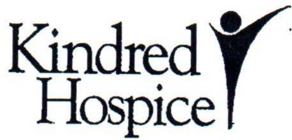

Continuous Care Progress Note

Patient: ______________________ MR#__________ Date: __________ *Time In:* ________ *Out:* ________

Diagnosis: ______________________ Location: ☐ Home ☐ Facility: ______________________

Primary CG*:* ______________________

Reason for Continuous Care: ______________________

Hospice Skilled Nurse or Hospice Aide Providing Care: ______________________ *Title:* __________

Time	Progress Notes

Reorder From: *MED-PASS* 800-438-8884

Page____of_____

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Form KHOS4042

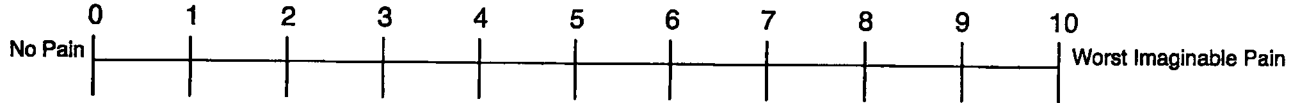
Hospice

MEDICATION FLOW SHEET

(* Refer to Hospice Eligibility Toolbox)

Patient Name: ______________________ **MR #** __________ **Date:** __________

Level of Care: ☐ **RHC** ☐ **CC** ☐ **In-Pt** ☐ **Respite**



(Circle highest level acceptable to pt if able to report)

Time	Pain / Distress Level (✓ if PainAD)	Medication Administered	Dosage	Route	30 min Follow up Level	1 hour Follow up Level	Comments	Initials
	☐							
	☐							
	☐							
	☐							
	☐							
	☐							
	☐							
	☐							
	☐							
	☐							
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	☐							
	☐							
	☐							
	☐							

Initials	Printed Name	Title	Signature

PAGE ______ OF ______

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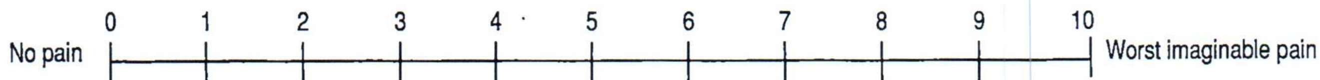
PAIN ASSESSMENT FLOW SHEET

Patient Name ______________________________ MR # ______________ Date ______________



(Circle highest level acceptable to pt, if able to report)

Date	Time	Pain Level	Medication Administered	# Increases/ 24 hours	Total Dosage / 24 hours	Nausea	Last BM	Change in sleep/wake pattern	Change in Appetite	Initials

Reorder From:
MED-PASS 800-438-8884

Initials	Printed Name	Title	Signature

White: Hospice
Yellow: Facility/Home

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Form KHOS4114

Kindred Hospice

MEDICATION COUNT FOR CC

Patient Name: ________________________________ MR # ____________

Date	Time	Controlled Medication	Amount of medication at start of shift	Total amount of medication administered during shift	Amount of medication at end of shift	CC staff initials	CC staff initials or family initials

Signature of CC Staff	Initials	Signature of Family Member or CC Staff	Initials