WORKSHEET FOR DETERMINING PROGNOSIS

Embracing Life
GATEWAY
HOSPICE

Stroke and Coma

The purpose of this worksheet is to guide initial and recertification assessments. This is a guide only; clinical judgment is required in each case. This worksheet is completed and signed by the RN and attached to a completed Admission/Recertification Evaluation form. After reviewing the completed paperwork, the Medical Director will sign the Admission/Recert Evaluation form and Recertification form for hospice eligible clients.

Client Name: _____ Medical Record Number: _____ Date: _____

The patient has both 1 and 2

1. Poor functional status with Palliative Performance Scale of 40% or less (unable to care for self)

   And

2. Poor nutritional status with inability to maintain sufficient fluid and calorie intake with either:
   - Greater than 10% weight loss over the previous 6 months
   - Greater than 7.5% weight loss over the previous 3 months
   - Serum albumin < 2.5 gm/dl
   - Current history of pulmonary aspiration without effective response to speech language patholoty interventions to improve dysphagia (difficulty swallowing) and decrease aspiration events

Supporting evidence of hospice eligibility:

□ Age >70
□ Poor functional status as evidenced by Karnofsky score of < 40%
□ Post stroke dementia as evidenced by a FAST score greater than 7
□ Unintentional progressive weight loss. Dates:_____
□ Caloric counts documenting inadequate calorie/fluid intake
□ BMI below 22kg/m2 _____
□ Systolic b/p below 90 or progressive postural hypotension

Other medical complications related to debility and support clinical decline:

□ aspiration pneumonia
□ upper urinary tract infection (pyelonephritis)
□ sepsis
□ refractory stage 3- 4 decubitus ulcers
□ fever recurrent after antibiotics
□ absent verbal response
□ absent withdrawal response to pain
□ serum creatinine > 1.5 gm/dl

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NARRATIVE SUMMARY OF PROGNOSIS DOCUMENTATION

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

Co-morbidities/secondary conditions that support hospice diagnosis_____

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Comments:_____

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Person completing form Signature

_____**Date:**_____

RN Signature:_____**Date:**_____

Md. Signature_____**Date:**_____