DISCHARGE ASSESSMENT / TRANSFER Including OASIS Elements

Patient Name: ______ ID #______

Date: ______ Time In: ______ Time Out: ______

= OASIS (must complete)

Includes OASIS C Data Set (12/2009)

All M00 numbers must be completed

Section A: Clinical Record Items / Demographics / Patient History

Certification Period: From: ___ / ___ / ___ To: ___ / ___ / ___

1. **(M0010) CMS Certification Number:** ___ | ___ | ___ | ___ | ___ | ___
2. **National Provider Identifier:** ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___
3. **(M0014) Branch State:** ___ | ___
4. **(M0016) Branch ID Number:** ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___
5. **(M0018) NPI for the attending physician who has signed the Plan of Care:** ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___
   ☐ UK – Unknown or Not Available

   Primary Referring Physician Name and Address Name ______

   Address ______ Phone ______

   City ______ State ______ Zip ______ Fax ______
6. **(M0020) Patient ID Number:** ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___
7. **(M0030) Start of Care Date:** ___ | ___ / ___ | ___ / ___ | ___ | ___ | ___
   Month Day Year
8. **(M0032) Resumption of Care Date:** ___ | ___ / ___ | ___ / ___ | ___ | ___ | ___ ☐ NA – Not Applicable
   Month Day Year
9. **(M0040) Patient Name:** (First Name) ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ (Middle Initial) ___
   (Last Name) ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ (Suffix (i.e. Sr., Jr., III) ___ | ___ | ___
10. **Patient Address:** ______ ______
    Street, Route, Apt. Number – not PO Box City
11. **(M0050) Patient State of Residence:** ___ | ___
12. **(M0060) Patient Zip Code:** ___ | ___ | ___ | ___ | ___ – ___ | ___ | ___ | ___
13. **Patient Phone:** (______) ______
14. **(M0063) Patient Medicare Number:** ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ ☐ NA - No Medicare
    (including suffix, if any)
15. **(M0064) Social Security Number:** ___ | ___ | ___ – ___ | ___ – ___ | ___ | ___ | ___ ☐ UK – Unknown or Not Available
16. **(M0065) Medicaid Number:** ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ ☐ NA – No Medicaid
17. **(M0066) Birth Date:** ___ | ___ / ___ | ___ / ___ | ___ | ___ | ___
    Month Day Year
18. **(M0069) Gender:** ☐ 1– Male ☐ 2 – Female
19. **Other Referral Sources:** Name ______

    Address ______ Phone ______ Fax ______
20. **(M0080) Discipline of Person Completing Assessment:** ☐ 1 – RN ☐ 2 – PT ☐ 3 – SLP/ST ☐ 4 – OT
21. **(M0090) Date Assessment Completed:** ___ | ___ / ___ | ___ / ___ | ___ | ___ | ___
    Month Day Year
22. **(M0100) This Assessment is Currently Being Completed for the Following Reason:**
    - ☐ **DISCHARGE FROM AGENCY** – Not to an inpatient facility (Go to M1040)
    - ☐ **DEATH AT HOME** (Go to M0906) (Death at Home: complete M0080 – M0100, M0903, M0906 only)
    - ☐ **TRANSFERRED** to an inpatient facility – patient not discharged from agency (Go to M1040)
    - ☐ **TRANSFERRED** to an inpatient facility – patient discharged from agency (Go to M1040)

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DISCHARGE ASSESSMENT / TRANSFER Including OASIS Elements

Patient Name: ______________________________ ID #______________

Clinician's Name: ______________________________ Date: ______________ [ ] = OASIS (must complete)

Includes OASIS C Data Set (12/2009)

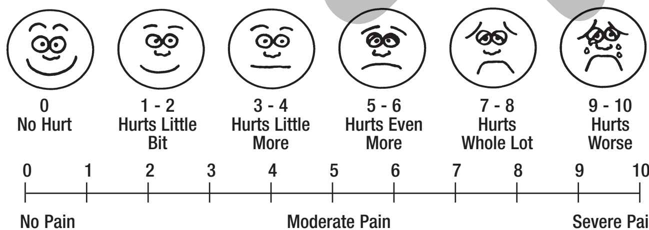
Section B: Risk Factors

1. **(M1040) Influenza Vaccine:** Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?
   - ☐ 0 – No
   - ☐ 1 – Yes *(Go to M1050)*
   - ☐ NA – Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. *(Go to M1050)*
2. **(M1045) Reason Influenza Vaccine not received:** If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason:
   - ☐ 1 - Received from another health care provider (e.g., physician)
   - ☐ 2 - Received from your agency previously during this year's flu season
   - ☐ 3 - Offered and declined
   - ☐ 4 - Assessed and determined to have medical contraindication(s)
   - ☐ 5 - Not indicated; patient does not meet age/condition guidelines for influenza vaccine
   - ☐ 6 - Inability to obtain vaccine due to declared shortage
   - ☐ 7 - None of the above
3. **(M1050) Pneumococcal Vaccine:** Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge)?
   - ☐ 0 - No
   - ☐ 1 - Yes *(Go to M1500 at TRN; Go to M1230 at DC)*
4. **(M1055) Reason PPV not received:** If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), state reason:
   - ☐ 1 - Patient has received PPV in the past
   - ☐ 2 - Offered and declined
   - ☐ 3 - Assessed and determined to have medical contraindication(s)
   - ☐ 4 - Not indicated; patient does not meet age/condition guidelines for PPV
   - ☐ 5 - None of the above

