START OF CARE ASSESSMENT Also used for Resumption of Care following Inpatient Stay

Patient Name: ____

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

Includes OASIS C Data Set (12/2009)

REASON FOR ASSESSMENT: ☐ Start of Care ☐ Resumption of Care

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:** ___ | ___ |
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:** ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ☐ NA - No Medicare BOX # 1
    (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:** ___ | ___ / ___ | ___ / ___ | ___ | ___ | ___ | BOX # 8
    Month Day Year
18. **(M0069) Gender:** ☐ 1– Male ☐ 2 – Female BOX # 9
19. **Other Referral Sources:** ______________________________
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:**
    START/RESUMPTION OF CARE ☐ 1 – Start of care, further visits planned ☐ 3 – Resumption of care (after inpatient stay)
23. **(M0102) Date of Physician-ordered Start of Care (Resumption of Care):** If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified. *[Go to M0110, if date entered]* ☐ NA – No specific SOC date ordered by physician
    ___ | ___ / ___ | ___ / ___ | ___ | ___ | ___ |
    Month Day Year
24. **(M0104) Date of Referral:** Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.
    ___ | ___ / ___ | ___ / ___ | ___ | ___ | ___ |
    Month Day Year
25. **(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.**

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START OF CARE ASSESSMENT

Patient Name: ____________________

Clinician's Name: ____________________ Date: ____________

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

Includes OASIS C Data Set (12/2009)

Section A: Clinical Record Items / Demographics / Patient History *continued*

26. **Marital Status:** ☐ Married ☐ Unmarried ☐ Widowed ☐ Divorced ☐ Separated ☐ Unknown

27. **(M0140) Race/Ethnicity (as identified by patient):** (Mark all that apply.)
   - ☐ 1 – American Indian or Alaska Native
   - ☐ 2 – Asian
   - ☐ 3 – Black or African-American
   - ☐ 4 – Hispanic or Latino
   - ☐ 5 – Native Hawaiian or Pacific Islander
   - ☐ 6 – White

28. **Does patient need an interpreter?** ☐ Yes ☐ No

29. **Emergency Contact** (Name / Relationship):
   ____

30. **Emergency Contact Address / City / State / Zip:**
   ____

31. **Emergency Contact Telephone No.:**
   ____

32. **(M0150) Current Payment Sources for Home Care:** (Mark all that apply.)
   - ☐ 0 – None; no charge for current services
   - ☐ 1 – Medicare (traditional fee-for-service)
   - ☐ 2 – Medicare (HMO/managed care/Advantage Plan)
   - ☐ 3 – Medicaid (traditional fee-for-service)
   - ☐ 4 – Medicaid (HMO/managed care)
   - ☐ 5 – Workers' compensation
   - ☐ 6 – Title programs (e.g., Title III, V, or XX)
   - ☐ 7 – Other government (e.g., Tricare, VA, etc.)
   - ☐ 8 – Private insurance
   - ☐ 9 – Private HMO/managed care
   - ☐ 10 – Self-pay
   - ☐ 11 – Other (specify)____________________
   - ☐ UK – Unknown

   A. Payor Source __________ Policy #__________ Group # ________
   Address____________________ Phone______________

   B. Payor Source __________ Policy #__________ Group # ________
   Address____________________ Phone______________

33. **(M1000)** From which of the following **Inpatient Facilities** was the patient discharged **during the past 14 days?** (Mark all that apply.)
   - ☐ 1 – Long-term nursing facility (NF)
   - ☐ 2 – Skilled nursing facility (SNF / TCU)
   - ☐ 3 – Short-stay acute hospital
   - ☐ 4 – Long-term care hospital (LTCH)
   - ☐ 5 – Inpatient rehabilitation hospital or unit (IRF)
   - ☐ 6 – Psychiatric hospital or unit
   - ☐ 7 – Other (specify)____________________
   - ☐ NA – Patient was not discharged from an inpatient facility *(Go to M1016)*

