

## PATIENT CORE MEASURE SHEET

### Patient Demographics

1. Patient's ID

2. Primary Diagnosis

- |                              |                                       |                                |                              |                                |
|------------------------------|---------------------------------------|--------------------------------|------------------------------|--------------------------------|
| <input type="radio"/> Cancer | <input type="radio"/> Heart           | <input type="radio"/> Dementia | <input type="radio"/> Lung   | <input type="radio"/> Kidney   |
| <input type="radio"/> Liver  | <input type="radio"/> HIV             | <input type="radio"/> Coma     | <input type="radio"/> Stroke | <input type="radio"/> Diabetes |
| <input type="radio"/> ALS    | <input type="radio"/> Other (specify) |                                |                              |                                |

3. Gender

- Male                       Female

4. Age (in years): \_\_\_\_\_

5. Language, if other than English: \_\_\_\_\_

6. Race/Ethnicity:

- |   |  |   |
|---|--|---|
| <input type="radio"/> Black or African American | <input type="radio"/> American Indian or Alaska Native | <input type="radio"/> Native Hawaiian or other Pacific Islander |
| <input type="radio"/> White or Caucasian        | <input type="radio"/> Asian                            | <input type="radio"/> Another Race                              |
| <input type="radio"/> Hispanic/Latino           | <input type="radio"/> Multi-racial                     | <input type="radio"/> Don't know                                |

7. Reason for excluding patient from the study:

- |   |   |  |
|---|---|--|
| <input type="radio"/> Unable to self-report | <input type="radio"/> Less than 18 years of age | <input type="radio"/> Language barrier |
|---|---|--|

### Step I: Section A

Tell the patient that now and in a few days someone from your hospice is going to ask a couple of yes/no questions that will help your hospice understand how to best treat patients in pain. Reassure them that there is no right or wrong answer.

8. Are you uncomfortable because of pain?

- Yes                       No

**Step I: Section B**

9. Was your pain brought to a comfortable level within 2 days of your admittance to the hospice program?

Yes

No

Unable to self-report

Indicate Reason:

Died  Discharged Alive

Due to disease

Other

**Step II: Hospitalization and CPR**

Numbers 10-13 are also to be completed at the time of admission. These questions rely on other respondents if the patient is unable to respond but should follow state laws regarding who has legal right to respond. Please note that for the purpose of this survey, hospital refers to acute not hospice inpatient care.

10: Date of Admission (mm/dd/yy): \_\_\_\_\_

11. Respondent (please check one):

Patient

Advance Directive

Healthcare Agent

Surrogate

12. Do you want to avoid hospitalization if your condition worsens?

Yes

No

Undecided

If appropriate, you may wish to have a discussion with the patient about the definition of CPR if they are unsure what it means.

13. Do you want cardiopulmonary resuscitation if your heart or lungs stop working?

Yes

No

Undecided

**Preference Change**

Initial preferences may be changed after admission. Please note these changes in the preference change section as they occur. Respondents should follow state laws regarding who has the legal right to respond.

Preference Change

14. Date of preference change (mm/dd/yy): \_\_\_\_\_

15. Respondent (please check one):

- Patient                       Advance Directive  
 Health Care Agent         Surrogate

16. Do you want to avoid hospitalization if your condition worsens?

- Yes                               No                               Undecided

17. Do you want cardiopulmonary resuscitation if your heart or lungs stop working?

- Yes                               No                               Undecided

**Please complete this last section AFTER the patient has been discharged.**

18. Date of discharge (mm/dd/yy): \_\_\_\_\_

19. Hospitalization:

- Yes                               No

20. CPR:

- Yes                               No