

# HOSPICE ADMISSION CHECKLIST/ASSESSMENT

VITALS

WISHES

NEURO

CV

RESP

GI

GU

SKIN

SLEEP

## HOSPICE ADMISSION CHECKLIST

| Patient: _____<br>DOB: _____ Age/Sex: _____<br>Admit Date: _____ Provider: _____<br>Emergency Contact: _____<br>Emergency Contact #: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Diagnosis: _____<br>Comorbidities: _____<br>Allergies: _____<br>Spiritual Wishes: _____<br>Tradition: _____ |                                                                                                                                   |                                          |                                          |                                    |                                    |                                                  |                                                |                                                       |                                            |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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| <b>CERTIFICATION</b><br>Resuscitation Status: <input type="checkbox"/> DNR <input type="checkbox"/> DNI <input type="checkbox"/> DNI <input type="checkbox"/> _____<br>Wishes: <input type="checkbox"/> Advanced Directive <input type="checkbox"/> Living Will <input type="checkbox"/> SPOA <input type="checkbox"/> _____<br>Prognosis: <input type="checkbox"/> Terminal Illness <input type="checkbox"/> Terminal Restlessness <input type="checkbox"/> Imminently Dying<br>Level of Care: <input type="checkbox"/> Routine <input type="checkbox"/> Continuous <input type="checkbox"/> GIP <input type="checkbox"/> Respite<br>Admitted From: <input type="checkbox"/> Home <input type="checkbox"/> SNF <input type="checkbox"/> ALF <input type="checkbox"/> Hospital <input type="checkbox"/> _____                                                                                                                                                                                                                                                                        | Mortuary Name: _____<br>Mortuary #: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                             | <b>VITALS</b><br>Time: _____ BP: _____ Weight: _____<br>SpO2: _____ SpO2: _____ Height: _____<br>HR: _____ Temp: _____ BMI: _____ |                                          |                                          |                                    |                                    |                                                  |                                                |                                                       |                                            |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>NEUROLOGICAL</b> <table border="1"> <tr> <th colspan="3">MENTAL STATUS &amp; LOC</th> <th>ORIENTATION</th> <th>FAIM</th> <th>SPEECH</th> <th>CONDITIONS</th> </tr> <tr> <td><input type="checkbox"/> Awake</td> <td><input type="checkbox"/> Lethargic</td> <td><input type="checkbox"/> Anxious</td> <td><input type="checkbox"/> Person</td> <td>____ / M</td> <td><input type="checkbox"/> Clear</td> <td><input type="checkbox"/> Seizures</td> </tr> <tr> <td><input type="checkbox"/> Alert</td> <td><input type="checkbox"/> Restless</td> <td><input type="checkbox"/> Depressed</td> <td><input type="checkbox"/> Place</td> <td><input type="checkbox"/> Location: _____</td> <td><input type="checkbox"/> Aphasia</td> <td><input type="checkbox"/> Paralysis</td> </tr> <tr> <td><input type="checkbox"/> Calm</td> <td><input type="checkbox"/> Confused</td> <td><input type="checkbox"/> Withdrawn</td> <td><input type="checkbox"/> Time</td> <td><input type="checkbox"/> Onset: _____</td> <td><input type="checkbox"/> Carotid</td> <td><input type="checkbox"/> Tremor</td> </tr> <tr> <td><input type="checkbox"/> Cooperative</td> <td><input type="checkbox"/> Agitated</td> <td><input type="checkbox"/> _____</td> <td><input type="checkbox"/> Situation</td> <td><input type="checkbox"/> Duration: _____</td> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> _____</td> </tr> <tr> <td><input type="checkbox"/> Forgetful</td> <td><input type="checkbox"/> Unresponsive</td> <td><input type="checkbox"/> _____</td> <td></td> <td><input type="checkbox"/> Quality: _____</td> <td><input type="checkbox"/> _____</td> <td><input type="checkbox"/> _____</td> </tr> </table> |                                                                                                             |                                                                                                                                   | MENTAL STATUS & LOC                      |                                          |                                    | ORIENTATION                        | FAIM                                             | SPEECH                                         | CONDITIONS                                            | <input type="checkbox"/> Awake             | <input type="checkbox"/> Lethargic    | <input type="checkbox"/> Anxious                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> Person      | ____ / M                                               | <input type="checkbox"/> Clear   | <input type="checkbox"/> Seizures                    | <input type="checkbox"/> Alert        | <input type="checkbox"/> Restless    | <input type="checkbox"/> Depressed      | <input type="checkbox"/> Place                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/> Location: _____  | <input type="checkbox"/> Aphasia    | <input type="checkbox"/> Paralysis                                                                                                                                                                                                                                                                                | <input type="checkbox"/> Calm           | <input type="checkbox"/> Confused     | <input type="checkbox"/> Withdrawn      | <input type="checkbox"/> Time        | <input type="checkbox"/> Onset: _____ | <input type="checkbox"/> Carotid         | <input type="checkbox"/> Tremor           | <input type="checkbox"/> Cooperative  | <input type="checkbox"/> Agitated | <input type="checkbox"/> _____ | <input type="checkbox"/> Situation | <input type="checkbox"/> Duration: _____ | <input type="checkbox"/> Normal | <input type="checkbox"/> _____ | <input type="checkbox"/> Forgetful | <input type="checkbox"/> Unresponsive | <input type="checkbox"/> _____ |  | <input type="checkbox"/> Quality: _____ |
