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DETERMINING TERMINAL STATUS PULMONARY DISEASE

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

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

Patients will be considered to be in the terminal stage of pulmonary disease (**life expectancy of six months or less**) if the terminal illness runs its normal course.

1 and 2 should be present. Documentation of 3, 4, and 5 will lend supporting documentation.

1. Severe chronic lung disease as documented by both a and b:
 - Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue, and cough. (Documentation of Forced Expiratory Volume in One Second (FEV1), after bronchodilator, less than 30% of predicted is objective evidence for disabling dyspnea, but is not necessary to obtain.)
 - Progression of end stage pulmonary disease, as evidenced by increasing visits to the emergency department or hospitalizations for pulmonary infections and/or respiratory failure or increasing physician home visits prior to initial certification. (Documentation of serial disease of FEV1 > 40 ml/year is objective evidence for disease progression, but is not necessary to obtain.)
2. Hypoxemia at rest on room air, as evidenced by $pO_2 \leq 55$ mmHg; or oxygen saturation $\leq 88\%$ on supplemental oxygen determined either by arterial blood gases or oxygen saturation monitors; (These values may be obtained from recent hospital records.) OR Hypercapnia, as evidenced by $pCO_2 \geq 50$ mmHg. (This value may be obtained from recent {within 3 months} hospital records.)
3. Right heart failure (RHF) secondary to pulmonary disease (Cor pulmonale) (e.g., not secondary to left heart disease or valvulopathy).
4. Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.
5. Resting tachycardia > 100/min.

Clinical Status

Progression of disease as documented by worsening clinical status, symptoms, signs and laboratory results.

- Recurrent or intractable infections such as pneumonia, sepsis or upper urinary tract.
- Weight loss not due to reversible causes such as depression or use of diuretics.
- Decreasing anthropomorphic measurements, not due to reversible causes such as depression or use of diuretics.
- Decreasing serum albumin or cholesterol.
- Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption.

Symptoms

- Dyspnea with increasing respiratory rate.
- Cough, intractable.
- Nausea/vomiting poorly responsive to treatment.
- Diarrhea, intractable.
- Pain requiring increasing doses of major analgesics more than briefly.

Signs

- Decline in systolic blood pressure to below 90 or progressive postural hypotension.
- Ascites.
- Venous, arterial or lymphatic obstruction due to local progression or metastatic disease.
- Edema.
- Pleural/pericardial effusion.
- Weakness.
- Change in level of consciousness.

Laboratory (When available. Lab testing is not required to establish hospice eligibility.)

- Increasing pCO₂ or decreasing pO₂ or decreasing SaO₂.
- Increasing calcium, creatinine or liver function studies.
- Increasing tumor markers (e.g., CEA, PSA).
- Progressively decreasing or increasing serum sodium or increasing serum potassium.
- Decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) from $\leq 70\%$ due to progression of disease.
- Increasing emergency room visits, hospitalizations, or physician's visits related to hospice primary diagnosis.
- Progressive decline in Functional Assessment Staging (FAST) for dementia (from $\geq 7A$ on the FAST).
- Progression to dependence on assistance with additional activities of daily living.
- Progressive stage 3-4 pressure ulcers in spite of optimal care.
- Physiologic impairment of functional status as demonstrated by:
Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) from $\leq 70\%$. Note that two of the disease specific guidelines (HIV Disease, Stroke and Coma) establish lower qualifying KPS or PPS.

Dependence on assistance for two or more activities of daily living (ADLs).

- Feeding
- Ambulation
- Continence
- Transfer
- Bathing
- Dressing

Co-morbidities

- Chronic obstructive pulmonary disease.
- Congestive heart failure.
- Ischemic heart disease.
- Diabetes mellitus.
- Neurologic disease (CVA, ALS, MS, Parkinson's).

- Renal failure.
- Liver disease.
- Neoplasia.
- Acquired immune deficiency syndrome.
- Dementia.

Other comments or supporting documentation:

Please read and/or update the above LMRP. If you agree with the documentation defining the terminal status of this patient, please sign below and FAX back.

Evaluation done by Rainbow Hospice RN _____ date _____

AND/OR

Signature _____ **Date** _____