Legacy Medical Group–Palliative Care

Physician Referral Form

Phone: 503-413-6862
Fax: 503-225-8813

LEGACY HEALTH | LEGACY MEDICAL GROUP

Date _____

☐ Routine ☐ Urgent

Please include all chart notes, labs, imaging, or anything pertinent to patient's health care and fax to 503-225-8813. **Missing or incomplete information will lead to delay or denial of referral.**

Location for referral

☐ **Legacy Good Samaritan Medical Center**
Medical Office Building 1
2222 NW Lovejoy St, Suite 315
Portland, OR 97210

☐ **Legacy Mount Hood Medical Center**
Medical Office Building 4, Suite 250
25050 S.E. Stark St.
Gresham, OR 97030

☐ **Legacy Meridian Park Medical Center**
Medical Plaza 2, Suite 280
19260 SW 65th Ave.
Tualatin, OR 97062

☐ **Legacy Salmon Creek Medical Center**
Medical Office Building B
2101 NE 139th St, Suite 380
Vancouver, WA 98686

Referral criteria

1. Not a request for primary care, case management, chronic pain management or in-home service.
2. If decision-making capacity in question, surrogate decision maker must present.
3. Patient must not be enrolled in Hospice.
4. Patient has been notified of referral prior to submission.
5. Six month minimum of medical health records (Test results, labs, imaging, or anything pertinent to patient's health care) required pertaining to life limiting illness.
6. Fax referral submission to LMG Palliative Care at 503-225-8813.

Reason for referral

(Please check all appropriate, must select at least one)

☐ Goals of care discussion
☐ Advance care planning, POLST, advance directive completion
☐ Anticipatory guidance
☐ Symptom support (not chronic pain)

Diagnosis related to medical necessity

(Please check all appropriate, must select at least one)

☐ Cancer Diagnosis: _____
☐ Cardiac disease (heart failure, PAH)
☐ CVA (stroke)
☐ Dementia
☐ End-stage liver disease
☐ Renal disease (CKD 4 or ESRD)
☐ Respiratory disease (ILD, IPF, COPD – GOLD Stage 3-4)
☐ Neurodegenerative disease (ALS, PD, MS, HD)

Patient information

Last name _____ First name _____ Middle initial ____

Date of birth _____ Phone _____

Does patient require an interpreter? ☐ Yes ☐ No If yes, what language? _____

Contact person _____ Relationship _____ Phone _____

Schedule appointments with: ☐ Patient ☐ Contact person (please attach ROI/POA)

Provider information

Primary care physician (PCP) _____ Phone _____

Referring provider (if different from PCP) _____ Phone _____