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:
- Ascites, refractory to treatment or patient non-compliant
- Spontaneous bacterial peritonitis
- Hepatic encephalopathy, refractory 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, albumin

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>
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<td>2. I will be patient’s attending physician.</td>
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<td>3. I have discussed hospice with patient/loved ones.</td>
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<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