

Worksheet For Determining Appropriateness For Hospice To Be Done For All Patients

General Guidelines – All Diagnoses

The purpose of this worksheet is to guide initial and rectification assessments. It must be accompanied by narrative documentation. These are guidelines only: clinical judgment is required in each case. Construct a narrative from the information on this worksheet and information from the patient's physician and record on back. The patient should be re-evaluated at specific intervals set by the interdisciplinary team and with sixty (60) days of clinical stabilization. This form may be used for initial and subsequent re-evaluation.

Patient's Name: _____ P # _____ Date: _____

The patient should meet the following criteria:

- 1. Life limiting condition..... Yes No
- 2. Pt/family informed condition is life limiting..... Yes No
- 3. Pt/family elected palliative care..... Yes No
- 4. Documentation of clinical progression of disease..... Yes No

Evidenced by (check all that apply and secure copies of documentation for Hospice record):

- | | |
|---|--|
| _____ serial physician assessment | _____ laboratory studies |
| _____ radiologic or other studies | _____ multiple Emergency Dept. visits in past year |
| _____ inpatient hospitalizations in past year | _____ Home Health Nursing assessment if patient is homebound |

- 5. Recent decline in functional status..... Yes No

Evidenced by:

- A. Karnofsky Performance Status \leq 50%..... Yes No

Check level:

- _____ 50% Requires considerable assistance and frequent medical care
- _____ 40% Disabled; requires special care and assistance
Unable to care for self; disease may be progressing rapidly
- _____ 30% Severely disabled; although death is not imminent
- _____ 20% Very sick; active supportive treatment necessary
- _____ 10% Moribound; fatal processes progressing rapidly

- B. Dependence in 3 of 6 Activities of Daily Living..... Yes No

Check activities in which patient is dependent:

- | | |
|-------------------------------------|------------------------------|
| _____ dressing | _____ bathing |
| _____ feeding | _____ transfers |
| _____ continence of urine and stool | _____ ambulation to bathroom |

- C. Recent impaired nutritional status..... Yes No

Evidenced by (check all appropriate):

- _____ unintentional, progressive weight loss of 10% over past six months
- _____ serum albumin less than 2.5 gm/dl (may be helpful prognostic indicator but should not be used by itself)



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Patient's Name _____ P # _____ Date _____

**Medical Guidelines for Determining Appropriateness for Hospice
Narrative Summary Of Prognosis Documentation**

Documentation should be complete, consistent, concise, specific, measurable and descriptive.

Diagnosis: Present underlying illness(es) and all other illness(es) affecting the terminal diagnosis:

Co-morbidity that affects the prognosis:

History and progression of the illness (es):

Physical baseline (e.g., weight and weight change, vital signs, heart rhythms, rates, degree of edema):

Laboratory (if pertinent):

Physician's prognosis stating why there is a life expectancy of 6 months or less (e.g., Patient depressed, will not eat and does not want anything done, or has had optimal therapy for illness.)

Information supplied by: _____ on _____ Check One. Hospital ___ SNF ___ Physician Office ___ Other ___

Information recorded by: _____ Hospice RN on _____ Assessment completed by: _____ Hospice RN on _____

*Physician Signature: _____ *Physician name printed: _____ Date: _____