RECERTIFICATION/FOLLOW-UP ASSESSMENT

QM = Quality Measures (must complete)
= 485 Data (must complete)
= OASIS (must complete)

Includes OASIS C Data Set (12/2009)

Patient Name: _____

REASON FOR ASSESSMENT: ☐ **Recertification** ☐ **Other Follow-up**

Date: _____ Time In: _____ Time Out: _____

This Assessment shall be part of the medical record.

Section A: Clinical Record Items / Demographics / Patient History

Certification Period: From: ____ / ____ / ____ To: ____ / ____ / ____ **BOX # 3**

1. (M0010) CMS Certification Number: ___|___|___|___|___|___ **BOX # 5**
2. National Provider Identifier: ___|___|___|___|___|___|___|___|___|___
3. (M0014) Branch State (optional): ___|___ 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 **BOX # 24** Name _____

Address _____ Phone _____

City _____ State _____ Zip _____ Fax _____

6. (M0020) Patient ID Number: ___|___|___|___|___|___|___|___|___|___|___|___ **BOX # 4**
7. (M0030) Start of Care Date: ___|___ / ___|___ / ___|___|___|___ **BOX # 2**
   Month Day Year
8. (M0032) Resumption of Care Date: ___|___ / ___|___ / ___|___|___|___ ☐ NA – Not Applicable
   Month Day Year
9. (M0040) Patient Name: (First Name) ___|___|___|___|___|___|___|___|___|___|___|___ (Middle Initial) ___ **BOX # 6**
   (Last Name) ___|___|___|___|___|___|___|___|___|___|___|___|___|___|___ (Suffix (i.e. Sr., Jr., III) ___|___|___
10. Patient Address: _____ _____ **BOX # 6**
    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: (including suffix, if any) ___|___|___|___|___|___|___|___|___|___|___|___ ☐ NA - No Medicare **BOX # 1**
15. (M0064) Social Security Number: ___|___|___ – ___|___ – ___|___|___|___ ☐ UK – Unknown or Not Available
16. (M0065) Medicaid Number: ___|___|___|___|___|___|___|___|___|___|___|___|___|___ ☐ NA – No Medicaid
17. (M0066) Birth Date: ___|___ / ___|___ / ___|___|___|___ **BOX # 8** 18. (M0069) Gender: ☐ 1– Male ☐ 2 – Female **BOX # 9**
    Month Day Year
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:
    FOLLOW-UP ☐ 4 – Recertification (follow-up) reassessment [Go to M0110] ☐ 5 – Other follow-up [Go to M0110]
23. (M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?
    ☐ 1 – Early ☐ 2 – Later ☐ UK – Unknown ☐ NA – Not Applicable: No Medicare case mix group to be defined by this assessment.
    *EARLY Episode is first or second episode in a sequence of adjacent episodes. LATER is the third and beyond in sequence of adjacent episodes. Adjacent episodes are separated by 60 days or fewer between episodes.

RECERTIFICATION/FOLLOW-UP ASSESSMENT

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Patient Name: _____

Clinician's Name: _____ Date: _____

Section B: Current Illness

Has patient been hospitalized or to the ER since last OASIS interview? ☐ No ☐ Yes, explain: _____

1. **M1020/1022/1024 Diagnoses, Symptom Control, and Payment Diagnoses:** List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-C M code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-C M sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare P P S case mix group. Do not assign symptom control ratings for V- or E-codes.

Code each row according to the following directions for each column:

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1; Rate the degree of symptom control for the condition listed in Column 1 using the following scale:

0 – Asymptomatic, no treatment needed at this time

1 – Symptoms well controlled with current therapy

2 – Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring

3 – Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring

4 – Symptoms poorly controlled; history of re-hospitalizations

Note that in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). See OASIS-C Guidance Manual.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-C M coding guidelines, enter the diagnosis descriptions and the ICD-9-C M codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment Diagnoses (OPTIONAL)	
Column 1	**Column 2**	**Column 3**	**Column 4**
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete **only if** the V code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	**ICD-9-CM / Symptom Control Rating**	**Description/ ICD-9-CM**	**Description/ ICD-9-CM**
(M1020) Primary Diagnosis BOX # 11 a. _____	**(V codes are allowed)** a. (__ __ __ • __ __) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	**(V or E codes NOT allowed)** a. _____ (__ __ __ • __ __)	**(V or E codes NOT allowed)** a. _____ (__ __ __ • __ __)
(M1022) Other Diagnoses BOX # 13 b. _____	**(V or E codes are allowed)** b. (__ __ __ __ • __ __) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	**(V or E codes NOT allowed)** b. _____ (__ __ __ • __ __)	**(V or E codes NOT allowed)** b. _____ (__ __ __ • __ __)
c. _____	c. (__ __ __ __ • __ __) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	c. _____ (__ __ __ • __ __)	c. _____ (__ __ __ • __ __)
d. _____	d. (__ __ __ __ • __ __) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	d. _____ (__ __ __ • __ __)	d. _____ (__ __ __ • __ __)
e. _____	e. (__ __ __ __ • __ __) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	e. _____ (__ __ __ __ • __ __)	e. _____ (__ __ __ • __ __)
f. _____	f. (__ __ __ __ • __ __) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	f. _____ (__ __ __ • __ __)	f. _____ (__ __ __ • __ __)

2. **Surgical Procedure BOX # 12**

	ICD Diagnosis	(Severity Rating) Least ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 Most
a. _____	__ __ __ • __ __	
b. _____	__ __ __ • __ __	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

RECERTIFICATION/FOLLOW-UP ASSESSMENT

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Includes OASIS C Data Set (12/2009)

Patient Name: _____

Clinician's Name: _____ Date: _____

Section B: Current Illness *continued*

3. **Patient/Caregiver Coping and Knowledge Assessment Regarding Present Illness:** (Indicate any applicable comments in section below:)

Patient: ☐ Coping Effective – Severity Rating 1-10 (_____) ☐ Informed
☐ Coping Not Effective – Severity Rating 1-10 (_____) ☐ Not Informed
Comments: _____

Caregiver: ☐ Coping Effective – Severity Rating 1-10 (_____) ☐ Informed
☐ Coping Not Effective – Severity Rating 1-10 (_____) ☐ Not Informed

