

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

Medical Guidelines for Determining Appropriateness for Hospice

HIV DISEASE

Patient Name: _____ Date: _____

1. **Has patient had a trial of protease inhibitor, antiviral, retroviral therapy?** ___ Yes ___ No
 If no, investigate further; Does patient know about this? ___ Yes ___ No
 Will physician provide this? ___ Yes ___ No Comments: _____
 If not a candidate for therapy noted in #1, proceed:

2. **CD4+ count**
 ___ ≥ 50 cells/mc/L: pt. probably has px of > 6 mo. unless there is a non-HIV-related co-existing life-threatening disease
 ___ ≤ 25 cells/mc/L:
 ___ measured during period when pt. is relatively free of acute illness
 ___ observed disease progression and decline in function status

3. **Viral load**
 ___ >100,000 copies/ml: pt. may have px of <6mo.
 ___ <100,000 copies/ml and meet following criteria:
 ___ pt. has elected to forego antiretroviral and prophylactic medication
 ___ functional status is declining
 ___ and Karnofsky rating is ___

4. **Life-threatening complications with (survival median):**
 ___ CNS lymphoma (2.5 mo.) ___ Untreated MAC bacteremia (<6 mo.)
 ___ PML (4 mo.) ___ Kaposi's refractory to tx (6 mo.)
 ___ Cryptosporidiosis (5 mo.) ___ Renal failure/refuses or fails dialysis (<6 mo.)
 ___ Wasting/loss of 33% lean body mass (<6mo.) ___ Toxoplasmosis (6 mo.)

5. **Factors which have been shown to decrease survival significantly.**
 ___ Chronic persistent diarrhea, 1 yr. regardless of etiology
 ___ Persistent serum albumin < 2.5 gm/dl
 ___ Concomitant substance abuse
 ___ Age >50 yrs.
 ___ CHF with sx at rest
 ___ Treatment refusal

6. **Karnofsky Performance Status Scale (check level assessed)**

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

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: _____