



147 W Rockwell St • Jefferson, WI
 53549
 Ph 920-674-6255 • Fax 920-674-5288
 Email rainbow@rainbowhospicecare.org

Please fill out
 Completely and Sign

DETERMINING TERMINAL STATUS
GENERAL GUIDELINES FOR ALL DIAGNOSES

Patient Name: _____ **MR:#** _____ **DOB:** _____

Admission Date: _____ **Attending Physician:** _____

The patient should meet the following criteria:

- 1. Life-limiting condition Yes No
- 2. Patient/family informed condition is life limiting. Yes No
- 3. Patient/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 assessments
- laboratory studies
- Radiological or other studies
- multiple Emergency Department visits
- inpatient hospitalizations
- home health or nursing home assessment

and/or

- 5. Recent decline in functional status Yes No

Evidenced by either:

- A. Karmofsky Performance Status <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 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 the 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 the past six months
 serum albumin less than 2.5 gm/dl (may be helpful prognostic indicator but should not be used by itself)

Other comments and supporting documentation:

Evaluation done by Rainbow Hospice RN _____ date _____

And/or

Date