

**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: ES Heart Disease** 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.

Specify type of heart disease: \_\_\_\_\_

Patient:

Has been optimally treated for heart disease (optimally treated means that patients who are not on vasodialators have a medical reason for refusing these drug e.g. hypotension, renal disease).

**AND**

Not a candidate, by medical criteria or personal choice for cardiac surgery.

**AND**

Meets NYHA IV criteria

Unable to carry on any physical activity without discomfort or shortness of breath.

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

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 dx with patient/family.	<input type="checkbox"/>	<input type="checkbox"/>	
I will sign the 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 \_\_\_\_\_