



Forks Community Hospital

"Pioneers in Rural Health Care"

Forks Community Hospital Palliative Care Referral Form

Referring Organization/Individual

Date:

Name:

Organization:

Phone Number:

Client Information

Full Name:

Date of Birth:

Phone Number:

Healthcare decision maker if the client is unable to decide for themselves:

Phone Number

Referral Details

Patient Need: ☐ Primary Care Provider ☐ Chronic Disease Education ☐ Healthcare Navigation

Comments:

I confirm that the client has consented to this referral and understands the nature of the services being requested.

Signature:

Date

Upon Completion Fax this form to 360-374-2598 or email the form to
PalliativeReferrals@fch.onmicrosoft.com and a nurse will reach out to the client