

Date: [Insert Date]
From: [Referring Clinician/Department Name]
Facility: [Hospital/Clinic Name]
Contact: [Phone Number/Email]

To: Palliative Care Team / [Recipient Name]
Facility: [Receiving Clinic Name]

Subject: Referral and Discharge Summary

Patient Name: [Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]
Address: [Patient Address]
Next of Kin/Proxy: [Name and Contact]

1. Diagnosis and Clinical Status

Primary Diagnosis: [Primary Illness]
Secondary Comorbidities: [List Other Conditions]
Reason for Referral: [e.g., Symptom management, end-of-life care, psychosocial support]

2. Hospital Course Summary

[Brief summary of recent admission, treatments provided, and reason for discharge to palliative clinic].

3. Current Symptoms and Management

Pain Control: [Current level and interventions]
Other Symptoms: [Nausea, dyspnea, anxiety, etc.]

4. Medication List (at time of discharge)

- [Medication Name, Dosage, Frequency]
- [Medication Name, Dosage, Frequency]
- [Medication Name, Dosage, Frequency]

5. Advance Care Planning

Resuscitation Status: [DNR / DNI / Full Code]
Goals of Care: [Summary of patient/family wishes and priorities]

6. Follow-up and Logistics

Discharge Destination: [Home / Hospice Facility / Nursing Home]
Follow-up Appointment: [Date and Time at Palliative Clinic]
Equipment Provided: [Oxygen, Hospital Bed, etc.]

Sincerely,

[Signature]
[Printed Name]
[Title/Credentials]