



# HEART 'N HOME HOSPICE

## Hospice Care Screening Tool

### Clinical Status Changes: Check all that apply

- Multiple hospitalizations and/or ER visits in the past 6 months     History of falls within the past 6 months

### Chronic Conditions: Check all that apply

- Chronic Obstructive Pulmonary Disease     Congestive Heart Failure     Ischemic Heart Disease  
 Diabetes Mellitus     Dementia     Renal Failure  
 Liver Disease     Neoplasia  
 Acquired Immune Deficiency Syndrome     Neurological Disease (CVA, ALS, MS, Parkinsons)

### Risk Factors: Check all that apply

- Increased infections (pneumonia, sepsis, UTI)     Falls     Decreasing albumin or cholesterol  
 Edema     Ascites     Change in level of consciousness  
 Nausea/vomiting poorly responding to treatment     Intractable cough     Intractable diarrhea  
 Dysphagia leading to aspiration or decreased food consumption     Dyspnea with increasing effort  
 Pain requiring increased doses of major analgesics more than briefly     Pleural/pericardial effusion  
 Weight loss (that is not reversible) or gain (in the case of conditions that may cause fluid retention)  
 Decline in systolic blood pressure to below 90 or progressive postural hypotension  
 Venous, arterial or lymphatic obstruction due to a local progression or metastatic disease  
 Dependence on assistance for 2 or more activities of daily living  
     Feeding     Ambulation     Continence     Transfer     Bathing     Dressing  
 Overall poor status/prognosis (likely to remain in fragile health and have ongoing high risk for serious complications or death within a year)

\_\_\_\_\_ = Total number of boxes checked

**Once complete, fill out referral form on back side and fax to Heart 'n Home Hospice at: 541-508-4037.**

*Continue on back*

*This screening form does not replace a doctor's advice nor is it a diagnosis or guarantee of services. This screening form is to assist with identifying people who may benefit from a hospice needs assessment to see if they are eligible for hospice services. The decision about prognosis is determined by the hospice physician and is individualized based on the patient's clinical status.*

# Heart 'n Home Hospice

## Hospice Referral Coordination Worksheet

Date: \_\_\_\_\_

### GENERAL PATIENT INFORMATION:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Residence: \_\_\_\_\_  
\_\_\_\_\_

Insurance: \_\_\_\_\_

Primary contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### REFERRAL INFORMATION:

Referring person: \_\_\_\_\_

Current patient location: \_\_\_\_\_

Tentative DC date if not at service location: \_\_\_\_\_

Patient/Family/Caregiver aware of referral?:  Y  N

### ADDITIONAL PATIENT INFORMATION:

Diagnosis: \_\_\_\_\_

PCP: \_\_\_\_\_

Previous / current hospice or home health: \_\_\_\_\_

Recent hospitalizations: \_\_\_\_\_

DME: \_\_\_\_\_

### ADDITIONAL REFERRAL INFORMATION:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Fax the front and back of this completed page to: 541-508-4037**

*Questions? Call us today! 541-508-4036*



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