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 CHF/Pyelonephritis or other UTI
☐ Serum creatinine > 8.0mg/dl (> 6.0mg/dl for diabetics) Decubitus ulcers
☐ Estimated glomerular filtration rate (GFR) <10 ml/min

COMORBID CONDITIONS

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

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

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.

Physician Signature  Date

Serving Yolo, Solano, Sutter, Colusa and Sacramento Counties.
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