VyncaCare Palliative Care Referral Form

Referral Information		
Date of Referral:	Vynca Admission Email*: **referrals@vyncacare.com**	Vynca Admission Fax: **833-593-2739**
Referring Organization:		
Individual Referring:	Individual Referring Email:	
Primary Care Physician Name: Practice Name:	Phone:	Fax:

Patient Information		
Patient Name:	DOB:	
Address:	City/State:	Zip:
Phone:	Email Address:	
Insurance Company Name:	Policy Number:	
Emergency Contact Name:	Relationship to Patient:	
Emergency Contact Phone Number:		

Clinical Information
Reason for Referral:
Preferred Documentation: ☐ Problem list ☐ Medication list ☐ Allergies ☐ Recent Labs ☐ Pertinent imaging reports ☐ Pro-work (See Specialist's Clinical Guidelines) ☐ Relevant clinical notes (do not include non relevant records) ☐ Other:
Primary Diagnosis:
Secondary Diagnoses:
Number of ED Visits in Last 12 Months (If known):
Number of Inpatient Bed Days in Last 12 Months (If known):
Number of Inpatient Admits in Last 12 Months (If known):
Reason for referral discussed with patient? ☐ Yes ☐ No: Explain

Patient Admission (To be completed by VyncaCare Admissions Team)	
Referral Received Date: *(Fax back to referring provider to acknowledge receipt of referral)*	
Request for additional information (please detail):	
Appointment Scheduled with:	Date & Time:

Non-enrollment Reason
☐ Patient Cancelled/No showed for appointment ☐ Patient will schedule at a later date ☐ Unable to contact patient ☐ Patient did not call for appt ☐ Other:

** All emailed referrals should be sent securely*