Section C: Review of Systems / Physical Assessment

1. **Eyes:** ☐ Normal ☐ Other (explain)______________________
2. **Head:** ☐ Normal ☐ Other (explain)______________________
3. **Ears:** ☐ Normal ☐ Other (explain)______________________
4. **Oral (M1230) Speech and Oral (Verbal) Expression of Language** (in patient's own language):
   - ☐ 0 – Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
   - ☐ 1 – Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
   - ☐ 2 – Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
   - ☐ 3 – Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
   - ☐ 4 – **UNABLE** to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).
   - ☐ 5 – Patient nonresponsive or unable to speak.

   Other: ☐ Gum problems ☐ Chewing problems
   ☐ Dentures: ☐ Upper ☐ Lower
   Other ______________________
5. **Nose & Sinus:** ☐ Normal ☐ Other (explain) ______________
6. **Neck & Throat:** ☐ Normal ☐ Other (explain) ______________
7. **Muscoloskeletal / Neurological:** ☐ Normal ☐ Other (explain)
8. **Pain: (M1242) Frequency of Pain** interfering with patient's activity or movement:
   - ☐ 0 – Patient has no pain
   - ☐ 1 – Patient has pain that does not interfere with activity or movement
   - ☐ 2 – Less often than daily
   - ☐ 3 – Daily, but not constantly
   - ☐ 4 – All of the time



Pain scale (0-10): ______________

***Pain** continued on next page*

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DISCHARGE ASSESSMENT / TRANSFER Including OASIS Elements

Patient Name: ______________________________ ID #______________

Clinician's Name: ______________________ Date: __________ [ ] = OASIS (must complete)

Includes OASIS C Data Set (12/2009)

Section C: Review of Systems / Physical Assessment *continued*

8. **Pain:** continued

Collected using: ☐ Faces Scale ☐ 0-10 Scale (subjective reporting)
Frequency: ☐ Occasionally ☐ Continuous ☐ Intermittent
☐ Other: ______________________

What makes pain worse?
☐ Movement ☐ Ambulation ☐ Immobility
☐ Other: ______________________

What makes pain better?
☐ Heat/Ice ☐ Massage ☐ Repositioning
☐ Rest/Relaxation ☐ Medication ☐ Diversion
☐ Other: ______________________

How often is breakthrough medication needed? ☐ Never
☐ Less than daily ☐ 2-3 times per day
☐ More than 3 times per day
☐ Current pain control medications adequate
☐ Other: ______________________

9. **Integumentary Status:**

A. **General Information on Skin**

Skin Color: ______________________

Turgor: ☐ Good ☐ Fair ☐ Poor

Check all that apply:
☐ Warm ☐ Cool ☐ Clammy ☐ Itching ☐ Rash
☐ Bruises

9. **Integumentary Status:** continued

☐ Petechiae ☐ Purpura ☐ Dry
☐ Other ______________________

B. **Nails** ☐ Normal
☐ Ingrown (Describe location and surrounding area)
____
☐ Poor Nail Care
☐ Other ______________________

C. **Hair** ☐ Normal ☐ Alopecia ☐ Infestation
☐ Other ______________________

D. **(M1306)** Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as "unstageable"?
☐ 0 - No *(Go to M1322)* ☐ 1 - Yes

E. **(M1307)** The **Oldest Non-epithelialized Stage II Pressure Ulcer** that is present at discharge
☐ 1 - Was present at the most recent SOC/ROC assessment
☐ 2 - Developed since the most recent SOC/ROC assessment: *record date pressure ulcer first identified:*
__ __ / __ __ / __ __ __ __
Month Day Year
☐ NA - No non-epithelialized Stage II pressure ulcers are present at discharge

F. **(M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage:** (Enter "0" if none; excludes Stage I pressure ulcers)

Stage description – unhealed pressure ulcers	Column 1 Complete at SOC/ROC/FU & D/C Number Currently Present	Column 2 Complete at FU & D/C Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)
a) **Stage II:** Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.		
b. **Stage III:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.		
c. **Stage IV:** Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.		
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device.		
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.		
d.3 Unstageable: Suspected deep tissue injury in evolution.		

Directions for M1310, M1312, and M1314: If the patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the **Stage III or IV pressure ulcer with the largest surface dimension (length x width)** and record in centimeters. If no Stage III or Stage IV pressure ulcers, go to M1320.