Section C: (M1030) Therapies the Patient Receives at Home: (Mark all that apply)

☐ 1 – Intravenous or infusion therapy (excludes TPN)
☐ 2 – Parenteral nutrition (TPN or lipids)
☐ 3 – Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
☐ 4 – None of the above

Section D: Allergies (Environmental, Drugs, Food, etc.) (Mark all that apply) BOX # 17

☐ No Known Allergies as of this date ☐ Milk Products ☑ Eggs ☐ Shellfish
☐ Other Food (specify):
☐ Aspirin
☐ Antibiotic (specify):
☐ Sulfa Drugs (specify):
☐ Other Drug (specify):
☐ Other Drug (specify):
☐ Insect Bites ☐ Pollen
☐ Other (specify):
☐ Other (specify):

Nutritional Requirements: Diet _____

Section E: Changes in Clinical Condition of Patient

List:

_____
_____
_____
_____

☐ No changes since Start of Care
☐ No changes since previous Recertification
☐ Falls in last 3 months _____ ☐ Injury Descibe: _____

Section F: Beneficiary Support System

1. **Length of time patient alone during the day:**
☐ 1 – Never
☐ 2 – Between 1 and 4 hours
☐ 3 – Between 5 and 7 hours
☐ 4 – All day

2. **Evidence of:** ☐ Neglect ☐ Abuse
Explain: _____
_____
_____
_____
_____

Referral made ☐ Yes ☐ No
To whom was referral made: _____
_____
Phone: _____
Date: _____

continued on next page

RECERTIFICATION/FOLLOW-UP ASSESSMENT

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Patient Name: _____

Clinician's Name: _____ Date: _____

Section F: Beneficiary Support System *continued*

3. **Safety Hazards:** ☐ None
- ☐ Inadequate Lighting
- ☐ Inadequate heating/cooling
- ☐ Unsafe floor coverings
- ☐ Lead-based paint
- ☐ Firearms
- ☐ Inadequate Floor/Windows
- ☐ Unsafe Appliances
- ☐ Lack of fire safety devices
- ☐ Inadequate stair railings
- ☐ Hazardous materials
- ☐ Pets in home (potential fall risk)

4. **Sanitation Hazards:** ☐ None
- ☐ Inadequate water supply
- ☐ Inadequate toileting facility
- ☐ Inadequate sewage
- ☐ Inadequate/improper food storage
- ☐ Inadequate cooking/refrigeration
- ☐ Insects/rodents present
- ☐ No scheduled trash removal
- ☐ Cluttered/soiled living area
- ☐ Pets in home (litter box/potential infection risk)
- ☐ Other _____

Comments:

Section G: Supportive Assistance

1. **Has there been any change in supportive assistance to the patient since the start of care?** ☐ No change

Describe any changes: _____

Describe relationship to patient: _____ Phone # of support system: _____

2. **AIDE / HOMEMAKER REFERRAL FOR SERVICES:** ☐ Yes ☐ No **PATIENT AGREES:** ☐ Yes ☐ No **PATIENT INITIALS:** _____ Date: _____

Section H: Review of Systems / Physical Assessment

1. **Eyes (M1200) Vision** with corrective lenses if the patient usually wears them:
- ☐ 0 – Normal vision: sees adequately in most situations; can see medication labels, newsprint.
- ☐ 1 – Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.
- ☐ 2 – Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

☐ **No Problem**

☐ Glasses ☐ Contacts: R / L ☐ Glaucoma
☐ Jaundice ☐ Blurred/double vision ☐ PERRLA
☐ Legally Blind ☐ Ptosis ☐ Prosthesis: R / L
☐ Infections ☐ Needs new prescription lenses
☐ Cataract surgery: Site _____ Date ____ / ____ / _____
☐ Other (specify) _____

2. **Head:**
- ☐ Dizziness: Duration _____ Frequency _____
- ☐ Headache: Duration _____ Location _____ Frequency _____
- ☐ Other (explain) _____

3. **Oral:**
- ☐ Gum problems ☐ Chewing problems
- ☐ Dentures: ☐ Upper ☐ Lower
- ☐ Difficulty _____

Referral for services: ☐ N/A ☐ ST ☐ Dentist
Patient/Caregiver agrees: ☐ Yes ☐ No

4. **Nose and Sinus:** ☐ Normal ☐ Epistaxis ☐ Pain
☐ Other (specify) _____

5. **Neck and Throat:** ☐ Normal ☐ Hoarseness ☐ Pain ☐ Difficulty swallowing
☐ Other (specify) _____

continued on next page

RECERTIFICATION/FOLLOW-UP ASSESSMENT

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Patient Name: _____

Clinician's Name: _____ Date: _____

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

6. **Musculoskeletal, Neurological:**

☐ **No Problem** ☐ Arthritis ☐ Gout ☐ Stiffness
☐ Swollen, painful joints (specify)_____
☐ Contractures: Joint _____
Location _____
☐ Unequal grasp ☐ Joint pain ☐ Weakness ☐ Leg cramps
☐ Numbness ☐ Temp changes ☐ Syncope ☐ Seizure
☐ Tremor ☐ Deformities ☐ Comatose ☐ Paresthesia
☐ Paralysis (Describe) _____
☐ Hemiplegia
☐ Paraplegia
☐ Quadiplegia
☐ Amputation: BK / AK / UE; R / L (specify)_____
☐ Tenderness (Where) _____
☐ Aphasia / inarticulate speech
☐ Other (specify)_____
☐ Decreased ROM _____
☐ Shuffling / Wide-based gait
☐ Imbalance disturbances
☐ Weakness _____

Coordination, gait balance (describe):

_____
_____
_____

Comments: (Prostheses, appliances, etc.)