34. **(M1005) Inpatient Discharge Date** (most recent):
   __ | __ / __ | __ / __ | __ | __ | __ ☐ UK – Unknown
   Month Day Year

35. **Patient has the following:**
   Living Will: ☐ Yes ☐ No
   Copies located at: ☐ Patient Home ☐ Agency ☐ Family Member ______________
   Durable Power of Attorney: ☐ Yes ☐ No
   Copies located at: ☐ Patient Home ☐ Agency ☐ Family Member______________
   Bill of Rights signed: ☐ Yes ☐ No
   Patient: ☐ understands ☐ May not understand (explain):
   ____

   Organ donor: ☐ Yes ☐ No
   Agency advance directives policy: ☐ Patient ☐ Family Informed.
   (If no, explain): ____________________
   Status: ☐ Code Patient ☐ No-Code Patient
   State Hotline Number left in home: ☐ Yes ☐ No

36. **(M1010)** List each Inpatient Diagnosis and ICD-9-CM code at the level of highest specificity **for only those conditions treated during an inpatient stay within the last 14 days** (no E-codes or V-codes):

Inpatient Facility Diagnosis	ICD-9-CM
a. ______________	__ | __ | __ • __ | __ |
b. ______________	__ | __ | __ • __ | __ |
c. ______________	__ | __ | __ • __ | __ |
d. ______________	__ | __ | __ • __ | __ |
e. ______________	__ | __ | __ • __ | __ |
f. ______________	__ | __ | __ • __ | __ |

37. **(M1012)** List each **Inpatient Procedure** and the associated ICD-9-C M procedure code relevant to the plan of care.

Inpatient Procedure	Procedure Code
a. ______________	__ | __ • __ | __ |
b. ______________	__ | __ • __ | __ |
c. ______________	__ | __ • __ | __ |
d. ______________	__ | __ • __ | __ |

   ☐ NA – Not applicable ☐ UK – Unknown

38. **(M1016) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days:** List the patient's Medical Diagnoses and ICD-9-CM codes at the level of highest specificity **for those conditions requiring changed medical or treatment regimen** (no surgical, E-codes, or V-codes):

Changed Medical Regimen Diagnosis	ICD-9-CM
a. ______________	__ | __ | __ • __ | __ |
b. ______________	__ | __ | __ • __ | __ |
c. ______________	__ | __ | __ • __ | __ |
d. ______________	__ | __ | __ • __ | __ |
e. ______________	__ | __ | __ • __ | __ |
f. ______________	__ | __ | __ • __ | __ |

   ☐ NA – Not applicable (no medical or treatment regimen changes within the past 14 days)

39. **(M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days:** If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions which existed **prior to** the inpatient stay or change in medical or treatment regimen. (Mark all that apply.)
   - ☐ 1 – Urinary incontinence
   - ☐ 2 – Indwelling/suprapubic catheter
   - ☐ 3 – Intractable pain
   - ☐ 4 – Impaired decision-making
   - ☐ 5 – Disruptive or socially inappropriate behavior
   - ☐ 6 – Memory loss to the extent that supervision required
   - ☐ 7 – None of the above
   - ☐ NA – No inpatient facility discharge **and** no change in medical or treatment regimen in past 14 days
   - ☐ UK – Unknown

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START OF CARE ASSESSMENT

Patient Name: ____________________

Clinician's Name: ____________________ Date: ____________

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

Includes OASIS C Data Set (12/2009)

Section B: Current Illness

Each patient's overall medical condition and care needs must be comprehensively assessed BEFORE the HHA identifies and assigns each diagnosis for which the patient is receiving home care.

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)
a. ____________	___ | ___ | ___ - ___ | ___	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
b. ____________	___ | ___ | ___ - ___ | ___	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

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START OF CARE ASSESSMENT

Patient Name: ______________________________

Clinician's Name: ______________________ Date: ____________

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

Includes OASIS C Data Set (12/2009)

Section C: History (Significant medical/surgical history; history of present illness; chief complaints)

Date onset/exacerbation (most recent):

___ | ___ / ___ | ___ / ___ | ___ | ___ | ___ |
Month Day Year

Physician:
Date last contacted: ____________ Date last visited: ________

Primary Reason for Home Health: ______________________

____

____

____

____

Treatment for infection in the past 14 days ☐ NA

Type______________________ Date________

Results ______________________

Significant Lab / Radiologic / Other Diagnostic Tests
(include Type of Test, Date, Results and Follow-up)

____

____

____

Pertinent History and/or Previous Outcomes
(note dates of onset/exacerbation when known)

- ☐ Hypertension ______________
- ☐ Cardiac ______________
- ☐ Diabetes ______________
- ☐ Endocrine ______________
- ☐ Respiratory ______________
- ☐ Osteoporosis ______________
- ☐ Fractures ______________
- ☐ Cancer (site: __________) ______________
- ☐ Infection ______________
- ☐ Immunosuppressed ______________
- ☐ Open Wound ______________
- ☐ Surgeries ______________
- ☐ Other (specify) ______________

____

____

Immunizations ☐ Up to date
Needs: ☐ Influenza ☐ Pneumonia ☐ Tetanus
☐ Other ______________________

Prior Hospitalizations ☐ No ☐ Yes Number of times: ________

Reason(s)/Date(s) ______________________

____

Section D: (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

Vascular Access Device: ______________________

Date Inserted: ______________________

Date Last Change: ______________________

Site Appearance: (include dressing, type, location) ______________

____

____

____

____

____

Section E: Prognosis

1. **(M1032) Risk for Hospitalization:** Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)
   - ☐ 1 – Recent decline in mental, emotional, or behavioral status
   - ☐ 2 – Multiple hospitalizations (2 or more) in the past 12 months
   - ☐ 3 – History of falls (2 or more falls – or any fall with an injury – in the past year)
   - ☐ 4 – Taking five or more medications
   - ☐ 5 – Frailty indicators, e.g., weight loss, self-reported exhaustion
   - ☐ 6 – Other
   - ☐ 7 – None of the above

2. **(M1034) Overall Status:** Which description best fits the patient's overall status? (Check one)
   - ☐ 0 – The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
   - ☐ 1 – The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
   - ☐ 2 – The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.
   - ☐ 3 – The patient has serious progressive conditions that could lead to death within a year.
   - ☐ UK – The patient's situation is unknown or unclear.

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

Comments: ______________________________

____

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START OF CARE 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 F: Allergies (Environmental, Drugs, Food, etc.) (Mark all that apply) BOX # 17

☐ NKA ☐ 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): ___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Section G: Screening Tests / Immunizations / Transfusions

1. **Screening:**

Cholesterol	☐ Yes	☐ No	Date ________	Results: ________
Mammogram	☐ Yes	☐ No	Date ________	Results: ☐ Neg. / ☐ Pos. ________
Colon	☐ Yes	☐ No	Date ________	Results: ☐ Neg. / ☐ Pos. ________
Prostate	☐ Yes	☐ No	Date ________	Results: ☐ Neg. / ☐ Pos. ________
Pap Smear	☐ Yes	☐ No	Date ________	Results: ☐ Neg. / ☐ Pos. ________

2. **Immunizations:**

Flu	☐ Yes	☐ No	Date ________
H1N1	☐ Yes	☐ No	Date ________
Tetanus	☐ Yes	☐ No	Date ________
Pneumonia	☐ Yes	☐ No	Date ________
Other	________		Date ________

3. **History of Blood Transfusions:**

☐ Yes ☐ No Date(s) ________________

Comments:

____

____

____

____

____

Section H: (M1036) Risk Factors either present or past, likely to affect current health status and/or outcome:

(Mark all that apply)

1. ☐ 1 – Smoking ☐ 3 – Alcohol dependency ☐ 5 – None of the above
   ☐ 2 – Obesity ☐ 4 – Drug dependency ☐ UK – Unknown

