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.

Please confirm terminal dx: _____________________________________________________________

- Decline in functional status as evidenced by:
  - Inability to ambulate without assistance
  - Inability to dress without assistance
  - Inability to bathe without assistance
  - Urinary & fecal incontinence, intermittent or constant
  - No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to 6 or fewer intelligible words
- FAST score_________________________

AND

ONE OF THE FOLLOWING COMORBID CONDITIONS OF A SEVERITY TO WARRANT MEDICAL TREATMENT WITHIN THE LAST YEAR

- Aspiration pneumonia
- Pyelonephritis or other UTI
- Decubitus ulcers
- Fever, recurrent after antibiotics
- Unintentional weight loss = or > 10% or serum albumin < 2.5 gm/dl.

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

<table>
<thead>
<tr>
<th>Number</th>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I support hospice care for this patient.</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>I will be patient’s attending physician.</td>
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<tr>
<td>3</td>
<td>I have discussed hospice with patient/loved ones.</td>
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<tr>
<td>4</td>
<td>I have discussed terminal diagnosis with patient/loved ones.</td>
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<tr>
<td>5</td>
<td>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 ___________________________