:___/___/___** **Referring Physician: _____phone:_____**	Total Yes	
Choice Health Palliative Care to evaluate and treat for palliative care. **Palliative Diagnosis:** **_____ Date: ___/___/___** **Physician Signature**		

FAX OR EMAIL THIS FORM ALONG WITH THE PATIENT FACESHEET AND H&P TO:
FAX: 806-310-2297 (use area code)
EMAIL: referrals@choicepalliative.com

Call 806-731-4000 if you have questions or need additional information.