Comments:

____

____

____

____

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START OF CARE ASSESSMENT

Patient Name: ______

Clinician's Name: ______ Date: ______

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

Section I: Living Arrangements

1. **Current Residence:**
   - ☐ 1 – Patient's owned or rented residence (house, apartment, or mobile home owned or rented by patient/couple/ significant other)
   - ☐ 2 – Family member's residence
   - ☐ 3 – Boarding home or rented room
   - ☐ 4 – Board and care or assisted living facility
   - ☐ 5 – Other (specify) ______

2. **Patient Lives With:** (Mark all that apply)
   - ☐ 1 – Lives alone
   - ☐ 2 – With spouse or significant other
   - ☐ 3 – With other family member
   - ☐ 4 – With a friend
   - ☐ 5 – With paid help (other than home care agency staff)
   - ☐ 6 – With other than above

3. **Length of time patient alone during the day:**
   - ☐ 1 – Never
   - ☐ 2 – Between 1 and 3 hours
   - ☐ 3 – Between 4 and 6 hours
   - ☐ 4 – All day

4. **Evidence of:** ☐ Neglect ☐ Abuse

   Explain: ______

   ☐ Referral made ______

5. **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)

6. **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 ______

7. **Home Safety Evaluation:**
   - ☐ Per Agency Policy

Section J: Supportive Assistance

1. **Assisting Person(s) Other than Home Care Agency Staff:** Mark all that apply
   - ☐ 1 – Relatives, friends, or neighbors living outside the home
   - ☐ 2 – Person residing in the home (EXCLUDING paid help)
   - ☐ 3 – Paid help
   - ☐ 4 – None of the above
   - ☐ UK – Unknown

2. **Primary Caregiver** taking lead responsibility for providing or managing the patient's care, providing the most frequent assistance, etc. (other than home care agency staff):
   - ☐ 0 – No one person
   - ☐ 1 – Spouse or significant other
   - ☐ 2 – Daughter or son
   - ☐ 3 – Other family member
   - ☐ 4 – Friend or neighbor or community or church member
   - ☐ 5 – Paid help
   - ☐ UK – Unknown

3. **How Often** does the patient receive assistance from the primary caregiver?
   - ☐ 1 – Several times during night
   - ☐ 2 – Several times during day
   - ☐ 3 – Once daily
   - ☐ 4 – Three or more times per week
   - ☐ 5 – One to two times per week
   - ☐ 6 – Less often than weekly
   - ☐ UK – Unknown

4. **(M1100) Patient Living Situation:** Which of the following best describes the patient's residential circumstance and availability of assistance? (Check **ONE** box only)

	Availability of Assistance				
Living Arrangement	Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	No assistance available
a. Patient lives alone	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
b. Patient lives with other person(s) in the home	☐ 06	☐ 07	☐ 08	☐ 09	☐ 10
c. Patient lives in congregate situation (e.g., assisted living)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

Primary Caregiver (name) ______

Phone # (if different from patient) ______

Relationship ______

Able to safely care for patient ☐ Yes ☐ No

Comments: ______

Others Living in Household

Name	Age	Sex	Relationship	Able/willing to assist?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Persons, organizations providing assistance/services (including HME, home infusion)

______

AIDE / HOMEMAKER REFERRAL FOR SERVICES: ☐ Yes ☐ No **PATIENT / CAREGIVER AGREES:** ☐ Yes ☐ No

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START OF CARE ASSESSMENT

Patient Name: ____________________

Clinician's Name: ____________________ Date: ____________

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Includes OASIS C Data Set (12/2009)

Section K: Sensory Status

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 ☐ PERRL
   - ☐ Legally Blind ☐ Ptosis ☐ Prosthesis: R / L
   - ☐ Infections ☐ Needs new prescription lenses
   - ☐ Cataract surgery: Site ____________ Date ____ / ____ / ____
   - ☐ Optometrist Contacted: Name ____________ Date ____ / ____ / ____
   - ☐ Ophthalmologist Contacted: Name ____________ Date ____ / ____ / ____
   - ☐ Other (specify) ____________

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

3. **Ears (M1210) Ability to hear** (with hearing aid or hearing appliance if normally used):
   - ☐ 0 – Adequate: hears normal conversation without difficulty.
   - ☐ 1 – Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.
   - ☐ 2 – Severely Impaired: absence of useful hearing.
   - ☐ UK – Unable to assess hearing.

