

**WORKSHEET
FOR DETERMINING PROGNOSIS**

Dementia

The purpose of this worksheet is to guide initial and recertification assessments. It must be accompanied by narrative documentation. These are guidelines only: clinical judgement 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 within 60 days of clinical stabilization. This form may be used for initial and subsequent re-evaluation.

Pt. Name: _____ ID#: _____ Date: _____

Both 1 and 2 must be present as evidence of hospice appropriateness.

1. Is patient severely demented? Yes No

Patient should be at or beyond Stage 7 of the Functional Assessment Staging Scale. *Check level:*

- ___ 7A Ability to speak is limited to approximately 6 intelligible words or fewer, in the course of an average day or in the course of an intensive interview.
- ___ 7B 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).
- ___ 7C Ambulatory ability is lost (cannot walk without personal assistance).
- ___ 7D Cannot sit up without assistance (e.g., patient will fall over if there are not lateral rests (arms) on the chair).
- ___ 7E Loss of ability to smile.
- ___ 7F Loss of ability to hold up head independently.

Patient should show ***all*** of the following characteristics. *Check all that apply:*

- ___ inability to ambulate independently (cannot walk without personal assistance)
- ___ unable to dress without assistance
- ___ unable to bathe properly
- ___ incontinence of urine *and* stool (occasionally or more frequently, over the past weeks as reported by a knowledgeable informant or caregiver)
- ___ unable to speak or communicate meaningfully (*see 7A above*)

2. Has the patient had one or more of the following medical complications related to dementia during the past year? Yes No
(conditions should have been severe enough for hospitalization whether or not hospitalization occurred).

Check all that are appropriate:

- ___ aspiration pneumonia
- ___ upper urinary tract infection
- ___ septicemia
- ___ decubitus ulcers, multiple, stage 3-4
- ___ fever recurrent after antibiotics
- ___ inability or unwillingness to take food or fluids sufficient to sustain life; not a candidate for feeding tube or parenteral nutrition

Patients who are receiving tube feedings must have documented impaired nutritional status as indicated by either:

- ___ unintentional, progressive weight loss of greater than 10% over prior 6 months, or
- ___ serum albumin less than 2.5 gm/dl (may be helpful prognostic indicator but should not be used by itself)

(over)

**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, rales, 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.):

RN Signature

Date

Physician signature

Date

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General Guidelines - All Diagnoses

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Pt. Name: _____ ID#: _____ 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
- ___ inpatient hospitalizations
- ___ home health nursing assessment if patient homebound

and/or

5. Recent decline in functional status Yes No

Evidenced by either:

- 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% Moribund; fatal processes progressing rapidly

and/or

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

Check activities in which patient is dependent:

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

and/or

6. 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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