SAMPLE

Hospice Intake Addendum

Individual's Name:		Prefers to be called:	
Birth Date:		Religion:	
Telephone Number:		Fax Number:	
Address:			

Medication Allergies:	
Food/Environmental Allergies:	
Type of Reaction(s):	

Emergency Contacts:

Name:	Name:
Telephone Number:	Telephone Number:

Health Insurance: (Type and Numbers)
Primary: _____
Secondary: _____

Service Provider Responsible for Care: ☐ No ☐ Yes
If Yes, List Name of Service Provider: _____
Hospice Point Person (HPP): _____
Service Provider Telephone Number: _____

Nursing Support: ☐ No ☐ Yes
If Yes, List Name of Nursing Agency: _____

Day Program: _____
Type of Day Program: _____
Day Program Contact Person: _____

Nursing Support: ☐ No ☐ Yes
If Yes, List Name of Nursing Agency: _____

State Agency: _____ Area Office: _____

Area Office Nurse: _____ Telephone Number: _____
Service Coordinator/ Case Manager: _____ Telephone Number: _____

Consent Status:
☐ Can Give Own Consent ☐ Consent from Guardian ☐ Unable to give Own Consent and No Guardian
Guardian Name: Telephone Number: _____
Guardian Contact Information:

Resuscitation Status: ☐ DNR ☐ Full Resuscitation
If DNR, is Comfort Care form available? ☐ No ☐ Yes ☐ Unknown

Health Care Proxy: ☐ No ☐ Yes
Health Care Agent Name: _____ Telephone Number: _____

Medications: ☐ Current Medication List Attached
Pharmacy Name: _____
Pharmacy Address: _____
Telephone Number:

Current Medical Problems and Diagnoses:

Communication:	☐ Verbally Communicates	☐ Uses Verbalizations	☐ Uses Gestures	☐ Not able to Communicate Needs
	☐ Not able to use Call Bell	☐ Speaks/ Understands Language other than English	Non-English Language (if applicable): ☐ ____	☐ Unknown
Vision:	☐ Normal ☐ Unknown	☐ Low Vision	☐ Blind	☐ Wears Glasses
Hearing:	☐ Normal ☐ Unknown	☐ Hard of Hearing	☐ Deaf	☐ Hearing Aid
Supportive Devices:	☐ Padded Side Rails	☐ Splints	☐ Braces	☐ Helmet
	☐ Other-(if applicable): ____		☐ Unknown	☐ None
Elimination:	☐ Continent	☐ Needs Assistance	☐ Incontinent	☐ Uses Catheter
	☐ Other-(if applicable): ____		☐ Unknown	
Medication Administration:	☐ Self-Administers	☐ Staff Administers	☐ Other-(if applicable): ____	
Dining/Eating:	☐ Independent	☐ Needs Assistance	☐ Dependent	☐ Feeding Tube
	☐ Other-(if applicable): ____		☐ Unknown	
Diet Texture:	☐ Regular	☐ Chopped	☐ Ground	☐ Pureed
	☐ Thickened Liquid	☐ Other-(if applicable): ____		
Diet Type: ____				
Ambulation:	☐ Independent (Steady)	☐ Independent (Unsteady)	☐ Needs Assistance (1 person)	☐ Needs Assistance (2 people or more)
Ambulation Aids:	☐ Walker	☐ Cane	☐ Crutches	☐ Wheelchair
	☐ Non-Ambulatory	☐ Other-(if applicable): ____		☐ Unknown
Personal Hygiene:	☐ Independent	☐ Needs Assistance	☐ Other-(if applicable): ____	
Oral Hygiene:	☐ Independent	☐ Needs Assistance	☐ Other-(if applicable): ____	
Head of Bed Elevated:	☐ No	☐ Yes	☐ Degree Elevated: ____	

Personal Preferences:	☐ Preferred Routines: ____
	☐ Likes: ____
	☐ Dislikes: ____
	☐ Communication Device/Method (if applicable): ____

Pain Response:	☐ Describe how the individual responds to pain: ____

Health Care Provider(s):						Telephone	Fax
Type/Specialty	Name	Address	City	State	Zip	Number	Number
Primary Care							
Dental Care							
Eye Care							

Additional Information:

Completed by: _____ Date: _____

Relationship to the Individual: _____