



Hospice of the Piedmont- ASH C
Hospice Admission Assessment

Patient: Handy, Robert W -MR#110145

Caregiver: Lovette, Michele (HSN) Visit Date: 10/06/2025

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Chart: 1 Benefit Period: 1

Mileage: 9

Location of Care: Home

Time In: 9:32 AM Time Out: 10:54 AM

This assessment includes the **Hospice Outcomes and Patient Evaluation (HOPE) Data Set** - OMB Control Number 0938-1153

Patient Number: 110145

Location Name: Hospice of the Piedmont- ASH C

Location Number: 718

Benefit Period: 1

Benefit Period Dates From: 10/05/2025 To: 01/02/2026

What is most important to the patient today?

Two (or more) patient identifiers used this visit:

- Assigned identification number (for example, MBI, SSN)
- Insurance card
- Passport
- Other patient identifier(s) used this visit:
- Direct facial recognition (known to staff)
- Patient address confirmed
- Social Security Card
- Driver's license
- Patient name
- Unknown or not assessed

(A0100. Facility Provider Numbers.)

Enter code in boxes provided.

A. National Provider Identifier (NPI):

1225017759

B. CMS Certification Number (CCN):

34-1511

Type text here

(A0215) Site of Service at Admission

- 01. Patient's Home/Residence
- 02. Assisted Living Facility
- 03. Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF)
- 04. Skilled Nursing Facility (SNF)
- 05. Inpatient Hospital
- 06. Inpatient Hospice Facility (General Inpatient (GIP))
- 07. Long Term Care Hospital (LTCH)
- 08. Inpatient Psychiatric Facility
- 09. Hospice Home Care (Routine Home Care (RHC)) Provided in a Hospice Facility
- 99. Not listed

(A0220. Admission Date.)

10/05/2025

(A0250) Reason for Record

- 01. Admission (ADM)

(A0500. Legal Name of Patient)

A. First name:

Robert

B. Middle initial:

W

C. Last name:

Handy

D. Suffix:

(A0550) Patient Zip Code:

27313

(A0600) Social Security and Medicare Numbers

A. Social Security Number:

240643310

B. Medicare number:

2XU8M03CJ51

(A0700. Medicaid Number)

- Enter "+" if pending, "N" if not a Medicaid Recipient

N

(A0810) Sex

- 1. Male
- 2. Female

(A0900. Birth Date)

07/24/1944

(A1005) Ethnicity

Are you of Hispanic, Latino/a, or Spanish origin?

Check all that apply

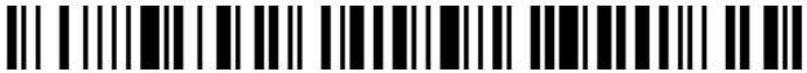
- A. No, not of Hispanic, Latino/a, or Spanish origin
- B. Yes, Mexican, Mexican American, Chicano/a
- C. Yes, Puerto Rican
- D. Yes, Cuban
- E. Yes, Another Hispanic, Latino, or Spanish origin
- X. Patient unable to respond
- Y. Patient declines to respond

(A1010) Race

What is your race?

Check all that apply

- A. White
- B. Black or African American
- C. American Indian or Alaska Native
- D. Asian Indian
- E. Chinese
- F. Filipino
- G. Japanese



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Patient: **Handy, Robert W.-MR# 110145**

Caregiver: **Lovette, Michele (HSN)** Visit Date: 10/06/2025

- H. Korean
- I. Vietnamese
- J. Other Asian
- K. Native Hawaiian
- L. Guamanian or Chamorro
- M. Samoan
- N. Other Pacific Islander
- X. Patient unable to respond
- Y. Patient declines to respond
- Z. None of the above

(A1400) Payer Information:

Check all existing payer sources that apply at the time of this assessment

- A. Medicare (traditional fee-for-service)
- B. Medicare (managed care/Part C/Medicare Advantage)
- C. Medicaid (traditional fee-for-service)
- D. Medicaid (managed care)
- G. Other government (e.g., TRICARE, VA, etc.)
- H. Private Insurance/Medigap
- I. Private managed care
- J. Self-pay
- K. No payer source
- X. Unknown
- Y. Other

(A1805) Admitted From:

Immediately preceding this admission, where was the patient?

- 01. Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
- 02. Nursing Home (long-term care facility)
- 03. Skilled Nursing Facility (SNF, swing beds)
- 04. Short-Term General Hospital (acute hospital, IPPS)
- 05. Long-Term Care Hospital (LTCH)
- 06. Inpatient Rehabilitation Facility (IRF, free standing facility or unit)
- 07. Inpatient Psychiatric Facility (psychiatric hospital or unit)
- 08. Intermediate Care Facility (ID/DD facility)
- 10. Hospice (institutional facility)
- 11. Critical Access Hospital (CAH)
- 99. Not Listed

Hospitalizations in the last 6 months: None 1-2 3-4 Greater than 4 Unknown

Emergency room visits in the last 6 months: None 1-2 3-4 Greater than 4 Unknown

Date of last physician visit:

Select documents, policies, and processes discussed with the patient and/or caregiver this visit:

- Rights /Responsibilities
- Charges for Services/Assignment of Benefits
- Hospice Benefit
- Pt /Caregiver Development of Care Plan
- Advance Directives
- Services Provided/Anticipated Frequency
- Fire/Safety/Disaster & Emergency Plan
- HIPAA Information
- Complaint Procedure & Hotline Number
- Policy for Managing Controlled Drugs Given

DIAGNOSIS

Diagnoses

Primary Diagnosis	Date	ICD Code	Additional Diagnosis related to prognosis
a. Nonrheumatic mitral (valve) insufficiency	10/05/2025	I34.0	
Other Diagnoses	Date	ICD Code	
b.			<input type="radio"/> Yes <input type="radio"/> No
c.			<input type="radio"/> Yes <input type="radio"/> No
d.			<input type="radio"/> Yes <input type="radio"/> No
e.			<input type="radio"/> Yes <input type="radio"/> No
f.			<input type="radio"/> Yes <input type="radio"/> No

Brief medical history (chemotherapy, surgeries, procedures etc.):

(10010) Principal Diagnosis

This section has more to offer regarding diagnosis selections, which you will need to utilize.

- 01. Cancer
- 02. Dementia (including Alzheimer's disease)
- 03. Neurological Condition (e.g., Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis (ALS))
- 04. Stroke
- 05. Chronic Obstructive Pulmonary Disease (COPD)



- 06. Cardiovascular (excluding heart failure)
- 07. Heart Failure
- 08. Liver Disease
- 09. Renal Disease
- 99. None of the Above

Comorbidities and Co-existing Conditions

↓ Check all that apply

Cancer

I0100. Cancer

Heart/Circulation

I0600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)

I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)

I0950. Cardiovascular (excluding heart failure)

Gastrointestinal

I1101. Liver disease (e.g., cirrhosis)

Genitourinary

I1510. Renal disease

Infections

I2102. Sepsis

Metabolic

I2900. Diabetes Mellitus (DM)

I2910. Neuropathy

Neurological

I4501. Stroke

I4801. Dementia (including Alzheimer's disease)

I5150. Neurological Conditions (e.g., Parkinson's disease, multiple sclerosis, ALS)

I5401. Seizure Disorder

Pulmonary

I6202. Chronic Obstructive Pulmonary Disease (COPD)

Other

I8005. Other Medical Condition

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This form has been electronically signed by:

[Redacted Signature] 10/06/2025 10:32:47 PM EDT

[Redacted Signature] 10/07/2025 12:00:11 PM EDT

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Chart: 1 Benefit Period: 1

Location of Care: Home

LIVING ARRANGEMENTS / ENVIRONMENTAL / SOCIAL

Marital Status: Married Significant Other Divorced Separated Single Widow/Widower

(A1110) Language

A. What is your preferred language?

English

B. Do you need or want an interpreter to communicate with a doctor or health care staff?

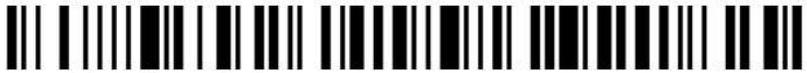
- 0. No
- 1. Yes
- 9. Unable to determine

Professional interpreter offered. Patient/Caregiver/Representative (if any):

- Accepted (interpreter service details):
- Declined, will use own interpreter (specify):
- Declined (specify):

Learning barriers:

Current Residence: Patient owned or rented residence Family member's residence Boarding home or rented room Board and care or assisted living facility
 Other (specify): Name of facility:



(A1905) Living Arrangements

Identify the patient's living arrangement at the time of this admission.

- 1. Alone (no other residents in the home)
- 2. With others in the home (e.g., family, friends, or paid caregiver)
- 3. Congregate home (e.g., assisted living or residential care home)
- 4. Inpatient facility (e.g., skilled nursing facility, nursing home, inpatient hospice, hospital)
- 5. Does not have a permanent home (e.g., has unstable housing or is experiencing homelessness)

(A1910) Availability of Assistance

Code the level of in-person assistance from available and willing caregiver(s), excluding hospice and facility staff, at the time of this admission.

- 1. Around-the-clock (24 hours a day with few exceptions)
- 2. Regular daytime (all day every day with few exceptions)
- 3. Regular nighttime (all night every night with few exceptions)
- 4. Occasional (intermittent)
- 5. No assistance available

Medications managed by: Patient Caregiver Facility Staff Other:

Risk factors that may impact Care Plan (mark all that apply):

- Alcohol dependency Drug dependency Smoking Obesity Chronic condition Cultural/Religious practices that may impact care
- Other:

Functional Limitations

FUNCTIONAL LIMITATIONS:

Dyspnea With Min. Exertion Start Effective Date: 10/06/2025
Endurance Start Effective Date: 10/06/2025

Safety/Sanitation risks affecting patient: (mark all that apply):

- Cluttered/Soiled living area Narrow or obstructed walkways Oxygen in use
- Inadequate lighting, heating or cooling No emergency plan in place Smoking in the home
- Insect/Rodent infestation No gas/electrical appliances Stairs
- Lack of safety devices No running water Unsafe use of assistive devices
- Other:

Additional details - living arrangements, environmental, social:

Safety Measures

SAFETY MEASURES:

Anticoagulant Precautions Start Effective Date: 10/06/2025
Elevate Head of Bed Start Effective Date: 10/06/2025
Equipment Safety Start Effective Date: 10/06/2025
Fall Precautions Start Effective Date: 10/06/2025
O2 Precautions Start Effective Date: 10/06/2025
Safety in ADLs Start Effective Date: 10/06/2025
Standard Precautions/Infection Control Start Effective Date: 10/06/2025

PSYCHOSOCIAL / ENVIRONMENTAL

Resuscitation status:

DNR

Additional details - resuscitation status:

Funeral arrangements: Completed Planning in progress No funeral arrangements reported

Additional details - funeral arrangements:

Tissue/Body Donor (specify details):

***Community Agencies/Social Services Screening (select all that apply):**

- Inadequate means to shop for groceries or cook Signs of depression Other:
- Needs community resources to manage care Suicidal Ideation

Suspected Abuse/Neglect (select all that apply):

- Neglect Inadequate food Unexplained bruises Caregiver exploitation of funds
- Fearful of family member(s) Left unattended when should be supervised Sexual abuse

Additional details - community agencies / social services screening:

Financial Patient/Family declined to answer financial questions

Patient/Family/Caregiver ability to manage personal finances: Independent Needs assistance Totally dependent

Inadequate finances to purchase necessities (food, medicine, etc.) Medical expenses not covered by insurance/Medicare

Additional details - financial:



Psychosocial/Environmental

Summary of Problems

Psychosocial/Environmental Interventions

Instruct patient/caregiver on basic home safety precautions HSN Start Effective Date: 10/06/2025

PREFERENCES / PRE-BEREAVEMENT / SPIRITUAL

(J0050) Death is imminent

At the time of this assessment and based on your clinical assessment, does the patient appear to have a life expectancy of 3 days or less?

- 0. No
- 1. Yes

(F2000. CPR Preference)

A. Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)? - Select the most accurate response

- 0. No - Skip F2000B
- 1. Yes, and discussion occurred (specify details):
Discussed with patient and pt chooses to be a DNR.
- 2. Yes, but the patient/responsible party refused to discuss

B. Date the patient/responsible party was first asked about preference regarding the use of CPR: 10/06/2025
i.e. "Discussion occurred regarding CPR/code status. Pt/pcg confirmed understanding and wishes to continue to with DNR status".

(F2200. Hospitalization Preference)

A. Was the patient/responsible party asked about preference regarding hospitalization? - Select the most accurate response

- 0. No - Skip F2200B
- 1. Yes, and discussion occurred (specify details):
Discussion occurred with pt and he would like to avoid any further hospitalizations.
- 2. Yes, but the patient/responsible party refused to discuss

B. Date the patient/responsible party was first asked about preference regarding hospitalization: 10/06/2025

(F3000. Spiritual/Existential Concerns)

A. Was the patient and/or caregiver asked about spiritual/existential concerns? - Select the most accurate response

- 0. No - Skip F3000B
- 1. Yes, and discussion occurred (specify details): Discussion occurred and pt is not affiliated with a church currently and did not have any spiritual concerns.
- 2. Yes, but the patient/caregiver refused to discuss

B. Date the patient and/or caregiver was first asked about spiritual/existential concerns: 10/06/2025

Additional details - preferences / concerns:

Bereavement risk factors

- Children/Adolescents in the home
- History of emotional/mental illness
- Loss of family member
- Past violent/untimely death
- Complicated grief
- History of potential suicide
- Loss of friend
- Physical illness/impaired survivor
- Conflict between patient and survivor
- History of substance abuse
- Loss of residence
- Other:
- Emotional dependence on patient
- Loss of a child
- Multiple losses

Patient spiritual issues

- Anger
- Expressed gratitude
- Fear
- Lack of inner peace
- Preparedness for own death
- Strong faith
- Anxiety
- Expressed hope
- Forgiveness issues
- Lonely/abandoned
- Reconciliation need
- Suicide
- Concern regarding afterlife
- Expressed joy
- Grief
- Loss of faith/hope
- Sense of chaos
- Other:
- Depressed
- Expressed peace
- Healing
- Meaning of suffering
- Shame

Pre-Bereavement

Summary of Problems

"Questioned pt for any spiritual or religious concerns and stated he does not" or "Pt reports strong faith and no current spiritual concerns and says his pastor visits him weekly"



Patient: **[REDACTED]**

Caregiver: **[REDACTED]** (HSN) Visit Date: 10/06/2025

Spiritual
 Summary of Problems

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Chart: 1 Benefit Period: 1
 Location of Care: **Home**

VITAL SIGNS

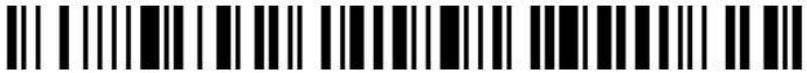
Prior vital signs historical data

Vital signs historical data - Hospice

BODY TEMPERATURE / ROUTE:	HEART RATE:	BLOOD PRESSURE - SYSTOLIC / DIASTOLIC:	RESPIRATORY RATE:	PULSE OXIMETRY:
97.7 F - degrees fahrenheit Temperature Method: Non-Contact Other	59 beats / minute Heart Rhythm: <input checked="" type="radio"/> Regular <input type="radio"/> Irregular Heart Rate Location: <input checked="" type="radio"/> Apical <input type="radio"/> Radial <input type="radio"/> Other Other Heart Rate Location:	118 /62 mmHg Position: Sitting BP Location: <input type="radio"/> L Arm <input checked="" type="radio"/> R Arm <input type="radio"/> Other Other BP Location: Additional Readings / Details:	22 breaths / minute Respiratory Rhythm: <input checked="" type="radio"/> Regular <input type="radio"/> Irregular	97 % Pulse Ox Location: Finger - Left Other Location: Oxygen status - Pulse Ox: <input type="radio"/> Room Air <input checked="" type="radio"/> Supplemental Oxygen
BODY HEIGHT:	BODY WEIGHT:	BMI:	BMI PERCENTILE:	ABDOMINAL GIRTH:
inches	213 lbs <input type="radio"/> Actual <input checked="" type="radio"/> Reported 96.489 kg	kg/m2	%	cm Measurement Location - Abdominal Girth:

Hospice scales and tools historical data

SCALES & TOOLS	VALUE / READING THIS VISIT	LAB (POC OR OTHER)	VALUE / READING THIS VISIT
Mid-Arm Circumference (MAC) (include unit of measure / location on arm):	RUA 30.2	Blood Sugar:	
Mid-Thigh Circumference (MTC) (include unit of measure / location on thigh):		PT / INR:	
SLEEP (time in last 24 hours):		Other Reading 2:	
Primary Caregiver ZBI:		Other Reading 3:	
NYHA:		Other Reading 4:	
Other Reading 1:		Other Reading 5:	
FAST:			



FAST - Copyright © 1984 by Barry Reisberg, M.D.
NYHA - The Criteria Committee of the New York Heart Association. Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Great Vessels. 9th ed. Boston, Mass: Little, Brown & Co; 1994:253-256.
ZBI - Zarit, S. H., Reever, K. E., Back-Peterson, J. (1980)

PAIN

View Historical Data

Pain level severity: 1-3 = mild 4-6 = moderate 7-10 = severe

Pain level now: 0

Worst pain level experienced: 0

Best pain level experienced: 0

Acceptable level of pain: 0

Primary pain site:

Pain rated by: Patient Caregiver Hospice Nurse Facility Staff
 Other:

Type of pain rating scale used: Numeric Verbal descriptor Patient Visual
 Staff Observation No scale used

Pain observations

Crying Facial grimacing Grabbing/holding body part
 Guarded movements Splinting Thrashing
 Wincing upon movement Other:

Pain duration:

Intermittent Frequent Constant
 Other:

Pain Frequency:

No pattern Constant Intermittent
 At night time In the morning Breakthrough
 Other:

Pain character:

Cramping Deep Exhausting
 Gnawing Miserable Nagging
 Numb Penetrating Pressure
 Sharp Shooting Squeezing
 Tender Tiring Unbearable
 Patient unable to describe Other:

Worsened by:

Change in position Cold Heat
 Movement Sitting Standing
 Walking Other:

Relieved by:

Heat Ice Massage
 Medication Repositioning Rest/relaxation
 Other:

Effects on function/quality of life:

Activities Appetite
 Energy Socialization
 Sleep Other:

Current pain management and effectiveness:

Breakthrough pain:

Never Less than daily Daily Several times a day

PAIN ASSESSMENT IN ADVANCED DEMENTIA SCALE - PAINAD

View Historical Data

Instructions:

- Observe the patient for five minutes before scoring his or her behaviors.
- Assess patient during periods of activity, such as turning, ambulating, and transferring.
- Assess patient for each of the 5 behaviors observed.
- Obtain a total score by adding scores from the five behaviors.
- Total score can range from 0 to 10.

Note - the 0 - 10 score of the PAINAD scale is not the same as the 0 to 10 verbal descriptive pain rating scale.

Behavior

*Breathing (independent of vocalization)

- *Normal (0)
- *Occasional laboured breathing *Short periods of hyperventilation (1)
- *Noisy laboured breathing *Long periods of hyperventilation *Cheyne-Stokes respirations (2)

*Negative vocalization

- *None (0)
- *Occasional moan or groan *Low level speech with a negative or disapproving quality (1)
- *Repeated troubled calling out *Loud moaning or groaning *Crying (2)

*Facial expression

- *Smiling or inexpressive (0)
- *Sad *Frightened *Frown (1)
- *Facial grimacing (2)

*Body language

- *Relaxed (0)
- *Tensed *Distressed pacing *Fidgeting (1)
- *Rigid *Fists clenched *Knees pulled up *Pulling or pushing away *Striking out (2)

*Consolability

- *No need to console (0)
- *Distractions or reassured by voice or touch (1)
- *Unable to console, distract, reassure. (2)

*PAINAD Total Score:

Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) scale. J Am Med Dir Assoc. 2003;4(1):9-15

FLACC Behavioral Pain Assessment Scale

CATEGORIE	SCORING		
	0	1	2
Face	<input type="radio"/> No particular expression or smile	<input type="radio"/> Occasional grimace or frown; withdrawn, disinterested	<input type="radio"/> Frequent to constant frown, clenched jaw, quivering chin

This hasn't changed and still needs to be documented as part of the comp pain assessment noted in (b)J0910



Patient: [Redacted]

Caregiver: [Redacted] Visit Date: 10/06/2025

Legs	<input type="radio"/> Normal position or relaxed	<input type="radio"/> Uneasy, restless, tense	<input type="radio"/> Kicking or legs drawn up
Activity	<input type="radio"/> Lying quietly, normal position, moves easily	<input type="radio"/> Squirming, shifting back and forth, tense	<input type="radio"/> Arched, rigid, or jerking
Cry	<input type="radio"/> No cry (awake or asleep)	<input type="radio"/> Moans or whimpers, occasional complaint	<input type="radio"/> Crying steadily, screams or sobs; frequent complaints
Consolability	<input type="radio"/> Content, relaxed	<input type="radio"/> Reassured by occasional touching, hugging, or being talked to; distractable	<input type="radio"/> Difficult to console or comfort
Total Score:			
Copyright 2002 The Regents of The University of Michigan			

(J0900. Pain Screening)

A. Was the patient screened for pain?

- 0. No → Skip J0900B, J0900C and J0900D
- 1. Yes

B. Date of first screening for pain: 10/06/2025

C. The patient's pain severity was:

- 0. None
- 1. Mild
- 2. Moderate
- 3. Severe
- 9. Pain not rated

D. Type of standardized pain tool used:

- 1. Numeric
- 2. Verbal descriptor
- 3. Patient visual
- 4. Staff observation
- 9. No standardized tool used

(J0905 - Pain Active Problem)

A. Is pain an active problem for the patient?

- 0. No → Skip J0910A, J0910B, J0910C and J0915
- 1. Yes

Comments:

Discussed pain level with pt and pt reported he has no pain.

(J0910. Comprehensive Pain Assessment)

A. Was a comprehensive pain assessment done?

- 0. No → Skip J0910B, J0910C, and J0915
- 1. Yes

B. Date of comprehensive pain assessment:

C. Comprehensive pain assessment included:

- ↓ Check all that apply
- 1. Location
 - 2. Severity
 - 3. Character
 - 4. Duration
 - 5. Frequency
 - 6. What relieves/worsens pain
 - 7. Effect on function or quality of life
 - 9. None of the above

(J0915) Neuropathic Pain

Does the patient have neuropathic pain (e.g., pain with burning, tingling, pins and needles, hypersensitivity to touch)?

