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

__________________________  ____________________________
Physician Signature             Date

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