yolo HOSPICE

DIAGNOSIS: ALS

MEDICARE EVALUATION TOOL | MEDICARE GUIDELINES

The patient listed or the patient's loved ones have expressed interest in Yolo Hospice's services. Please return this form ***by fax ONLY*** to: **530-758-9017**

From:_____ Phone:_____

Patient Name:_____ Date:_____

PATIENT INFORMATION

Medicare requires documentation of need for hospice through prognostic data. **Please supply that below:**

DOCUMENTATION OPTION 1.

Patient desires no tracheostomy or invasive ventilation AND displays critically impaired ventilatory capacity as evidence by: ❑ FVC < 40% and 2 or more of the following symptoms +/or signs:

DOCUMENTATION OPTION 2.

If unable to perform the FVC test, patients must manifest 3 or more of the symptoms below to qualify for hospice care.

- ❑ Dyspena at rest
- ❑ Respiratory rate > 20
- ❑ Reduced speech/vocal volume
- ❑ Orthopnea
- ❑ Unexplained headaches
- ❑ Unexplained confusion
- ❑ Unexplained anxiety
- ❑ Unexplained nausea
- ❑ Paradoxical abdominal motion
- ❑ Weakened cough
- ❑ Use of respiratory musculature
- ❑ Frequent wakening
- ❑ Symptoms of sleep disordered breathing
- ❑ Daytime somnolence/ excessive daytime sleepiness

AND (this item must be checked for patient to qualify under option 2)

- ❑ Severe nutritional insufficiency as evidence by: Dysphagia with progressive weight loss of at least 5% of body weight with or without election for gastrostomy tube insertion.

Please respond YES or NO to the questions in this section:	YES	NO
1. I support hospice care for this patient.	❑	❑
2. I will be patient's attending physician.	❑	❑
3. I have discussed hospice with patient/loved ones.	❑	❑
4. I have discussed terminal diagnosis with patient/loved ones.	❑	❑
5. I will sign death certificate when it becomes necessary.	❑	❑

Based on the information indicated above, the above named patient has a medical prognosis that life expectancy is six (6) months or less, if the terminal illness runs its normal course

Physician Signature Date