Harbors Home Health & Hospice
201 7th Street, Hoquiam, Washington 98550 / (360) 532-5454 or (800) 772-1319

Hospice Certification Paperwork

Date: _____ Total Number of Pages: _____

To: _____ Fax Number: _____

From: _____ Fax Number: **(360) 533-0999**

Patient Name: _____ **Date of Birth:** _____

Please complete and return the following documentation via fax to complete your hospice referral.

1.	Certification of Terminal Illness **(Please complete a brief narrative in order to comply with Medicare requirements. Narrative must be handwritten and reflect accurately why the patient qualifies for Hospice.)**.
2.	Home Symptom Relief Kit.
3.	Hospice admission and symptom management orders.
4.	**In addition:** ~ Supporting chart documentation for terminal diagnosis. ~ Medication list. ~ Demographics ~ Please note that **non-cancer diagnosis** must be approved by the Hospice Director, prior to care.

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Hospice Certification & Attestation

Patient Name: _____ Patient Code: _____

Address: _____ City: _____ State: ____ Zip Code _____

I certify that the above beneficiary is terminally ill with a life expectancy of six months or less, if the terminal illness runs it's normal course.

Effective Date of Certification: _____

Benefit Period From: _____ to: _____

Terminal Diagnosis: _____

Brief narrative statement: (review the individual's clinical circumstances and synthesize the medical information to provide clinical justification for admission to hospice services.)

Narrative must be handwritten by the physician in order to meet Medicare requirements - cannot accept notes - Thank you.

Narrative to be completed by Attending Physician

Attestation: I confirm that I composed this narrative and it is based on my review of the patient's medical record and/or examination of the patient.

Name of Hospice Medical Director/ Hospice Physician	Signature of Hospice Medical Director/ Hospice Physician	Date
Name of Attending Physician	Signature of Attending Physician	Date

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Hospice Home Symptom Relief Kit

Patient Name: _____ Date: _____

Patient Birth Date: _____ Patient Phone: _____ Patient Code: _____

Patient Address: _____ City: _____ State: ____ Zip Code _____

Drug Allergies: _____

Pharmacy Name: _____ Pharmacy Fax: _____

1. Morphine Sulfate: 20 mg/ml 60 ml (May dispense 30 ml and then dispense the 2nd 30 ml)
   Dosage: 0.25 - 1 ml (5-20 mg) under tongue every hour as needed (titrate to comfort r/t pain and air hunger).

2. Lorazepam: 2 mg/ml liquid 30 ml
   Dosage: 0.25 - 0.5 ml (0.5 mg - 1 mg) under tongue q 4-8 hours **as needed** for anxiety/sedation **(Refill PRN)**

   ☐ Prefer Diazepam 5 mg/1ml liquid 30ml
   Doseage: 0.5 ml - 1 ml (2.5 mg - 5 mg) under tongue every 4-8 hours **as needed** for anxiety/sedation **(Refill PRN)**

3. Hyoscyamine SL (Levsin SL) 0.125 mg PO/SL every 4 hours **as needed** for secretions
   Dispense #12.

4. Prochlorperazine 25 mg Suppository #2 (Refill PRN)
   Dosage: 1 suppository in rectum every 6 hours as needed for nausea/vomiting

5. Bisacodyl Supp 10 mg 1 per rectum QD as needed for constipation. Dispense #2

6. Acetaminophen Supp 650 mg 1 per rectum Q 6 hours as needed for fever or pain, dispense #2.

Physician Name: _____ Phone Number: _____

Address _____ Fax Number: _____

City _____ State ____ Zip Code _____

DEA Number: _____

_____ _____

Signature of Attending Physician Date

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Hospice Admission & Symptom Management Orders

PATIENT NAME: _____ DATE OF BIRTH: _____

DIAGNOSIS: _____

ALLERGIES: _____

ENCLARA PHARMACIA FAX: (800) 530-1565

ATTENDING PHYSICIAN: _____ PHONE: _____ FAX: _____

LOCAL PHARMACY: _____ PHONE: _____ FAX: _____

Line Out Unauthorized Orders

☐ Full Code ☐ Do Not Resuscitate

Diet: _____

- Activity as tolerated.
- Durable medical equipment (DME) as needed.
  Hospital bed, commode, bath bench, standard wheelchair, suction, front wheel walker, oxygen.
- Skilled nursing 1-3x/week and as needed for symptom management, and/or Nurse Aid Certified (NAC) visit 1-3x/week and as needed bathing assistance.
- Evaluation and treatment as needed by therapies:
  RPT, OTR, SLP, MSW, Massage Therapy

NOTE: May use generic substitution when available. May crush all medications as needed. Oral medications may be given rectally as needed. Medication administration by patient, care givers, other family members, and hospice nurses. May discontinue medication if patient is unable to swallow secondary to disease process or refusing to take medications.