(M1310) Pressure Ulcer Length: Longest length "head-to-toe" | ___ | ___ | . | ___ | (cm)

(M1312) Pressure Ulcer Width: Width of the same pressure ulcer; greatest width perpendicular to the length | ___ | ___ | . | ___ | (cm)

(M1314) Pressure Ulcer Depth: Depth of the same pressure ulcer; from visible surface to the deepest area | ___ | ___ | . | ___ | (cm)

Integumentary Status *continued on next page*

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DISCHARGE ASSESSMENT / TRANSFER Including OASIS Elements

Patient Name: ______________________ ID #______________

Clinician's Name: ______________________ Date: ______________ [ ] = OASIS (must complete)

Includes OASIS C Data Set (12/2009)

Section C: Review of Systems / Physical Assessment *continued*

9. **Integumentary Status:** continued

Wound / Lesion (specify)	#1	#2	#3	#4	#5
Location:					
Type: diabetic ulcer pressure ulcer venous statis ulcer arterial ulcer traumatic wound burn wound surgical wound other (specify)					
Size (cm) (LxWxD)					
Stage (pressure ulcers only)					
Tunneling/undermining (cm)					
Odor					
Surrounding Skin					
Edema					
Stoma					
Appearance of the Wound Bed					
Drainage/Amount	☐ None ☐ Small ☐ Moderate ☐ Large	☐ None ☐ Small ☐ Moderate ☐ Large	☐ None ☐ Small ☐ Moderate ☐ Large	☐ None ☐ Small ☐ Moderate ☐ Large	☐ None ☐ Small ☐ Moderate ☐ Large
Color	☐ Clear ☐ Tan ☐ Serosanguineous ☐ Other ________	☐ Clear ☐ Tan ☐ Serosanguineous ☐ Other ________	☐ Clear ☐ Tan ☐ Serosanguineous ☐ Other ________	☐ Clear ☐ Tan ☐ Serosanguineous ☐ Other ________	☐ Clear ☐ Tan ☐ Serosanguineous ☐ Other ________
Consistency	☐ Thin ☐ Thick	☐ Thin ☐ Thick	☐ Thin ☐ Thick	☐ Thin ☐ Thick	☐ Thin ☐ Thick

(M1320) Status of Most Problematic (Observable) Pressure Ulcer:

☐ 0 - Newly epithelialized ☐ 2 - Early/partial granulation
☐ 1 - Fully granulating ☐ 3 - Not healing
☐ NA - No observable pressure ulcer

(M1322) Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

(M1324) Stage of Most Problematic (Observable) Pressure Ulcer:

☐ 1 - Stage I ☐ 3 - Stage III
☐ 2 - Stage II ☐ 4 - Stage IV
☐ No observable pressure ulcer or unhealed pressure ulcer

G. **(M1330)** Does this patient have a **Stasis Ulcer?**

☐ 0 - No *(Go to M1340)*
☐ 1 - Yes, patient has BOTH observable and unobservable stasis ulcers
☐ 2 - Yes, patient has observable stasis ulcers ONLY
☐ 3 - Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing) *(Go to M1340)*

(M1332) Current Number of (Observable) Stasis Ulcer(s):

☐ 1 - One ☐ 2 - Two ☐ 3 - Three ☐ 4 - Four or more

(M1334) Status of Most Problematic (Observable) Stasis Ulcer:

☐ 0 - Newly epithelialized ☐ 2 - Early/partial granulation
☐ 1 - Fully granulating ☐ 3 - Not healing

H. **(M1340)** Does this patient have a **Surgical Wound?**

☐ 0 - No *(Go to M1350)*
☐ 1 - Yes, patient has at least one (observable) surgical wound
☐ 2 - Surgical wound known but not observable due to non-removable dressing *(Go to M1350)*

(M1342) Status of Most Problematic (Observable) Surgical Wound:

☐ 0 - Newly epithelialized ☐ 2 - Early/partial granulation
☐ 1 - Fully granulating ☐ 3 - Not healing

I. **(M1350)** Does this patient have a **Skin Lesion** or **Open Wound,** excluding bowel ostomy, other than those described above **that is receiving intervention** by the home health agency?

☐ 0 - No ☐ 1 - Yes

10. **Respiratory Status:**

(M1400) When is the patient dyspneic or noticeably **Short of Breath?**

☐ 0 - Patient is not short of breath
☐ 1 - When walking more than 20 feet, climbing stairs
☐ 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)

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DISCHARGE ASSESSMENT / TRANSFER Including OASIS Elements

Patient Name: ______________________________ ID #______________

Clinician's Name: ______________________ Date: ____________ = OASIS (must complete)

Includes OASIS C Data Set (12/2009)

Section C: Review of Systems / Physical Assessment *continued*

10. **Respiratory Status:** continued

- ☐ 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- ☐ 4 - At rest (during day or night)

Temperature __________ Respirations __________

Blood Pressure _______ /________

(Record lying and standing if indicated)

Lying _______ /________ Standing _______ /________

Pulse (record apical and radial if indicated)

Radial ________ Apical ________ Character ________

Heart Sounds: ☐ Normal ☐ Abnormal (explain) _______________

____

(M1410) Respiratory Treatments utilized at home: Mark all that apply.

- ☐ 0 - Oxygen (intermittent or continuous)
- ☐ 2 - Ventilator (continually or at night)
- ☐ 3 - Continuous / Bi-level positive airway pressure
- ☐ 4 - None of the above

Comments: ____

____

11. **Cardiac Status:**

(M1500) Symptoms in Heart Failure Patients If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?