   Ears (M1220) Understanding of Verbal Content in patient's own language (with hearing aid or device if used):
   - ☐ 0 – Understands: clear comprehension without cues or repetitions.
   - ☐ 1 – Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
   - ☐ 2 – Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
   - ☐ 3 – Rarely/Never Understands.
   - ☐ UK – Unable to assess understanding.

☐ **No Problem**
- ☐ HOH: R / L ☐ Deaf: R / L ☐ Hearing aid: R / L
- ☐ Vertigo ☐ Tinnitus: R / L ☐ Excess Cerumen
- ☐ Labyrinthis ☐ Rupture of Eardrum: R / L ☐ Pain
- ☐ Other (specify) ________

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
   ☐ Difficulty ________

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

5. **Nose and Sinus:** ☐ Normal ☐ Epistaxis ☐ Pain
   ☐ Other (specify) ________

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

7. **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
   - ☐ Ampuation: 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):

____

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START OF CARE ASSESSMENT

Patient Name: ___

Clinician's Name: ___ Date: ___

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Includes OASIS C Data Set (12/2009)

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

7. **Musculoskeletal, Neurological** *continued*

Comments: (Prostheses, appliances, etc.)

___

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

8. **Pain**

(M1240) Has this patient had a formal **Pain Assessment** using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?
- ☐ 0 – No standardized assessment conducted
- ☐ 1 – Yes, and it does not indicate severe pain
- ☐ 2 – Yes, and it indicates severe pain

QM **(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

continued on next column

8. **Pain** *continued*

0 No Hurt	1 - 2 Hurts Little Bit	3 - 4 Hurts Little More	5 - 6 Hurts Even More	7 - 8 Hurts Whole Lot	9 - 10 Hurts Worse

0 1 2 3 4 5 6 7 8 9 10
No Pain — Moderate Pain — Severe Pain

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: ___

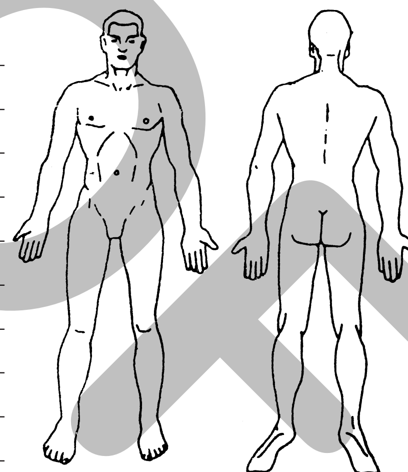
What makes pain better?
☐ Heat/Ice ☐ Massage ☐ Repositioning
☐ Rest/Relaxation ☐ Medication ☐ Diversion
☐ Other: ___

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

9. **Integumentary Status:**

A. **Skin Condition** *(On the diagram, sequentially number the location of each skin condition. Beside the corresponding number below, code the type and specify the size.)*

	Type Code	Size	Amount	Odor	Location
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					



Type Code: a - Bruises, b - Erythema (redness), c - Surgical, d - Traumatic, e - Masses, f - Pressure Ulcers, g - Scars, h - Stasis Ulcers, i - Burns, j - Diabetic, k - Other (Specify) ___

B. **Skin General Information** *(where applicable indicate location, date of onset, etc.)*

Skin Color: ___ **Turgor:** ☐ Good ☐ Fair ☐ Poor

Check all that apply: ☐ Warm ☐ Cool ☐ Clammy ☐ Itching ☐ Rash ☐ Bruises ☐ Petechiae ☐ Purpura ☐ Dry
☐ Other ___

