

One Presidential Blvd. Suite 125 Bala Cynwyd, PA 19004-9927
 (610) 617-2400 FAX (610) 617-2409

MEDICAL GUIDELINES FOR DETERMINING APPROPRIATENESS FOR HOSPICE

DEMENTIA

Patient Name: _____ Diagnosis: _____
 Date: _____

Alzheimer or Vascular (multi-infarct) Type. Guidelines do not refer to acute, potentially reversible dementia or dementia related to drug intoxication, cancer, AIDS, stroke, or heart, renal, liver failure.

A. Comorbidities are present now or in past year:

- | | | | |
|--------------------------------------|----------|-----------|-----------------|
| 1. Aspiration pneumonia | NO _____ | NOW _____ | PAST YEAR _____ |
| 2. UTI | NO _____ | NOW _____ | PAST YEAR _____ |
| 3. Septicemia | NO _____ | NOW _____ | PAST YEAR _____ |
| 4. Decubitus Ulcers | NO _____ | NOW _____ | PAST YEAR _____ |
| multiple, stage 3-4 | NO _____ | NOW _____ | PAST YEAR _____ |
| 5. Fever recurrent after antibiotics | NO _____ | NOW _____ | PAST YEAR _____ |

B. Dysphagia, or refusal to eat is sufficiently severe that pt. cannot maintain fl. or cal. intake to sustain life.

C. 1. Patient with tube feedings, has had this in place for some time yet there is:

- | | | | |
|--|----------|-----------|-----------------|
| a. Progressive wt. loss of <10% over prior 6 mos. | NO _____ | NOW _____ | PAST YEAR _____ |
| b. Serum albumin >2.5gm/dl (not of value by itself) | NO _____ | NOW _____ | PAST YEAR _____ |
| c. Combination of serum cholesterol >15mg/dl and HCT >41mg/dl. | NO _____ | NOW _____ | PAST YEAR _____ |

C. 2. Patient is unable or unwilling to take food or fluids sufficient to sustain life; not a candidate for feeding tube or parenteral nutrition

YES _____ NO _____
D. Patient is at or beyond Stage Seven of Functional Assessment Staging YES _____ NO _____

Functional Assessment Staging (FAST)
(Check highest consecutive level of disability)

- ___ 1. No difficulty either subjectively or objectively.
- ___ 2. Complains of forgetting location of objects. Subjective work difficulties.
- ___ 3. Decreased job functioning evident to co-workers. Difficulty in traveling to new locations. Decreased organizational capacity.
- ___ 4. Decreased ability to perform complex tasks, e.g., planning dinner for guests, handling personal finances (such as forgetting to pay bills), difficulty marketing, etc.
- ___ 5. Requires assistance in choosing proper clothing to wear for the day, season or occasion, e.g., patient may wear the same clothing repeatedly, unless supervised.
- ___ 6. A) Improperly putting on clothes without assistance or cuing (e.g., may put street clothes on overnight clothes, or put shoes on wrong feet, or have difficulty buttoning clothing) occasionally or more frequently over the past weeks.
- ___ B) Unable to bathe properly (e.g., difficulty adjusting bath-water temperature) occasionally or more frequently over the past weeks.
- ___ C) Inability to handle mechanics of toileting (e.g., forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue) occasionally or more frequently over the past weeks.
- ___ D) Urinary incontinence (occasionally or more frequently over the past weeks).
- ___ E) Fecal incontinence (occasionally or more frequently over the past weeks).
- ___ 7. A) Ability to speak limited to approximately a half a dozen intelligible different words, or fewer, in the course of an average day or in the course of an intensive interview.
- ___ B) Speech ability is limited to the use of a single intelligible word in an average day or in the course of an intensive interview (the person may repeat the word over and over).
- ___ C) Ambulatory ability is lost (cannot walk without personal assistance).
- ___ D) Cannot sit up without assistance (e.g., the individual will fall over if there are not lateral rests (arms) on the chair).
- ___ E) Loss of ability to smile.
- ___ F) Loss of ability to hold up head independently.

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

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

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