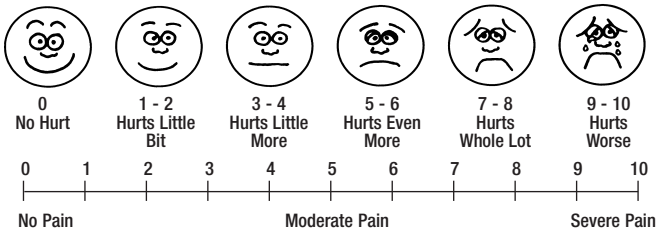
_____
_____
_____

Referral for services: ☐ N/A ☐ PT ☐ OT
Patient/Caregiver agrees: ☐ Yes ☐ No

7. **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



7. **Pain** *continued*

Pain scale (0-10): _____

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 ☐ Once daily ☐ 2-3 times per day
☐ More than 3 times per day
☐ Current pain control medications adequate
☐ Other: _____

Location of Pain: _____

Patient's description of pain: _____
_____
_____

How pain interferes with daily activity/movement:
_____
_____
_____

Comments on Pain Management:

☐ Onset of Pain: _____
☐ Medication Management for Pain: _____
_____
How often? _____
☐ Non Pharmalogical Management techniques (i.e., Heat/Ice, Massage, Diversion, etc.): _____
☐ Effectiveness: _____
☐ Other: _____
_____
_____
_____
_____

continued on next column

RECERTIFICATION/FOLLOW-UP ASSESSMENT

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Patient Name: _____

Clinician's Name: _____ Date: _____

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

8. **Integumentary Status:**

A. **General Information on Skin** **Skin Color:** _____

Turgor: ☐ Good ☐ Fair ☐ Poor

Check all that apply:

☐ Warm ☐ Cool ☐ Clammy
☐ Itching ☐ Rash ☐ Bruises
☐ Petechiae ☐ Purpura ☐ Dry
☐ Other _____

Referral to Dermatologist ☐ No ☐ Yes: _____

B. **Nails** ☐ Normal ☐ Ingrown (Describe location and surrounding area)

_____

☐ Poor Nail Care
☐ Other _____

C. **(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

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

(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.		

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Patient Name: _____

Clinician's Name: _____ Date: _____

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

8. **Integumentary Status** *continued*

(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 Unhealed (Observable) Pressure Ulcer:

☐ 1 - Stage 1 ☐ 2 - Stage 2 ☐ 3 - Stage 3 ☐ 4 - Stage 4

☐ NA - No observable pressure ulcer or unhealed pressure ulcer

Definition: WOCN Guidance

1. **Fully Granulating:** Wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium; no dead space, no avascular tissue (eschar and/or slough); no signs or symptoms of infection; wound edges are open.

2. **Early Partial Granulation:** Greater than or equal to 25% of the wound bed is covered with granulation tissue; there is minimal avascular tissue (eschar and/or slough) (i.e., less than 25% of the wound bed is covered with avascular tissue); may have dead space; no signs or symptoms of infection; wound edges open.

3. **Non-healing:** Wound with greater than or equal to 25% avascular tissue (eschar and/or slough) OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management. **Note:** A new Stage I pressure ulcer is reported on OASIS as not healing.

(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 ☐ 1 - Fully granulating
☐ 2 - Early/partial granulation ☐ 3 - Not healing

D. **(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 ☐ 1 - Fully granulating
☐ 2 - Early/partial granulation ☐ 3 - Not healing
Skip this item if the patient no longer has surgical wounds.

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

☐ 0 - No ☐ 1 - Yes

Comments: (Wound/lesion history, treatments, dressings, frequency of change, etc.)

_____
_____
_____

Definition: (M1342) WOCN Guidance

Description/classification of wounds healing by primary intention (i.e., approximated incisions)

- **Fully granulating/healing:** Incision well-approximated with complete epithelialization of incision; no signs or symptoms of infection.
- **Early/partial granulation:** Incision well-approximated but not completely epithelialized; no signs or symptoms of infection.
- **Non-healing:** Incisional separation OR incisional necrosis OR signs or symptoms of infection.
- **Newly epithialized:** To cover with epithelial tissue.

Description/classification of wounds healing by secondary intention (i.e, healing of deshisced wound by granulation, contraction and epithelialization)

1. **Fully Granulating:** Wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium; no dead space, no avascular tissue (eschar and/or slough); no signs or symptoms of infection; wound edges are open.
2. **Early/Partial Granulation:** Greater than or equal to 25% of the wound bed is covered with granulation tissue; there is minimal avascular tissue (eschar and/or slough) (i.e., less than 25% of the wound bed is covered with avascular tissue); may have dead space; no signs or symptoms of infection; wound edges open.
3. **Non-healing:** Wound with greater than or equal to 25% avascular tissue (eschar and/or slough) OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.

9. **Cardiopulmonary:**

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

Vital Signs/Cardiovascular:

Temperature: _____ ☐ Oral ☐ Rectal ☐ Axillary ☐ Tympanic

Blood Pressure: ☐ Sitting/lying _____ / _____
☐ Standing _____ / _____

Respirations: _____
☐ Regular ☐ Irregular ☐ Cheynes Stokes ☐ Death rattle
☐ Apnea periods _____ sec ☐ Accessory muscles used

Pulse: ☐ Regular ☐ Irregular ☐ Rest ☐ Activity
Radial _____ Apical _____
Brachial _____ Carotid _____

Heart Sounds: ☐ Normal
☐ Abnormal (Describe) _____
☐ Palpitations ☐ Dyspnea on exertion
☐ Hypertension ☐ Murmurs
☐ Claudication ☐ Paroxysmal noctural dyspnea
☐ Chest pain ☐ Edema
☐ Fatigues easily ☐ Orthopnea (# of pillows _____)
☐ Cardiac problems (Specify) _____
☐ Cyanosis ☐ Varicosities
☐ Pacemaker (date of last battery change) _____
☐ Pedal pulse absent (left or right _____)
☐ Syncope ☐ CHF
☐ Edema pitting ☐ Edema non-pitting R ___ L ___
☐ Post CABG/PTCA ☐ Diminished peripheral pulse

Comments: _____
_____
_____
_____
_____

continued on next page

RECERTIFICATION/FOLLOW-UP ASSESSMENT

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= 485 Data (must complete)
= OASIS (must complete)

Includes OASIS C Data Set (12/2009)

Patient Name: _____

Clinician's Name: _____ Date: _____

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

9. **Cardiopulmonary** *continued*

Respiratory:

☐ Asthma ☐ Bronchitis
☐ Pneumonia ☐ Pleurisy
☐ O2 Saturation ☐ No ☐ Yes _____ %
☐ Emphysema
☐ Other (Specify) _____

Cough:

