HOSPICE INTERDISCIPLINARY PLAN OF CARE/PHYSICIAN ORDERS

Patient Name:_____ ID #:_____ HICN #:_____

Signature of Clinician Completing Form:_____

Attending Physician:_____ Date of Birth:_____

Start of Care Date:_____ Certification Period:_____

Terminal Diagnosis:_____ ICD Code:_____

Related Diagnosis:_____ ICD Code:_____

Other Diagnosis:_____ ICD Code:_____

Hospice Admission Status: ❍ Routine Home Care ❍ Inpatient Respite ❍ Continuous Home Care ❍ General Inpatient Care

Resides at: ❍ Home ❍ Nursing Home ❍ Assisted Living ❍ Residential Hospice ❍ Other:_____

DNR: ❍ Yes ❍ No Diet:_____

Allergies: ❍ NKA ❍ Yes, list_____

ACTIVITY LEVEL

❍ Independent/UAL ❍ Minimal assist ❍ Maximum assist
❍ Bedbound

FUNCTIONAL LIMITATIONS

❑ Incontinent: ❑ Bowel ❑ Bladder ❑ Dysphagia ❑ Amputation
❑ Paralysis: ❍ Hemi ❍ Para ❍ Quad ❑ Speech/Language
❑ Contracture ❑ Dyspnea with minimal exertion
❑ Hearing deficit ❑ Other:_____
❑ Primary language:_____

MENTAL STATUS

❍ Alert/Oriented ❍ Lethargic ❍ Confused ❍ Unresponsive
❑ Other:_____

SAFETY MEASURES

❑ Oxygen/Electrical ❑ Fall precautions ❑ Environmental barriers
❑ Assistive devices ❑ Slow position changes
❑ Other:_____

EQUIPMENT

❑ Hospital bed ❑ Bed rails ❑ Commode ❑ Overbed table
❑ Wheelchair ❑ Walker ❑ Cane ❑ Oxygen
❑ Other:_____

PAIN (Current Level)

Mark appropriate response
❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7 ❍ 8 ❍ 9 ❍ 10
Location (specify):_____

SERVICES

Interdisciplinary group (IDG) services and frequency as recommended by IDG (The IDG reviews and updates the POC at least every 2 weeks).

Services & Frequency	SERVICE DECLINED	Services & Frequency	SERVICE DECLINED
❑ Skilled Nursing _____ x week and prn	❑	❑ Chaplain/Clergy _____ month/prn	❑
❑ Medical Social Worker _____ x month/prn	❑	❑ Volunteer _____ month/prn	❑
❑ Aide/Homemaker _____ x week/prn	❑	❑ Dietitian _____ prn	❑
❑ Therapy (PT, OT, ST) _____ x week/prn	❑	❑ Other:_____	❑

Dear Physician – Please review the following hospice orders. Record additional orders where indicated. If you have any questions, please call us. Thank you. **(See back for additional orders)**

ORDERS: ❑ Admit to hospice care

❑ Continue with hospice care/services

❑ Interdisciplinary group to determine equipment and supply needs based on assessment for comfort and symptom control (may include but not limited to: hospital bed, special mattress, bedside commode, overbed table, shower chair, wheelchair walker, suction machine, etc.).

❑ Assess and evaluate cardiac, respiratory, GI, GU, pain, mobility, skin, nutrition/hydration, comfort level and symptom management, disease progression, safety and family/caregiver needs

❑ Instruct on care of terminally ill, medications, safety, nutritional needs, pain and symptom control based on assessment

❑ Assess and evaluate current medications

❑ Medications to be administered by licensed staff, patient and/or family member/caregiver per medication profile and current orders

❑ Other:

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ADDITIONAL ROUTINE ORDERS

PAIN/COMFORT

- ❑ Acetominophen 650 mg po/rectally q̄ 4hrs prn for pain or temperature of _____ or higher. Notify physician if temperature persists more than 48 hours or if other signs/symptoms of infection/sepsis are present.
- ❑ _____ (drug, dose, route, frequency) prn for breakthrough pain
- ❑ _____ (drug, dose, route, frequency) prn for pain
- ❑ Artificial tears for comfort prn
- ❑ Other:

ANXIETY

- ❑ _____ (drug, dose, route, frequency) prn for agitation/restlessness (consider the needs for po, im, rectal)
- ❑ Other:

SKIN INTEGRITY

- ❑ Use hospice skin protocol(s) for altered skin integrity. May use skin care products of choice. _____ to red areas prn _____ (drug, dose, route, frequency) for itching prn
- ❑ Ice packs/heating pad for comfort prn
- ❑ Other:

SLEEP

- ❑ _____ (drug, dose, route, frequency) @ hs, prn insomnia
- ❑ Other:

BOWEL ELIMINATION

- ❑ _____ (drug, dose, route, frequency) for stool softener
- ❑ _____ (drug, dose, route, frequency) for constipation
- ❑ Check for impaction and remove prn
- ❑ Fleets/oil retention enema prn for constipation
- ❑ Milk of magnesia 2 Tbsp. po prn
- ❑ Use hospice bowel protocol for constipation/diarrhea
- ❑ Other:

URINARY ELIMINATION

- ❑ May insert #16-#22 foley catheter (with 5-10 cc balloon) for incontinence or retention. Change foley every 4-6 weeks and prn
- ❑ Straight catheter _____ Fr prn for bladder distention
- ❑ Irrigate foley with normal saline or _____ prn (per organizational policy)
- ❑ Condom catheter prn
- ❑ Other:

RESPIRATORY

- ❑ Oxygen per _____ @ _____lpm. May increase to _____lpm as needed for comfort.
- ❑ _____ (drug, dose, route, frequency) prn for dyspnea and/or congestion
- ❑ _____ tsp. po q̄ 3-4° prn for cough/congestion. Notify physician if no relief.
- ❑ _____ for excessive secretions q̄ _____ prn
- ❑ Other:

NUTRITION

- ❑ Diet/Fluids as tolerated
- ❑ Antacid of choice for indigestion, heartburn
- ❑ _____ (drug, dose, route, frequency) for nausea and vomiting prn
- ❑ Other:

ORAL/MUCOUS MEMBRANES/SWALLOWING

- ❑ Oral or nasopharyngeal suction prn for comfort
- ❑ Artificial saliva for dry mouth prn
- ❑ Consult with pharmacy when medications are unable to be tolerated orally, to suggest permissable route changes (liquid, crushing, rectal, etc.)
- ❑ Other:

SELF CARE DEFICIT

- ❑ Activity as tolerated
- ❑ Other:

TREATMENTS

- ❑

OTHER MEDICATIONS

(Dose/Frequency/Route (N)ew, (C)hanged)

- ❍ N ❍ C _____
- ❍ N ❍ C _____
- ❍ N ❍ C _____
- ❍ N ❍ C _____
- ❍ N ❍ C _____
- ❍ N ❍ C _____
- ❍ N ❍ C _____

Verbal orders received by_____ Date_____

Attending Physician	Date	Hospice Medical Director	Date