DIAGNOSIS: HIV

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

Please confirm terminal: ____

PATIENT WITH:

- ❑ CD4 + count < 25 cells/mc/L OR
- ❑ viral load 100,000 copies/ml (2 or more assays at least one month apart)

AND

- ❑ CNS iymphoma is systemic lymphoma
- ❑ Loss of at least 10% body mass
- ❑ Mycobacterium avium complex unresponsive to treatment
- ❑ Visceral kaposis sarcoma

AND

- ❑ PPS less than or equal to 50%

SUPPORTING EVIDENCE

- ❑ Chronic persistent diarrhea for 1 year, regardless of etiology
- ❑ Concomitant, active substance abuse
- ❑ Advanced AIDS dementia complex
- ❑ Advanced liver disease
- ❑ Persistent serum albumin < 2.5gm/dl.
- ❑ Age > 50
- ❑ Toxoplasmosis
- ❑ Absence of or resistance to effective antiretroviral, chemotherapeutic, and prophylactic drug therapy related specifically to HIV disease
- ❑ Congestive heart failure, symptomatic at rest

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

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Physician Signature Date

Serving Yolo, Solano, Sutter, Colusa and Sacramento Counties.

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