The following interventions are uses as a ladder, beginning with the first intervention unless otherwise ordered.

Agitation: Do Not Use In Severe Parkinson's:
- Haloperidol 0.5 mg (#30) 0.5-2 mg by mouth/rectally every 4 hours as needed. May titrate to 2mg/dose. May schedule the lowest effective dose every 4 hours around the clock. Refill PRN.
- Haloperidol 2 mg/ml oral concentrate (15 ml) Give 0.5ml (1 mg) by mouth or sublingual every 6 hours as needed for agitation.

Anxiety or Anxiety related to Dyspnea:
- Lorazepam 0.5-1 mg orally every 4 hours as needed (0.5mg #30 Refill PRN)
- Lorazepam 2 mg/cc oral concentrate: same dosing (#15mg Refill PRN)

Bladder spasms/Dysuria:
- Phenazopyridine 100mg (#9) by mouth three times daily for three days. Refill PRN
- Oxybutynin 5 mg (#30) by mouth twice daily as needed. May titrate to four times daily as needed. Refill PRN.
- UA with reflex C&S if infection suspected and treatment desired.

Candidiasis:
- Nystatin suspension, 5 ml (240 ml) swish & swallow 4 times a day for 7 days. (Refill PRN
- Nystatin cream/ointment/powder 100,000 units/gram, topically, twice daily to fungal rash. May titrate to three times daily. (Refill PRN)
- Fluconazole 100 mg, 2 tablets orally the first day, then 1 orally for 4 days (#6 PRN).

Constipation:
- Senna-S 8.6/50 mg 1-4 tablets (#60) by mouth twice a day PRN. May increase by 1 tablet/day up to 4 tablets twice daily. Refill PRN.
- Bisacodyl 10 mg 1-2 suppositories (#2) Insert 1 suppository rectally once daily as needed. Refill PRN.
- Milk of magnesia 30-60 ml at bedtime as needed. (#240ml PRN)
- Fleet Enema daily as needed.
- Check for and remove fecal impaction as needed.
- Lactulose 10 grams (15 ml) 20-60 ml as needed for stooling. (#240ml PRN)

Cough:
- Guaifenesin 100 mg/5ml (120 ml); 15 ml by mouth every 4 hours as needed for thick secretions. Refill PRN
- Tessalon Perles 100 mg, 1-2 gel tabs every 8 hours as needed. (#30 PRN)
- Cheratussin AC 2 teaspoons every 6 hours as needed. (120cc PRN)

Diarrhea:
- Loperamide 2 mg (#30) 2 tablets by mouth now, then 1 tablet after each loose stool as needed. (Maximum of 16 mg/day). Refill PRN.

Dry Eyes:
- Artificial Tears, 2 drops into each eye every 4 hours as needed.

Dyspnea:
- Elevate the head of the bed; open the window, bedside fan.
- Oxygen 1-4 liters by nasal cannula as needed.
- Morphine Sulfate oral concentrate 20 mg/ml titrate from 0.25 mg sublingual to 10 mg/dose as needed.
- Lorazepam 0.5-1 mg orally every 4 hours as needed or use
- Lorazepam oral concentrate (2 mg/cc) every 4 hours as needed.

Fever:
- Acetaminophen 325 mg-650 mg orally (#12) or rectally (#2) every 4 hours as needed. Maximum of 4000 mg/day. (Refill PRN)
- Ibuprofen 200 mg; 2 tablets by mouth every 6 hours as needed. (#30 PRN)

Gas/Belching:
- Simethicone 80 mg (#30) 1-2 tablets; chew and swallow every 4 hours as needed. May titrate to 160 mg/dose. Refill PRN.

Gastrointestinal:
- TUMS over the counter as container directs.
- Ranitidine 75 mg (#30) by mouth twice a day as needed. Refill PRN If patient taking Ranitidine 75 mg more frequently than 4 consecutive days
- Omeprazole OTC 20 mg (#15) by mouth daily as needed. Refill PRN

Hiccups (Intractable):
- Haldol 5 mg (loading dose) then 1-4 mg orally three times a day as needed.
- Thorazine 25 mg (#30) by mouth three times a day as needed. Refill PRN.

Insomnia:
- Review sleeping hygiene with patient and family.
- Diphenhydramine (Benadryl) 25-50 mg orally every 4 hours as needed. (Avoid in those with Dementia).
- Lorazepam 0.5-2 mg orally/sublingual/rectally every 4 hours as needed or 2 mg/cc liquid orally/sublingual every 4 hours as needed.

