

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

To: \_\_\_\_\_ Fax #: \_\_\_\_\_ Tel #: \_\_\_\_\_

From: ADMISSION DEPARTMENT Fax #: (831) 430-9271 Tel #: (831) 430-3093

Patient Name: \_\_\_\_\_ Terminal Dx: **DEBILITY** Date: \_\_\_\_\_

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

Secondary Dx(s): \_\_\_\_\_

**Recent Decline in Functional Status over the past 3 months** as evidenced by:

**A. Declining Palliative Performance Status from \_\_\_% to \_\_\_% over past 3 mos.....**  Yes  No

Patient with decreased activity, increased time in bed.

AND

**B. Dependence in 3 of 6 Activities of Daily Living.....**  Yes  No

*Check activities in which patient is dependent:*

Unable to dress without assistance

Unable to bathe independently.

Urinary & fecal incontinence.

Unable to feed self.

Unable to ambulate independently to bathroom.

Unable to transfer independently.

AND

**C. Recent impaired nutritional status with progressive weight loss.....**  Yes  No

AND

**D. Other symptoms & signs contributing to limited prognosis.**

Recurrent or intractable serious infections

Dysphagia

Progressive weigh loss

Dyspnea with increased respiratory rate

Escalating or intractable symptom(s) \_\_\_\_\_

Please check yes or no in each box below

I support hospice care at this time.

Yes

No

I will be pt's attending physician.

I have discussed prognosis with patient/family.

I will sign the death certificate.

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 \_\_\_\_\_

FAX TRANSMITTAL