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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: |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |
| Additional Information:       |
| Completed by: |       | Date: |       |
| Relationship to the Individual: |       |