uchealth

Neurology/Neuro-palliative Care
1635 Aurora Court, Mail Stop F727
Aurora, Colorado 80045

Palliative Neurologist: Christina Vaughan, MD, MHS
Physician Assistant: Julie Berk, MS, PA-C
Please email this form to Alan R. Hall
alan.hall@uchealth.org
Phone: 720.848.8761, Fax: 720.848.0117

Neurology Supportive & Palliative Care Evaluation Request

For Completion By Referring Physician

I wish to refer my patient for a Neurology Supportive & Palliative Care evaluation and treatment, as appropriate. I have indicated below my preferences for the consult.

Reason for referral and primary life-limiting neurologic diagnosis: _____

Referral is for: □ **One-time Consult** □ **Co-management (most common)** □ **Transfer of care**

□ Goals of Care
□ Advance Care Planning
□ Complex Symptom Management
□ Difficult Medical Decision-Making/Transitions
□ Care Transitions
□ Psychosocial Distress
□ Spiritual Support
□ Carepartner Support
□ Other (Specify)

Certification Statement: I have received authorization from this patient to release the information below, and to permit the staff of the Neurology clinic to contact him/her directly for follow-up.
(Physician signature required below)

Physician Signature: _____ **Date:** _____

Patient Information

Patient Name: _____ Phone: _____

Alternate Phone: _____ Date of Birth: _____ Sex: _____

Address: _____

Diagnosis (neurological condition): _____

Primary Insurance Company: _____ Phone: _____

Name of Insured: _____ Date of Birth: _____

Relationship to Patient:_____ Policy/Plan ID #: :_____ Group ID #: :_____

Secondary Insurance Company: _____ Phone: _____

Name of Insured: _____ Date of Birth: _____

Relationship to Patient:_____ Policy/Plan ID #: :_____ Group ID #: :_____

Referring Physician Information -- Please Provide for Correspondence Regarding Patient

Name: _____ Specialty: _____
Phone: _____ Address: _____
Fax: _____ _____
Email: _____ _____

Additional Information or Instructions

Please include most recent clinic notes and any relevant lab/test results with this referral form.