VERMONT
DEPARTMENT OF HEALTH

Pediatric Palliative Care Program (PPCP) REFERRAL FORM page 1 of 2

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 are encouraged to submit a letter of **medical necessity**. You may be contacted for additional information.

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)	
Diagnosis				ICD-10 Code	Date of Diagnosis
Gender ☐ M ☐ F	Age	Date of Birth	Medicaid ID No.	Primary Language: Interpreter Needed? ☐ Yes ■ No	
Home Address					
City		State **VT**	Zip	Phone	
Mailing Address, if different					

REFERRING PROVIDER INFORMATION

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

City	State	Zip	Phone

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

☐ Cure oriented
☐ No artificial life-prolonging measures
☐ Quality of life is most important
☐ Conversation has not taken place

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