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

AND

- PPS less than or equal to 50%

SUPPORTING EVIDENCE

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

Please respond YES or NO to the questions in this section:

1. I support hospice care for this patient. YES NO
2. I will be patient’s attending physician. YES NO
3. I have discussed hospice with patient/loved ones. YES NO
4. I have discussed terminal diagnosis with patient/loved ones. YES NO
5. I will sign death certificate when it becomes necessary. YES NO

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 ___________________________