C. **Nails** ☐ Normal ☐ Ingrown (Describe) ___ ☐ Poor Nail Care ☐ Other ___

D. **Hair** ☐ Normal ☐ Alopecia ☐ Infestation ☐ Other ___

continued on next page

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START OF CARE ASSESSMENT

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Clinician's Name: ______________________ Date: ______________

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

9. **Integumentary Status** *continued*

E. **(M1300) Pressure Ulcer Assessment:** Was this patient assessed for **Risk of Developing Pressure Ulcers**?
- ☐ 0 – No assessment conducted (Go to M1306)
- ☐ 1 – Yes, based on an evaluation of clinical factors, e.g., mobility, incontinence, nutrition, etc., without use of standardized tool
- ☐ 2 – Yes, using a standardized tool, e.g., Braden, Norton, other

(M1302) Does this patient have a **Risk of Developing Pressure Ulcers**?
☐ 0 – No ☐ 1 – Yes

(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

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

Complete at SOC/ROC/FU & D/C

Stage description – unhealed pressure ulcers	Number Currently Present
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)

(M1320) Status of Most Problematic (Observable) Pressure Ulcer:
☐ 0 - Newly epithelialized ☐ 1 - Fully granulating ☐ 2 - Early/partial granulation ☐ 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 Unhealed (Observable) Pressure Ulcer:
☐ 1 - Stage I ☐ 2 - Stage II ☐ 3 - Stage III ☐ 4 - Stage IV ☐ NA - No observable pressure ulcer or unhealed pressure ulcer

continued on next page

Definition: Integumentary Status (M1320, M1330, M1332, M1334)
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.

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START OF CARE ASSESSMENT

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Clinician's Name: ______________________ Date: ______________

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

9. **Integumentary Status** *continued*

F. **(M1330)** Does this patient have a **Stasis Ulcer?**
- ☐ 0 - No (If 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 ☐ 3 - Three
- ☐ 2 - Two ☐ 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

G. **(M1340)** Does this patient have a **Surgical Wound**
- ☐ 0 - No (If 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

H. **(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

Definition: Integumentary 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.

10. **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)

(M1410) Respiratory Treatments utilized at home: (Mark all that apply.)
- ☐ 0 - Oxygen (intermittent or continuous)
- ☐ 2 - Ventilator (continually or at night)
- ☐ 3 - Continuous/bilevel positive airway pressure
- ☐ 4 - None of the above

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: ______________________________________

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Patient Name: ______________________________

Clinician's Name: ______________________ Date: __________

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

10. **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:
☐ Clear ☐ Crackles ☐ Rales ☐ Wheezes ☐ Rhonchi
☐ Diminished ☐ Absent
Anterior: Right __________ Left __________
Posterior: Right Upper __________ Right Lower __________
Left Upper __________ Left Lower __________

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: ______________________

____

____

____

11. **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
☐ UK - Unknown

QM **(M1610) Urinary Incontinence or Urinary Catheter Presence:**
☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) (If No, go to M1620)
☐ 1 - Patient is incontinent
☐ 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) (Go to M1620)

(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

Urinary Catheter: **BOX # 21**
Type __________ Size __________ Change every __________
Care Orders ______________________
Other symptoms: ______________________

continued on next column

11. **Genitourinary Tract** *continued*

☐ Foley inserted (date) __________ with __________ French
Inflated balloon with _____ mL ☐ without difficulty ☐ Suprapubic
Irrigation solution: Type (specify): ______________________
Amount _____ mL Frequency __________ Returns __________
☐ Patient tolerated procedure well ☐ Yes ☐ No
☐ Urostomy (describe skin around stoma): ______________________

____

____

____

Ostomy care managed by: ☐ Self ☐ Caregiver
☐ Other (specify): ______________________

