

### HOSPICE CLINICAL RECORD REVIEW

Review Date	Name - Patient	License Number
Birth Date	Date of Death	Record Number open/closed
		MB Election Date / SOC

**Service Agreement** DHS 131.17(4)(b)
  **Patient Rights** DHS 131.19

<b>Diagnosis</b>	<b>Certification of Terminal Illness</b>
	<input type="checkbox"/> Initial 90 days (both) <span style="float: right;"><input type="checkbox"/> Subsequent 90 – 60 (either)</span> <input type="checkbox"/> Medical Director <span style="float: right;"><input type="checkbox"/> Medical Director</span> <input type="checkbox"/> Attending <span style="float: right;"><input type="checkbox"/> Attending</span>
	<input type="checkbox"/> Narrative <span style="float: right;"><input type="checkbox"/> Attending</span>

<b>Initial Plan of Care</b> 131.21(2)	<i>DHS</i>
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A nurse and one other core team person develop the POC. [DHS 131.21(2)(c)]  
 Attending MD     RN     Med. Dir./Phys.     SW     Counselor

<b>Revised Plan of Care / IDGs</b>	<i>CFR 418.56(d) (at least every 15 days) DHS 131.21(3)(c)</i>
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Date	Discipline	IDG Discussion / Comments
	<input type="checkbox"/> Att. MD <input type="checkbox"/> RN <input type="checkbox"/> Med. DIR./Phys. <input type="checkbox"/> SW <input type="checkbox"/> Counselor	
	<input type="checkbox"/> Att. MD <input type="checkbox"/> RN <input type="checkbox"/> Med. DIR./Phys. <input type="checkbox"/> SW <input type="checkbox"/> Counselor	
	<input type="checkbox"/> Att. MD <input type="checkbox"/> RN <input type="checkbox"/> Med. DIR./Phys. <input type="checkbox"/> SW <input type="checkbox"/> Counselor	
	<input type="checkbox"/> Att. MD <input type="checkbox"/> RN <input type="checkbox"/> Med. DIR./Phys. <input type="checkbox"/> SW <input type="checkbox"/> Counselor	

<b>Content of Plan</b>	<i>CFR 418.56(c) &amp; DHS 131.21(3)(b) - Assessment / Scope and Frequency of Services CFR 418.54(c) &amp; DHS 131.20(3) - Assessments Complete, Consistent</i>
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<b>Home Health Aide</b>		
Assignment Date 418.76(g) & 131.26(2)(a)	Documentation CFR 418.104 & DHS 131.33 <input type="checkbox"/> Yes <input type="checkbox"/> No	Supervision Every 2 Weeks 418.76(h) & 131.26(2)(c) <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Volunteers / Companions</b>	
Assignment Date DHS 131.26(1)(b)	Documentation CFR 418.104 & DHS 131.33 <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Physician Orders</b> (Medication and Treatment)	<i>DHS 131.21(2)(d)</i>
All verbal orders are signed within 20 days.	

<b>Bereavement Care Plan and Services Documentation</b>	<i>CFR 418.64(d) &amp; DHS 131.21(3)(d)</i>
Compatible with core team direction within the plan of care (POC).	

<b>Controlled Drug Disposal</b>		<i>CFR 418.106 &amp; DHS 131.32(2)(g)</i>
RN participated? <input type="checkbox"/> Yes <input type="checkbox"/> No	RN educated the family on how to dispose of drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Social Services</b>		<i>CFR 418.64 &amp; DHS 131.25(5)</i>
Services provided by a qualified person in accordance with the plan of care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		

