Patient Name _____ Election Date _____ Assessment Date _____

MR# _____ Date of Birth _____ Age _____

Vital Signs
T _____ Pulse (Resting) _____ Resp _____ BP _____ Weight: _____ MAC_____

Pain Assessment
Intensity: none = 0 1 2 3 4 5 6 7 8 9 10 = most intense Acceptable level: _____ /10
Frequency: none occasionally frequently constantly
Location: _____
Description of pain: _____
Nonverbal signs of pain: _____
Associated symptoms: _____
Current medications: Effective? ❑ Yes ❑ No

Immediate Care & Support Needs: Document patient rating from ESAS assessment

_____ Pain/Comfort Describe _____
_____ Fatigue Describe _____
_____ Nausea Describe _____
_____ Depression Describe _____
_____ Anxiety Describe _____
_____ Drowsiness Describe _____
_____ Appetite Describe _____
_____ Shortness of breath Describe _____
_____ Well-being Describe _____
_____ Other Describe _____

Patient's Primary Concern/Goals

_____
_____
_____

Caregiver's Primary Concern/Goals

_____
_____
_____

Evaluation of Physical, Psychosocial, Emotional and Spiritual Status/Immediate Care Needs

_____
_____
_____
_____
_____
_____

Interventions and Teaching

_____
_____
_____
_____
_____
_____

Need for Comprehensive Assessment

❑ Nursing ❑ Social work ❑ Spiritual care ❑ Physician ❑ Bereavement
❑ Dietitian ❑ Physical Therapy ❑ Occupational Therapy ❑ Speech Therapy

Patient /Caregiver refuses the following services and assessments: _____

RN Signature _____Date

Patient Name _____ MR# _____ Election Date _____ Assessment Date _____

Date of Birth _____ Age _____ Hospice Dx _____ Is death imminent? ❑ Yes ❑ No
Level of Care: ❑ RHC ❑ CC ❑ INPT ❑ Respite Location: ❑ Home ❑ Nsg Hm ❑ ALF ❑ Hospital ❑ Bd/care
Admission: Precipitating factors Patient/family subjective complaint(s) _____
In last year (include date, if known):
❑ Hospitalized _____ ❑ Pneumonia _____ ❑ Aspiration pneumonia _____ ❑ UTI _____
❑ Recurrent fever after atb _____ ❑ Stage 3–4 decubitus _____ ❑ ER visit _____ ❑ Hip fx _____
❑ Septicemia _____ ❑ Pyelonephritis _____ ❑ Unexplained syncope _____ ❑ Cardiac arrest/resuscitation_____

Alteration in Comfort **Problem:** ❑ Yes ❑ No

No Pain	Mild Pain	Moderate Pain	Severe Pain	Very Severe Pain	Pain as Bad as You Can Imagine

Circle the one number that best fits the patient's pain at its worst in past week.

0	1	2	3	4	5	6	7	8	9	10

*Circle the one number that best describes the patient's pain **right now**.*

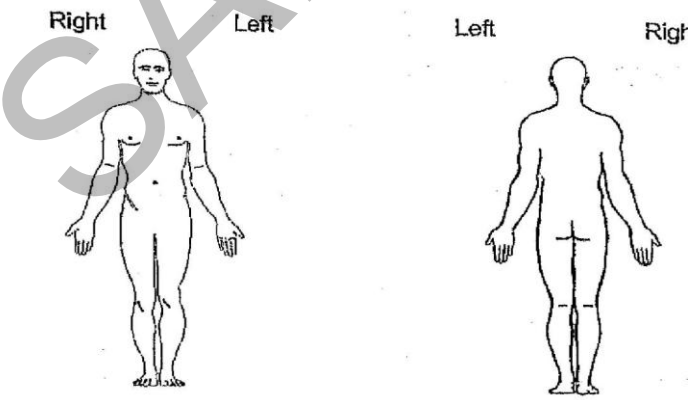
0	1	2	3	4	5	6	7	8	9	10

Circle the one number that best describes the level of pain acceptable to the patient.

0	1	2	3	4	5	6	7	8	9	10

Patient response: ❑ Number scale (0–10) pain rating used ❑ Wong-Baker Faces pain rating used
ESAS pain assessment: _____ Pt/family goal: _____ Intervention change needed: ❑ Yes ❑ No
Comment: _____

What kinds of things make the patient's pain feel better (for example: heat, meds, rest)? _____
_____
What kinds of things make the patient's pain worse (for example: walking, standing, lifting)? _____
_____
What treatments or meds is the patient receiving for pain?_____ Effective: ❑ Yes ❑ No
Barriers to pain management _____
Describe the pain:
❑ Aching ❑ Throbbing ❑ Shooting ❑ Stabbing ❑ Gnawing ❑ Sharp ❑ Tender ❑ Numb
❑ Burning ❑ Exhausting ❑ Tiring ❑ Penetrating ❑ Nagging ❑ Miserable ❑ Unbearable
Nonverbal signs of pain/discomfort:
❑ Grimacing ❑ Moaning ❑ Guarded ❑ Frowning ❑ Restless ❑ Increased BP ❑ Increased pulse
❑ Poor appetite ❑ Perspiring ❑ Crying ❑ Agitation ❑ Rigid posture ❑ Jaws clenched ❑ Legs drawn up



On the diagram, shade in the areas where the patient feels pain. Put an X on the area that hurts the most.

Alteration in Urinary Elimination/GU Status _____ **Problem: ❑ Yes ❑ No**
Output: ❑ Good ❑ Moderate ❑ Poor ❑ Minimal Odor _____ Color _____
Frequency: ❑ Normal ❑ Frequent ❑ Infrequent ❑ No output last 24 hrs Retention_____ Incontinent: ❑ Yes ❑ No
Catheter _____ Type _____ Size _____ Date Foley changed _____
UTI: ❑ Frequent ❑ Occasional ❑ None in last yr Date of last UTI _____ Tx_____
Current Medications _____ Effective: ❑ Yes ❑ No
Comment: _____

Alteration in Bowel Elimination **Problem:** ❑ Yes ❑ No
Constipation _____ Diarrhea _____
Incontinence: ❑ Yes ❑ No Frequency of incontinence _____ Bowel sounds _____
Colostomy _____ Ileostomy _____
Usual bowel pattern _____ Last BM _____
Current bowel regimen _____ Effective? _____
Comment: _____

Alteration in Nutrition/Hydration **Dietitian referral needed:** ❑ Yes ❑ No **Problem:** ❑ Yes ❑ No
Ht _____ Wt _____ BMI _____ MAC _____ Normal weight _____ Weight ❑ gain ❑ loss in last ____ months: # lbs_____
Nutrition Intake (% usual daily amt) _____ ❑ Anorexia Number of meals per day: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 4+
Pt/family acceptance/understanding of weight loss: ❑ Yes ❑ No ❑ Restricted/special diet _____ Appetite _____
Tube Feeding: ❑ Yes ❑ No Type_____ Amt_____ ❑Nausea ❑Vomiting: Frequency_____
Dysphagia: ❑ Yes ❑ No Prevents sufficient intake to sustain life: ❑ Yes ❑ No Number of dysphagia event in last week: ____
ESAS nausea assessment _____ Pt/family goal _____ Intervention change needed: ❑ Yes ❑ No
ESAS appetite assessment _____ Pt/family goal _____ Intervention change needed: ❑ Yes ❑ No
Comment: _____

Alteration in Respiratory Status **Problem:** ❑ Yes ❑ No
O_2 sat level on RA _____ O_2 sat level on O_2@ _____ O_2 _____ L/min ❑ Continuous ❑ Intermittent ❑ Pt removes/refuses
Breath sounds (Rt) _____ (Lt)_____ Quality _____ Orthopnea _____
Dyspnea: at rest: ❑ disabling ❑ moderate ❑ minimal Dyspnea: on exertion: ❑ disabling ❑ moderate ❑ minimal
Amount of exertion before patient becomes dyspneic: ❑ distance amb _____ ❑ minutes talking _____ ❑ other _____
Cough _____ Sputum color _____ Infections _____
Current Medications _____ Effective: ❑ Yes ❑ No
ESAS SOB assessment _____ Pt/family goal _____ Intervention change needed: ❑ Yes ❑ No
Comment: _____

Alteration in Cardiac/Circulatory Function **Problem:** ❑ Yes ❑ No
Heart sounds _____ Pulses _____ Pulse deficit _____
Regular rate/volume _____ Hypo/hypertension _____ Cyanosis _____
Chest pain: ❑ Yes ❑ No Number of episodes in last week _____ Precipitating factors _____
What relieves chest pain? ❑ Nitro ❑ Rest ❑ Other med _____ ❑ Other _____
Edema ❑ RLE Degree _____ Pitting? _____ ❑ LLE Degree _____ Pitting? _____ Other location: _____
❑ RUE Degree _____ Pitting? _____ ❑ LUE Degree _____ Pitting? _____ Degree _____ Pitting? _____
Current Medications _____ Effective: ❑ Yes ❑ No
Comment: _____

Alteration in Physical Mobility **Problem:** ❑ Yes ❑ No
↑Weakness AEB _____ Disability _____
Ambulation ❑ Indep ❑ Walker ❑ Need assistance ❑ Holds furn/walls ROM limitations _____
Ambulation Distance _____ (steps or feet) Decrease: ❑ Yes ❑ No Transfer ability: ❑ Indep ❑ Needs assist
❑ Mainly sit/lie ❑ Mainly in bed ❑ Totally bed bound ❑ Unable to do most activity ❑ Unable to do any activity
Family/facility report of ↓ in functional ability: _____ AEB _____
ESAS tiredness assessment _____ Pt/family goal _____ Intervention change needed: ❑ Yes ❑ No
Comment: _____

ADL Assessment **HHA Needed:** ❑ Yes ❑ No **Frequency** _____
I=Independent **P**=Partially able **N**=Needs assistance **U**=Unable to Do
Feeding Self _____ Transferring _____ Dressing _____ Bathing _____
Toileting _____ Ambulating _____ Sit Independently _____ Prepare Meals _____
Light Housekeeping _____ Personal Laundry _____
Ability of caregiver to assist with custodial needs of patient _____
Comment: _____

Fall Risk Assessment *Circle appropriate item and add scores* **Problem:** ❑ Yes ❑ No

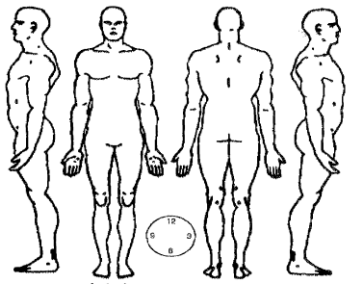
Hx of falls = 15	Incontinence = 5	Unable to ambulate independently = 5
Confusion = 5	Increased anxiety = 5	Decreased level of cooperation = 5
Age > 65 = 5	Cardio/pulm disease = 5	Meds for HTN or level of consciousness = 5
Impaired judgment = 5	Postural hypotension = 5	Initial admission to hospice/facility = 5
Sensory deficit = 5	Attached equip (IV, O2 tubes) = 5	

Score of 15 or higher is considered high risk Patient Score: _____ High Risk: ❑ Yes ❑ No
Comment: _____

Alteration in Skin Integrity **Problem:** ❑ Yes ❑ No

Wounds/Decubiti _____ Skin color _____
Lacerations _____ Skin turgor _____
Contusions _____ Skin to touch _____
Petechiae _____ Rash _____
Skin tears _____ Abrasions _____
Comment: _____ "Wound Assessment" form included in this assessment: ❑ Yes ❑ No

Document stage of each pressure ulcer on diagram.



Alteration in Mental/Neurological Functioning **Problem:** ❑ Yes ❑ No

Pupils equal _____ Disorientation _____ Responsiveness _____
Cognition _____ Level of consciousness _____ Seizures _____
Syncope _____ Headache _____ Anxiety _____
Depression _____ Memory impairment: ❑ Long term ❑ Short term Progressing: ❑ Yes ❑ No
Vision _____ Hearing _____ Sensory impairment _____
Speech: 6 words or less ❑ Yes ❑ No One word or less ❑ Yes ❑ No Nonverbal ❑ Yes ❑ No
Dysphasia: ❑ Yes ❑ No Able to smile: ❑ Yes ❑ No Able to hold head up independently: ❑ Yes ❑ No
Coma: ❑ Abnormal brain stem response: _____ ❑ Absent verbal response ❑ Absent withdrawal response to pain
Current Medications _____ Effective: ❑ Yes ❑ No
ESAS drowsiness assessment: _____ Pt/family goal: _____ Intervention change needed: ❑ Yes ❑ No
ESAS anxiety assessment: _____ Pt/family goal: _____ Intervention change needed: ❑ Yes ❑ No
ESAS depression assessment: _____ Pt/family goal: _____ Intervention change needed: ❑ Yes ❑ No
Comment: _____

Alteration in Sleep Patterns **Problem:** ❑ Yes ❑ No

Current sleep pattern _____ Change in pattern
Sedatives used _____ Effective
Comment:

Alteration in Endocrine System **Problem:** ❑ Yes ❑ No

Diabetes _____ *Treatment*
Current Medications _____ Effective
Comment:

Vital Signs:

T _____ Pulse (Resting) _____ Resp _____ BP _____ Ascites: ❑ Yes ❑ No Abdominal girth _____
Pertinent Laboratory Results (if known): _____

