# CLINICAL RECORD

**Rev 07/18**

## Table of Contents

Note: Information may be in the Electronic Medical Record

### Behind Table of Contents:
- Chart Check Sheet
- Staff Signature Sheet
- Patient/Family Record – Computer generated “Face Sheet”
- Certifications of Eligibility for Hospice
- Face-to-Face Visit for Recertification
- Recertification from Medical Director
- IDT Care Plan

### TABS

1. **Intake/Consents**
   - Request for Hospice Consultation (if used)
   - Referral/Informational for Hospice Care
   - Admission and Care Consent
   - Change in Attending Physician Statement (if used)
   - Patient/Family Bill of Rights
   - Live Alone Consent Addendum (if used)
   - HIV Release of Information (if used)
   - Informed Consent
   - Patient/Family Responsibilities Sheet
   - Letter to Attending Physician
   - Medicare Election or Commercial Insurance
   - Insurance company correspondence (if any)
   - Room and Board Authorization if Nursing Home
   - Revocation of Hospice Benefit (if used)

2. **Advance directives**
   - Non-Hospital DNR Order (DOH)/DNR Waiver Form
   - Health Care Proxy/Hospice Care Agreement
   - Living Will (if any)
   - MOLST (Copy only) if available

3. **Medical Information**
   - History and Physical

4. **Physician orders**
   - Physician Orders for Care/Signed by Dr and RN
   - Modifications to POs (verbal/written)
   - Copies of Facility Physician Orders
5. Medications
Drug Classification Sheets (plastic sleeve)
Current Medication Profile
Controlled Substance Disposal Record

6. Assessments
Initial RN/SW/Chaplain Assessment
Pain Assessment/Fall Risk Assessment
Home Safety Checklist
Oxygen Use and Instruction
Psychosocial/Spiritual Assessment

7. Bereavement
Survivor Risk Assessment
Names and Telephone Numbers
Bereavement Contact Sheet
Circle of Care
Bereavement Note (in Client Chart)
Authorizations to Release Information

8. Team Notes
Documentation Guidelines (plastic sleeve)
RN Assessment and Reassessment
Wound Flow Sheet
Social Work, Chaplain, Bereavement and LPN Visit Notes
Discharge Summary (at end of care)
Change of Hospice Provider Statement
Continuous Care Notes
Note at Time of Death

9. In-Patient Care
General Inpatient Worksheet
General Inpatient Checklist
All other Inpatient documentation

10. Hospice Aide
Hospice Aide Request Sheet
Hospice Aide Tracking Sheet
Hospice Aide Care Plan
Hospice Aide Orientation/Supervision Summary
Hospice Aide Activity Sheets

11. Volunteers
Volunteer Patient/Family Narrative/Notes

12. Reports
DME Tracking
DME Contracts (if temporary)
Lab and X-ray Reports (if any)
Nutritional Consults/Dietitian notes (if any)
Therapy notes (PT, OT, ST, etc.) (if any)
Family correspondence (if any)
Miscellaneous Information

Insurance billing information is maintained in a separate file.