

**RN ADMISSION CHECKLIST**  
**for**  
**NON-ELECTRONIC DOCUMENTATION**

Patient Name: \_\_\_\_\_ MR#: N\_\_\_\_\_

Date of Admission: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date Submitted to PCC: \_\_\_\_/\_\_\_\_/\_\_\_\_

	<u>PCC Initials</u>
<input type="checkbox"/> Informed Consent/Election of Benefit	_____
<input type="checkbox"/> Implanted Defibrillator Release (if applicable)	_____
<input type="checkbox"/> Hospice DNR Request/Order	_____
<input type="checkbox"/> Hospice Home Health Aide Plan of Care	_____
<input type="checkbox"/> Health Care Proxy Form (if applicable)	_____
<input type="checkbox"/> Living Will (if Applicable)	_____

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Submitted by: \_\_\_\_\_

Hospice of New York Staff Member

**The above forms must be completed upon admission by the RN, SW, patient, and or patient representative. This checklist and all required forms must be faxed, or physically submitted, within 24 hours of admission to the assigned Patient Care Coordinator.**

Please make your report on the On-Call line concise and organized. Use the following template for your presentation. You may write on this page if you think it would be helpful:

1. Introduce yourself and the purpose of your report – Admission, Expiration, Discharge, Change in Level of Care, Change in status, New medication, etc...
2. Patient's Medical Record No.
3. Patient's Name
4. Physician – the one following, whether in SNF, IPU or Community
5. Name of Facility and/or County of Residence
6. If any information in ALLSCRIPTS is incorrect, please make correction statement here...i.e. Phone number is incorrect in ALLSCRIPTS, correct phone number is....., or Address is incorrect.....etc.
7. Ancillary Needs – Volunteer, Pastoral Care, HHA, Equipment, Supplies and what you have done to meet these needs.
8. Medications/Allergies. If already in ALLSCRIPTS, just make statement to that effect.
9. Primary problems/symptoms
10. What you have done to address same.