- ☐ 0 - No *(Go to M1600)*
- ☐ 1 - Yes
- ☐ 2 - Not assessed *(Go to M1600)*
- ☐ NA - Patient does not have diagnosis of heart failure *(Go to M1600)*

(M1510) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? (Mark all that apply.)

- ☐ 0 - No action taken
- ☐ 1 - Patient's physician (or other primary care practitioner) contacted the same day
- ☐ 2 - Patient advised to get emergency treatment (e.g., call 911 or go to emergency room)
- ☐ 3 - Implemented physician-ordered patient-specific established parameters for treatment
- ☐ 4 - Patient education or other clinical interventions
- ☐ 5 - Obtained change in care plan orders (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.)

12. **Genitourinary Tract:**

(M1600) Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?

☐ 0 - No ☐ 1 - Yes ☐ NA - Patient on prophylactic treatment

(M1610) Urinary Incontinence or Urinary Catheter Presence:

- ☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) *(Go to M1620)*
- ☐ 1 - Patient is incontinent
- ☐ 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) *(Go to M1620)*

12. **Genitourinary Tract:** continued

(M1615) When does **Urinary Incontinence** occur?

- ☐ 0 - Timed-voiding defers incontinence
- ☐ 1 - Occasional stress incontinence
- ☐ 2 - During the night only
- ☐ 3 - During the day only
- ☐ 4 - During the day and night

Catheter Information: Type ________________ Size ___________

Last change date ____

13. **Gastrointestinal Tract:**

(M1620) Bowel Incontinence Frequency:

- ☐ 0 - Very rarely or never has bowel incontinence
- ☐ 1 - Less than once weekly
- ☐ 2 - One to three times weekly
- ☐ 3 - Four to six times weekly
- ☐ 4 - On a daily basis
- ☐ 5 - More often than once daily
- ☐ NA - Patient has ostomy for bowel elimination

Comments: (e.g., bowel function, stool color, bowel program, GI series, abdominal girth)

____

____

____

14. **Reproductive System:** ☐ Normal

☐ Other (explain) ____

____

____

____

15. **Nutritional Status:** ☐ Normal

Appetite: ☐ NPO ☐ Good ☐ Fair ☐ Poor

Intake Adequate: ☐ Yes ☐ No Hydration Adequate: ☐ Yes ☐ No

☐ Other (explain) ____

____

____

16. **Neuro/Emotional/Behavioral Status:**

(M1700) Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

- ☐ 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- ☐ 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
- ☐ 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- ☐ 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

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DISCHARGE ASSESSMENT / TRANSFER Including OASIS Elements

Patient Name: ______________________________ ID #______________

Clinician's Name: ______________________ Date: ____________ = OASIS (must complete)

Includes OASIS C Data Set (12/2009)

Section C: Review of Systems / Physical Assessment *continued*

16. **Neuro/Emotional/Behavioral Status:** continued

(M1710) When Confused (Reported or Observed Within the Last 14 Days):
- ☐ 0 - Never
- ☐ 1 - In new or complex situations only
- ☐ 2 - On awakening or at night only
- ☐ 3 - During the day and evening, but not constantly
- ☐ 4 - Constantly
- ☐ NA - Patient nonresponsive

(M1720) When Anxious (Reported or Observed Within the Last 14 Days):
- ☐ 0 - None of the time
- ☐ 1 - Less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 - All of the time
- ☐ NA - Patient nonresponsive

(M1740) Cognitive, behavioral, and psychiatric symptomst that are demonstrated **at least once a week** (Reported or Observed): Mark all that apply.
- ☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- ☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions

continued on next column

16. **Neuro/Emotional/Behavioral Status:** continued

***M1740** continued*
- ☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- ☐ 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- ☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- ☐ 6 - Delusional, hallucinatory, or paranoid behavior
- ☐ 7 - None of the above behaviors demonstrated

(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed) Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.
- ☐ 0 - Never
- ☐ 1 - Less than once a month
- ☐ 2 - Once a month
- ☐ 3 - Several times each month
- ☐ 4 - Several times a week
- ☐ 5 - At least daily

Comments:

____
____
____
____
____
____

Section D: ADL / IADLs (Life System Profile) For M1800-M1900, record what the patient **CURRENTLY** is able to do.

1. **(M1800) Grooming:** Current ability to tend to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).
   - ☐ 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
   - ☐ 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
   - ☐ 2 - Someone must assist the patient to groom self.
   - ☐ 3 - Patient depends entirely upon someone else for grooming needs.

2. **(M1810)** Current **Ability to Dress UPPER Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:
   - ☐ 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
   - ☐ 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
   - ☐ 2 - Someone must help the patient put on upper body clothing.
   - ☐ 3 - Patient depends entirely upon another person to dress the upper body.

3. **(M1820)** Current **Ability to Dress LOWER Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:
   - ☐ 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
   - ☐ 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
   - ☐ 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.

continued on next column

***M1820** continued*
   - ☐ 3 - Patient depends entirely upon another person to dress lower body.

4. **(M1830) Bathing:** Current ability to wash entire body safely. **EXCLUDES grooming (washing face, washing hands, and shampooing hair).**
   - ☐ 0 - Able to bathe self in **shower or tub** independently, including getting in and out of tub/shower.
   - ☐ 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
   - ☐ 2 - Able to bathe in shower or tub with the intermittent assistance of another person:
     (a) for intermittent supervision or encouragement or reminders, **OR**
     (b) to get in and out of the shower or tub, **OR**
     (c) for washing difficult to reach areas.
   - ☐ 3 - Able to participate in bathing self in shower or tub, **BUT** requires presence of another person throughout the bath for assistance or supervision.
   - ☐ 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
   - ☐ 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath.
   - ☐ 6 - Unable to participate effectively in bathing and is bathed totally by another person.

