

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

To: _____ Fax #: _____ Phone#: _____

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

Pt Name: _____ Terminal Dx: **STROKE/COMA** 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.

<p>STROKE Inability to maintain hydration and caloric intake with <u>one</u> of the following</p> <ul style="list-style-type: none"> <input type="checkbox"/> Weight loss > 10% in last 6 months or > 7.5% in the last 3 months <input type="checkbox"/> Serum albumin < 2.5 gm/dl <input type="checkbox"/> Current history of pulmonary aspiration not response to speech language pathology intervention <input type="checkbox"/> Sequential calorie counts documenting inadequate caloric/fluid intake <input type="checkbox"/> Dysphagia severe enough o prevent patient from continuing fluids/foods necessary to sustain life and patient does not receive artificial nutrition & hydration 				
<p>COMA (any etiology) Comatose patient with any <u>3 of the following on day 3 of coma.</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormal brain stem response <input type="checkbox"/> Absent verbal response <input type="checkbox"/> Absent withdrawal response to pain <input type="checkbox"/> Serum creatinine > 1.5 mg/dl <p><i>Supporting documentation</i> Incidence of any of the following within the previous 12 months</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Aspiration pneumonia.</td> <td><input type="checkbox"/> Pyelonephritis</td> </tr> <tr> <td><input type="checkbox"/> Fever recurrent after antibiotics</td> <td><input type="checkbox"/> Refractory stage 3-4 decubitus ulcers</td> </tr> </table>	<input type="checkbox"/> Aspiration pneumonia.	<input type="checkbox"/> Pyelonephritis	<input type="checkbox"/> Fever recurrent after antibiotics	<input type="checkbox"/> Refractory stage 3-4 decubitus ulcers
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<input type="checkbox"/> Fever recurrent after antibiotics	<input type="checkbox"/> Refractory stage 3-4 decubitus ulcers			
<p>Documentation of diagnostic imaging factors which support poor prognosis after stroke include</p> <ul style="list-style-type: none"> <input type="checkbox"/> For non-traumatic hemorrhagic stroke <ul style="list-style-type: none"> <input type="checkbox"/> Large-volume hemorrhage on CT (Infratentorial: >= 20 ml; supratentorial >= 50 ml) <input type="checkbox"/> Ventricular extension of hemorrhage <input type="checkbox"/> Surface area of involvement of hemorrhage >= 30% cerebrum <input type="checkbox"/> Midline shift >= to 1.5 cm <input type="checkbox"/> Obstructive hydrocephalus in patient who declines or is not a candidate for ventriculoperitoneal shunt <input type="checkbox"/> For thrombotic/embolic stroke <ul style="list-style-type: none"> <input type="checkbox"/> Large anterior infarcts with both cortical & subcortical involvement <input type="checkbox"/> Large bihemispheric infarcts <input type="checkbox"/> Basilar artery occlusion <input type="checkbox"/> Bilateral vertebral artery occlusion 				

	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 _____