SHARP

Intake Department

Phone 619-667-1900

Fax 619-740-8588

COMFORT CARE REFERRAL FORM

☐ St Paul's PACE ☐ FHC of SD PACE ☐San Diego PACE ☐ Gary & Mary West PACE

Patient Information (please print)		
Name		
PACE info	ID#:	Authorization#:
Patient Sex	☐ Male ☐ Female	DOB:
Telephone	Home:	Mobile:
Address		
City/Zip Code		
Contact Person	Name: Relationship to Patient:	
Contact Phone	Home: Email:	Mobile:
Diagnosis		
PACE IDT Team information:		
Physician:	________________ email:_____________	phone:___________
RNCM:	________________ email:_____________	phone:___________
MSW:	________________ email:_____________	phone:___________
Chaplain:	________________ email:_____________	phone:___________
After hours/on-call:	________________ email:_____________	phone:___________
Other Care Providers	☐ Home Health ☐ Outpatient Rehab ☐Other:	Agency Name: Contact: Phone:
Comments		
Will you be the primary physician while the patient is on hospice? ☐ Yes ☐ No		
PHYSICIAN ORDER		
Name		
Telephone		
M.D. Signature		

Please fax completed form to 619-740-8584 or email to HospiceIntake@sharp.com