

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

To: _____ Fax: _____ Phone: _____

From: ADMISSION DEPT Fax: 831-430-9271 Phone: 831-430-3093

Patient Name: _____ Terminal Dx: **HIV 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

Patient with:
 CD4+ count \leq 25 cells/mc/L **OR**
 viral load > 100,000 copies/ml (2 or more assays at least one month apart)

AND
One of the following:
 CNS lymphoma
 Untreated or persistent despite treatment, wasting (loss of at least 10% lean body mass)
 MAC bacteremia, untreated, unresponsive to treatment or treatment refused
 Progressive multifocal leukoencephalopathy
 Systemic lymphoma, with advanced HIV disease & partial response to chemotherapy
 Visceral Kaposi's sarcoma unresponsive to therapy
 Renal failure in the absence of dialysis
 Cryptosporidium infection
 Toxoplasmosis, unresponsive to therapy

AND
 PPS less than or equal to 50%

Supporting Evidence
 chronic persistent diarrhea for 1 year, regardless of etiology persistent serum albumin < 2.5gm/dl
 concomitant, active substance abuse age > 50 absence of or resistance to effective antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease
 advanced AIDS dementia complex Toxoplasmosis advanced liver disease
 congestive heart failure, symptomatic at rest

	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 _____