## HOSPICE CARE PLAN OVERVIEW

**Patient Name:** __________________________________________________________
**Phone:** _______________________

- [ ] Home
- [ ] Nursing Home
- [ ] Other: ____________________________________________________________________

**Physician Name:** __________________________________
**Phone:** _______________________
**FAX:** _______________________

**Advance Directives:**
- [ ] Yes
- [ ] No
- Details (specify): ________________________________________________________

**Lives Alone:**
- [ ] Yes
- [ ] No

**Primary Caregiver Name:** ____________________________________
**Relationship:** _______________________
**Phone:** _______________________

**Emergency Contact (if different than caregiver) Name:** _______________________
**Phone:** _______________________

**Religion/Church:** _______________________________________________________
**Phone:** _______________________

**Funeral Arrangements:**
- [ ] Yes
- [ ] No
- **Funeral Home:** _______________________
**Phone:** _______________________

**Organ Donor:**
- [ ] Yes
- [ ] No

- **Attending Physician to Sign Death Certificate:**
  - [ ] Yes
  - [ ] No
  - [ ] N/A

### SERVICES/FREQUENCY LEVEL OF CARE

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<th>Date</th>
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### LEVEL OF CARE

- H = Routine Home
- I = Inpatient
- R = Respite
- C = Continuous

### DIAGNOSES/PROCEDURES

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### MEDS

**Allergies:**

- Admission Ht. _______ Wt. _______

**Hospice orders meds?**
- [ ] Yes
- [ ] No

- **Pharmacy & contact:**
  - Phone: _______________________
  - **FAX:** _______________________

**Hospice prefills meds?**
- [ ] Yes
- [ ] No

- **Glucometer frequency & range:**

### HME

**Provider:** _______________________
**Phone:** _______________________

- [ ] (✓ all applicable)
- [ ] (✓ all applicable)

- [ ] Hospital bed
- [ ] Oxygen (type) ________ @ ________ lpm
- [ ] Nebulizer cx
- [ ] W/C
- [ ] Suction machine
- [ ] Walker/cane
- [ ] IV pole:
  - [ ] Yes
  - [ ] No
- [ ] Pressure mattress
- [ ] Pump type
- [ ] Bedside commode
- [ ] Suction machine
- [ ] Bathbar/RAIS
- [ ] IV pole:
  - [ ] Yes
  - [ ] No
- [ ] Overbed table
- [ ] Monitor
- [ ] Other: ____________________________________________________________________

### PRIMARY PROBLEM AREA(S)

**Pain:** Location _______________________
**Intensity:** _______________________

- [ ] Incontinent
- [ ] Diarrhea
- [ ] Constipation
- [ ] Straight cath

- [ ] Rest/Comfort

**Nutrition/hydration:**
- [ ] Tube feed
  - IV type/location ________
  - Solution/meds ________

- [ ] Skin (wound, breakdown):

- [ ] Cardiopulmonary
- [ ] Coping
- [ ] Self-care
- [ ] Spiritual

### SCHEDULING

- **Catheter change due:** ________________________________________________
- **Wound care due:** ________________________________________________
- **IV site care due:** ________________________________________________
- **IV flush due:** ________________________________________________
- **Lab work: (specify)_______ Due________**
- **Aide supervision q:** ________________________________________________
- **Recertification due:** ________________________________________________

### MISCELLANEOUS (Specify)

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### CONTACT INFORMATION

**Address:** _______________________
**Directions to home:**

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