☐ No ☐ Yes ☐ Non-Productive ☐ Productive
List character and amount of sputum: _____

Breath Sounds:

☐ Rales:	Anterior:	☐ Right Lung	☐ Left Lung
	Posterior:	☐ Upper Right	☐ Lower Right
		☐ Upper Left	☐ Lower Left
☐ Wheezes:	Anterior:	☐ Right Lung	☐ Left Lung
	Posterior:	☐ Upper Right	☐ Lower Right
		☐ Upper Left	☐ Lower Left
☐ Rhonchi:	Anterior:	☐ Right Lung	☐ Left Lung
	Posterior:	☐ Upper Right	☐ Lower Right
		☐ Upper Left	☐ Lower Left
☐ Diminished/Absent: .	Anterior:	☐ Right Lung	☐ Left Lung
	Posterior:	☐ Upper Right	☐ Lower Right
		☐ Upper Left	☐ Lower Left
☐ Clear:	Anterior:	☐ Right Lung	☐ Left Lung
	Posterior:	☐ Upper Right	☐ Lower Right
		☐ Upper Left	☐ Lower Left

Describe: _____

Tuberculosis symptoms:

☐ No ☐ Yes
☐ Persistent (3 weeks) cough of unknown origin
☐ Bloody sputum
☐ Other _____

Tuberculosis risk factors:

☐ No ☐ Yes ☐ Immigrated within last 5 years
☐ Known exposure ☐ HIV positive
☐ Other _____

Comments: _____

Track patient ☐ Yes ☐ No

Disease Management Problems: _____

10. **Genitourinary** ☐ No Problem

QM **(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)*

continued on next column

10. **Genitourinary Tract** *continued*

Timed Voiding Schedule _____
Effectiveness of Timed Voiding Schedule _____
☐ Hx UTI
☐ Renal Dialysis: Schedule _____
☐ Peritoneal Dialysis

Comments: _____

Urinary Catheter: BOX # 21

Type _____ Size _____ Change every _____
Care Orders _____
Date last changed: _____
☐ Foley inserted (date) _____ Details: _____

GU Elimination Status ☐ WNL

☐ Frequency _____ ☐ Urgency ☐ Nocturia
☐ Hematuria ☐ Pain on urination ☐ Lesions
☐ Urinary retention ☐ Hesitancy ☐ Oliguria/Anuria

Color: ☐ Yellow/straw ☐ Amber ☐ Brown/gray ☐ Blood-tinged
Other: _____
Clarity: ☐ Clear ☐ Cloudy ☐ Sediment/mucous
Odor: ☐ Yes ☐ No

11. **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

(M1630) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days):
a) was related to an inpatient facility stay, **OR**
b) necessitated a change in medical or treatment regimen?

☐ 0 - Patient does **not** have an ostomy for bowel elimination.
☐ 1 - Patient's ostomy was **not** related to an inpatient stay and did **not** necessitate change in medical or treatment regimen.
☐ 2 - The ostomy **was** related to an inpatient stay or **did** necessitate change in medical or treatment regimen.

Bowel sounds: ☐ Active ☐ Absent ☐ Hypoactive ☐ Hyperactive
x _____ quadrants
Elimination Status ☐ WNL
Last Bowel Movement _____ Usual Frequency _____

☐ Indigestion ☐ Pain ☐ Rectal Bleeding
☐ Jaundice ☐ Nausea, vomiting ☐ Hemorrhoids
☐ Tenderness ☐ Ulcers
☐ Hernias (where) _____

continued on next page

RECERTIFICATION/FOLLOW-UP ASSESSMENT

QM = Quality Measures (must complete)
= 485 Data (must complete)
= OASIS (must complete)

Includes OASIS C Data Set (12/2009)

Patient Name: _____

Clinician's Name: _____ Date: _____

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

11. **Gastrointestinal Tract** *continued*

☐ Diarrhea/constipation (specify) _____
☐ Gallbladder problems
☐ Other (specify) _____

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

12. **Nutritional Status:**

Height _____ Weight _____

Diet: _____ **BOX # 16**

Increase fluids _____ amt. Restrict fluids _____ amt.

☐ Normal meal patterns Normal food/fluid intake _____

Check all that apply:

☐ Recently changed kind/amount of food eaten due to illness or injury or surgery
☐ Eats fewer than 2 meals a day
☐ Eats fewer than 2-3 servings of fruits/vegetables a day
☐ Eats fewer than 1-2 servings of meats, fish, poultry or legumes a day
☐ Eats fewer than 2 servings of dairy products a day
☐ Eats fewer than 2-3 servings of breads, cereals, pasta a day
☐ Eats alone most of the time

Not able to independently: ☐ cook ☐ shop ☐ feed self

Nutritional Risk Screen

Risk Factors	Score
☐ Unintentional weight loss > 10 lbs. in 3 months	3
☐ Chewing and/or swallowing problems	3
☐ Inadequate or poorly balanced diet	3
☐ Slow healing wound	3
☐ Hyperemesis gravidarum	6
☐ Tube feeding / TPN	6
☐ Cachexia	4
☐ Diabetes mellitus	2
☐ Modified diet	2
☐ Difficulty managing diet	4
TOTAL (sum of scores)	_____

If TOTAL score is 6 or more, patient may require referral to registered dietician.

Was patient referred? ☐ No ☐ Yes.

Patient was referred to: _____

Patient has: ☐ Own teeth ☐ Dentures ☐ No teeth or dentures

Indicate problems in the following areas and describe:

☐ Chewing ☐ Swallowing ☐ Oral mucosa ☐ Gums ☐ Tongue

continued on next column

12. **Nutritional Status** *continued*

Enteral Feedings ☐ Not Applicable

☐ NG Tube ☐ Peg Tube ☐ G Tube ☐ J Tube
☐ Other (specify) _____

Date Changed _____ Date Inserted _____

By whom _____

Type of Feeding (i.e., Bolus, Continuous) _____ Rate _____

Infusion Rate _____ Type of Pump _____

Interventions and Education _____

Parenteral Feedings ☐ Not Applicable

☐ Hydration ☐ TPN ☐ Other _____

(Refer to Medication Section for information on Parenteral Feedings.)

