

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
		LyingSitting		
		○ Standing		

Temperature

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

Pulse

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

Respiratory Rate

Re	spiration T	уре				Respiratory Rate (bpm)
0	Normal	0	Cheyne-Stokes	0	Increased Expiratory Phase	
0	Stridor	0	Orthopnea	0	Ineffective Lung Expansion	O ₂ Saturation (%)
0	Pursed	0	Apnea	0	Uses Accessory Muscle	O2 Saturation (70)
0	Labored	0	Barrel Chest		Other:	
0	Shallow	0	Hypoxia			

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HOSPICE SKILLED NURSING SOFT ASSESSMENT

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

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COVID-19 Screening

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				
		ily, or anyone in th	ne home reside in any area where			
Yes	No	Comments				
Vitals Notes:			<u>. </u>			
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HOSPICE SKILLED NURSING SOFT ASSESSMENT

Summary	
Description	

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