

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

To: _____ Fax #: _____ Tel #: _____

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

Pt. Name: _____ Tr Dx: **ES Pulmonary 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:	
<input type="checkbox"/>	disabling dyspnea at rest, poorly or unresponsive to bronchodialators resulting in decreased functional capacity e.g. bed to chair existence, fatigue, cough. <i>(FEV 1 after bronchodialator < 30% is objective evidence of disabling dyspnea, but not required).</i>
AND	
<input type="checkbox"/>	increasing visits to ER/hospital/Physician visits <i>(Serial decrease of FEV1 > 40 ml/year is objective evidence for disease progression, but not required.)</i>
AND	
<input type="checkbox"/>	Hypoxemia at rest on room air as evidenced by O2 saturation < or equal to 88%.
<i>Supporting Evidence</i>	
<input type="checkbox"/>	Right heart failure secondary to pulmonary disease (Cor pulmonale)
<input type="checkbox"/>	Unintentional, progressive weight loss > 10% of body weight over preceding 6 months.
<input type="checkbox"/>	Resting tachycardia > 100/min.

	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 _____