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 been treated for heart disease or vasodilators OR
- The patient has a medical reason for refusing these drug e.g. hypertension, renal disease

AND
The patient is not a candidate, by medical criteria or personal choice for cardiac surgery

AND
- Meets NYHA IV criteria
- Is unable to carry on any physical activity without discomfort or shortness of breath.
- Has symptoms of heart failure or angina at rest
- Any physical activity increases discomfort
- Ejection fraction <20%

SUPPORTING DATA
- Treatment-resistant symptomatic supraventricular or ventricular arrhythmias
- History of cardiac arrest or resuscitation
- History of unexplained syncope
- Brain embolism of cardiac origin
- Concomitant HIV disease

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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