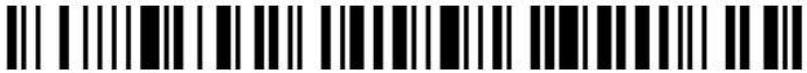
- 0. No
- 1. Yes

Additional details - pain:

Pain

Pain Interventions

Assess pain status each visit HSN Start Effective Date: 10/06/2025



Patient: [Redacted]

Caregiver: [Redacted] Visit Date: 10/06/2025

- Breathing: Unlabored Labored
- Apnea
- Cheyne - Stokes Breathing
- Agonal Breathing

- Cough: Productive Non-productive
- Increase in respiratory secretions / audible congestion
- Hemoptysis
- Other:

Lung Sounds	RUL	RML	RLL	LUL	LLL	
Clear	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Oxygen at: 10 L/min <input checked="" type="checkbox"/> Continuous <input type="checkbox"/> PRN <input type="checkbox"/> NOC <input checked="" type="checkbox"/> Nasal Cannula <input type="checkbox"/> Mask <input type="checkbox"/> Other:
Diminished	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	FI02 - Inhaled O2 Concentration: <input type="checkbox"/> Inhalation treatments (specify details): <input type="checkbox"/> BIPAP
Crackles	<input type="checkbox"/>	<input type="checkbox"/> Ventilator: <input type="checkbox"/> Continuous <input type="checkbox"/> At night				
Rhonchi	<input type="checkbox"/>	<input checked="" type="checkbox"/> CPAP - Continuous Positive Airway Pressure				
Wheezing	<input type="checkbox"/>					
Rales	<input type="checkbox"/>					
Absent	<input type="checkbox"/>					

Tracheostomy Size:

Managed by:

Family/Care Self Hospice Nurse

Facility Nurse

Other:

Additional details - respiratory interventions:

Chest tube

Location:

Type:

Drainage:

Serous

Sanguineous

Serosanguineous

Purulent

None

Amount of Drainage:

Gravity

Suction

Other:

Shortness of Breath Screening: 3

Key: 0=None 1-3=Mild 4-7=Moderate 8-10=Severe

Shortness of Breath level now: 3

Best Shortness of Breath level experienced: 3

Worst Shortness of Breath level experienced: 10

Patient's acceptable level of Shortness of Breath: 3

When is patient short of breath?:

- When climbing stairs
- When walking over 20 ft
- When dressing
- When using the bathroom
- When eating
- When talking
- When agitated
- When resting

Shortness of breath improved by:

Additional details - respiratory:

Respiratory

Summary of Problems

[Empty text box for Summary of Problems]

Respiratory Interventions

- Assess respiratory status HSN Start Effective Date: 10/06/2025
- Instruct patient/caregiver on administration of respiratory medications and treatments HSN Start Effective Date: 10/06/2025
- Instruct patient/caregiver on measures to manage shortness of breath HSN Start Effective Date: 10/06/2025
- Instruct patient/caregiver on safe use and maintenance of respiratory equipment HSN Start Effective Date: 10/06/2025

Respiratory Goals

Changes in respiratory status will be identified and managed by: Start Effective Date: 10/06/2025

(J2030. Screening for Shortness of Breath)

A. Was the patient screened for shortness of breath?

- 0. No - Skip J2030B, J2030C and J2040A - J2040B
- 1. Yes

B. Date of first screening for shortness of breath:

10/06/2025

C. Did the screening indicate the patient had shortness of breath?

- 0. No - Skip J2040A, J2040B
- 1. Yes

(J2040) Treatment for Shortness of Breath

A. Was treatment for shortness of breath initiated?

- 0. No - Skip B - Date treatment initiated
- 1. No, patient declined treatment - Skip B - Date treatment initiated
- 2. Yes

B. Date treatment for shortness of breath initiated:

10/06/2025

Document instructions pt/pcg on meds/tx for dyspnea





Patient: [Redacted]

Caregiver: [Redacted]

Date: 10/06/2025

<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Inability to swallow (change)	<input type="checkbox"/> Pleasure Food	Hyper-active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nausea	<input type="checkbox"/> Ostomy Details:	<input type="checkbox"/> Ascites:	Hypo-active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Swallowing deficits	<input type="checkbox"/> Drain Details:		Absent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Vomiting						
	<input type="checkbox"/> Hemorrhoids						

Additional details - gastrointestinal:

DIET

DIET/HYDRATION:
Diet as Tolerated Start Effective Date: 10/06/2025
Regular Diet Start Effective Date: 10/06/2025

(N0500) Scheduled Opioid
A. Was a scheduled opioid initiated or continued?
 0. No → Skip to N0510, PRN Opioid
 1. Yes
 B. Date scheduled opioid initiated or continued:

(N0510) PRN Opioid
A. Was a PRN opioid initiated or continued?
 0. No → Skip to N0520, Bowel Regimen
 1. Yes
 B. Date PRN opioid initiated or continued: 10/06/2025

(N0520. Bowel Regimen) Bowel Regimen - Complete only if N0500A or N0510A = 1
 A. Was a bowel regimen initiated or continued? - Select the most accurate response
 0. No → Skip N0520B
 1. No, but there is documentation of why a bowel regimen was not initiated or continued → Skip N0520B
 2. Yes (specify details): Discussed with pt and pt takes Senna Plus and Miralax for constipation.
 B. Date bowel regimen initiated or continued: 10/06/2025

You must add an intervention or statement that you have instructed pt/pcg on bowel regimen. You can add this for example in the interventions "instruct patient/pcg on bowel regimen/constipation prevention" by adding this intervention, we can be sure that the intervention of education/instruction is continued on each visit.

GENITOURINARY

No deficits
 Burning
 Decrease in urinary output
 Frequency
 Incontinent
 Retention
 Urine color:
 Current UTI
 Dialysis (specify):

Urinary Diversion/Ostomy
 Ileal conduit
 Site/flush:
 Uret
 Site/flush:
 Suprapubic Catheter
 Indwelling Catheter Flush: Size/balloon:
 Date of Insertion:

No urinary output in last 24 hr.
 Change in bladder incontinence
 Distention
 Hematuria
 Oliguria/anuria
 Other:
 Urine odor:
 Frequent UTI's (# in last 3 mo.):

Nephrostomy Site/flush:
 Other Site/flush:
 Condom Catheter

ENDOCRINE

No deficits Diabetes (type):
 Insulin dependent? No Yes
 How long insulin dependent?
 Who manages insulin administration:
 Blood sugar glucometer use
 Most Recent BS: Fasting Random
 Who manages BS monitoring:
 Neuropathy Hypoglycemia
 Hyperglycemia

Additional details - genitourinary:

Additional details - endocrine:

GI/GU/Nutritional/Endocrine
Summary of Problems

GI/GU/Nutritional/Endocrine interventions
Instruct patient/caregiver on expected changes in nutritional status related to patient decline HSN Start Effective Date: 10/06/2025

GI/GU/Nutritional/Endocrine Goals
Patient's desired nutrition/hydration needs will be met by: Start Effective Date: 10/06/2025



Hospice of the Piedmont- ASH C
Hospice Admission Assessment

Patient: [Redacted]

Caregiver: [Redacted]

Visit Date: 10/06/2025

MUSCULOSKELETAL / ACTIVITIES

Hand Dominance: Right Left

- No deficits
- Bedbound
- Decreased mobility/endurance
- Paralysis

- Assistive device(s) used:
- Safety precautions maintained

Ambulation: **Independent**

Bed Mobility: **Independent**

Transfer: **Independent**

Grip Strength: Right: Left:

- Amputation of:
- Chair bound
- Limited mobility/ROM
- Tremors

Hours per day spent in bed/chair:

- Atrophy
- Balance/gait abnormal
- Contracture
- Pain
- Weakness

Toileting: **Independent**

Dressing: **Independent**

Bathing: **Independent**

Additional details - musculoskeletal, activities:

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Chart: 1 Benefit Period: 1
Location of Care: **Home**

MUSCULOSKELETAL / ACTIVITIES (cont.)

MAHC 10 - FALL RISK ASSESSMENT

Required Core Elements

Assess one point for each core elements "yes".

Information may be gathered from medical record, assessment and if applicable, the patient/caregiver.
Beyond protocols listed below, scoring should be based on your clinical judgment.

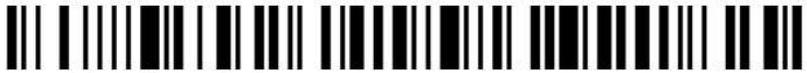
Points

Age 65+	<input checked="" type="checkbox"/>
Diagnosis (3 or more co-existing) Includes only documented medical diagnosis	<input checked="" type="checkbox"/>
Prior history of fall within 3 months An unintentional change in position resulting in coming to rest on the ground or at a lower level	<input type="checkbox"/>
Incontinence Inability to make it to the bathroom or commode in timely manner Includes frequency, urgency, and/or nocturia.	<input type="checkbox"/>
Visual impairment Includes but not limited to, macular degeneration, diabetic retinopathies, visual field loss, age related changes, decline in visual acuity, accommodation, glare tolerance, depth perception, and night vision or not wearing prescribed glasses or having the correct prescription.	<input type="checkbox"/>
Impaired functional mobility May include patients who need help with IADLS or ADLS or have gait or transfer problems, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination or improper use of assistive devices.	<input checked="" type="checkbox"/>
Environmental hazards May include but not limited to, poor illumination, equipment tubing, inappropriate footwear, pets, hard to reach items, floor surfaces that are uneven or cluttered, or outdoor entry and exits.	<input checked="" type="checkbox"/>
Poly Pharmacy (4 or more prescriptions - any type) ALL PRESCRIPTIONS including prescriptions for OTC meds. Drugs highly associated with fall risk include but not limited to, sedatives, anti-depressants, tranquilizers, narcotics, antihypertensives, cardiac meds, corticosteroids, anti-anxiety drugs, anticholinergic drugs, and hypoglycemic drugs.	<input checked="" type="checkbox"/>
Pain affecting level of function Pain often affects an individual's desire or ability to move or pain can be a factor in depression or compliance with safety recommendations.	<input type="checkbox"/>
Cognitive impairment Could include patients with dementia, Alzheimer's or stroke patients or patients who are confused, use poor judgment, have decreased comprehension, impulsivity, memory deficits. Consider patients ability to adhere to the plan of care.	<input type="checkbox"/>
A score of 4 or more is considered at risk for falling	
Total	5

Missouri Alliance for HOME CARE 2420 Hyde Park, Suite A, Jefferson City, MO 65108-4731 (573) 614-7777 (573) 634-4274 fax

PALLIATIVE PERFORMANCE SCALE V2 (PPSV2)

PPS Level	Ambulation	Activity-Evidence of disease	Self-care	Intake	Conscious level
-----------	------------	------------------------------	-----------	--------	-----------------



Patient: [REDACTED]

Caregiver: [REDACTED] Visit Date: 10/06/2025

<input type="radio"/> PPS 100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
<input type="radio"/> PPS 90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
<input type="radio"/> PPS 80%	Full	Normal activity & work <i>with effort</i> Some evidence of disease	Full	Normal or reduced	Full
<input type="radio"/> PPS 70%	Reduced	Unable normal activity & work Significant disease	Full	Normal or reduced	Full
<input checked="" type="radio"/> PPS 60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance	Normal or reduced	Full or confusion
<input type="radio"/> PPS 50%	Mainly sit/lie	Unable to do any work Extensive disease	Considerable assistance	Normal or reduced	Full or drowsy or confusion
<input type="radio"/> PPS 40%	Mainly in bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or drowsy +/- confusion
<input type="radio"/> PPS 30%	Totally bed bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or drowsy +/- confusion
<input type="radio"/> PPS 20%	Totally bed bound	Unable to do any activity Extensive disease	Total Care	Minimal sips	Full or drowsy +/- confusion
<input type="radio"/> PPS 10%	Totally bed bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or coma
<input type="radio"/> PPS 0%	Dead	-	-	-	-

Instructions: PPS level is determined by reading left to right to find a 'best horizontal fit.' Begin at left column reading downwards until current ambulation is determined, then, read across to next and downwards until each column is determined. Thus, 'leftward' columns take precedence over 'rightward' columns.

The Palliative Performance Scale v2, Copyright © 2001 Victoria Hospice Society - Used with permission.

Musculoskeletal/Activities

Summary of Problems

Musculoskeletal/Activities Interventions

Instruct patient/caregiver in fall prevention HSN Start Effective Date: 10/06/2025
 Provide personal care/ADL instructions to caregiver HSN Start Effective Date: 10/06/2025

Musculoskeletal/Activities Goals

Patient will maintain optimal mobility by: Start Effective Date: 10/06/2025
 Patient will remain safe in environment by: Start Effective Date: 10/06/2025
 Patient's personal care/ADL needs will be met by: Start Effective Date: 10/06/2025

Activities Permitted

ACTIVITIES PERMITTED:

Independent At Home Start Effective Date: 10/06/2025
 Up As Tolerated Start Effective Date: 10/06/2025

NEUROLOGICAL / MENTAL / EMOTIONAL / BEHAVIORAL

- Oriented To: Person Place Time Situation
 - Patient unable to understand and participate in care
 - Sensory Impairment: Hearing Speech Visually
 - Level of Consciousness: Semi-Comatose Lethargic Comatose
 - Unresponsive Agitation Anxiety
 - Combative Confused Decreased level of consciousness
 - Other:
- Minimally Responsive Disoriented Drooling
 - Drowsy Facial drooping Forgetful
 - Hallucinations Hostile Non-Reactive Pupils
 - Non-Verbal Restless Seizures
 - Tremors Tearful Withdrawn

Additional details - neuro, mental, emotional, behavioral:

Mental Status

MENTAL/PSYCHOSOCIAL/COGNITIVE STATUS:

Anxious Start Effective Date: 10/06/2025
 Oriented Start Effective Date: 10/06/2025

Psych/Mental/Emotional/Behavioral

Summary of Problems



Patient [Redacted]

Caregiver [Redacted]

Visit Date: 10/06/2025

[Empty form area]

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Chart: 1 Benefit Period: 1

Location of Care: Home

INTEGUMENTARY

Color: Normal for patient Pale Ashen Jaundice Mottled
 Other:

Skin Turgor: Good Fair Poor

Temperature/Moisture: Dry Warm Cool Clammy Diaphoretic

Surgical wound (complete for closed surgical wounds only):

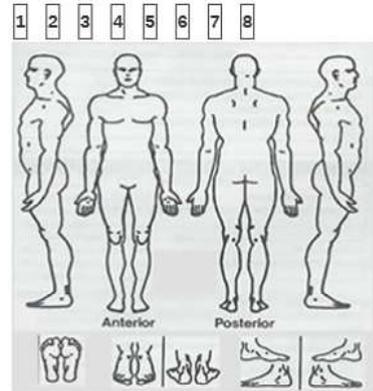
Location:

Incision closed with: Staples Sutures Steri-strips
 Skin/surgical adhesive Other:

Incision size/appearance:

Wound(s) identified? No Yes (complete wound information below)

Drag and drop a label to the appropriate wound location.



See Wound Addendum

Pressure relief device(s) in use:

Mattress Overlay
 WC Cushion
 Other:

Additional integumentary findings/comments:

Wound #1	Wound #2	Wound #3	Wound #4
Location:	Location:	Location:	Location:
Type:	Type:	Type:	Type:
Wound Status:	Wound Status:	Wound Status:	Wound Status:
Stage:	Stage:	Stage:	Stage:
Length: cm	Length: cm	Length: cm	Length: cm
Width: cm	Width: cm	Width: cm	Width: cm
Sq. cm:	Sq. cm:	Sq. cm:	Sq. cm:
Depth: cm	Depth: cm	Depth: cm	Depth: cm
Undermining:	Undermining:	Undermining:	Undermining:
Tunneling:	Tunneling:	Tunneling:	Tunneling:
Surrounding Tissue:	Surrounding Tissue:	Surrounding Tissue:	Surrounding Tissue:
<input type="checkbox"/> Normal for ethnic group			
<input type="checkbox"/> Pale <input type="checkbox"/> Blended <input type="checkbox"/> Shiny	<input type="checkbox"/> Pale <input type="checkbox"/> Blended <input type="checkbox"/> Shiny	<input type="checkbox"/> Pale <input type="checkbox"/> Blended <input type="checkbox"/> Shiny	<input type="checkbox"/> Pale <input type="checkbox"/> Blended <input type="checkbox"/> Shiny
<input type="checkbox"/> Red <input type="checkbox"/> Purple <input type="checkbox"/> Black	<input type="checkbox"/> Red <input type="checkbox"/> Purple <input type="checkbox"/> Black	<input type="checkbox"/> Red <input type="checkbox"/> Purple <input type="checkbox"/> Black	<input type="checkbox"/> Red <input type="checkbox"/> Purple <input type="checkbox"/> Black
<input type="checkbox"/> Edema <input type="checkbox"/> Cool <input type="checkbox"/> Warm	<input type="checkbox"/> Edema <input type="checkbox"/> Cool <input type="checkbox"/> Warm	<input type="checkbox"/> Edema <input type="checkbox"/> Cool <input type="checkbox"/> Warm	<input type="checkbox"/> Edema <input type="checkbox"/> Cool <input type="checkbox"/> Warm
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
Wound Bed Color:	Wound Bed Color:	Wound Bed Color:	Wound Bed Color:
Wound Bed Tissue:	Wound Bed Tissue:	Wound Bed Tissue:	Wound Bed Tissue:



Hospice of the Piedmont- ASH C
Hospice Admission Assessment

Patient: [Redacted]

Caregiver: [Redacted] Date: 10/06/2025

<input type="checkbox"/> Bloody <input type="checkbox"/> Granular <input type="checkbox"/> Sloughing <input type="checkbox"/> Weeping <input type="checkbox"/> Necrotic <input type="checkbox"/> Healthy <input type="checkbox"/> Eschar <input type="checkbox"/> Other:	<input type="checkbox"/> Bloody <input type="checkbox"/> Granular <input type="checkbox"/> Sloughing <input type="checkbox"/> Weeping <input type="checkbox"/> Necrotic <input type="checkbox"/> Healthy <input type="checkbox"/> Eschar <input type="checkbox"/> Other:	<input type="checkbox"/> Bloody <input type="checkbox"/> Granular <input type="checkbox"/> Sloughing <input type="checkbox"/> Weeping <input type="checkbox"/> Necrotic <input type="checkbox"/> Healthy <input type="checkbox"/> Eschar <input type="checkbox"/> Other:	<input type="checkbox"/> Bloody <input type="checkbox"/> Granular <input type="checkbox"/> Sloughing <input type="checkbox"/> Weeping <input type="checkbox"/> Necrotic <input type="checkbox"/> Healthy <input type="checkbox"/> Eschar <input type="checkbox"/> Other:
Drainage Type:	Drainage Type:	Drainage Type:	Drainage Type:
Drainage Amount:	Drainage Amount:	Drainage Amount:	Drainage Amount:
Drainage Odor:	Drainage Odor:	Drainage Odor:	Drainage Odor:
Wound Care Provided	Wound Care Provided	Wound Care Provided	Wound Care Provided
<input type="checkbox"/> See Interventions section			
<input type="checkbox"/> Not due today			
Cleansed with:	Cleansed with:	Cleansed with:	Cleansed with:
Packed with:	Packed with:	Packed with:	Packed with:
Dressed with:	Dressed with:	Dressed with:	Dressed with:
Covered with:	Covered with:	Covered with:	Covered with:
Secured with:	Secured with:	Secured with:	Secured with:
NPWT - Type:	NPWT - Type:	NPWT - Type:	NPWT - Type:
Foam: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Green	Foam: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Green	Foam: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Green	Foam: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Green
# Pieces:	# Pieces:	# Pieces:	# Pieces:
Peri wound Protection:	Peri wound Protection:	Peri wound Protection:	Peri wound Protection:
Wound Bed:	Wound Bed: type text here	Wound Bed:	Wound Bed:
Pressure: mmHG	Pressure: mmHG	Pressure: mmHG	Pressure: mmHG
<input type="radio"/> Continuous <input type="radio"/> Intermittent			
<input type="checkbox"/> Canister Change			
Patient response to treatment:			
Wound #5	Wound #6	Wound #7	Wound #8
Location:	Location:	Location:	Location:
Type:	Type:	Type:	Type:
Wound Status:	Wound Status:	Wound Status:	Wound Status:
Stage:	Stage:	Stage:	Stage:
Length: cm	Length: cm	Length: cm	Length: cm
Width: cm	Width: cm	Width: cm	Width: cm
Sq. cm:	Sq. cm:	Sq. cm:	Sq. cm:
Depth: cm	Depth: cm	Depth: cm	Depth: cm
Undermining:	Undermining:	Undermining:	Undermining:
Tunneling:	Tunneling:	Tunneling:	Tunneling:
Surrounding Tissue:	Surrounding Tissue:	Surrounding Tissue:	Surrounding Tissue:
<input type="checkbox"/> Normal for ethnic group			
<input type="checkbox"/> Pale <input type="checkbox"/> Blanched <input type="checkbox"/> Shiny	<input type="checkbox"/> Pale <input type="checkbox"/> Blanched <input type="checkbox"/> Shiny	<input type="checkbox"/> Pale <input type="checkbox"/> Blanched <input type="checkbox"/> Shiny	<input type="checkbox"/> Pale <input type="checkbox"/> Blanched <input type="checkbox"/> Shiny
<input type="checkbox"/> Red <input type="checkbox"/> Purple <input type="checkbox"/> Black	<input type="checkbox"/> Red <input type="checkbox"/> Purple <input type="checkbox"/> Black	<input type="checkbox"/> Red <input type="checkbox"/> Purple <input type="checkbox"/> Black	<input type="checkbox"/> Red <input type="checkbox"/> Purple <input type="checkbox"/> Black
<input type="checkbox"/> Edema <input type="checkbox"/> Cool <input type="checkbox"/> Warm	<input type="checkbox"/> Edema <input type="checkbox"/> Cool <input type="checkbox"/> Warm	<input type="checkbox"/> Edema <input type="checkbox"/> Cool <input type="checkbox"/> Warm	<input type="checkbox"/> Edema <input type="checkbox"/> Cool <input type="checkbox"/> Warm
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
Wound Bed Color:	Wound Bed Color:	Wound Bed Color:	Wound Bed Color:
Wound Bed Tissue:	Wound Bed Tissue:	Wound Bed Tissue:	Wound Bed Tissue:
<input type="checkbox"/> Bloody <input type="checkbox"/> Granular			
<input type="checkbox"/> Sloughing <input type="checkbox"/> Weeping			
<input type="checkbox"/> Necrotic <input type="checkbox"/> Healthy			
<input type="checkbox"/> Eschar <input type="checkbox"/> Other:			
Drainage Type:	Drainage Type:	Drainage Type:	Drainage Type:
Drainage Amount:	Drainage Amount:	Drainage Amount:	Drainage Amount:



