HospiceTools™
How Hospice Happens

PsychoSocial eDocs EMR Forms Patient Care Checklist

This checklist details the most common and regulatorily required forms a social worker will use at the start & during ongoing patient care

Title	Notes
PSYCHOSOCIAL ASSESSMENT	Complete with 5 days of starting care
PSYCHOSOCIAL VISIT NOTE	Completed at each scheduled visit. Document a patent and family's mental, emotional and behavioral status in addition to needs for support and resources. Prompts social worker to update care plan.
SOCIAL WORKER PROGRESS NOTE	The Social Work Progress Note can be used for a variety of situations including PRN visits, phone calls, care plan meetings, care coordination, etc.
CARE PLAN & UPDATE	Create/update as needed during care. The plan of care needs to be updated with any changes in problems, goals, & interventions every 15 days min.
IDG UPDATE	Completed at each IDG meeting. Documentation of changes to patient/family condition and needs over the past two weeks. Also, collaboration with patient/family, attending physician, facility (if applicable) and hospice team. Planned frequencies for next IDG period.
DEATH VISIT REPORT	Complete upon patient death (if SW is primary at death visit)
VETERAN HISTORY CHECKLIST	If patient is a veteran, complete within 5 days of start of care
VOLUNTEER REQUEST FORM	As needed when patient/caregiver requests a volunteer (if request is made of social worker). Sent to volunteer coordinator for review and volunteer assignment
PATIENT INCIDENT REPORT	As needed to document incidents that occur such as falls, suspected abuse/neglect etc.
STICKY NOTES TAB	As needed: eDocs Sticky Notes Tab is often used for planning & note taking for funeral planning / polst / and sharing relevant data with team that will not hit the chart.
HOMEMAKER ASSIGNMENT AND PLAN OF CARE	If applicable, complete upon admission. Assigns specific tasks for homemaker to perform. Updated as needed during care with changes.

Notes