Patient ID		Date	
Patient Name		Start Time	
Visit Type		End Time	

Hospice Skilled Nursing Assessment

HOSPICE SKILLED NURSING SOFT ASSESSMENT

*Items that trigger a suggested item in the Plan of Care

Items in Blue are also in Vitals, items related to the HIS, will have the corresponding HIS reference number

Vitals

☐ Patient declines Vitals Assessment

Decline Reason:

Blood Pressure

Side	Location	Position	Systolic	Diastolic
--	--	○ Lying ○ Sitting ○ Standing		

Temperature

Route	Temperature (F)
○ Axillary ○ Oral ○ Rectal ○ Temporal ○ Tympanic	

Pulse

* Rhythm *	Strength *	Location	Heart Rate (bpm)
--	--	--	
Other:	Other:	Other:	

Respiratory Rate

Respiration Type			Respiratory Rate (bpm)
○ Normal ○ Stridor ○ Pursed ○ Labored ○ Shallow	○ Cheyne-Stokes ○ Orthopnea ○ Apnea ○ Barrel Chest ○ Hypoxia	○ Increased Expiratory Phase ○ Ineffective Lung Expansion ○ Uses Accessory Muscle Other:	O_2 Saturation (%)

Height

Current

Feet inches

Weight

lbs kg

MUAC

Left Arm

inches cm

☐ Unable to Assess

Right Arm

inches cm

☐ Unable to Assess

COVID-19 Screening

Has the patient, family or anyone in the home engaged in any international travel in the last 14 days to countries with sustained community transmission of COVID-19?

○ Yes ○ No Comments

Does the patient, family or anyone in the home have a respiratory illness?

○ Yes ○ No Comments

COVID-19 Screening

Has the patient, family or anyone in the home experienced any signs or symptoms of COVID-19, including but not limited to fever, cough and sore throat?

Yes No Comments

Has the patient, family, or anyone in the home had contact with someone under investigation for COVID-19 within the past 14 days?

Yes No Comments

Does the patient, family, or anyone in the home reside in any area where community transmission is occurring?

Yes No Comments

Vitals Notes:

Summary

Description