VERMONT

Department of Health

Pediatric Palliative Care Program

Expressive Therapy Referral Form

Patient Name:		DOB:	
Parent/Guardian Name:			
Phone Number/Email:			
Address:			
Preferred Communication Method:			
Best time to contact family:			

Referral Information		
Who is the referral for? (If a sibling, please list name and age)		
Reason for Referral:		
School/Grade:		
Desired location (home, school, telehealth, other) and preferred availability:		
Family Composition:		
Summary of Pt's Diagnosis:		
Other Therapies:		
Communication (verbal, nonverbal, limitations, etc), Functional Limits:		
Music/Art Preferences, General interests:		
Symptom Management:	☐Pain ☐Fatigue ☐Respiratory Symptoms ☐Secretion Control ☐GI distress	☐Anxiety ☐Depression ☐Agitation ☐Fatigue/Activity Intolerance

Date:

CULTURAL CONSIDERATIONS:	
PSYCHOSOCIAL CONSIDERATIONS:	
OTHER COMMENTS:	
REFERRING PROVIDER/AGENCY:	
REFERRING PROVIDER CONTACT INFO:	

Date: