

Pediatric Palliative Care (PPC) Referral and 5-Day Notification

Fax: 360-725-1965

PPC Program Manager

Please fill out the form electronically, then print the form and fax it to 360-725-1965.

PPC Referral From: PROVIDER NPI		PROVIDER ONE CLIENT ID	DATE OF BIRTH	CLIENT NAME: LAST FIRST MI
HOSPICE AGENCY NAME		SOCIAL SECURITY NUMBER		Proposed treatment and case management needs:
CONTACT NAME		DIAGNOSIS		
TELEPHONE NUMBER	FAX NUMBER	PPC CHECKLIST – CHILD (check all that apply)		
ANTICIPATED ADMIT DATE		<input type="checkbox"/> Has current Medicaid eligibility noted in chart. <input type="checkbox"/> Is 20 years of age or younger. <input type="checkbox"/> Has a physician order for PPC. <input type="checkbox"/> Has a life- limiting medical condition with a complex set of needs requiring case management and coordination of medical services. <input type="checkbox"/> Has immediate medical needs during a time of crisis. <input type="checkbox"/> Requires coordination with family members in more than one setting. Where? _____ <input type="checkbox"/> Condition impacts cognitive, social, and physical development. <input type="checkbox"/> The medical condition overwhelms family coping skills, including ability to parent. <input type="checkbox"/> Family member/caregiver lacks knowledge regarding the child's medical needs.		
CURRENT FOCUS OF CARE FOR PPC <input type="checkbox"/> Curative treatment with unsure outcome <input type="checkbox"/> Palliative treatment with unsure outcome <input type="checkbox"/> Palliative treatment only <input type="checkbox"/> Treatment for chronic condition and life-limiting complications.		CHANGE OF CIRCUMSTANCES: <input type="checkbox"/> Discharge Date _____ <input type="checkbox"/> Transfer		Medical necessity for case management/care coordination:
REASON:		APPROVAL DATE (HCA USE ONLY)		
HCA USE ONLY		NOTES		
CNP ProviderOne Database	MNP/LCP			

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