

**HOSPICE OF SANTA CRUZ COUNTY
ATTENDING PHYSICIAN CERTIFICATION**

To: _____ Fax: _____ Phone: _____
From: ADMISSION DEPT Fax: 831-430-9271 Phone: 831-430-3093
Patient Name: _____ Terminal Dx: **ALS** Date: _____

The above named patient/family has expressed interest in Hospice services. Medicare requires documentation of prognostic data. The prompts below are intended to make the process as convenient as possible. Thank you.

Patient desires no tracheostomy and invasive ventilation

AND

Displays critically impaired ventilatory capacity as evidenced by:

FVC < 40% and 2 or more of the following symptoms +/- or signs:

If unable to perform the FVC test patients meet this criterion if they manifest 3 or more s/s below.

Dyspnea at rest Orthopnea Use of accessory respiratory musculature
 Paradoxical abdominal motion Respiratory rate > 20 reduced speech/vocal volume
 Weakened cough Symptoms of sleep disordered breathing Frequent wakening
 Daytime somnolence/excessive daytime sleepiness Unexplained headaches
 Unexplained confusion Unexplained anxiety Unexplained nausea

AND

Severe nutritional insufficiency as evidenced by:

Dysphagia with progressive weight loss of at least 5% of body weight with or without election for gastrostomy tube insertion.

	Yes	No
I support hospice care at this time.	<input type="checkbox"/>	<input type="checkbox"/>
I will be pt's attending physician.	<input type="checkbox"/>	<input type="checkbox"/>
I have discussed px with patient/family.	<input type="checkbox"/>	<input type="checkbox"/>
I will sign death certificate.	<input type="checkbox"/>	<input type="checkbox"/>

Based on the information indicated above, the above named patient has a medical prognosis that life expectancy is 6 months or less, if the terminal illness runs its normal course.

Telephone Order by _____ Date _____

Physician Signature _____ Date _____