

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

Preferences	Assessment With
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Patient/Responsible Party Caregiver Family

Patient preference for CPR

Does the patient/r	esponsible	party understand CPR?	
Yes	No	Refused to discuss	Did not ask
Does the patient v	vant CPR pe	erformed?	
Yes	No	Refused to discuss	Did not ask
Does the patient h	ave an out-	of-hospital Do Not Resus	citate (DNR)?
Yes	No	Refused to discuss	Did not ask
Code Status		Where is the out-of-hos	pital DNR located?
Date Signed		Name of physician	

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05OCT2023 CURANTIS SOLUTIONS PAGE 1 OF 3

HOSPICE SKILLED NURSING SOFT ASSESSMENT

Physician Orders for Life-Sustaining Treatment (POLST)

Does the patient have Physician Orders for Life-Sustaining Treatment (POLST)?				
Yes	No	Refused to discuss	Did not ask	
POLST Location		Name of physician		
Date Signed				

Medical Orders for Scope of Treatment (MOST)

Does the patient have a Medical Orders for Scope of Treatment (MOST)?				
Yes	No	Refused to discuss	Did not ask	
MOST Location		Name of physician		
Date Signed				

Further Hospitalizations

Does the patient want any further hospitalizations (other than hospice GIP)?			
No	Refused to discuss	Did not ask	
nospitalizatio	ons does the patient want	?	
	No		

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Spiritual/Existential Concerns

Does the patient and/or caregiver have spiritual or existential concerns?				
Yes	No	Refused to discuss	Did not ask	
Other spiritua	al/existential	concerns?		
igns of Immin	ent Death			
		nent and based on your of fe expectancy of 3 days o		s the
Yes	No	Refused to discuss	Did not ask	
Explanation				
Preferences N	Notes:			

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