curantis solutions

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? ◯ Yes ◯ No

Anxiety Score

0 1 2 3 4 5 6 7 8 9 10

In the last 2 days, to what degree has the patient been affected by this symptom?

◯ 0 - Not Impacted ◯ 1 - Mild Impact ◯ 2 - Moderate Impact ◯ 3 - Severe Impact

◯ 9 - Patient not experiencing the symptom

Patient has been impacted in these areas (check all that apply)

☐ Intake ☐ Daily Activities ☐ Fatigue & Weakness ☐ Sleep

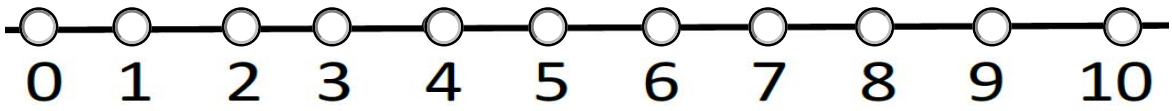
☐ Concentration ☐ Cognitive impairment ☐ Ability to interact ☐ Emotional distress

☐ Spiritual distress Other

Explanation

Agitation Patient Experiences Agitation? ◯ Yes ◯ No

Agitation Score



In the last 2 days, to what degree has the patient been affected by this symptom?

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Patient has been impacted in these areas (check all that apply)

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☐ Concentration ☐ Cognitive impairment ☐ Ability to interact ☐ Emotional distress

☐ Spiritual distress Other

Explanation

Confusion Patient Experiences Confusion? ◯ Yes ◯ No

Depression Patient Experiences Depression? ◯ Yes ◯ No

Headaches

Patient Experiences Headaches? ◯ Yes ◯ No

Nature

◯ Episodic ◯ Continuous

Onset Date

Location

☐ Unilateral

☐ Bilateral

☐ Fronto-Temporal

☐ Occipital

Other

Most Recent

Frequency

time(s) per --

Duration Number

Duration Time

◯ Hour(s) ◯ Day(s)

Pain Characteristics

--

Severity

0 1 2 3 4 5 6 7 8 9 10

☐ Associated Nausea ☐ Radiation ☐ Recent Head Inury ☐ Associated Vomiting

Recent Head Injury Date

Associated Vomiting Date

☐ Recent Concussion

Recent Head Injury Date

Associated Vomiting Frequency

time(s) per --

Recent Concussion

- ☐ Akinesthesia
- ☐ Blindness
- ☐ Decreased Vison
- ☐ Dysphasia
- ☐ Dysarthia
- ☐ Dyskinesia
- ☐ Gag Reflex Absent
- ☐ Gag Reflex Imparied
- ☐ Impaired Speech Pattern
- ☐ Obtunded
- ☐ Pill Rolling
- ☐ Shuffling Gait
- ☐ Stupor
- ☐ Syncope
- ☐ Terminal Restlessness
- ☐ Tremors
- ☐ TIA
- ☐ Vertigo
- ☐ Insomnia

Other

Neurological Notes

Summary

Description