Patient: [Redacted]

Caregiver: [Redacted] Visit Date: 10/06/2025

Drainage Odor:	Drainage Odor:	Drainage Odor:	Drainage Odor:
Wound Care Provided <input type="checkbox"/> See Interventions section			
<input type="checkbox"/> Not due today Cleansed with: Packed with: Dressed with: Covered with: Secured with:	<input type="checkbox"/> Not due today Cleansed with: Packed with: Dressed with: Covered with: Secured with:	<input type="checkbox"/> Not due today Cleansed with: Packed with: Dressed with: Covered with: Secured with:	<input type="checkbox"/> Not due today Cleansed with: Packed with: Dressed with: Covered with: Secured with:
NPWT - Type: Foam: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Green # Pieces: Peri wound Protection: Wound Bed: Pressure: mmHG <input type="radio"/> Continuous <input type="radio"/> Intermittent <input type="checkbox"/> Canister Change	NPWT - Type: Foam: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Green # Pieces: Peri wound Protection: Wound Bed: Pressure: mmHG <input type="radio"/> Continuous <input type="radio"/> Intermittent <input type="checkbox"/> Canister Change	NPWT - Type: Foam: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Green # Pieces: Peri wound Protection: Wound Bed: Pressure: mmHG <input type="radio"/> Continuous <input type="radio"/> Intermittent <input type="checkbox"/> Canister Change	NPWT - Type: Foam: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Green # Pieces: Peri wound Protection: Wound Bed: Pressure: mmHG <input type="radio"/> Continuous <input type="radio"/> Intermittent <input type="checkbox"/> Canister Change
Patient response to treatment:			

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Chart: 1 Benefit Period: 1

Location of Care: Home

INTEGUMENTARY (Cont)

PRESSURE ULCER RISK ASSESSMENT

PU Risk - View Historical Data

PURPOSE T v2 Results: No pressure ulcer and not currently at risk

Other Pressure Ulcer Risk Tool:

Other Pressure Ulcer Risk Results:

SKIN CONDITIONS / TREATMENTS

(M1190) Skin Conditions

Does the patient have one or more skin conditions?

0. No - Skip M1195 and M1200

1. Yes

(M1195) Types of Skin Conditions

Indicate which following skin conditions were identified at the time of this assessment.

Check all that apply

A. Diabetic foot ulcer(s)

B. Open lesion(s) other than ulcers, rash, or skin tear (cancer lesions)

C. Pressure Ulcer(s)/injuries

D. Rash(es)

E. Skin tear(s)

F. Surgical wound(s)

G. Ulcers other than diabetic or pressure ulcers (e.g., venous stasis ulcer, Kennedy ulcer)

H. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)

Z. None of the above were present

(M1200) Skin and Ulcer/Injury Treatments

Indicate the interventions or treatments in place at the time of this assessment.

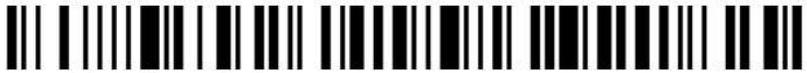
Check all that apply

A. Pressure reducing device for chair

B. Pressure reducing device for bed

C. Turning/repositioning program

Type text here



Patient: [Redacted]

Caregiver: [Redacted] 10/06/2025

- D. Nutrition or hydration intervention to manage skin problems
- E. Pressure ulcer/injury care
- F. Surgical wound care
- G. Application of nonsurgical dressings (with or without topical medications) other than to feet
- H. Application of ointments/medications other than to feet
- I. Application of dressings to feet (with or without topical medications)
- J. Incontinence Management
- Z. None of the above were provided

Integumentary

Summary of Problems

[Empty text box for Summary of Problems]

Integumentary Interventions

Assess skin integrity Start Effective Date: 10/06/2025

[Empty text box for Integumentary Interventions]

SYMPTOM IMPACT SCREENING

(J2050) Symptom Impact Screening

A. Was a symptom impact screening completed?

- 0. No → Skip B - Date of AND symptom impact screening
- 1. Yes

Always "Yes" if anything is Moderate/Severe--add SFV visit frequency

B. Date of symptom impact screening:

10/06/2025

(J2051) Symptom Impact

IF J2051 A-H have any "2-Moderate" or "3-Severe" responses, complete J2052 & J2053 after results of Symptom Follow Up Visit obtained

Over the past 2 days, how has the patient been affected by each of the following symptoms? Base this on your clinical assessment (including input from patient and/or caregiver). Symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day to day activities, or ability to interact with others.

Coding:

- 0. Not at all - symptom does not affect the patient, including symptoms well-controlled with current treatment
- 1. Slight
- 2. Moderate
- 3. Severe
- 9. Not applicable (the patient is not experiencing the symptom)

"0. Not at all" means the patient DOES have the symptom but it is not impacting their quality of life at all right now.
"9. Not applicable" means the patient does NOT have this symptom.

Enter Code ↓	
0. Not at all	A. Pain
2. Moderate	B. Shortness of breath
2. Moderate	C. Anxiety
9. Not applicable	D. Nausea
9. Not applicable	E. Vomiting
9. Not applicable	F. Diarrhea
1. Slight	G. Constipation
9. Not applicable	H. Agitation

If any responses to J2051 A-H are 2- Moderate -OR- 3- Severe , ADD frequency for Symptom Follow Up Visit

FREQUENCIES

[Empty text box for Frequencies]



Patient: [Redacted]

Caregiver: [Redacted]

Visit Date: 10/06/2025

HSN: HS Nursing: 1 x week for 1 week starting 10/06/2025 (week 1),
Nursing: 2 x week for 12 weeks starting 10/12/2025 (week 2)
HSW: HSA: HSC:

Add your SFV visit frequency if applicable, add typical VF (if RNCM completing) + PRN's

Complete section below (J2052 & J2053) AFTER results of Symptom Follow Up Visit obtained

SFV Symptom Impact Data Report - HOPE

SYMPTOM FOLLOW UP VISIT RESULTS Skip this part on the initial assessment

DO NOT COMPLETE J2052 / J2053 DURING THE ADMISSION VISIT

(J2052) Symptom Follow-up Visit (SFV) (Complete only if any response to J2051 Symptom Impact = 2 Moderate or 3. Severe)

An in-person Symptom Follow-up Visit (SFV) should occur within 2 calendar days as a follow-up for any moderate or severe pain or non-pain symptom identified during Symptom Impact assessment at Admission or HOPE Update Visit (HUV)

A. Was an in-person SFV completed?

- 0. No - Skip J2052B
- 1. Yes

B. Date of in-person SFV - Complete and skip J2052C

C. Reason SFV Not Completed - Skip J2053

- 1. Patient and/or caregiver declined an in-person visit.
- 2. Patient unavailable (e.g., in ED, hospital, travel outside of service area, expired).
- 3. Attempts to contact patient and/or caregiver were unsuccessful.
- 9. None of the above

(J2053) SFV Symptom Impact

Since the last Symptom Impact assessment was completed, how has the patient been affected by each of the following symptoms? Base this on your clinical assessment (including input from patient and/or caregiver). Symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day to day activities, or ability to interact with others.

