PALLIATIVE & HOSPICE CARE NOTE

<table>
<tr><td colspan="4">Hospice Provider:</td></tr>
<tr><td colspan="4">Patient Information</td></tr>
<tr><td>Name:</td><td colspan="2">DOB:</td><td>MRN:</td></tr>
<tr><td>Date & Time:</td><td colspan="3">Location: ☐ Inpatient ☐ Outpatient ☐ Home ☐ Hospice Facility</td></tr>
<tr><td colspan="2">Primary Diagnosis:</td><td colspan="2">Relevant Conditions/Allergies</td></tr>
<tr><td colspan="4">Medical Insurance Policy Number:</td></tr>
<tr><td colspan="4">Family & Provider Contact Information</td></tr>
<tr><td colspan="2">Primary Family Contact:</td><td>Phone:</td><td>Email:</td></tr>
<tr><td colspan="2">Secondary Family Contact:</td><td>Phone:</td><td>Email:</td></tr>
<tr><td colspan="2">Primary Care Physician (PCP)</td><td>Phone:</td><td>Email:</td></tr>
<tr><td colspan="4">Chief Concern & Goals of Care</td></tr>
<tr><td>Current concerns:</td><td colspan="2">Patient's Goals:</td><td>Patient's Goals:</td></tr>
<tr><td colspan="4">Changes in Goals of Care (if applicable):</td></tr>
<tr><td colspan="4">Medical History</td></tr>
<tr><td colspan="4">Primary Diagnosis:</td></tr>
<tr><td colspan="2">Recent Hospitalizations & Procedures:</td><td colspan="2">Mx:</td></tr>
<tr><td colspan="4">Advanced Care Planning & Directives</td></tr>
<tr><td colspan="4">☐ Advance Directive on File
☐ POLST/MOLST on File
☐ DNR/DNI Status: ____
☐ Health Care Proxy: Name: ____ Contact: ____
☐ Preferred Location of Care: ☐ Home ☐ Hospital ☐ Hospice Facility
☐ Emergency Preferences: ☐ No CPR ☐ No ICU ☐ Symptom relief only</td></tr>
<tr><td colspan="2" rowspan="2">Symptom Assessment & Management

☐ Pain: ____/10 | Location: ____ | Description: ____
☐ Dyspnea: ☐ None ☐ Mild ☐ Mod ☐ Severe | ☐ O_2 in use
☐ Nausea/Vomiting: ☐ None ☐ Present (Triggers: ____)
☐ Anxiety/Agitation: ☐ None ☐ Mild ☐ Mod ☐ Severe
☐ Fatigue: ☐ None ☐ Mild ☐ Mod ☐ Severe
☐ Delirium/Confusion: ☐ None ☐ Intermittent ☐ Persistent
☐ GI Symptoms: ☐ Constipation ☐ Diarrhea ☐ Anorexia
☐ Other: ____</td><td colspan="2">Physical Exam (PE)

VS: T: ____ BP: / HR: ____ RR: ____ SpO_2: __%</td></tr>
<tr><td colspan="2">Gen: ☐ A&O x ☐ AMS ☐ Cachectic ☐ NAD ☐ Weak/Frail
HEENT: ☐ NCAT ☐ PERRL ☐ Oral mucosa dry ☐ Dysphagia
Resp: ☐ CTAB ☐ Rales ☐ Rhonchi ☐ Dyspnea ☐ ↑ Work of Breathing
CV: ☐ RRR ☐ Tachy ☐ Brady ☐ Edema (1+ to 4+)</td></tr>
</table>

Freed: Clinician Happiness

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	Neuro: ☐ A&O ☐ Lethargic ☐ Myoclonic Jerks ☐ Tremors Skin: ☐ W/D ☐ Cool/Clammy ☐ Cyanosis ☐ Pressure Ulcers (Loc: ____)
Hospice Admission Narrative *(if applicable)*	
This is to certify that_____________ was diagnosed with __________in _______________. The patient has received a medical prognosis of ___________, as of _____________, and is therefore eligible for hospice care. The patient understands their prognosis and does not wish to return to the hospital. The patient is seeking comfort measures only.	
Beneficiary Signature:	Date:
Medical Decision-Making	
Current Status and Decline:	Recent Hospitalizations or Complications:
Symptom Management Plan	
Pain: ☐ Acetaminophen ☐ NSAIDs ☐ Opioids ☐ Other: ____ Dyspnea: ☐ O_2 ☐ Opioids ☐ Anxiolytics ☐ Other: ____ GI Support: ☐ Laxatives ☐ Antiemetics ☐ Dietary Support Anxiety/Agitation: ☐ Benzodiazepines ☐ Antipsychotics ☐ Supportive Care	☐ Emotional/Spiritual Support: Chaplain ☐ Yes ☐ No ☐ Psychosocial Needs: Counseling ☐ Yes ☐ No ☐ Caregiver Support Plan: ____ ☐ Hospice Enrollment: ☐ Discussed ☐ Initiated ☐ Declined
Disposition & Plan	
☐ Continue Current Palliative Plan ☐ Adjust Medications for Symptom Relief ☐ Follow-up in: ____ days/weeks ☐ Care Coordination: ☐ PCP ☐ Oncologist ☐ Hospice Team ☐ Discuss End-of-Life Care Goals with Family	
Clinician Signature	Date: