

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
		<input type="radio"/> Lying <input type="radio"/> Sitting <input type="radio"/> Standing		

#### Temperature

Route	Temperature (F)
<input type="radio"/> Axillary <input type="radio"/> Oral <input type="radio"/> Rectal <input type="radio"/> Temporal <input type="radio"/> Tympanic	

#### Pulse

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

#### Respiratory Rate

Respiration Type	Respiratory Rate (bpm)
<input type="radio"/> Normal <input type="radio"/> Cheyne-Stokes <input type="radio"/> Increased Expiratory Phase <input type="radio"/> Stridor <input type="radio"/> Orthopnea <input type="radio"/> Ineffective Lung Expansion <input type="radio"/> Pursed <input type="radio"/> Apnea <input type="radio"/> Uses Accessory Muscle <input type="radio"/> Labored <input type="radio"/> Barrel Chest    Other: <input type="radio"/> Shallow <input type="radio"/> Hypoxia	O <sub>2</sub> Saturation (%)

## HOSPICE SKILLED NURSING SOFT ASSESSMENT

### Height

<b>Current</b>
Feet inches

### Weight

lbs kg
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### MUAC

<b>Left Arm</b>
inches cm
Unable to Assess
<b>Right Arm</b>
inches cm
Unable to Assess

### COVID-19 Screening

<b>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?</b>		
Yes	No	Comments
<b>Does the patient, family or anyone in the home have a respiratory illness?</b>		
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