Coding:

- 0. Not at all - symptom does not affect the patient, including symptoms well-controlled with current treatment
- 1. Slight
- 2. Moderate
- 3. Severe
- 9. Not applicable (the patient is not experiencing the symptom)

Enter Code	
	A. Pain
	B. Shortness of breath
	C. Anxiety
	D. Nausea
	E. Vomiting
	F. Diarrhea
	G. Constipation
	H. Agitation

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Chart: 1 Benefit Period: 1

Location of Care: Home

SERVICES PROVIDED / PATIENT / CAREGIVER RESPONSE

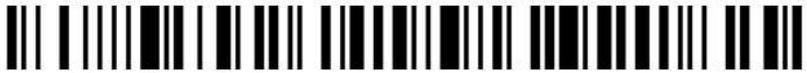
Instructed on: Catheter care Dietary counseling Dying process Equipment safety Infection control Medications Oxygen safety
 Ostomy care Tracheostomy care Standard Precautions Pain Management Safety Wound care
 Other:

Instruction details:

Patient/Caregiver demonstrate understanding Patient/Caregiver need additional instruction:

Interventions provided and response:

ESTABLISHMENT OF PLAN OF CARE



Hospice of the Piedmont- ASH C
Hospice Admission Assessment

Patient [Redacted]

Caregiver [Redacted] Visit Date: 10/06/2025

Initial Plan of Care was established with the following Interdisciplinary Team Members:

Date established:

	Name	Coordination Details	Plan of Care understanding/agreement	
<input checked="" type="checkbox"/> Attending Physician	[Redacted]			
<input checked="" type="checkbox"/> Hospice Physician	[Redacted]			
<input checked="" type="checkbox"/> Hospice Nurse	[Redacted]			
<input checked="" type="checkbox"/> Medical Social Services	[Redacted]			
<input type="checkbox"/> Spiritual Care Coordinator				
<input checked="" type="checkbox"/> Patient				<input checked="" type="checkbox"/> Understands the plan of care <input checked="" type="checkbox"/> Patient agrees with plan of care
<input checked="" type="checkbox"/> Family/Caregiver(s)	[Redacted]			<input checked="" type="checkbox"/> Understands the plan of care <input checked="" type="checkbox"/> Family/Caregiver(s) agrees with plan of care
<input type="checkbox"/> Facility Nurse		<input type="checkbox"/> Understands the plan of care <input type="checkbox"/> Facility nurse agrees with plan of care		

Referrals made to:

- Bereavement
- Volunteer
- Aide
- Therapy (PT, OT, ST)
- Other:
- Other:

DME/SUPPLIES / OTHER

DME/Supplies

DME:
 Bath bench Start Effective Date: 10/06/2025
 Bedside Commode Start Effective Date: 10/06/2025
 Hospital Bed Start Effective Date: 10/06/2025
 Overbed table Start Effective Date: 10/06/2025
 Oxygen concentrator Start Effective Date: 10/06/2025

Other Interventions/Goals

- Other
- Cancel all standing orders for lab/x-ray
 - Blood Sugar via: per SN Caregiver, frequency: PRN: Blood Sugar range:
 - Other:

SUMMARY

SN Admission Assessment Visit

Present for visit [Redacted]

Admission diagnosis [Redacted]

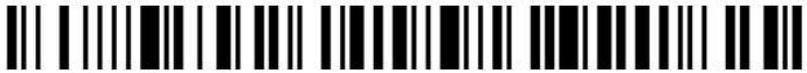
Medical history [Redacted] ... severe mitral regurgitation and leaflet perforation, CAD w/ CABG, chronic HFrEF (EF 25-30%), PAD on Enbrylo, CAD stage IIIb, HTN, DM, and hyperlipidemia.

Code status: DNR

Background [Redacted] ... was hospitalized in late September with CHF exacerbation. He has known MESA NY endocarditis identified on prior TEE 8/15 and was not felt a surgical candidate. Repeat TEE showed large vegetation with leaflet perforation and severe mitral regurgitation. Surgery consulted again and he remains not a candidate for surgery. He was discharged from that admission on new to him home oxygen. He returned back to hospital on 9/30 due to worsening shortness of breath and worsening edema. He was found to have moderate pulmonary edema and bilateral pleural effusions. He was treated with diuretics and oxygen. He was discharged but was readmitted due to worsening kidney function and causing confusion. He was unable to be toileted and gives patient a poor prognosis. A goals of care meeting was had with patient and family and patient made his decision to focus on comfort and chose to go home with hospice support.

Visit summary [Redacted] ... Pt was able to have a conversation and sat/walk range from 90-95%. Appetite is fair eating 2-3 meals a day with weight loss. He is unable to be toileted and gives patient a poor prognosis. Pt ambulates independently and is able to provide his own care at this time.

Education provided on disease progression, medications, s/s EOL, when to call HOR, and 24/7 availability reiterated.
Reviewed meds with: Pt and PCG



Patient: [Redacted]

Caregiver: [Redacted]

Date: 10/06/2025

Refills: [Redacted]

Plan: SNV 2x weekly to focus on Dyspnea, anxiety, disease progression, symptom management, and EOL comfort measures and care.

COORDINATION / PLAN

Care coordination with:

- Skilled Nurse
- Spiritual Care Coordinator
- Social Worker
- Volunteer Coordinator
- Hospice Aide
- Caregiver
- Facility Staff
- Physician
- Bereavement Coordinator
- Clinical Manager
- Other:

Patient -

- Patient agrees with plan of care
- Patient understands the plan of care

Family / Caregiver -

- Family/Caregiver(s) agrees with plan of care
- Family/Caregiver(s) understands the plan of care

Facility Nurse - (if applicable)

- Facility nurse agrees with plan of care
- Facility nurse understands the plan of care

Additional details - coordination/plan:

SECTION Z RECORD ADMINISTRATION

(Z0400. Signature(s) of Person(s) Completing the Record)

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that reporting this information is used as a basis for payment from federal funds. I further understand that failure to report such information may lead to a payment reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this provider on its behalf.

Name / Signature	Title	Sections	Date of your assessment Date Section Completed
[Redacted] / See electronic signature below	RN	All except Z0500, SFV	10/06/2025
B. / See electronic signature below			
C. / See electronic signature below			
D. / See electronic signature below			
E. / See electronic signature below			
F. / See electronic signature below			
G. / See electronic signature below			
H. / See electronic signature below			
I. / See electronic signature below			
J. / See electronic signature below			
K. / See electronic signature below			
L. / See electronic signature below			

Type text here

"all except SFV" if SFV is required.
If SFV wasn't required then choose "all"

(Z0500. Signature of Person Verifying Record Completion)

A. Name / Signature

/ See electronic signature below

B. Date:

PATIENT NAME - (Last, First, Middle Initial)

ID#

110145

PRA Disclosure Statement

Hospice Outcomes and Patient Evaluation (HOPE) [Item Set name] (Abbreviation) OMB Control Number 0938-1153 Expiration 03/31/2028 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. HOPE is a patient assessment instrument that intends to collect data during a hospice patient's stay. Data collected using this instrument will be used to measure the quality of care provided by a hospice provider. The valid OMB control number for this information collection is 0938-1153. Submission of this data is required by Section 1814(i)(5) of the Social Security Act. The time required to complete this data collection per item set is estimated to average 41 minutes for the Admission, 22 minutes for the Hope Update Visit, and 9 minutes for the Discharge, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the data collected. Submitted patient-level data will remain confidential and is protected from public dissemination in accordance with the Privacy Act of 1974, as amended. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4- 26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Jermama Keys, National Coordinator, Hospice Quality Reporting Program Centers for Medicare & Medicaid Services, at Jermama.Keys@cms.hhs.gov