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DISCHARGE ASSESSMENT / TRANSFER Including OASIS Elements

Patient Name: ______________________________ ID #______________

Clinician's Name: ______________________ Date: ____________ = OASIS (must complete)

Includes OASIS C Data Set (12/2009)

Section D: ADL / IADLs (Life System Profile) *continued*

5. **(M1840) Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely **AND** transfer on and off toilet/commode.
   - ☐ 0 - Able to get to and from the toilet independently with or without a device.
   - ☐ 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
   - ☐ 2 - **UNABLE** to get to and from the toilet but is able to use a bedside commode (with or without assistance).
   - ☐ 3 - **UNABLE** to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
   - ☐ 4 - Is totally dependent in toileting.
6. **(M1845) Toileting Hygiene:** Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.
   - ☐ 0 - Able to manage toileting hygiene and clothing management without assistance.
   - ☐ 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
   - ☐ 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
   - ☐ 3 - Patient depends entirely upon another person to maintain toileting hygiene.
7. **(M1850) Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.
   - ☐ 0 - Able to independently transfer.
   - ☐ 1 - Able to transfer with minimal human assistance or with use of an assistive device.
   - ☐ 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
   - ☐ 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
   - ☐ 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
   - ☐ 5 - Bedfast, unable to transfer and is unable to turn and position self.
8. **(M1860) Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces
   - ☐ 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
   - ☐ 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
   - ☐ 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human super-vision or assistance to negotiate stairs or steps or uneven surfaces.
   - ☐ 3 - Able to walk only with the supervision or assistance of another person at all times.
   - ☐ 4 - Chairfast, **UNABLE** to ambulate but is able to wheel self independently.
   - ☐ 5 - Chairfast, unable to ambulate and is **UNABLE** to wheel self.
   - ☐ 6 - Bedfast, unable to ambulate or be up in a chair.
9. **(M1870) Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of **EATING, CHEWING, and SWALLOWING, not preparing** the food to be eaten.
   - ☐ 0 - Able to independently feed self.

continued on next column

9. **Feeding (M1870):** continued
   - ☐ 1 - Able to feed self independently but requires:
     (a) meal set-up;
     OR
     (b) intermittent assistance or supervision from another person;
     OR
     (c) a liquid, pureed or ground meat diet.
   - ☐ 2 - **UNABLE** to feed self and must be assisted or supervised throughout the meal/snack.
   - ☐ 3 - Able to take in nutrients orally **AND** receives supplemental nutrients through a nasogastric tube or gastrostomy.
   - ☐ 4 - **UNABLE** to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
   - ☐ 5 - Unable to take in nutrients orally or by tube feeding.
10. **(M1880)** Current **Ability to Plan and Prepare Light Meals** (e.g., cereal, sandwich) or reheat delivered meals safely:
    - ☐ 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; **OR**
      (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
    - ☐ 1 - **UNABLE** to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
    - ☐ 2 - Unable to prepare any light meals or reheat any delivered meals.
11. **(M1890) Ability to Use Telephone:** Current ability to answer the phone safely, including dialing numbers, and **EFFECTIVELY** using the telephone to communicate.
    - ☐ 0 - Able to dial numbers and answer calls appropriately and as desired.
    - ☐ 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.
    - ☐ 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
    - ☐ 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
    - ☐ 4 - **UNABLE** to answer the telephone at all but can listen if assisted with equipment.
    - ☐ 5 - Totally unable to use the telephone.
    - ☐ NA - Patient does not have a telephone.

ENTERAL FEEDINGS – ACCESS DEVICE ☐ N/A

☐ Nasogastric ☐ Gastrostomy ☐ Jejunostomy

☐ Other (specify) ______________________________

____

Pump: (type/specify) ______________________________

Feedings: ☐ Bolus ☐ Continuous Rate: __________

Flush Protocol: (amt./specify) ______________________________

____

Performed by: ☐ Self ☐ RN ☐ Caregiver

☐ Other ______________________________

continued on next page

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DISCHARGE ASSESSMENT / TRANSFER Including OASIS Elements

Patient Name: ______________________ ID #______________

Clinician's Name: ______________________ Date: ______________

▭ = OASIS (must complete)

Includes OASIS C Data Set (12/2009)

Section D: ADL / IADLs (Life System Profile) *continued*

ENTERAL FEEDINGS *continued*

Dressing/Site care: (specify) ______________________

____

____

Interventions/Instructions/Comments:

