SPIRITUAL ASSESSMENT

Information Obtained By: ❑ Phone ❑ Visit

GENERAL INFORMATION

	Patient	Primary Caregiver	Family
Faith/Denomination			
Church Affiliation			
Name/Title of Spiritual Advisor			
Phone No.	( )	( )	( )
Contact Requested	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Hospice Chaplain Referral Requested	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Importance of Religion in Life: (Great, Moderate, Unimportant, Unknown)			

PATIENT ASSESSMENT

Patient in pain: ❑ Yes ❑ No Rate 0-10___________ Non-verbals (explain)___________

Current Support Systems:

❑ Family ❑ Friends ❑ Community Groups ❑ Religious Groups

❑ Prayer/Meditation ❑ Worship Services ❑ Religious Rituals (sacraments, etc.)

❑ Other (Specify)___________

❑ Shared spiritual complementary therapies: ❑ Visualization ❑ Meditation ❑ Music

Patient is satisfied with current spiritual support: ❑ Yes ❑ No (Explain)___________

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INDICATORS OF SPIRITUAL STRENGTH DEMONSTRATED/EXPRESSED (Check all that apply)		INDICATORS OF SPIRITUAL DISTRESS DEMONSTRATED/EXPRESSED (Check all that apply)	
Patient	**Primary Caregiver**	**Patient**	**Primary Caregiver**
❑ Acceptance of Reality	❑ Acceptance of Reality	❑ Depression	❑ Depression
❑ Eternal Life Beliefs	❑ Eternal Life Beliefs	❑ Anxiety	❑ Anxiety
❑ Spiritual Discipline	❑ Spiritual Discipline	❑ Guilt	❑ Guilt
❑ Serenity/Peace	❑ Serenity/Peace	❑ Shame	❑ Shame
❑ Life Meaning/Purpose	❑ Life Meaning/Purpose	❑ Anger	❑ Anger
❑ Hope	❑ Hope	❑ Hopelessness/Despair	❑ Hopelessness/Despair
❑ Forgiveness	❑ Forgiveness	❑ Powerlessness	❑ Powerlessness
❑ Reconciliation	❑ Reconciliation	❑ Meaninglessness	❑ Meaninglessness
❑ Acceptance of Limits	❑ Acceptance of Limits	❑ Grief	❑ Grief
❑ Self Worth	❑ Self Worth	❑ Denial of Reality	❑ Denial of Reality
❑ Unknown at This Time	❑ Unknown at This Time	❑ Withdrawal/Isolation	❑ Withdrawal/Isolation
❑ Other (specify)	❑ Other (specify)	❑ Self Pity	❑ Self Pity
		❑ Suicidal Thoughts	❑ Suicidal Thoughts
		❑ Fear of (specify)	❑ Fear of (specify)
		❑ Other (specify)	❑ Other (specify)

Overall patient demonstrates: ❑ Spiritual Connection ❑ Spiritual Distress ❑ Uncertain

Further spiritual follow-up desired: ❑ Patient ❑ Primary Caregiver ❑ Family

Specify type of follow-up desired:___________

Comments/Counseling/Care plan implementation:___________

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Signature and Title of Assessor___________ Date_____/_____/_____

PATIENT NAME–Last, First, Middle Initial	ID#

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