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| Hospice Intake Addendum |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | | | | | | If DNR, is Comfort Care form available? | | | | | | | | No  Yes  Unknown | | | | |
|  | | | | | Full Resuscitation | | | | | |  | | | | | | | |  | | | | |
| Health Care Proxy: | | | | | No | | | | | |  | | | |  | | | | | |  | |  |
|  | | | | | Yes | | | | | | Health Care Agent Name: | | | |  | | | | | | Telephone Number: | |  |
|  | | | | |  | | | | | | | | | | | | | | | | | | |
| Medications: | | | | | Current Medication List Attached | | | | | | | | | | Current Medical Problems and Diagnoses: | | | | | | | | |
| Pharmacy Name: | | | | | |  | | | | | | | | |
| Pharmacy Address: | | | | | |  | | | | | | | | |
| Telephone Number: | | | | | |  | | | | | | | | |

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| 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 | | | | | Low Vision | | | | | | Blind | | | | | | Wears Glasses | | |
|  | | Unknown | | | | |  | | | | | |  | | | | | |  | | |
| Hearing: | | Normal | | | | | Hard of Hearing | | | | | | Deaf | | | | | | Hearing Aid | | |
|  | | Unknown | | | | |  | | | | | |  | | | | | |  | | |
| 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 |  | | | | |  | | | | |  | | |  | | |  |  | | |  |
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| Additional Information: | | | | | | | | | | | | | | | | | | | | | |
| Completed by: |  | | | | | | | | | Date: | |  | | |
| Relationship to the Individual: | | | |  | | | | | | | | | | |