Harborview Medical Center
Palliative Care | Healthcare for the Homeless

Palliative Care Team Services

- Clarification of goals of care
- Advance care planning and documentation
- Co-management of symptoms
- Psychosocial support
- Evaluation and coordination for hospice referrals
- Complex care coordination
- End-of-life planning and legacy support
- Staff and community training on relevant topics

Referral Criteria

- Persons without housing including persons sleeping
    - in encampments, tent cities, shelters, abandoned buildings, vehicles, or on streets;
    - in transitional housing or permanent supportive housing;
    - "doubled up" with friends/extended family;
    - independently housed who have experienced homelessness in the past 12 months
- Primarily living in Seattle area
- Diagnosed with serious, life-limiting, or life-threatening illness
- Diagnosed with advanced chronic disease and significant functional decline
- Insurance coverage not required for service

Priority Referrals

- Recent and significant diagnoses
- High risk of death in next 12 months
- Current health crisis
- Limited or no existing medical team or support network
- High degree of vulnerability
- Living unhoused or in emergency shelter
- High number ED visits / admissions for progressive illness

Referral Process

- Referrals can be made by any healthcare provider or case manager in King County
- Early hospital referrals appreciated to allow for engagement and care coordination
- Fax referral form on next page or complete electronic referral in Epic
- Please provide as much detail as possible with referral
- Follow-up contact to discuss referral required before outreach
- Typical response to referrals within two weeks; for immediate needs please call

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For questions or consultation please call our **voicemail: 206-744-5060**

To send new referrals and other documents please **fax: 206-744-0032**
(Note: this is *not* a hospital extension – please enter all 10 digits)

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PATIENT INFORMATION					
Patient Name:					
Age:		**DOB:**		**MRN#:**	
Best Contact for Patient:					
Patient Address / Location:					
Diagnoses:					
Clinical Course:					

CONTACTS			
Referral Contact:		**Contact:**	
Primary Care Provider:		**Contact:**	
Case Manager:		**Contact:**	
Other:		**Contact:**	

SERVICES REQUESTED			
☐	**Clarification of Goals of Care**	☐	**Hospice Evaluation / Referral**
☐	**Advance Care Planning**	☐	**End-of-Life Planning**
☐	**Symptom Co-Management**	☐	**Care Coordination**
☐	**Psychosocial Support**	☐	**Consultation / Other (details below)**

ADDITIONAL DETAILS

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