# Hospice referral checklist - Coma

**All Hospice referrals should have a prognosis of 6 months or less if the illness follows its expected course**

**The patient's goals should align with hospice philosophy which includes prioritizing comfort and quality of life over disease modifying and life-prolonging therapies.**

For a referral for **Routine Home Care** (home hospice such as in a private home, ALF, LTC, etc.) use the list below. For **General Inpatient level of care** (Gosnell Memorial Hospice House) consider items on both the front and back of the form.

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## Routine Home Care referral checklist:

☐ Diagnosis:

What are the patient's relevant diagnoses? What diagnosis is **primarily** driving this patient's decline/impacting prognosis (Primary hospice diagnosis)? What **other diagnoses** are negatively **impacting the patient's prognosis** (Related hospice diagnoses)? Does the patient have other **stable or chronic conditions** which are **not impacting prognosis?**

☐ Pain / Symptoms:

- Is the patient experiencing pain?
- Are there other distressing symptoms?

☐ Functional status:

What is the current performance status and how has this changed over time? (i.e., PPS, ECOG, Karnofsky)

- Changes in **ambulation** (full, reduced, mostly sit/lie, mostly in bed, bed bound)
- **Activity and evidence of disease** (normal activity and work; normal activity with effort, unable to work, unable to do hobbies/housework, unable to do any work, unable to do most activity, unable to do any activity)
- **Self-care/ADLs** (full, occasional assistance needed, considerable assistance required, mainly assist, total care)
- **Consciousness level** (full, confusion, drowsy, coma)
- **Oral intake** (normal, reduced, minimal, mouth care only)

☐ Nutritional status:

- What is the patient's nutritional status? Is there objective data? (i.e., weight, mean arm circumference, BMI, percentage of meals consumed, albumin level)
- Is patient able to take PO? Are they aspirating? Diet modifications? Comfort feeds?
- Plan for IV fluids and/or medically administered nutrition (i.e., TPN, tube feeds)?

☐ Cognitive status:

- Impairments?
- Prior psych diagnosis?
- Mood/coping?

☐ Infections:

- Current or recurrent infections?
- Plan to treat current or future infections?

☐ Falls:

- Recent falls and/or injuries?
- Fall risk?

☐ Medication Changes:

- What are the current medications?
- Recent medication changes?
- Were any medications recently discontinued?

**To make a referral to Hospice of Southern Maine call 207-289-3649**

For more information about this or other hospice diagnoses, scan the QR code.

# General Inpatient referral checklist

☐ What are the **uncontrolled symptoms** and what efforts have there been to address these so far?

- **Respiratory distress** that is poorly controlled and/or inadequately managed in current setting.
- **Agitation, anxiety, delirium and/or behavioral issues** that are severe and are not adequately managed in current setting.
- **Sudden or imminent decline** that requires intensive, continuous, and skilled nursing interventions.
- **Nausea and/or vomiting** that is intractable and/or unrelenting.
- **Seizures** that are uncontrolled and/or inadequately managed in the current setting.
- **Advanced wounds** that require complex, multiple assisted dressing changes and close monitoring.

☐ Discharge Planning

Inpatient hospice is intended for the ***short-term management of uncontrolled symptoms***. Eligibility for inpatient admission is determined on a day-by-day basis. Once symptoms are controlled, patient will be discharged to a lower level of care (i.e. routine home hospice care in private home or facility).

Inpatient stays are generally not covered by insurance once symptoms are stabilized which can result in patients being billed for services.

- Has prognosis been discussed with patient/surrogates including potential that conditions sometimes stabilize or improve?
- Have patient and family been provided anticipatory guidance that patient may require discharge planning from the inpatient facility should symptoms stabilize with palliative interventions?

☐ Ethical/legal considerations

- Code status discussed?
- Expectations for patients who remain full code addressed?

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## Coma Guidelines

**Comatose patients with at least three of the following on day three of coma:**

- Abnormal brain stem response
- Absent verbal response
- Absent withdrawal response to pain
- Serum creatinine >1.5 mg/dl

**The following support terminal diagnosis:**

- Documentation of the following medical complications, in the context of progressive clinical decline within the past 12 months:
  - Aspiration pneumonia
  - Pyelonephritis
  - Refractory stage 3-4 decubitus ulcers
  - Fever recurrent after antibiotics
- Documentation of the following diagnostic imaging, supporting poor prognosis:
  Non-traumatic hemorrhagic stroke:
  - Large volume hemorrhage on CT (infratentorial ≥20ml, supratentorial ≥50ml)
  - Ventricular extension of hemorrhage
  - Surface area of involvement of hemorrhage ≥30% of cerebrum
  - Midline shift ≥1.5 cm
  - Obstructive hydrocephalus in patient who declines, or is not a candidate for, ventriculoperitoneal shunt

  Thrombotic/embolic stroke:
  - Large anterior infarcts with both cortical and subcortical involvement: Large bihemispheric infarcts: Basilar artery occlusion: Bilateral vertebral artery occlusion

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