Nausea/Vomiting:
- Check for cause (medications?)
- NPO until vomiting subsides.
- Prochlorperazine 10 mg (#6) by mouth every 6 hours as needed for nausea or vomiting.
- Prochlorperazine 25 mg suppository rectally every 6 hours as needed. (#2 PRN)
- Zofran 8 mg sublingual every 8 hours as needed. (#6 PRN)
- Haloperidol 0.5 mg (#30) 0.5-2 mg orally/rectally/sublingual every 4 hours as needed. May titrate up to 2 mg/dose. May schedule lowest effective dose up to 2 mg every 4 hours. (Refill PRN)

Pain (Mild) 1-3/10:
- Non-medicinal measures such as ice, heat, repositioning.
- Acetaminophen 325mg, 1-2 tablets by mouth (12 PRN) or 650mg rectally every 4 hours as needed. (#12 PRN) Not to exceed 4,000mg/day.
- Ibuprofen 200mg, 1-2 tablets orally every 6 hours as needed. (#30 PRN)

Pain (Moderate) 4-5/10:
- Hydrocodone 5 mg/APAP 325 mg, 1-2 tablets by mouth every 4 hours as needed. (#30 PRN)

Pain (Moderate to Severe) 6-10/10:
- Oxycodone 5-10 mg orally every 4-6 hours as needed. (#30)
- MS Contin 10-20 mg orally/rectally every 12 hours as needed. (#30)
- Liquid Morphine (Roxanal) 20 mg/cc; ½ to 1 cc orally/sublingual every 1-2 hours as needed. (#30cc)
- Duragesic patch 25 mcg (#5) to 100 mcg; change every 3 days.

Pruritis
- Hydroxyzine (Vistaril) 25 mg orally three times a day as needed. (#12 PRN)
- Diphenhydramine (Benadryl) 25 mg, 1-2 orally every 4 hours as needed. (#12 PRN)

Secretions:
- Suction as needed
- Scopolamine patches 1.5 mg topical, change every 3 days. (#1 PRN)
- Atropine eye drops 1% 1-2 gtts SL every 4 hours. PRN (#10cc PRN) get compounded from Enclara Pharmacia only.
- Hyoscyamine 0.125 mg (#12) Place 1 tablet under the tongue every 4 hours as needed. (Refill PRN)

Skin Care/Wounds:
- May cleanse area with normal bathing soap or saline as needed.
- Barrier protection ointment as needed.
- Aquaphor three times day topical-if dry skin.
- Hydrocortisone 1% cream topically 2-4 times a day as needed for focused area of inflammation. (28.4g)
- Egg crate or alternating pressure mattress as needed.
- Hydrocolloid dressing to wound, change every 3-5 days and as needed.

Stomatitis/Oral Care:
- Ointment for lips as needed.
- Artificial saliva as indicated.
- Viscous Lidocaine as directed.
- Equal parts Diphenhydramine/Mg: AL antacid/viscous Lidocaine 5-10 ml swish and swallow four times daily as needed, or swab patients mouth with swabs using same. May titrate to 10 ml/dose.

Urinary:
- May insert indwelling Foley catheter (14 Fr, 16 Fr, 18 Fr, 20 Fr, 5 cc and 30cc) for urinary retention or incontinence, change as needed.
- May irrigate Foley catheter with 60-120 cc saline as needed.
- May apply Lidocaine gel 2% prior to cath insertion for 5-10 min. (#30ml PRN)

*** Enclara Pharmacia ComfortPak ***

Acetaminophen 650 mg suppositories	4 (four) suppositories
Haloperidol 2 mg/ml oral concentrate	15 (fifteen) ml
Hyoscyamine 0.125 mg SL tablets	12 (twelve) tablets
Lorazepam 2 mg/ml liquid	30 (thirty) ml
Lorazepam 0.5 mg tablets	10 (ten) tablets
Prochlorperazine 10 mg tablets	6 (six) tablets
Prochlorperazine 25 mg suppositories	2 (two) suppositories
Transderm Scopolamine Patch	1 (one) patch
Bisacodyl 10 mg suppositories	2 (two) suppositories

Instructions for use are included in the standing orders.

*** To Include Morphine in the ComfortPak ***

If Morphine allergy exists, contact provider for alternative!

- Morphine Sulfate oral concentrate, 20 mg/ml, take 0.25 ml (5 mg) by mouth or under the tongue every 3 hours as needed for pain or shortness of breath. Dispense 30 (thirty) ml. No Refills

Provider Initial _____

PRESCRIBER SIGNATURE: _____ DATE: _____

PRESCRIBER PRINTED NAME: _____ DEA #: _____

PRESCRIBER ADDRESS: _____

City _____ State _____ Zip Code _____