DIAGNOSIS: LIVER DISEASE

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

- ❑ The patient has Prothrombin time prolonged more than 5 sec. over control, or INR > 1.5 and Serum Albumin < 2.5 gm/dl.

AND AT LEAST ONE OF THE FOLLOWING:

- ❑ Ascities, refactory to treatment or patient non-compliant
- ❑ Spontaneous bacterial peritonitis
- ❑ Hepatic encephalopathy, refactory to treatment or patient non-compliant
- ❑ Recurrent variceal bleeding, despite intensive therapy

SUPPORTING DATA

- ❑ Progressive malnutrition
- ❑ Muscle wasting with reduced strength and endurance
- ❑ continued alcoholism (>80 gm ethanol/day)
- ❑ Hepatocellular carcinoma
- ❑ HBsAg (Hepatitis B) positivity
- ❑ Hepatitis C refractory to interferon
- ❑ bilirubin, liver enzymes, albumm

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