Comments: _____

13. **Psychological / Mental Status:**

Any significant changes in Neuro/Emotional/Behavioral Status since start of care? ☐ No changes

Mental Status: **BOX # 19**

☐ 1 - Oriented ☐ 6 - Lethargic
☐ 2 - Comatose ☐ 7 - Agitated
☐ 3 - Forgetful ☐ 8 - Anxious at times
☐ 4 - Depressed ☐ 9 - Confused at times
☐ 5 - Disoriented ☐ 10 - Anxiety
☐ Other _____

14. **Endocrine and Hematopoietic:** (Indicate if experiencing problems with any of the following)

☐ Within Normal Limits
☐ Diabetes (Type) _____
☐ Thyroid ☐ Pituitary
☐ Pancreas ☐ Adrenals ☐ Obesity
☐ Hypoglycemia sweats / weaks / faints
☐ Hyperglycemia polyuria / polydipsia / glycosuria
☐ Other (specify) _____
☐ Hematopoietic

Explain: (Include usual glucose levels if diabetic; if glucometer used, indicate who performs)

RECERTIFICATION/FOLLOW-UP ASSESSMENT

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= 485 Data (must complete)
= OASIS (must complete)

Includes OASIS C Data Set (12/2009)

Patient Name: _____

Clinician's Name: _____ Date: _____

Section I: ADL / IADLs (Life System Profile) Record what the patient is currently able to do.

(M1810) **2.** 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.

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

(M1830) **4. 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.

(M1840) **5. 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.

(M1850) **6. 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 - Transfers with minimal human assistance or with use of an assistive device.
- ☐ 2 - **UNABLE** to transfer self but is able to bear weight and pivot during the transfer process.
- ☐ 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.

(M1860) **7. Ambulation/Locomotion:** Current Ability to **SAFELY** walk, 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 supervision 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.

MEDICATIONS

(M2030) **8. 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(s) at the 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.

RECERTIFICATION/FOLLOW-UP ASSESSMENT

QM = Quality Measures (must complete)
= 485 Data (must complete)
= OASIS (must complete)

Includes OASIS C Data Set (12/2009)

Patient Name: _____

Clinician's Name: _____ Date: _____

Section J: Equipment / Supplies

HME Supplier Name/# _____ Phone _____

1. **Supplies Needed:** (check all that apply) **BOX # 14** — N/A | Has | Needs

a. Wound supplies ☐ ☐ ☐
- ☐ 2x2's ☐ 4x4's ☐ ABD's
- ☐ Cotton tipped applicators ☐ Wound cleanser
- ☐ Wound gel ☐ Drain sponges
- Gloves: ☐ Sterile ☐ Non-sterile
- ☐ Hydrocolloids ☐ Kerlix size _____
- ☐ Nu-gauze ☐ Saline ☐ Tape
- ☐ Transparent dressings
- ☐ Other _____ ☐ ☐ ☐

b. IV Supplies ☐ ☐ ☐
- ☐ IV starter kit ☐ IV pole ☐ IV tubing
- ☐ Alcohol swabs ☐ Angiocatheter size ____
- ☐ Tape ☐ Extension tubings ☐ Infusion pump
- ☐ Injection caps ☐ Central line dressing
- ☐ Batteries size _____
- ☐ Syringes size _____
- ☐ Other _____ ☐ ☐ ☐

c. Urinary / Ostomy ☐ ☐ ☐
- ☐ Underpads ☐ External catheters
- ☐ Urinary bag/pouch
- ☐ Ostomy pouch (brand, size) _____
- ☐ Ostomy wafer (brand, size) _____
- ☐ Stoma adhesive tape ☐ Skin protectant

d. Foley supplies ☐ ☐ ☐
- ☐ _____ Fr catheter kit (tray, bag, foley)
- ☐ Straight catheter ☐ Irrigation tray
- ☐ Saline ☐ Acetic acid
- ☐ Other _____ ☐ ☐ ☐

e. Feeding tube/supplies ☐ ☐ ☐
- ☐ Type: _____ Size: _____

f. Diabetic ☐ ☐ ☐
- ☐ Chemstrips ☐ Syringes
- ☐ Other _____

2. **Equipment:** (continued) — N/A | Has | Needs

g. Syringes ☐ ☐ ☐

h. Miscellaneous
- Enema supplies ☐ ☐ ☐
- Suture removal kit ☐ ☐ ☐
- Staple removal kit ☐ ☐ ☐
- Steri strips ☐ ☐ ☐

i. Other (specify) _____ ☐ ☐ ☐
- _____ ☐ ☐ ☐
- _____ ☐ ☐ ☐
- _____ ☐ ☐ ☐

2. **Equipment:** (check all that apply) **BOX # 14** — N/A | Has | Needs

a. Bathbench ☐ ☐ ☐
b. Cane ☐ ☐ ☐
c. Hospital Bed ☐ ☐ ☐
d. Commode ☐ ☐ ☐
e. Special mattress overlay _____
f. Pressure relieving device _____
g. Eggcrate ☐ ☐ ☐
h. Hospital bed ☐ ☐ ☐
i. Hoyer lift ☐ ☐ ☐
j. Enteral feeding pump ☐ ☐ ☐
k. Nebulizer ☐ ☐ ☐
l. Oxygen concentrator ☐ ☐ ☐
m. Suction machine ☐ ☐ ☐
n. Ventilator ☐ ☐ ☐
o. Walker ☐ ☐ ☐
p. Wheelchair ☐ ☐ ☐
q. Tens unit ☐ ☐ ☐
r. Other (specify) _____ ☐ ☐ ☐
- _____ ☐ ☐ ☐
- _____ ☐ ☐ ☐
- _____ ☐ ☐ ☐
- _____ ☐ ☐ ☐

Section K: Safety Measures for Patient's Protection

Safety Measures **BOX # 15**

- ☐ Emergency care
- ☐ Smoke detectors
- ☐ Fire escape routes
- ☐ Bleeding precautions
- ☐ Evacuation sites (hurricane, flood, etc.)
- ☐ Clear paths
- ☐ Medical alert devices
- ☐ Plan for power failure
- ☐ Infection control measures
- ☐ Restraints
- ☐ Fall precautions
- ☐ Oxygen Safety
- ☐ Cardiac
- ☐ Diabetic
- ☐ Sharps
- ☐ Seizure Precautions
- ☐ Requires assistance to ambulate safely
  Explain: _____
- ☐ Anticoagulation Safety
- ☐ Patient able to summon help/911
- ☐ Patient able to call MD
- ☐ Lock wheelchair with transfer

