DIAGNOSIS: RENAL 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

Please confirm terminal dx:____

PATIENT OF PATIENT'S LEGAL DESIGNEE DESIRES:

- ❑ No dialysis
- ❑ No transplant
- ❑ Discontinuing dialysis

AND ONE OF THE FOLLOWING COMORBID CONDITIONS OF A SEVERITY TO WARRANT MEDICAL TREATMENT WITHIN THE LAST YEAR

- ❑ Patient with creatinine clearance of < 10cc/in (less than 15cc/min for diabetics) or < 15cc/min (<20cc/min for diabetics) with comorbidity of CHFPyelonephritis or other UTI
- ❑ Serum creatinine > 8.0mg/dl (> 6.0mg/dl for diabetics) Decubitus ulcers
- ❑ Estimated flomerular filtration rate (GFR) <10 ml/min

COMORBID CONDITIONS

- ❑ mechanical ventilation
- ❑ Malignancy (other organ system)
- ❑ Chronic lung disease
- ❑ Advance cardiac disease
- ❑ Advance liver disease
- ❑ Immunosupression/AIDS
- ❑ Albumin < 3.5 gm/dl
- ❑ Platelet count <25,000
- ❑ DIC
- ❑ Gastrointestinal bleeding

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