Hospice Care Eligibility Assessment

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Address: [Insert Patient Address]

Patient ID: [Insert Patient ID]

Dear [Patient's Name or Caregiver's Name],

We are writing to inform you about the eligibility assessment for hospice care and the transition to palliative care services. After a thorough evaluation of your medical condition and treatment options, we have determined the following:

Eligibility Criteria:

- The patient has a diagnosis of a terminal illness with a prognosis of [Insert Prognosis] months or less.
- The patient is experiencing significant symptoms that are not well-managed with curative treatment.
- The patient has given consent for hospice care services.

Plan for Transition:

Based on this assessment, we recommend the following steps for the transition to hospice care:

1. Schedule a care planning meeting with the hospice team.
2. Discuss pain management and symptom relief strategies.
3. Engage with support services for both the patient and family.

If you have any questions or concerns regarding this assessment or the upcoming transition, please do not hesitate to reach out to our office at [Insert Contact Information].

Sincerely,

[Your Name]
[Your Title]
[Your Organization]