____

____

____

____

____

INFUSION ☐ N/A

☐ Peripheral (specify) ______________________

☐ PICC: (specify size, brand) ______________________

☐ Central ☐ Midline/Midclavicular

☐ Single lumen ☐ Double lumen ☐ Triple lumen

Date of placement ______________________

☐ X-ray verification: ☐ Yes ☐ No

☐ Mid arm circumference _____ in/cm

☐ External catheter length ________ in/cm

☐ Hickman ☐ Broviac ☐ Groshong ☐ Jugular ☐ Subclavian

☐ Single lumen ☐ Double lumen ☐ Triple lumen

Date of placement ______________________

☐ Epidural catheter ☐ Tunneled ☐ Port

Date of placement ______________________

☐ Implanted VAD ☐ Venous ☐ Arterial ☐ Peritoneal

Date of placement ______________________

☐ Intrathecal ☐ Port ☐ Reservoir

Date of placement ______________________

☐ Medication(s) administered:

Name of Drug ______________________

Dose ____________ Dilution ____________ Route ____________

Frequency ______________ Duration of therapy ______________

☐ Medication(s) administered:

Name of Drug ______________________

Dose ____________ Dilution ____________ Route ____________

Frequency ______________ Duration of therapy ______________

☐ Medication(s) administered:

Name of Drug ______________________

Dose ____________ Dilution ____________ Route ____________

Frequency ______________ Duration of therapy ______________

continued on next column

INFUSION *continued*

☐ Pump: (type, specify) ______________________

Administered by: ☐ Self ☐ Caregiver ☐ RN

☐ Other: ______________________

Purpose of Intravenous Access:

☐ Antibiotic therapy ☐ Pain control

☐ Chemotherapy ☐ Maintain venous access

☐ Hydration ☐ Parenteral nutrition

☐ Other ______________________

☐ Infusion care provided during visit ______________________

____

____

☐ Dressing change: ☐ Sterile ☐ Clean

Performed by: ☐ Self ☐ Caregiver ☐ RN

☐ Other: ______________________

Frequency (specify)______________________

Injection cap change (specify frequency) ______________

Labs drawn ______________

____

Interventions/Instructions/Comments ______________________

____

____

____

____

____

____

____

____

MEDICATIONS

12. **(M2004) Medication Intervention:** If there were any clinically significant medication issues since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day of the assessment to resolve clinically significant medication issues, including reconciliation?
    ☐ 0 - No ☐ 1 - Yes
    ☐ NA - No clinically significant medication issues identified since the previous OASIS assessment.

13. **(M2015) Patient/Caregiver Drug Education Intervention:** Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects, and how and when to report problems that may occur?
    ☐ 0 - No ☐ 1 - Yes
    ☐ NA - Patient not taking any drugs.

continued on next page

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DISCHARGE ASSESSMENT / TRANSFER Including OASIS Elements

Patient Name: ______________________ ID #______________

Clinician's Name: ______________________ Date: ______________ [ ] = OASIS (must complete)

Includes OASIS C Data Set (12/2009)

Section D: ADL / IADLs (Life System Profile) *continued*

14. (M2020) **Management of Oral Medications: Patient's current ability** to prepare and take **ALL** oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **EXCLUDES injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**
   - ☐ 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
   - ☐ 1 - Able to take medication(s) at the correct times if:
     (a) individual dosages are prepared in advance by another person; **OR**
     (b) another person develops a drug diary or chart.
   - ☐ 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times.
   - ☐ 3 - **UNABLE** to take medication unless administered by another person.
   - ☐ NA - No oral medications prescribed.

15. (M2030) **Management of Injectable Medications: Patient's current ability** to prepare and take **ALL** prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **EXCLUDES IV medications.**
   - ☐ 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.
   - ☐ 1 - Able to take injectable medication at correct times if:
     (a) individual syringes are prepared in advance by another person, **OR**
     (b) another person develops a drug diary or chart.
   - ☐ 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection.
   - ☐ 3 - **UNABLE** to take injectable medication unless administered by another person
   - ☐ NA - No injectable medications prescribed.

CASE MANAGEMENT

16. (M2100) **Types and Sources of Assistance:** Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. (Check only **ONE** box in each row.)

Type of Assistance	No assistance needed in this area	Caregiver(s) currently provide assistance	Caregiver(s) need training/supportive services to provide assistance	Caregiver(s) NOT LIKELY to provide assistance	Unclear if Caregiver(s) will provide assistance	Assistance needed, but no Caregiver(s) available
a. ADL assistance (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. Medication administration (e.g., oral, inhaled or injectable)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d. Medical procedures/ treatments (e.g., changing wound dressing)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e. Management of Equipment (includes oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
f. Supervision and safety (e.g., due to cognitive impairment)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
g. Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from appointments)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

17. (M2110) **How Often** does the patient receive **ADL or IADL assistance** from any caregiver(s) (other than home health agency staff)?
   - ☐ 1 - At least daily
   - ☐ 2 - Three or more times per week
   - ☐ 3 - One to two times per week
   - ☐ 4 -Received, but less often than weekly
   - ☐ 5 - No assistance received

Section E: Emergent Care

1. (M2300) **Emergent Care:** Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/ observation)?
   - ☐ 0 - No *(Go to M2400)*
   - ☐ 1 - Yes, used hospital emergency department WITHOUT hospital admission
   - ☐ 2 - Yes, used hospital emergency department WITH hospital admission
   - ☐ UK - Unknown *(Go to M2400)*