☐ Other (specify) _____

Instructions given to:
☐ Patient ☐ Caregiver (Name) _____

Functional Limitations **BOX # 18A**

- ☐ 1 Amputation
- ☐ 2 Bowel/Bladder (incontinence)
- ☐ 3 Contracture
- ☐ 4 Hearing
- ☐ 5 Paralysis
- ☐ A Dyspnea with Exertion (check one) : __ Min. __ Mod. __ Max.
- ☐ B Other (specify) _____
- ☐ 5 Paralysis
- ☐ 6 Endurance
- ☐ 7 Ambulation
- ☐ 8 Speech
- ☐ 9 Legally Blind

Explain checked limitations: _____

Other needs and limitations since initial Start of Care or most recent OASIS:

_____

_____ ☐ No change

continued on next page

RECERTIFICATION/FOLLOW-UP ASSESSMENT

QM = Quality Measures (must complete)
= 485 Data (must complete)
= OASIS (must complete)

Includes OASIS C Data Set (12/2009)

Patient Name: _____

Clinician's Name: _____ Date: _____

Section K: Safety Measures *continued*

Activities Permitted **BOX # 18B**

- ☐ 1 Complete Bedrest
- ☐ 2 Bedrest/BRP
- ☐ 3 Up As Tolerated
- ☐ 4 Transfer Bed/Chair
- ☐ 5 Exercises Prescribed
- ☐ 6 Partial Weight Bearing
- ☐ 7 Independent At Home
- ☐ 8 Ambulates with assistance of another person
- ☐ 9 Crutches
- ☐ A Cane
- ☐ B Wheelchair
- ☐ C Walker
- ☐ D No Restrictions
- ☐ E Other (specify) _____

Explain checked activities: _____

FALL RISK ASSESSMENT

Assess each factor and circle the score when "yes", then total the points

Patient Factors	Score
History of falls (any in the past 3 months?)	15
Sensory deficit (vision and/or hearing)	5
Age (over 65)	5
Confusion	5
Impaired judgment	5
Decreased level of cooperation	5
Increased anxiety/emotional liability	5
Unable to ambulate independently (needs to use ambulatory aide, chairboard, etc.)	5
Gait/balance/coordination problems	5
Incontinence/urgency	5
Cardiovascular/respiratory disease affecting perfusion and/or oxygenation	5
Postural hypotension with dizziness	5
Medications affecting blood pressure or level of consciousness (consider antihistamines, antihypertensives, antiseizure, benzodiazepines, cathartics, diuretics, hypoglycemics, narcotics, psychotropics, sedatives/hyponotics	5
Alcohol use	5
Environmental Factors	
Home safety issues (lighting, pathway, cord, tubing, floor coverings, stairs, etc.	5
Lack of home modifications (bathroom, kitchen, stairs entries, etc.)	5
Total points:	

Implement fall precautions for a total score of 15 or greater.

As guided by organizational guidelines:

1. Educate on fall prevention strategies specific to areas of risk
2. Refer to Physical Therapy and/or Occupational Therapy
3. Monitor areas of risk to reduce falls
4. Reassess patient

Plan/Comments: _____

Section K: Safety Measures *continued*

(M2200) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)?

(Enter zero ["000"] if no therapy visits indicated.)

(__ __ __) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).

☐ NA - Not Applicable: No case mix group defined by this assessment.

Section L: Goals/Rehab Potential/Orders/ Conclusions/Impressions/Skilled Interventions and Teaching Performed this Visit/Discharge Plans

(include Amount/Frequency/Duration) **BOX # 22**

REHAB POTENTIAL FOR STATED GOALS:

☐ Excellent ☐ Good ☐ Fair ☐ Poor **BOX # 22**

Comments: _____

PROGNOSIS:

☐ Excellent ☐ Good ☐ Fair ☐ Guarded ☐ Poor **BOX # 20**

Comments: _____

HOMEBOUND REASON Check all that apply and explain

☐ Needs assistance for all activities ☐ Residual weakness

☐ Requires assistance of another person to ambulate

(Explain): _____

☐ Confusion, unable to go out of home alone

☐ Unable to safely leave home unassisted

☐ Severe SOB, SOB upon exertion

(Explain): _____

☐ Considerable and taxing effort for patient to leave home (eg. SOB, altered mobility, inability to transport self, confusion, dependent on adaptive device)

(Explain): _____

☐ Dependent upon adaptive device(s)

☐ Medical restrictions (Explain): _____

☐ Other (specify): _____

continued on next page

RECERTIFICATION/FOLLOW-UP ASSESSMENT

QM = Quality Measures (must complete)
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= OASIS (must complete)

Includes OASIS C Data Set (12/2009)

Patient Name: _____

Clinician's Name: _____ Date: _____

Section L: Goals/Rehab Potential/Orders/Conclusions/Impressions/Skilled Interventions and Teaching Performed this Visit/Discharge Plans *continued*

NURSING INTERVENTIONS / SKILLED SERVICES PROVIDED

- ☐ Skilled Observation / Assessment
- ☐ Foley Change / Irrigation
- ☐ W/C / Dressing Change
- ☐ Tracheostomy Care
- ☐ Prep / Admin of Insulin
- ☐ IM / SQ Injection
- ☐ Diabetic Obs/Care
- ☐ Inst. Safety / Precaution
- ☐ Diet Teaching
- ☐ Teach Infant/Childcare
- ☐ Inst. Disease Process
- ☐ Safety Factors
- ☐ Peg/GT Tube Site Care
- ☐ Observation / Teach (N-C) Medication: Effects / Side Effects
- ☐ Teach/Administer IV Infusion
- ☐ Teach/Administer Tube Feed
- ☐ Psych Intervention
- ☐ Pain Management
- ☐ Management & Evaluation of Patient's Care Plan
- ☐ Other: _____

