HOSPICE AIDE VISIT

Kindred Hospice

PATIENT NAME:		MR#	TIME IN	TIME OUT
DATE	LEVEL OF CARE ☐ Routine ☐ General Inpatient ☐ Continuous Care ☐ Respite	PRINCIPLE DIAGNOSIS		

Patient Identifier:
- ☐ Patient Name
- ☐ Date of Birth
- ☐ Social Security Number
- ☐ Photo Identification
- ☐ Insurance Card
- ☐ Family/Caregiver verified identity
- ☐ Visual recognition
- ☐ Other: _____

Primary Language:
- ☐ English
- ☐ Spanish
- ☐ Other

Interpreter needed:
- ☐ yes ☐ no

Plan of Care Tasks:

Signature of RN Completing Plan of Care _____

☐ **Bathing (Shower)**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Shampoo**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Oral Care**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Prepare Meal**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Intake – Fluids**
Frequency _____
☐ Completed - Amt. _____
☐ Not Completed
Reason _____

☐ **Blood Pressure**
Frequency _____
☐ Completed - _____
☐ Not Completed
Reason _____

☐ **Weight**
Frequency _____
☐ Completed - _____
☐ Not Completed
Reason _____

☐ **Assist to Toilet**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Routine Catheter Care**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Other** (specify)
_____
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Bathing (Bed Bath)**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Hair Care**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Ear Care**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Prepare Snack**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Intake – Food**
Frequency _____
☐ Completed – Amt. _____
☐ Not Completed
Reason _____

☐ **Temperature**
Frequency _____
☐ Completed - _____
☐ Not Completed
Reason _____

☐ **Assist with Feeding**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Transfer (Bed/Chair , Chair/Bed)** circle
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Perineal Care**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Other** (specify)
_____
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Bathing (Tub Bath)**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Skin Care**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Nail Care**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Offer Fluids**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Output - Urine**
Frequency _____
☐ Completed – Amt. _____
☐ Not Completed
Reason _____

☐ **Respirations**
Frequency _____
☐ Completed - _____
☐ Not Completed
Reason _____

☐ **Assist to Bedside Commode**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Turn and Position in Bed**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Assist to Bedside Commode**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Other** (specify)
_____
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Bathing (Partial Sponge Bath)**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Shaving**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Dressing**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **ROM (RUE / LUE / RLE / LLE)** circle
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Date of Last BM**
Frequency _____
☐ Completed – Date _____
☐ Not Completed
Reason _____

☐ **Pulse**
Frequency _____
☐ Completed - _____
☐ Not Completed
Reason _____

☐ **Assist with Bedpan**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Stand-By Assist w/ Ambulation**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Assist with Bedpan**
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

☐ **Other** (specify)
_____
Frequency _____
☐ Completed
☐ Not Completed
Reason _____

Patient Name:	MR #:	Date:

RN Collaboration:
Was report given to RN? ☐ No ☐ Yes Name/Tile of person report given to:_____

If no, indicate reason _____

Indicate Items Report Contained: ☐ patient condition ☐ patient requests ☐ other:_____

Facility Collaboration:
Is the patient in a facility? ☐ No ☐ Yes Was the facility given a report? ☐ No ☐ Yes Name/Tile of person report given to:_____

If no, indicate reason _____

Indicate Items Report Contained: ☐ patient condition ☐ patient requests ☐ other:_____

Additional Documentation:

_____

_____

_____

_____

Visit Time:
Travel To Time: Begin _____ **End** _____ **Travel From Time: Begin** _____ **End** _____

In Home Time: Begin _____ **End** _____ **Mileage: Begin** _____ **End** _____

Patient / Caregiver Signature	Date
Aide Signature	Date