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.

- Dyspnea 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:

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>1. I support hospice care for this patient.</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>2. I will be patient’s attending physician.</td>
<td>☐</td>
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<td>3. I have discussed hospice with patient/loved ones.</td>
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<tr>
<td>4. I have discussed terminal diagnosis with patient/loved ones.</td>
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<td>5. I will sign death certificate when it becomes necessary.</td>
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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: ___________________

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