

Directions: A Medical Provider (MD, NP, or PA) must complete this **ENTIRE** form and fax it to:
802-863-6344, Attn: Pediatric Palliative Care Program

Questions? Call Jess Boyea, PPCP Nurse Program Coordinator, at (802) 865-1312 or email:
Jessica.Boyea@vermont.gov

REFERRAL REQUIREMENTS – The child must meet all of the below:

- Current Vermont resident
- Less than 21 years old
- Vermont Medicaid beneficiary
- Living with a life-threatening illness from which they may not live into adulthood
- Submit clinical documentation**

Please state the reason for referral:

You will be contacted if additional information is needed to determine clinical eligibility.

LEVEL OF CARE - Please complete all of the following questions:

Is this a new diagnosis? Yes No

Is the prognosis unclear? Yes No

Are there complex care coordination needs? Yes No

Is there concern for family strain or family coping? Yes No

Is the family having difficulty managing the child's needs at home? Yes No

Does the child have difficult-to-control physical or emotional symptoms? Yes No

Does the family access the ED frequently (>once per month)? Yes No

Has there been a poor response to treatment or increase in burden of treatments? Yes No

Has there been a decline in function specific to activity or self-care? Yes No

Has there been cognitive decline related to disease process? Yes No

Has advanced care planning been started? Yes No

Has the child's PCP (if not the referring provider) been informed of the referral? Yes No

CHILD'S INFORMATION

Full Name	Parent/Guardian Name(s)
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Diagnosis	ICD-10 Code	Date of Diagnosis
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Gender <input type="checkbox"/> M <input type="checkbox"/> F	Age	Date of Birth	Medicaid ID No.	Primary Language: Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Home Address

City	State VT	Zip	Phone
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Mailing Address, if different

REFERRING PROVIDER INFORMATION

Full Name	Provider#	Practice Care Coordinator Name
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Practice Name & Address

City	State	Zip	Phone
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GOALS OF CARE – How would you describe the family's goals for their child? Check all that apply:

<input type="checkbox"/> Cure oriented	<input type="checkbox"/> Quality of life is most important
<input type="checkbox"/> No artificial life-prolonging measures	<input type="checkbox"/> Conversation has not taken place

MD/NP/PA Signature	Date	FOR VDH USE ONLY Date Received Initials
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