Community Hospice Service - Admission Note

Patient: Harrison, George Franklin **MRN:** SYN015 **DOB:** 1952-11-08
Date of Hospice Admission: May 5, 2022
Admitting Hospice Diagnosis: Metastatic Non-Small Cell Lung Cancer (Adenocarcinoma)
Referring Physician: Dr. Kenji Tanaka (Medical Oncology)
Certifying Physicians: Dr. K. Tanaka (Oncology), Dr. L. Martin (Hospice Medical Director)
Benefit Period: First 90-day period

SUMMARY OF ILLNESS & REASON FOR HOSPICE REFERRAL:
Mr. Harrison is a 69-year-old male with widely metastatic NSCLC (Adenocarcinoma, WT, PD-L1 <1%) diagnosed in March 2021. He experienced rapid disease progression after a short duration of response to first-line chemotherapy/immunotherapy (Carboplatin/Pemetrexed/Pembrolizumab, approx. 7 months PFS). He subsequently received one cycle of second-line Docetaxel in December 2021 but experienced significant toxicity (febrile neutropenia requiring hospitalization) and chose not to pursue further cycles due to poor tolerance and perceived lack of benefit. Since then (last 4-5 months), he has experienced progressive clinical decline with worsening fatigue, anorexia, weight loss (~30 lbs since diagnosis), and increasing pain primarily related to adrenal metastasis enlargement. Recent CT scans (April 20, 2022) confirmed continued disease progression with enlarging bilateral adrenal masses and new small liver lesions. His performance status has declined significantly (ECOG 3-4). Dr. Tanaka discussed goals of care with Mr. Harrison and his wife, and they mutually agreed that further anti-cancer therapy is futile and the focus should shift entirely to comfort, symptom management, and quality of life. Patient wishes to receive care at home. He meets hospice eligibility criteria due to terminal diagnosis, disease progression despite therapy, and declining functional status.

PERTINENT HISTORY:

- **Oncologic:** Stage IV NSCLC Adeno (Dx 03/29/21). Primary site unclear (small LUL nodule suspected). Metastases at diagnosis: Bilateral Adrenal Glands (R 4cm, L 3cm). Molecular: WT. PD-L1 (22C3) TPS 0%, CPS <5, IC 0.
    - 1L Rx: Carbo/Pem/Pembro (04/20/21 - Nov 2021)
    - 2L Rx: Docetaxel x 1 cycle (Dec 2021). Complicated by febrile neutropenia. No further chemo.
- **Comorbidities:** Type 2 Diabetes Mellitus (on Metformin, Glyburide - *Note: A1c likely irrelevant now, simplify regimen for comfort*), Coronary Artery Disease s/p MI 2015 (medically managed), Hypertension, Hyperlipidemia. History of smoking (quit >10 years).

CURRENT STATUS & SYMPTOMS (Hospice Assessment):

- **Performance Status:** ECOG 3-4. Spends >50% of day in bed or chair. Needs assistance with most ADLs.
- **Pain:** Reports constant dull ache in bilateral flanks/back, rated 5-6/10 at rest, increasing to 7-8/10 with movement. Attributed to adrenal mets. Currently taking Oxycodone 10mg q4-6h PRN, using 4-5 doses/day with partial relief.
- **Dyspnea:** Mild dyspnea at rest, worse with minimal exertion. SpO2 92-94% RA. Not currently using O2.
- **Nutrition/Hydration:** Poor appetite, eats only small amounts. Significant weight loss. Nausea occasional.

- **Energy:** Severe fatigue, profound weakness.
- **Psychosocial:** Patient appears withdrawn but acknowledges terminal diagnosis and desire for comfort care. Wife is primary caregiver, appears stressed but capable, receptive to support. Living situation: Single-family home, supportive wife.

CURRENT MEDICATIONS (To be reviewed/reconciled by hospice team):

- Oxycodone 10 mg PO Q4-6H PRN pain
- Metformin 1000 mg PO BID
- Glyburide 5 mg PO Daily
- Lisinopril 20 mg PO Daily
- Metoprolol Succinate ER 50 mg PO Daily
- Atorvastatin 40 mg PO Daily
- Aspirin 81 mg PO Daily
- Ondansetron 4 mg ODT PRN nausea

HOSPICE PLAN OF CARE - INITIAL:

1. **Pain Management:** Convert PRN opioid to scheduled regimen. Recommend Morphine Sulfate Immediate Release (MSIR) liquid 10mg PO q4h ATC, with additional 10mg q1h PRN breakthrough pain. Provide Bowel Regimen (Senna-S + Miralax). Educate patient/caregiver on administration, side effects, titration.
2. **Dyspnea Management:** Initiate Morphine Sulfate liquid 2.5-5mg PO q4h PRN dyspnea. Arrange for home oxygen concentrator setup for comfort/exertional use.
3. **Nausea Management:** Continue Ondansetron PRN. Consider adding Prochlorperazine suppository PRN if PO not tolerated or ineffective.
4. **Fatigue/Weakness:** Counsel on energy conservation. PT/OT consult for safety eval/equipment needs (hospital bed, commode).
5. **Nutrition:** Encourage small, frequent meals/supplements as desired. Focus on intake for pleasure/comfort, not calories.
6. **Medication Reconciliation:** Simplify non-essential meds. Consider stopping statin, possibly transitioning diabetic meds to sliding scale insulin only if symptomatic hypo/hyperglycemia occurs, or stopping altogether if intake minimal. Discuss stopping Aspirin given palliative goals (unless strong indication). Continue BP meds for now if BP tolerates.
7. **Support Services:** Introduce RN Case Manager, Social Worker, Chaplain, Home Health Aide services. Establish visit frequency. Provide 24/7 hospice contact info.
8. **Advance Care Planning:** Confirm Code Status (DNR documented in referral). Review existing advance directives / POLST form. Ensure understanding of hospice philosophy.

DEATH STATEMENT: Patient died on May 20, 2022

_____ MD/DO
L. Martin, MD (Hospice Medical Director) / K. Tanaka, MD (Attending) - Signatures on File