

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 			
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			

HOSPICE SKILLED NURSING SOFT ASSESSMENT

Agitation	Patient Experiences Agitation?	Yes	No
Agitation Score  <div style="display: flex; justify-content: space-around; margin-top: 5px;"> 012345678910 </div>			
In the last 2 days, to what degree has the patient been affected by this symptom?			
<div style="display: flex; justify-content: space-between; padding: 5px;"> 0 - Not Impacted 1 - Mild Impact 2 - Moderate Impact 3 - Severe Impact </div> <div style="padding: 5px;">9 - Patient not experiencing the symptom</div>			
Patient has been impacted in these areas (check all that apply)			
<div style="display: flex; flex-wrap: wrap; padding: 10px;"> <div style="width: 25%;">Intake</div> <div style="width: 25%;">Daily Activities</div> <div style="width: 25%;">Fatigue & Weakness</div> <div style="width: 25%;">Sleep</div> <div style="width: 25%;">Concentration</div> <div style="width: 25%;">Cognitive impairment</div> <div style="width: 25%;">Ability to interact</div> <div style="width: 25%;">Emotional distress</div> <div style="width: 25%;">Spiritual distress</div> <div style="width: 25%;">Other</div> </div>			
Explanation			

Confusion	Patient Experiences Confusion?	Yes	No
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Depression	Patient Experiences Depression?	Yes	No
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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

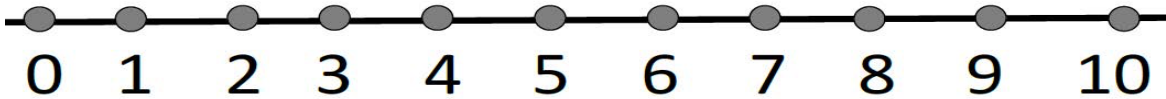
Duration Time

Hour(s)

Day(s)

Pain Characteristics

Severity



0

1

2

3

4

5

6

7

8

9

10

Associated Nausea

Radiation

Recent Head Injury

Associated Vomiting

Recent Head Injury Date

Associated Vomiting Date

Recent Concussion

Associated Vomiting Frequency

Recent Head Injury Date

time(s) per

Recent Concussion

Akinesthesia	Blindness	Decreased Vision	Dysphasia
Dysarthria	Dyskinesia	Gag Reflex Absent	Gag Reflex Impaired
Impaired Speech Pattern	Obtunded	Pill Rolling	Shuffling Gait
Stupor	Syncope	Terminal Restlessness	Tremors
TIA	Vertigo	Insomnia	
Other			

Neurological Notes

Summary

Description