| MENTAL STATUS & LOC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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| <input type="checkbox"/> Awake                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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 | <input type="checkbox"/> Clear           | <input type="checkbox"/> Seizures  |                                    |                                                  |                                                |                                                       |                                            |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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| <input type="checkbox"/> Alert                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Restless                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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_____ | <input type="checkbox"/> Aphasia         | <input type="checkbox"/> Paralysis |                                    |                                                  |                                                |                                                       |                                            |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            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| <input type="checkbox"/> Calm                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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 | <input type="checkbox"/> Carotid         | <input type="checkbox"/> Tremor    |                                    |                                                  |                                                |                                                       |                                            |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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| <input type="checkbox"/> Cooperative                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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_____ | <input type="checkbox"/> Normal          | <input type="checkbox"/> _____     |                                    |                                                  |                                                |                                                       |                                            |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            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| <input type="checkbox"/> Forgetful                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> Unresponsive                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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 | <input type="checkbox"/> _____           | <input type="checkbox"/> _____     |                                    |                                                  |                                                |                                                       |                                            |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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| <b>CARDIOVASCULAR</b> <table border="1"> <tr> <th colspan="2">HEART SOUNDS</th> </tr> <tr> <td><input type="checkbox"/> Regular</td> <td><input type="checkbox"/> Chest pain</td> </tr> <tr> <td><input type="checkbox"/> Irregular</td> <td><input type="checkbox"/> Pacemaker</td> </tr> <tr> <td><input type="checkbox"/> Murmur</td> <td><input type="checkbox"/> Implanted defibrillator</td> </tr> <tr> <td><input type="checkbox"/> Distal</td> <td><input type="checkbox"/> Edema +0 / +1 / +2 / +3 / +4</td> </tr> <tr> <td><input type="checkbox"/> Extra sound</td> <td>Location: _____</td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                               | HEART SOUNDS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                             | <input type="checkbox"/> Regular                                                                                                  | <input type="checkbox"/> Chest pain      | <input type="checkbox"/> Irregular       | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Murmur    | <input type="checkbox"/> Implanted defibrillator | <input type="checkbox"/> Distal                | <input type="checkbox"/> Edema +0 / +1 / +2 / +3 / +4 | <input type="checkbox"/> Extra sound       | Location: _____                       | <b>RESPIRATORY</b> <table border="1"> <tr> <th>CHEST</th> <th>LUNG SOUNDS</th> <th>PHARYNX</th> </tr> <tr> <td><input type="checkbox"/> SOB</td> <td><input type="checkbox"/> CTA</td> <td><input type="checkbox"/> Easy</td> </tr> <tr> <td><input type="checkbox"/> Cough</td> <td><input type="checkbox"/> Diminished</td> <td><input type="checkbox"/> Regular</td> </tr> <tr> <td><input type="checkbox"/> Secretions</td> <td><input type="checkbox"/> Wheeze</td> <td><input type="checkbox"/> Shallow</td> </tr> <tr> <td>Color: _____</td> <td><input type="checkbox"/> Crackles</td> <td><input type="checkbox"/> Deep</td> </tr> <tr> <td><input type="checkbox"/> Trach</td> <td><input type="checkbox"/> _____</td> <td><input type="checkbox"/> Periods of apnea</td> </tr> </table> | CHEST                                | LUNG SOUNDS                                            | PHARYNX                          | <input type="checkbox"/> SOB                         | <input type="checkbox"/> CTA          | <input type="checkbox"/> Easy        | <input type="checkbox"/> Cough          | <input type="checkbox"/> Diminished                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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| HEART SOUNDS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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| <input type="checkbox"/> Regular                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Chest pain                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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| <input type="checkbox"/> Irregular                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> Pacemaker                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       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| <input type="checkbox"/> Murmur                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Implanted defibrillator                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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| <input type="checkbox"/> Distal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Edema +0 / +1 / +2 / +3 / +4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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| <input type="checkbox"/> Extra sound                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Location: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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| CHEST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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| <input type="checkbox"/> SOB                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> CTA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             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| <input type="checkbox"/> Cough                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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| <input type="checkbox"/> Secretions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/> Wheeze                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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| Color: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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| <input type="checkbox"/> Trach                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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| <b>GASTROINTESTINAL</b> <table border="1"> <tr> <td><input type="checkbox"/> Distended / Incontinent</td> <td><input type="checkbox"/> Continence / Incontinent</td> </tr> <tr> <td>Last BM: _____</td> <td><input type="checkbox"/> Urgency</td> </tr> <tr> <td>Bowel Sounds: _____</td> <td><input type="checkbox"/> Nocturia</td> </tr> <tr> <td><input type="checkbox"/> Gas</td> <td><input type="checkbox"/> Frequency</td> </tr> <tr> <td><input type="checkbox"/> Abdo Tenderness</td> <td><input type="checkbox"/> Dysuria</td> </tr> <tr> <td><input type="checkbox"/> Nausea / Vomiting</td> <td><input type="checkbox"/> Incontinence</td> </tr> <tr> <td><input type="checkbox"/> Constipation / Diarrhea</td> <td><input type="checkbox"/> Pain</td> </tr> <tr> <td><input type="checkbox"/> Colic</td> <td><input type="checkbox"/> Burning</td> </tr> <tr> <td><input type="checkbox"/> _____</td> <td><input type="checkbox"/> Color: _____</td> </tr> <tr> <td><input type="checkbox"/> _____</td> <td><input type="checkbox"/> Clarity: _____</td> </tr> </table> | <input type="checkbox"/> Distended / Incontinent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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        | Bowel Sounds: _____                      | <input type="checkbox"/> Nocturia  | <input type="checkbox"/> Gas       | <input type="checkbox"/> Frequency               | <input type="checkbox"/> Abdo Tenderness       | <input type="checkbox"/> Dysuria                      | <input type="checkbox"/> Nausea / Vomiting | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Constipation / Diarrhea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> Pain        | <input type="checkbox"/> Colic                         | <input type="checkbox"/> Burning | <input type="checkbox"/> _____                       | <input type="checkbox"/> Color: _____ | <input type="checkbox"/> _____       | <input type="checkbox"/> Clarity: _____ | <b>INTEGUMENTARY</b> <table border="1"> <tr> <th>SKIN</th> <th>WOUND</th> </tr> <tr> <td><input type="checkbox"/> Intact / Clean / Dry</td> <td><input type="checkbox"/> Pressure ulcer</td> </tr> <tr> <td><input type="checkbox"/> Color: _____</td> <td><input type="checkbox"/> Pressure ulcer</td> </tr> <tr> <td><input type="checkbox"/> Temp: _____</td> <td><input type="checkbox"/> Wound</td> </tr> <tr> <td><input type="checkbox"/> Moisture: _____</td> <td><input type="checkbox"/> Wound</td> </tr> <tr> <td><input type="checkbox"/> Tumor: _____</td> <td><input type="checkbox"/> Dressing</td> </tr> <tr> <td><input type="checkbox"/> _____</td> <td><input type="checkbox"/> Dressing</td> </tr> </table> | SKIN                                      | WOUND                               | <input type="checkbox"/> Intact / Clean / Dry                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Pressure ulcer | <input type="checkbox"/> Color: _____ | <input type="checkbox"/> Pressure ulcer | <input type="checkbox"/> Temp: _____ | <input type="checkbox"/> Wound        | <input type="checkbox"/> Moisture: _____ | <input type="checkbox"/> Wound            | <input type="checkbox"/> Tumor: _____ | <input type="checkbox"/> Dressing | <input type="checkbox"/> _____ | <input type="checkbox"/> Dressing  |                      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| <input type="checkbox"/> Distended / Incontinent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       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| Last BM: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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| Bowel Sounds: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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| <input type="checkbox"/> Gas                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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| <input type="checkbox"/> Abdo Tenderness                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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| <input type="checkbox"/> Nausea / Vomiting                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             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| <input type="checkbox"/> Constipation / Diarrhea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       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| <input type="checkbox"/> Colic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Burning                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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| <input type="checkbox"/> _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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| <input type="checkbox"/> Color: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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| <input type="checkbox"/> Temp: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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| <input type="checkbox"/> Moisture: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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| <input type="checkbox"/> Tumor: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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| <input