2. (M2310) **Reason for Emergent Care:** For what reason(s) did the patient receive emergent care (with or without hospitalization)? Mark all that apply.
   - ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
   - ☐ 2 - Injury caused by fall
   - ☐ 3 - Respiratory infection (e.g., pneumonia, bronchitis)
   - ☐ 4 - Other respiratory problem
   - ☐ 5 - Heart failure (e.g., fluid overload)
   - ☐ 6 - Cardiac dysrhythmia (irregular heartbeat)
   - ☐ 7 - Myocardial infarction or chest pain
   - ☐ 8 - Other heart disease
   - ☐ 9 - Stroke (CVA) or TIA
   - ☐ 10 - Hypo/Hyperglycemia, diabetes out of control
   - ☐ 11 - GI bleeding, obstruction, constipation, impaction
   - ☐ 12 - Dehydration, malnutrition
   - ☐ 13 - Urinary tract infection
   - ☐ 14 - IV catheter-related infection or complication
   - ☐ 15 - Wound infection or deterioration
   - ☐ 16 - Uncontrolled pain
   - ☐ 17 - Acute mental/behavioral health problem
   - ☐ 18 - Deep vein thrombosis, pulmonary embolus
   - ☐ 19 - Other than above reasons
   - ☐ UK - Reason unknown

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DISCHARGE ASSESSMENT / TRANSFER Including OASIS Elements

Patient Name: ______________________________ ID #______________

Clinician's Name: ______________________ Date: __________

= OASIS (must complete)

Includes OASIS C Data Set (12/2009)

Section F: Inpatient Facility Admission or Agency Discharge Data Only

1. **(M2400) Intervention Synopsis:** (Check only **ONE** box in each row.) Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

Plan / Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐ 0	☐ 1	☐ NA	Patient is not diabetic or is bilateral amputee
b. Falls prevention interventions	☐ 0	☐ 1	☐ NA	Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐ 0	☐ 1	☐ NA	Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment
d. Intervention(s) to monitor and mitigate pain	☐ 0	☐ 1	☐ NA	Formal assessment did not indicate pain since the last OASIS assessment
e. Intervention(s) to prevent pressure ulcers	☐ 0	☐ 1	☐ NA	Formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment
f. Pressure ulcer treatment based on principles of moist wound healing	☐ 0	☐ 1	☐ NA	Dressings that support the principles of moist wound healing not indicated for this patient's pressure ulcers **OR** patient has no pressure ulcers with need for moist wound healing

2. **(M2410)** To which **Inpatient Facility** has the patient been admitted?
   - ☐ 1 - Hospital *(Go to M2430)*
   - ☐ 2 - Rehabilitation facility *(Go to M0903)*
   - ☐ 3 - Nursing home *(Go to M2440)*
   - ☐ 4 - Hospice *(Go to M0903)*
   - ☐ NA - No inpatient facility admission

3. **(M2420) Discharge Disposition:** Where is the patient after discharge from your agency? (Choose only one answer.)
   - ☐ 1 - Patient remained in the community (without formal assistive services)
   - ☐ 2 - Patient remained in the community (with formal assistive services)
   - ☐ 3 - Patient transferred to a non-institutional hospice
   - ☐ 4 - Unknown because patient moved to a geographic location not served by this agency
   - ☐ UK - Other unknown *(Go to M0903)*

4. **(M2430) Reason for Hospitalization:** For what **Reason(s)** did the patient **require Hospitalization**? Mark all that apply.
   - ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
   - ☐ 2 - Injury caused by fall
   - ☐ 3 - Respiratory infection (e.g., pneumonia, bronchitis))
   - ☐ 4 - Other respiratory problem
   - ☐ 5 - Heart failure (e.g., fluid overload)
   - ☐ 6 - Cardiac dysrhythmia (irregular heartbeat)
   - ☐ 7 - Myocardial infarction or chest pain
   - ☐ 8 - Other heart disease
   - ☐ 9 - Stroke (CVA) or TIA
   - ☐ 10 - Hypo/Hyperglycemia, diabetes out of control
   - ☐ 11 - GI bleeding, obstruction, constipation, impaction
   - ☐ 12 - Dehydration, malnutrition
   - ☐ 13 - Urinary tract infection
   - ☐ 14 - IV catheter-related infection or complication
   - ☐ 15 - Wound infection or deterioration

continued on next column

4. **M2430:** continued
   - ☐ 16 - Uncontrolled pain
   - ☐ 17 - Acute mental/behavioral health problem
   - ☐ 18 - Deep vein thrombosis, pulmonary embolus
   - ☐ 19 - Scheduled treatment or procedure
   - ☐ 20 - Other than above reasons
   - ☐ UK - Reason unknown

   (Go to M0903)

5. **(M2440)** For what **Reason(s)** was the patient **Admitted** to a **Nursing Home**? Mark all that apply.
   - ☐ 1 - Therapy Services
   - ☐ 2 - Respite care
   - ☐ 3 - Hospice care
   - ☐ 4 - Permanent placement
   - ☐ 5 - Unsafe for care at home
   - ☐ 6 - Other
   - ☐ UK - Unknown

   (Go to M0903)

6. **(M0903) Date of Last (Most Recent) Home Health Agency Visit:**

   __ | __ / __ | __ / __ | __ | __ | __
   Month Day Year

7. **(M0906) Discharge/Transfer/Death Date:** Enter the date of the discharge, transfer, or death (at home) of the patient.

