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Medical Guidelines For Determining Appropriateness For Hospice

CARDIAC DISEASE

Patient Name: _____ Diagnosis: _____ Date: _____

Is patient a candidate for a heart transplant: ___ Yes ___ No

1. Does the patient have symptoms and signs of congestive heart failure at rest? ___ Yes ___ No

Check all that apply:

| Symptoms | Signs |
|---|--|
| <input type="checkbox"/> dyspnea at rest: "Short winded", "Can't breathe" | <input type="checkbox"/> diaphoresis: sweating |
| <input type="checkbox"/> dyspnea on exertion: "Can't breathe with exercise" | <input type="checkbox"/> cachexia: profound weight loss |
| <input type="checkbox"/> orthopnea: "Can't breathe lying down" | <input type="checkbox"/> juguloenous distension (JVD) |
| <input type="checkbox"/> paroxysmal nocturnal dyspnea (PND): "Waking up at night short of breath" | <input type="checkbox"/> neck veins distended above clavicle |
| <input type="checkbox"/> edema "Swollen ankles, legs" | <input type="checkbox"/> rales: wet crackles in lungs heard on inspiration |
| <input type="checkbox"/> syncope | <input type="checkbox"/> gallop rhythm: S3, S4 |
| <input type="checkbox"/> weakness | <input type="checkbox"/> liver enlargement |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> edema, pitting edema |

2. Has the physician verified that the patient is on optimal diuretic and vasodilator therapy? ___ Yes ___ No

Diuretics (patient should be on optimal dose following). *Check all that apply:*

- | | | |
|---|---|---|
| <input type="checkbox"/> Furosemide (Lasix) | <input type="checkbox"/> Ethacrynic Acid (Edecrin) | |
| <input type="checkbox"/> Bumetanide (Bumex) | <input type="checkbox"/> Torsemide (Demedex) | |
| | <input type="checkbox"/> Metolazone (Zarloxlyn, Mykrox) | Note: Must be combined with any of the above, Not used alone. |

Vasodilators (patient should be on optimal dose of one of the following). *Check all that apply:*

- A. Nitrates (e.g., Nitro patch, Isosorbide) plus Hydralazine ___
- B. Apressoline Angiotensin Converting Enzyme (ACE) Inhibitor:
- | | |
|--|---|
| <input type="checkbox"/> Benazepril (Lotensin) | <input type="checkbox"/> Lisinopril (Prinivil, Zestril) |
| <input type="checkbox"/> Captopril (Capoten) | <input type="checkbox"/> Quinapril (Accupril) |
| <input type="checkbox"/> Enalapril (Vasotec) | <input type="checkbox"/> Ramipril (Altace) |
| <input type="checkbox"/> Fosinopril (Monopril) | |

3. Does the patient have ejection fraction of ≤ 20 (only if test results available)? ___ Yes ___ No

4. The following factors are further indications of decreased survival time. *Check all that apply:*

- symptomatic supraventricular or ventricular arrhythmias resistant to antiarrhythmic therapy
- history of cardiac arrest and resuscitation in any setting
- history of syncope of any cause, cardiac or otherwise
- cardiogenic brain embolism, i.e., embolic CVA of cardiac origin
- concomitant HIV disease

5. Karnofsky Performance Status Scale *Check level assessed:*

- | | | |
|--|-----|---|
| • Able to carry on normal activity to work; no special care needed | 100 | Normal / no complaints; on evidence of disease |
| | 90 | Able to carry on normal activity; minor s/s of disease |
| | 80 | Normal activity with effort; some s/s of disease |
| • Unable to work; able to live at home and care for most personal needs; varying amounts of assistance needed | 70 | Cares for self, unable to do active work or normal activity |
| | 60 | Requires occasional assistance, but is able to care for most of needs |
| | 50 | Requires considerable assistance / frequent medical care |
| • Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly | 40 | Disabled; requires special care and assistance |
| | 30 | Severely disabled; hospital admission indicated although death not imminent |
| | 20 | Very sick; active support treatment necessary |
| | 10 | Moribund, fatal processes progressing rapidly |
| | 0 | Dead |

Information supplied by: _____ on: _____ *Check one.* Hospital: ___ ECF: ___ Physician's office: ___ Other: ___

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

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