Referral Form

Patient Name:	**DOB:**
Address:	
Primary Contact:	**Phone:**
Diagnosis:	

Above patient is under my care whom I am referring to Solace Hospice and Palliative Care, Inc. for Hospice / Comfort Care.

Assigned case manager, please fax referral to Solace Hospice & Palliative Care Inc. at 847-250-5467 or email to referrals@solacehospicepci.com. Please include the following:

- ☐ **MD order for Hospice Eval & Treat with Dx**
- ☐ **H&P, Recent Prog Notes (Clinicals)**
- ☐ **Medication Profile**
- ☐ **Labs, Test Results**
- ☐ **Copy of Photo ID & Insurance**
- ☐ **Copy of Advance Directives: DNR/POA**

I certify that above patient is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

Physician Name:	**NPI:**
Address:	**Phone:**
Signature:	**Date:**

Counties Solace serves: Boone, Cook, Dupage, DeKalb, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, Will, Winnebago

Payers Solace accepts: Medicare, Medicaid, AETNA, AETNA Better Health, Blue Cross Blue Shield, Cigna, County Care, Coventry, Healthlink, HFN, Illinicare, Meridian, Molina, Multiplan, United Healthcare, Wellcare, Zing Health