type="checkbox"/> _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Dressing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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| <b>FUNCTION</b> <table border="1"> <tr> <td><input type="checkbox"/> Diet: _____</td> <td><input type="checkbox"/> Sleep Duration: _____</td> </tr> <tr> <td><input type="checkbox"/> Appetite: _____</td> <td><input type="checkbox"/> Sleep Apnea</td> </tr> <tr> <td><input type="checkbox"/> Diabetes: Y / N</td> <td><input type="checkbox"/> Fatigue</td> </tr> <tr> <td><input type="checkbox"/> Dysphagia</td> <td><input type="checkbox"/> _____</td> </tr> <tr> <td><input type="checkbox"/> Assistance with meals</td> <td><input type="checkbox"/> _____</td> </tr> <tr> <td><input type="checkbox"/> _____</td> <td><input type="checkbox"/> _____</td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/> Diet: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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 | <input type="checkbox"/> Diabetes: Y / N | <input type="checkbox"/> Fatigue   | <input type="checkbox"/> Dysphagia | <input type="checkbox"/> _____                   | <input type="checkbox"/> Assistance with meals | <input type="checkbox"/> _____                        | <input type="checkbox"/> _____             | <input type="checkbox"/> _____        | <b>ACTIVITY</b> <table border="1"> <tr> <td><input type="checkbox"/> Independent</td> <td><input type="checkbox"/> Strong: R/L / L/R / R/L / L/L</td> </tr> <tr> <td><input type="checkbox"/> Assist</td> <td><input type="checkbox"/> Weak: R/L / L/R / R/L / L/L</td> </tr> <tr> <td><input type="checkbox"/> Rural</td> <td><input type="checkbox"/> Gait: _____</td> </tr> <tr> <td><input type="checkbox"/> Bedbound</td> <td><input type="checkbox"/> Recent Falls: _____</td> </tr> <tr> <td><input type="checkbox"/> Assistive Device</td> <td><input type="checkbox"/> _____</td> </tr> </table>                                                                                                                                                                                          | <input type="checkbox"/> Independent | <input type="checkbox"/> Strong: R/L / L/R / R/L / L/L | <input type="checkbox"/> Assist  | <input type="checkbox"/> Weak: R/L / L/R / R/L / L/L | <input type="checkbox"/> Rural        | <input type="checkbox"/> Gait: _____ | <input type="checkbox"/> Bedbound       | <input type="checkbox"/> Recent Falls: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Assistive Device | <input type="checkbox"/> _____      | <b>ADDITIONAL</b> <table border="1"> <tr> <td><input type="checkbox"/> Nightly MD</td> </tr> <tr> <td><input type="checkbox"/> _____</td> </tr> <tr> <td><input type="checkbox"/> _____</td> </tr> <tr> <td><input type="checkbox"/> _____</td> </tr> <tr> <td><input type="checkbox"/> _____</td> </tr> </table> | <input type="checkbox"/> Nightly MD     | <input type="checkbox"/> _____        | <input type="checkbox"/> _____          | <input type="checkbox"/> _____       | <input type="checkbox"/> _____        |                                          |                                           |                                       |                                   |                                |                                    |                               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| <input type="checkbox"/> Diet: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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| <input type="checkbox"/> Appetite: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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| <input type="checkbox"/> Diabetes: Y / N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> Fatigue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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| <input type="checkbox"/> Dysphagia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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| <input type="checkbox"/> Independent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> Strong: R/L / L/R / R/L / L/L                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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| <input type="checkbox"/> Assist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Weak: R/L / L/R / R/L / L/L                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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| <input type="checkbox"/> Rural                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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| <input type="checkbox"/> Bedbound                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Recent Falls: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             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| <input type="checkbox"/> Assistive Device                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              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| <input type="checkbox"/> Nightly MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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# Hospice Documentation Audit Tool

**M Lipman**



**Hospice Documentation Audit Tool:**

Eventually, you will agreed discover a new experience and feat by spending more cash. nevertheless when? reach you endure that you require to acquire those every needs behind having significantly cash? Why dont you attempt to get something basic in the beginning? Thats something that will lead you to understand even more in this area the globe, experience, some places, subsequent to history, amusement, and a lot more?

It is your totally own epoch to be active reviewing habit. in the course of guides you could enjoy now is **Hospice Documentation Audit Tool** below.

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## **Table of Contents Hospice Documentation Audit Tool**

1. Understanding the eBook Hospice Documentation Audit Tool
  - The Rise of Digital Reading Hospice Documentation Audit Tool
  - Advantages of eBooks Over Traditional Books
2. Identifying Hospice Documentation Audit Tool
  - 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 Audit Tool
  - User-Friendly Interface
4. Exploring eBook Recommendations from Hospice Documentation Audit Tool
  - Personalized Recommendations
  - Hospice Documentation Audit Tool User Reviews and Ratings
  - Hospice Documentation Audit Tool and Bestseller Lists
5. Accessing Hospice Documentation Audit Tool Free and Paid eBooks

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