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:

STROKE | INABILITY TO MAINTAIN HYDRATION AND CALORIC INTAKE WITH ONE OF THE FOLLOWING:

- weight loss > 10% in last 6 months or > 7.5% in the last 3 months
- serum albumin < 2.5 gm/dl
- current history of pulmonary aspiration no response to speech language pathology intervention
- sequential calorie counts documenting inadequate caloric/fluid intake
- Dysphagia severe enough to prevent patient from continuing fluids/foods necessary to sustain life and patient does not receive artificial nutrition or hydration

Documentation supporting poor prognosis after stroke:

- For non-traumatic hemorrhagic stroke
  - Large-volume hemorrhage on CT (Infratentorial: >/= 20 ml; supratentorial >/= 50 ml)
  - Ventricular extension of hemorrhage
  - Surface area of involvement of hemorrhage >/= 30% cerebrum
  - Midline shift >/= to 1.5 cm
  - Obstructive hydrocephalus in patient who declines or is not a candidate for ventriculoperitoneal shunt

- For thrombotic/embolic stroke
  - Large anterior infarcts with both cortical & subcortical involvement
  - Large bihemispheric infarcts
  - Basilar artery occlusion
  - Bilateral vertebral artery occlusion

COMA | Comatose patient with any three (3) of the following on day three (3) of coma

- Abnormal brain stem response
- Absent verbal response
- Absent withdrawal response to pain
- Serum creatinine > 1.5 mg/dl
- Fever recurrent after antibiotics
- Refractory stage 3-4 decubitus ulcers

Supporting documentation: Incidence of any of the following within the previous 12 months

- Aspiration pneumonia
- Pyelonephritis

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

1. I support hospice care for this patient.
   YES □ NO □
2. I will be patient’s attending physician.
   YES □ NO □
3. I have discussed hospice with patient/loved ones.
   YES □ NO □
4. I have discussed terminal diagnosis with patient/loved ones.
   YES □ NO □
5. I will sign death certificate when it becomes necessary.
   YES □ NO □

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 ___________________________