Alteration in Coping **Problem:** ❑ Yes ❑ No

Signs of psychosocial/emotional distress _____ ❑ Pt ❑ Caregiver
Signs of spiritual distress _____ ❑ Pt ❑ Caregiver
Signs of family discord/distress _____ ❑ Pt ❑ Caregiver
Caregiving environment is adequate to meet patient needs: ❑ Yes ❑ No Comment _____
Caregiver expressing anticipatory grief: ❑ Yes ❑ No Comment _____

DME & Supplies

Medical Supplies and Equipment in home _____
Medical Supplies and Equipment needed _____
Patient/caregiver to demonstrate equipment use and safety? _____

Infusion

Type: ❑ Peripheral ❑ PICC ❑ Central Venous ❑ Subcutaneous ❑ Other: _____
Location: _____ Date placed: _____ Size/gauge: _____ Type/brand: _____
Purpose: ❑ Pain mgmt ❑ Hydration ❑ Antibiotics ❑ Maintain venous access ❑ Other: _____
Pump: Type: _____ Pump setting: _____ Verified w/ orders: ❑ Yes ❑ No
Comments: _____

Medications

See Medication Profile for current medications ❑ List of medications reviewed with patient/representative
Pt able to take medications as prescribed: ❑ Yes ❑ No Caregiver able to administer medications as prescribed: ❑ Yes ❑ No
Medications effective: ❑ Yes ❑ No Unwanted side effects: ❑ Yes ❑ No
Drug interactions: ❑ Yes ❑ No Need for pharmacist consultation: ❑ Yes ❑ No
❑ Reviewed facility orders & Notes ❑ New orders found ❑ Copy of orders/Notes obtained for hospice chart
❑ Provided written policy on disposal of controlled drugs to patient/family ❑ Reviewed drug disposal policy

Eligibility Assessment **❑ Prognosis Guideline (LCD) attached for _____ (dx)**

Patient is eligible for hospice care *as evidenced by* (AEB). Document comparisons of current status with baseline assessments (admission or recertification assessments). Reference changes with specific time period. Check all that apply.

❑ Progressive malnutrition: AEB _____
❑ ↑ weakness: AEB _____
❑ ↓ function: AEB _____
❑ ↓ cognitive status: AEB _____
❑ ↓ skin integrity: AEB _____
❑ Recent infections: AEB _____
❑ Changes in medications _____
❑ ↑ need for services: AEB _____
❑ Diminishing lab results: AEB _____
❑ ↓ pulmonary function: AEB _____
❑ ↓ cardiac function: AEB _____
❑ Other: _____ AEB _____

Plan of Care

Complications/risk factors affecting care planning _____
❑ The plan of care was presented to and discussed with the patient and representative
Level of understanding: ❑ Good understanding ❑ Partial understanding ❑ Do not understand
Level of ability to participate in care: ❑ Good participation ❑ Partial participation ❑ Cannot participate ❑ Decline

Patient/Representative Instructions

❑ Hospice Services	❑ Plan of Care	❑ How to Contact Hospice	❑ Resuscitation Policy
❑ After Hours Services	❑ Emergency Procedures	❑ Grievance Procedure	❑ Bill of Rights
❑ Use of Equipment	❑ Infection Control	❑ Confidentiality of Records	❑ Advance Directives

Teaching

Understand disease process and signs of disease progression: Patient ❑ Yes ❑ No Representative ❑ Yes ❑ No
Caregiver willing and able to receive instructions and provide care: ❑ Yes ❑ No Comment: _____
Reviewed PoC with: ❑ Patient ❑ Representative ❑ Facility staff _____
Teaching to: ❑ Patient ❑ Representative ❑ Facility staff _____
Teaching topics: _____
Caregiver expresses confidence in providing care: ❑ Yes ❑ No Response to teaching: _____
Level of understanding: ❑ Excellent _____ ❑ Good _____ ❑ Poor _____

Communication/Collaboration/Referrals/Need for Comprehensive Assessment

❑ SW _____ ❑ Spiritual Care _____
❑ Facility staff _____ ❑ Volunteer Coordinator _____
❑ Aide _____ ❑ Dietician _____
❑ Bereavement _____ ❑ Other _____

Attending Physician:

❑ Reported patient status ❑ Reported on plan of care problems, interventions, goals & patient response
❑ Received new order(s) _____
Consultation results _____

Summary

Need for Comprehensive Assessment:

❑ Nursing ❑ Social work ❑ Spiritual care ❑ Physician ❑ Bereavement
❑ Dietitian ❑ Physical Therapy ❑ Occupational Therapy ❑ Speech Therapy
Patient /Caregiver refuses the following services and assessments: _____

Signature/Title _____ Date _____