   __ | __ / __ | __ / __ | __ | __ | __
   Month Day Year

8. **Length of service:** ______ week(s)

9. **Number of visits:**

   SN ______ OT _______ Other _______________
   HHA _____ ST _______
   PT ______ SW_______ Total __________

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DISCHARGE ASSESSMENT / TRANSFER Including OASIS Elements

Patient Name: ______________________________ ID #______________

Clinician's Name: ______________________ Date: ____________

= OASIS (must complete)
Includes OASIS C Data Set (12/2009)

Section G: Outcomes

Outcome Key: 4 = Unstable; 3 = Max Assist; 2 = Mod Assist; 1 = Min Assist; 0 = Independent

FUNCTIONAL OUTCOME

	ADM	DISCHARGE
Walking		
Cane		
Walker		
Wheelchair		
Standing		
Sitting		
Bed		
Stairs		
Transfers		
Exercise program		
Equipment use		
Communication		
Bathing		
Toileting		
Dressing		
Eating		
______		
______		

KNOWLEDGE/SELF CARE OUTCOMES

	PATIENT	CAREGIVER
Treatments		
Return demonstrate		
Explains		
Has literature		
Has supplied equipment		
How to obtain supplies		
Explains alternatives		
States proper disposal		
States problems/complaints		
When to call M.D./agency/911		
Activity		
States recommendations		
States limitations		
Demonstrates exercise program		
Diet, fluids		
Explains corrected diet, fluids		
Has copy of diet		

	PATIENT	CAREGIVER
Medications (knows for each)		
Name/proper dose/frequency		
Actions		
Precautions/side effects		
When to call M.D.		
Able to self administer		
Has prescriptions		
Appointment/M.D. contact		
Know why to contact M.D.		
Knows when to schedule		
Has appointment		
______		
______		
______		
______		
______		
______		

DISCHARGE INSTRUCTIONS: (V = Verbal, W = Written, N/A = Not applicable)
Check all that apply

- ☐ Community Services ☐ V ☐ W ☐ N/A
- ☐ Medication Schedule ☐ V ☐ W ☐ N/A
- ☐ Dietary Requirements ☐ V ☐ W ☐ N/A
- ☐ Symptoms reported to MD ☐ V ☐ W ☐ N/A
- ☐ Safety Instructions ☐ V ☐ W ☐ N/A
- ☐ Follow-up appointments with MD ☐ V ☐ W ☐ N/A
- ☐ Other ______________________

Overall Status at Discharge: ______________________

Comments: ______________________

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DISCHARGE ASSESSMENT / TRANSFER Including OASIS Elements

Patient Name: ____________________ ID #____________

Clinician's Name: ____________________ Date: ____________ [ ] = OASIS (must complete)

Includes OASIS C Data Set (12/2009)

Summary

COMPLETE THIS SECTION FOR DISCHARGE PURPOSES (Unless Summary is written elsewhere)

Reason for Admission (describe condition)

____
____
____
____

Summary of Care (including progress toward goals to date and understanding disease management)

____
____
____
____

Medication Status: ☐ Medication regimen reviewed

Check if any of the following were identified:

☐ Potential adverse effects/drug reactions
☐ Non-compliance with drug therapy
☐ Significant drug reactions
☐ No change
☐ Ineffective drug therapy
☐ Significant side effects
☐ Duplicate drug therapy

Indicate Reason for Discharge

☐ Patient-centered goals achieved
☐ Geographic relocation
☐ No longer home bound
☐ Physician request
☐ Patient expired
☐ Patient refused further care
☐ Patient/Family request
☐ Repeatedly not home/not found
☐ Patient refused to accept care/treatments as ordered
☐ Persistent non-compliance with POC
☐ Failure to maintain services of an attending physician
☐ Agency/Organization decision.

Explain: ____________________
____
____
____
____
____
____

Discharge Instructions (specify future follow-up, referrals, etc.)

____
____
____
____
____

Reviewed: ☐ Home safety ☐ Fall safety ☐ Medication safety
☐ When to contact physician ☐ Next appointment physician
☐ Standard precautions
☐ Other (describe) ____________________

Immunizations current: ☐ Yes ☐ No, explain:

____
____
____

Written instructions given to patient/caregiver: ☐ Yes ☐ No, explain:

____

Patient/Caregiver demonstrates understanding of instructions:

☐ Yes ☐ No, explain: ____________________

____
____

SIGNATURE / DATES

X ____________________ ______ / _____ / ______

Patient/Caregiver (if applicable) Date

X ____________________ ______ / _____ / ______

Person Completing This Form (Signature/Title) Date

Agency Name ____________________ Phone # ____________________

OASIS INFORMATION

Date Reviewed ______ / _____ / ______ Date Entered & Locked ______ / _____ / ______ Date Transmitted ______ / _____ / ______

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