

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: **Acute Renal Failure** 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. Thank you for your cooperation.

Patient/Designee desires: no dialysis no transplant discontinue dialysis

AND

One of the following:

Patient with creatinine clearance of < 10cc/min (less than 15cc/min for diabetics) or < 15cc/min (<20cc/min for diabetics) with comorbidity of CHF

Serum creatinine > 8.0mg/dl (> 6.0mg/dl for diabetics)

Estimated glomerular filtration rate (GFR) <10ml/min

Comorbid Conditions:

Mechanical ventilation Malignancy (other organ system) Chronic lung disease

Advance cardiac disease Advance liver disease Immunosuppression/AIDS

Ablumin < 3.5 gm/dl Platelet count < 25,000 DIC Gastrointestinal bleeding

	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 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 _____