____

____

____

GU Elimination Status ☐ WNL
☐ Frequency ☐ Urgency ☐ Nocturia
☐ Hematuria ☐ Pain on urination ☐ Lesions
☐ Urinary retention ☐ Hesitancy
Color: ☐ Yellow/straw ☐ Amber ☐ Brown/gray ☐ Blood-tinged
Other: ______________________
Clarity: ☐ Clear ☐ Cloudy ☐ Sediment/mucous
Odor: ☐ Yes ☐ No

12. **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
☐ UK - Unknown

(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

continued on next page

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START OF CARE ASSESSMENT

Patient Name: ____________________

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

12. **Gastrointestinal Tract** *continued*
- ☐ Hernias (where) __________
- ☐ Diarrhea/constipation (specify) __________
- ☐ Gallbladder problems
- ☐ Other (specify) __________

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

13. **Reproductive System:**

Breasts: (For both male and female)
☐ Per Exam ☐ Reported by Patient/Family ☐ Normal
☐ Lumps ☐ Tenderness ☐ Discharge
☐ Pain ☐ Other (specify) __________
☐ Mastectomy: R ____ L ____ (date) __________
☐ Menses Present ☐ Menses Absent
☐ Vaginal discharge Date last PAP __________
☐ Contraception ☐ Hysterectomy (date) __________
☐ STD Gravida ______ Para __________
(describe) __________
☐ Lesions / Blisters / Masses / Cysts
☐ Prostate disorder: BPH/TURP (date) __________
☐ Other (specify) __________

External Genitalia (for both male and female) ☐ WNL
Abnormal (specify) __________

Does patient have sexuality concerns? ☐ No ☐ Yes
(Explain) __________

Comments: (specify location, duration, results)
____
____
____
____
____
____
____

14. **Nutritional Status:**

Height __________ ☐ Actual ☐ Reported
Weight __________ ☐ Actual ☐ Reported
☐ Recent Weight Gain ☐ Recent Weight Loss
☐ Overweight ☐ Underweight

Diet: __________ **BOX # 16**
Increase fluids ______ amt. Restrict fluids ______ amt.

☐ Normal meal patterns Normal food/fluid intake __________
Appetite: ☐ Good ☐ Fair ☐ Poor ☐ Anorexic
☐ Nausea/Vomiting: Frequency ______ Amount ______
☐ Heartburn (food intolerance)
☐ Other __________

14. **Nutritional Status** *continued*

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? ☐ Yes ☐ No

***SCORING KEY**
0-2: **Good.** As appropriate reassess and/or provide information based on situation.
3-5: **Moderate risk.** Educate, refer, monitor and reevaluate based on patient situation and organization policy.
6 or more: **High risk.** Coordinate with physician, dietitian, social service professional or nurse about how to improve nutritional health. Reassess nutritional status and educate based on plan of care.

Describe at risk intervention: __________
____
____

Patient has: ☐ Own teeth ☐ Dentures ☐ No teeth or dentures
Indicate problems in the following areas and describe:
☐ Chewing ☐ Swallowing ☐ Oral mucosa ☐ Gums ☐ Tongue

Enteral Feedings **BOX # 21**
☐ NG Tube ☐ Peg Tube ☐ G Tube ☐ J Tube
☐ Other __________
Date Changed __________ Date Inserted __________
Type of Feeding __________
Infusion Rate __________ Type of Pump __________

Parenteral Feedings **BOX # 21**
☐ Hydration ☐ TPN ☐ Orders __________
____
____
____

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START OF CARE ASSESSMENT

Patient Name: ______________________________

Clinician's Name: ______________________ Date: __________

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Includes OASIS C Data Set (12/2009)

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

15. **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.

