HOSPICE OF SANTA CRUZ COUNTY
ATTENDING PHYSICIAN CERTIFICATION

To: Fax #: Tel #:

From: ADMISSION DEPT Fax #: 831-430-9271 Tel #: 831-430-3093

Patient Name: **Terminal Dx: ES Alzheimers/Dementia** Date:

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

☐ Please confirm Dx____

Patient with:

☐ 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

AND

One of the following comorbid conditions of sufficient severity to warrant medical treatment **within the last year**.

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

	Yes	No
I support hospice care at this time.	☐	☐
I will be pt's attending physician.	☐	☐
I have discussed px 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.

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Telephone Order by Date

____

Physician Signature Date

FAX TRANSMITTAL