PHYSICAL THERAPY

- ☐ Evaluation
- ☐ Therapeutic Exercise
- ☐ Transfer Training
- ☐ Home Program
- ☐ Gait Training
- ☐ Chest Physiotherapy
- ☐ Ultrasound
- ☐ Eltro Therapy
- ☐ Prosthetic Training
- ☐ Teach Use of Assistive/Adaptive Devices
- ☐ Muscle Re-education
- ☐ Management & Evaluation of Patient Care Plan
- ☐ Patient/Family Education
- ☐ Teach Fall Safety/Safety Precautions
- ☐ Other: _____

SPEECH THERAPY

- ☐ Evaluation
- ☐ Voice Disorders Treatment
- ☐ Speech Articulation
- ☐ Dysphagia Treatment
- ☐ Language Disorder Treatment
- ☐ Oral Rehabilitation
- ☐ Non-Oral Communication
- ☐ Patient/Family Education
- ☐ Teach/Develop Communication System
- ☐ Other: _____

OCCUPATIONAL THERAPY

- ☐ Evaluation
- ☐ ADL Skills / Training
- ☐ Muscle Re-Education
- ☐ Perceptual Motor
- ☐ Fine Motor Coordination
- ☐ Neuro-Development Treatment
- ☐ Sensory Treatment
- ☐ Orthotics / Splinting
- ☐ Adaptive Equipment
- ☐ Establish HEP
- ☐ Therapeutic Exercises
- ☐ Teach Alternative Skills (ADL's)
- ☐ Cognitive. Perceptual Skills
- ☐ Teach Fall Safety
- ☐ Other: _____

AIDE SUPERVISORY VISIT

Aide: ☐ Present ☐ Not Present
Supervisory Visit: ☐ Scheduled ☐ Unscheduled
Aide Care Plan Updated: ☐ Yes ☐ No
Observation of: _____
Teaching / Training of: _____
Next Scheduled Supervisory Visit: ____ / ____ / ____
Patient / Family Satisfied with Care: ☐ Yes ☐ No
Explain: _____

SUMMARY CHECKLIST

Care Plan Reviewed: ☐ No
☐ Yes, reviewed with:
- ☐ Patient
- ☐ Caregiver
- ☐ Other (Name): _____

Medication Status:
☐ Medication regimen completed/reviewed **BOX # 10** (See Medicine Schedule)
☐ No change ☐ Order obtained

Check if any of the following were identified:
- ☐ Potential adverse effects/drug reactions
- ☐ Ineffective drug therapy
- ☐ Significant side effects
- ☐ Significant drug interactions
- ☐ Duplicate drug therapy
- ☐ Non-compliance with drug therapy

Care Coordination:
☐ Physician ☐ SN ☐ PT ☐ OT
☐ ST ☐ MSW ☐ Aide
☐ Other (specify) _____

SKILLED INTERVENTION DAILY NOTE (Clinician Free Style Charting)

Teaching: _____

Skill: _____

ADDITIONAL NOTES ON SKILLED CARE PROVIDED THIS VISIT

RECERTIFICATION/FOLLOW-UP ASSESSMENT

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= 485 Data (must complete)
= OASIS (must complete)

Includes OASIS C Data Set (12/2009)

Patient Name: _____

Clinician's Name: _____ Date: _____

Section M: Goals/Orders/Discharge Plans/Referrals/Additional Services *Utilize this section to assist with completion of 485 (optional)*

PROFESSIONAL SERVICES **BOX # 21**

Emergency Code: _____

Check and specify patient specific orders for POC

☐ **DNR** – Do Not Resuscitate **(must have MD order)**

SN – FREQUENCY / DURATION _____

☐ Skilled Observation for _____
☐ Evaluate Cardiopulmonary Status
☐ Evaluate Nutrition / Hydration / Elimination
☐ Evaluate for S/S of Infections
☐ Teach Disease Process
☐ Teach S/S of Infection and Standard Precautions
☐ Teach Diet
☐ Teach Home Safety / Falls Prevention
☐ Other _____
☐ PRN Visits for _____
☐ Psychiatric Nursing for _____

MEDICATIONS

☐ Medication Teaching
☐ Evaluate Med Effects / Compliance
☐ Set up Meds Every _____ Weeks
☐ Administer medication(s) (name, dose, route, frequency)
_____
☐ Administer medication(s) (name, dose, route, frequency)
_____
☐ Administer medication(s) (name, dose, route, frequency)
_____

INTRAVENOUS

☐ Administer IV medication (name, dose, route, frequency and duration)
_____
_____

FLUSHING PROTOCOL / FREQUENCY (specify)

☐ Administer Flush(es) _____
___ mL normal saline
_____
___ mL normal saline
_____
___ mL sterile water
_____
___ mL heparin ____ unit/mL
_____
___ mL heparin ____ unit/mL
_____
☐ Teach S/S of IV Complications
☐ Teach IV Site Care
☐ Teach Infusion Pump
☐ Teach Complete Parenteral Nutrition
☐ Site Care (specify) _____
☐ Line Protocol (specify) _____
☐ ___ PRN Visits for IV Complications
☐ Anaphylaxis Protocol (specify orders)
_____
_____
_____
☐ Other _____

RESPIRATORY

☐ O2 at _____ liters per _____ minute
☐ Pulse Oximetry: Every Visit
☐ Pulse Oximetry: PRN Dyspnea
☐ Teach Oxygen Use / Precautions
☐ Teach Trach Care ☐ Administer Trach Care
☐ Other _____

INTEGUMENTARY

☐ Wound Care (specify each site) _____
_____
_____
_____
_____
☐ Evaluate Wound / Decub for Healings
☐ Measure Wound(s) Weekly
☐ Teach Wound Care / Dressing
☐ Other _____

ELIMINATION

☐ Foley _____ French inflated balloon with _____ mL changed every _____
☐ Suprapubic Cath Insertion every _____ with size _____ Fr. balloon _____
☐ Teach Care of Indwelling Catheter
☐ Teach Self - Cath ☐ Teach Ostomy Care
☐ Teach Bowel Regime
☐ Other _____

GASTROINTESTINAL

☐ Teach N/G Tube Feeding
☐ Teaching G-Tube Feeding
☐ Other _____

DIABETES

☐ Administer Insulin
☐ Prepare Insulin Syringes
☐ Blood Glucose Monitoring PRN or _____
☐ Teach Diabetic Care
☐ Other _____

