



# HOSPICE

Name |  
DX |

| NEURO                              | RESP                             | CARDIAC                                              | GI / GU                                       | SKIN                                                   |
|------------------------------------|----------------------------------|------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Alert     | <input type="checkbox"/> Coughs  | <input type="checkbox"/> Discomfort                  | Incont: <input type="text"/>                  | <input type="checkbox"/> Cold                          |
| <input type="checkbox"/> Oriented  | <input type="checkbox"/> Wheeze  | <input type="checkbox"/> Murmur                      | Stool: <input type="text"/>                   | <input type="checkbox"/> Diaphoretic                   |
| <input type="checkbox"/> Lethargic | <input type="checkbox"/> Dyspnea | <input type="checkbox"/> Edema: <input type="text"/> | N/V/D/C                                       | <input type="checkbox"/> Pallor                        |
| <input type="checkbox"/> Seizure   | O2: <input type="text"/> L       |                                                      | BM: <input type="text"/>                      | <input type="checkbox"/> Mottled: <input type="text"/> |
| <input type="checkbox"/> PERR      |                                  |                                                      | K <input type="text"/> Q <input type="text"/> |                                                        |

  

| VITAL SIGNS                                                                | PAST MEDICAL |
|----------------------------------------------------------------------------|--------------|
| HT: <input type="text"/> W: <input type="text"/> BMI: <input type="text"/> |              |
| TEMP: <input type="text"/> / <input type="text"/>                          |              |
| HR: <input type="text"/> SPO2: <input type="text"/>                        |              |
| RR: <input type="text"/> MAC: <input type="text"/>                         |              |

  

| CLINICAL DECLINE        | ACTIVITY                            | IDG |
|-------------------------|-------------------------------------|-----|
| Hospitalizations: _____ | <input type="checkbox"/> Ambulatory |     |
| Falls: _____            | <input type="checkbox"/> Walker     |     |
| Weight Loss: _____      | <input type="checkbox"/> Wheelchair |     |
| Infections: _____       | <input type="checkbox"/> Bedbound   |     |
| Labs: _____             | <input type="checkbox"/> Assist x   |     |
| Speech: _____           |                                     |     |
| Appetite: _____         |                                     |     |
| Pain: _____             |                                     |     |
| PPS: _____ KPS: _____   |                                     |     |
| FAST: _____ NYHA: _____ |                                     |     |

  

| CHECK LIST                                                                  |
|-----------------------------------------------------------------------------|
| <input type="checkbox"/> Primary Contact: _____                             |
| <input type="checkbox"/> Attending Dr: _____                                |
| <input type="checkbox"/> Hospice Dr: _____                                  |
| <input type="checkbox"/> Dme: _____ <input type="checkbox"/> Ekit: _____    |
| <input type="checkbox"/> Diet: _____ <input type="checkbox"/> Orders: _____ |
| <input type="checkbox"/> _____ <input type="checkbox"/> _____               |

# Hospice Documentation Forms

**Arturo Cuomo**



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### **Table of Contents Hospice Documentation Forms**

1. Understanding the eBook Hospice Documentation Forms
  - The Rise of Digital Reading Hospice Documentation Forms
  - Advantages of eBooks Over Traditional Books
2. Identifying Hospice Documentation Forms
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Hospice Documentation Forms
  - User-Friendly Interface
4. Exploring eBook Recommendations from Hospice Documentation Forms
  - Personalized Recommendations
  - Hospice Documentation Forms User Reviews and Ratings

- Hospice Documentation Forms and Bestseller Lists
- 5. Accessing Hospice Documentation Forms Free and Paid eBooks
  - Hospice Documentation Forms Public Domain eBooks
  - Hospice Documentation Forms eBook Subscription Services
  - Hospice Documentation Forms Budget-Friendly Options
- 6. Navigating Hospice Documentation Forms eBook Formats
  - ePub, PDF, MOBI, and More
  - Hospice Documentation Forms Compatibility with Devices
  - Hospice Documentation Forms Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Hospice Documentation Forms
  - Highlighting and Note-Taking Hospice Documentation Forms
  - Interactive Elements Hospice Documentation Forms
- 8. Staying Engaged with Hospice Documentation Forms
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Hospice Documentation Forms
- 9. Balancing eBooks and Physical Books Hospice Documentation Forms
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Hospice Documentation Forms
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Hospice Documentation Forms
  - Setting Reading Goals Hospice Documentation Forms
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Hospice Documentation Forms
  - Fact-Checking eBook Content of Hospice Documentation Forms
  - Distinguishing Credible Sources

13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
14. Embracing eBook Trends
  - Integration of Multimedia Elements
  - Interactive and Gamified eBooks

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