

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

Neurological Patient declines Neurological Assessment

Decline Reason:

Orientation

Oriented	Disoriented
Person	Person
Place	Place
Time	Time
Situation	Situation
Unable to Assess	Unable to Assess

Anxiety	Patient Experiences Anxiety?			ety?	Yes		No	
Anxiety Score								
					<u> </u>	—		<u> </u>
0 1	2 3	4	5	6	7	8	9	10
In the last 2 days, t	o what degr	ee has the	patient	been aff	ected by	this sy	mptom?	
0 - Not Impacted	l 1 - Mild	Impact	2 - Mo	derate Im	pact	3 - Se	evere Impa	ct
9 - Patient not ex	xperiencing th	e symptom						
Patient has been in	npacted in th	nese areas	(check	all that a	apply)			
Intake	Daily	Activities		Fatigue	& Weakr	ness	Sleep	
Concentration	Cogn	itive impairı	ment	Ability to	o interact		Emotiona	al distress
Spiritual distres	s Other							
Explanation								
]								

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05OCT2023 CURANTIS SOLUTIONS PAGE 1 OF 9

Agitation	Patient Experiences Agitation?			Yes	No
Agitation Score					
					
1	2 3 4		7		9 10
In the last 2 days, to v	what degree has the	e patient been a	affected by	this sympton	om?
0 - Not Impacted	1 - Mild Impact	2 - Moderate	Impact	3 - Severe	e Impact
9 - Patient not expe	eriencing the sympton	n			
Patient has been impa	acted in these area	s (check all tha	t apply)		
Intake	Daily Activities	Fatig	ue & Weakı	ness Slee	эр
Concentration	Cognitive impair	ment Ability	/ to interact	Em	otional distress
Spiritual distress	Other				
Explanation					
Confusion	Patient Exp	periences Conf	usion?	Yes	No
Depression	Patient Exp	periences Depr	ession?	Yes	No

05OCT2023 CURANTIS SOLUTIONS PAGE 2 OF 9

Headaches

Patient Experiences Headaches? Yes No **Nature Onset Date Episodic** Continuous **Most Recent** Location Unilateral Frequency Bilateral time(s) per Fronto-Temporal **Duration Number** Occipital **Duration Time** Other Hour(s) Day(s) **Pain Characteristics** Severity 6 Recent Head Inury Associated Vomiting **Associated Nausea** Radiation **Recent Head Injury Date Associated Vomiting Date** Recent Concussion **Associated Vomiting Frequency** time(s) per **Recent Head Injury Date**

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Recent Concussion					
Akine	sthesia	Blindness	Decreased Vison	Dysphasia	
Dysar	rthia	Dyskinesia	Gag Reflex Absent	Gag Reflex Imparied	
Impair Patter	red Speech m	Obtunded	Pill Rolling	Shuffling Gait	
Stupo	or	Syncope	Terminal Restlessness	Tremors	
TIA		Vertigo	Insomnia		
Other					

Neurological Notes	

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Summary	
Description	

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