Hospice of Charleston
a Gentiva® company

INTERDISCIPLINARY HOSPICE COMMUNICATION

Patient Name _____ MR# _____

Terminal Diagnosis _____ Time Began: _____ Time Ended: _____

Type of Contact	Discipline	
☐ Telephone Contact	☐ SN	☐ BC
☐ Other _____	☐ SCC	☐ Physician
☐ Reason for Visit: _____	☐ MVS	☐ Medical Director
_____	☐ HA	☐ Therapist – PT – OT – ST
	☐ Dietician	☐ Other
	☐ SW	☐ Reportable SW Telephone Call PCM Initial _____

☐ Visit Documentation Continuation

PAIN	No pain = 0 1 2 3 4 5 6 7 8 9 10 = worst possible pain *PAINAD Scale Score: _____
Rated by:	☐ Patient ☐ Caregiver (telephone contact only)

Time	Notes *(Multiple entries must have writer's signature/title & date following each entry)*

*Refer to Hospice Eligibility Toolbox

page ____ of ____

Signature: _____ / _____ Date: _____
For Single Entry Only — Title