DIAGNOSIS: CANCER

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: ______________________________

❑ Primary dx/site: ______________________________

Confirmed by: ❑ Biopsy ❑ CT ❑ MRI ❑ other:________________

❑ Metastatic disease/site: ______________________________

Confirmed by: ❑ Biopsy ❑ CT ❑ MRI ❑ other:________________

❑ Patient has had treatment and desires no further treatment

❑ Patient declines oncology work up or treatment

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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