MATERNAL/CHILD

☐ Evaluate Fetal / Maternal Status
☐ Evaluate Growth and Development
☐ Evaluate Parenting
☐ Teach S/S of Preterm Labor
☐ Teach Growth and Development
☐ Teach Apnea Monitor Use

LABORATORY

☐ Venipuncture for _____
Frequency _____
☐ Other _____

PT - FREQUENCY/DURATION _____

☐ Evaluation and Treatment
☐ Pulse Oximetry PRN
☐ Home Safety / Falls Prevention
☐ Therapeutic Exercise
☐ Transfer Training
☐ Gait Training
☐ Establish Home Exercise Program
☐ Modality (specify frequency, duration, amount)
_____
☐ Prosthetic Training
☐ Muscle Re-Education
☐ Other _____

OT - FREQUENCY/DURATION _____

☐ Evaluation and Treatment
☐ Pulse Oximetry PRN
☐ Home Safety / Falls Prevention
☐ Adaptive Equipment
☐ Therapeutic Exercise
☐ Muscle Re-Education
☐ Establish Home Exercise Program
☐ Homemaker Training
☐ Modality (specify frequency, duration, amount)
_____
_____
☐ Prosthetic Training
☐ Other _____

ST - FREQUENCY/DURATION _____

☐ Evaluation and Treatment
☐ Voice Disorder Treatment
☐ Speech Articulation Disorder Treatment
☐ Dysphagia Treatment
☐ Receptive Skills
☐ Expressive Skills
☐ Cognitive Skills
☐ Other _____

HOME HEALTH AIDE - FREQUENCY / DURATION _____

☐ Personal Care of ADL Assistance
☐ Other (specific task for HHA) _____
_____

OTHER SERVICES (specify) _____
FREQUENCY/DURATION _____

☐ Homemaking
☐ Other _____

MSW - FREQUENCY / DURATION _____

☐ Evaluate and Treat
☐ Evaluate Family Situation
☐ Evaluate/Refer to Community Resources
☐ Evaluate Financial Status
☐ Other _____
☐ Other _____

RECERTIFICATION/FOLLOW-UP ASSESSMENT

QM = Quality Measures (must complete)
= 485 Data (must complete)
= OASIS (must complete)

Includes OASIS C Data Set (12/2009)

Patient Name: _____

Clinician's Name: _____ Date: _____

Section M: Goals/Orders/Discharge Plans/Referrals/Additional Services *continued*

REHABILITATION POTENTIAL / GOALS **BOX # 22** *Check goal(s), circle for specifics and insert information.*

DISCIPLINE GOALS AND DATES WILL BE ACHIEVED

NURSING:
- ☐ Demonstrates compliance with medication by _____ (date)
- ☐ Stabilization of cardiovascular pulmonary condition by _____ (date)
- ☐ Demonstrates competence in following medical regime by _____ (date)
- ☐ Verbalizes pain controlled at acceptable level by _____ (date)
- ☐ Demonstrates independence in _____ by _____ (date)
- ☐ Verbalizes/demonstrates independence with care by _____ (date)
- ☐ Wound healing without complications by _____ (date)
- ☐ Expect daily SN visits to end by _____ (date)
- ☐ Other _____ by _____ (date)

PHYSICAL THERAPY:
- ☐ Demonstrates ability to follow home exercise program by _____ (date)
- ☐ Other _____ by _____ (date)

OCCUPATIONAL THERAPY:
- ☐ Demonstrates ability to follow home exercise program by _____ (date)
- ☐ Other _____ by _____ (date)

SPEECH THERAPY:
- ☐ Demonstrates swallowing skills in formal/informal dysphagia evaluation exercise program by _____ (date)
- ☐ Completes speech therapy program by _____ (date)
- ☐ Other _____ by _____ (date)

AIDE
- ☐ Assumes responsibility for personal care needs by _____ (date)
- ☐ Other _____ by _____ (date)

MEDICAID SOCIAL SERVICES
- ☐ Verbalizes information about community resources and how to obtain assistance by _____ (date)
- ☐ Other _____ by _____ (date)

DISCHARGE PLANS
- ☐ Return to an independent level of care (self-care)
- ☐ Able to remain in residence with assistance of primary caregiver/support from community agencies
- ☐ When patient knowledgeable about when to notify physician
- ☐ Able to understand medication regime and care related to diagnoses
- ☐ Medical condition stabilizes
- ☐ When maximum functional potential reached
- ☐ Discharge at the end of the episode if the patient is hospitalized
- ☐ Other _____ by _____ (date)
- ☐ Other _____ by _____ (date)

DISCUSSED WITH PATIENT: ☐ Yes ☐ No

REHAB POTENTIAL: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Verbal Order obtained: ☐ No ☐ Yes, specify date **BOX # 23**

_____ / _____ / _____
Date of Verbal Order for Recertification

ADDITIONAL NOTES:

SIGNATURE / DATES

X _____ _____ / _____ / _____
Patient/Caregiver (if applicable) Date

X _____ _____ / _____ / _____
Person Completing This Form (Signature/Title) Date

OASIS INFORMATION

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

RECERTIFICATION/FOLLOW-UP ASSESSMENT

Patient Name: _____ ID #: _____

Care Summary

Dear Dr. _____ ☐ Recertification (follow-up) ☐ Other follow-up

Disciplines Involved	Comments
☐ SN	
☐ PT	
☐ OT	
☐ ST	
☐ MSW	
☐ Aide: _____	
☐ Other: _____	

Date of last home visit _____ / _____ / _____ Physician notified: ☐ No ☐ Yes. Date: _____ / _____ / _____

☐ POC 485 attached for signature. Please sign, date and return. ☐ Copy of Care Summary (check one): ☐ mailed ☐ faxed Date: _____ / _____ / _____

Summary Complete this Section for Recertification (Unless Summary is written elsewhere)

REASON FOR HOME CARE (describe condition):

SUMMARY OF HOME HEALTH CARE TO DATE (including progress towards goals, treatment modalities, etc.)

PLANS FOR DISCHARGE

PERSON COMPLETING THIS FORM

Signature/Title _____ Date _____ / ____ / _____

Agency Name _____ Phone #_____

ORIGINAL – Clinical Record (Provide copy to Physician per agency policy)