☐ No problem
☐ Headache: Location ____________ Frequency ________
☐ PERRLA ☐ Unequal pupils: R / L (circle)
☐ Aphasia: Receptive / Expressive
☐ Motor change: Fine / Gross Site: ____________
☐ Dominant side: R / L (circle)
☐ Weakness: UE / LE Location: ____________
☐ Tremors: Fine / Gross / Paralysis Site: ____________
☐ Stuporous / Hallucinations: Visual / Auditory
Hand grips: Equal / Unequal (specify): ____________
Strong / Weak (specify): ____________
☐ Psychotropic drug use (specify): ____________
Dose / Frequency: ____________
☐ Other (specify):____________

(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

PSYCHOSOCIAL

Primary Language ____________
☐ Language barrier Needs interpreter ☐ No ☐ Yes
☐ Learning barrier: Mental / Psychosocial / Physical / Functional
☐ Unable to read / write Educational level ________
☐ Spiritual / cultural implications that impact care. Explain:
____
Spiritual resource: ____________
Phone No.: ____________
☐ Sleep / Rest: ☐ Adequate ☐ Inadequate. Explain:
____

continued on next column

PSYCHOSOCIAL *continued*

☐ Inappropriate responses to caregivers/clinicians
☐ Inappropriate follow-through in the past
☐ Angry ☐ Flat affect ☐ Discouraged
☐ Withdrawn ☐ Difficulty coping ☐ Disorganized
☐ Depressed: Recent / Long term
Treatment: ____________
☐ Inability to cope with altered health status as evidence by:
☐ Lack of motivation ☐ Inability to recognize problems
☐ Unrealistic expectations ☐ Denial of problems
☐ Evidence of abuse / neglect / exploitation:
☐ Potential ☐ Actual ☐ Verbal / Emotional ☐ Physical
☐ Financial ☐ Intervention
Describe: ____________

Comments

____
____
____
____
____

(M1730) Depression Screening: Has the patient been screened for depression, using a standardized depression screening tool?
☐ 0 - No
☐ 1 - Yes, patient was screened using the PHQ-2©* scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")

PHQ-2©*	Not all all 0-1 day	Several days 2-6 days	More than half of the days 7-11 days	Nearly every day 12-14 days	N/A Unable to respond
a. Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3	☐ NA
b. Feeling down, depressed, or hopeless?	☐ 0	☐ 1	☐ 2	☐ 3	☐ NA

☐ 2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.
☐ 3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression.

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(M1740) Cognitive, behavioral, and psychiatric symptoms 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
☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.

continued on next page

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START OF CARE ASSESSMENT

Patient Name: ___

Clinician's Name: ___ Date: ___

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

15. **Neuro/Emotional Behavioral Status**
M1740 Cognitive *continued*

- ☐ 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

(M1750) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?

- ☐ 0 - No
- ☐ 1 - Yes

Comments:

___

Mental Status: **BOX # 19**

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

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

- ☐ WNL
- ☐ Thyroid
- ☐ Pituitary
- ☐ Pancreas
- ☐ Adrenals
- ☐ Obesity
- ☐ Hypoglycemia sweats / weaks / faints
- ☐ Hyperglycemia polyuria / polydipsia / glycosuria
- ☐ Other (specify) ___
- ☐ Type I or Type II Diabetes (Date of onset if known) ___
- ☐ Diet / Oral control ☐ New Insulin dependent
- ☐ Blood sugar normal range for patient ___
- ☐ Self care demonstrated
- ☐ Needs diabetic care education
- ☐ **Hematopoietic**
  - ☐ WNL
  - ☐ Anemia, iron deficiency / pernicious
  - ☐ Other (specify) ___
  - ☐ Thrombocytopenia
  - ☐ GI Bleed / unknown source
  - ☐ Coagulation disorder
  - ☐ Aplastic Anemia
  - ☐ Hemolytic Polythermia

Notes:

___

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Includes OASIS C Data Set (12/2009)

Section L: ADL / IADLs (Life System Profile)

(M1800) 1. Grooming: Current ability to tend safely 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.

(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.

continued on next column

M1830 4. Bathing *continued*

- ☐ 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.

(M1845) 6. 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.

(M1850) 7. 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.

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START OF CARE ASSESSMENT

Patient Name: ______________________________

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

(M1860) 8. 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 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.

(M1870) 9. 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.
- ☐ 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.

(M1880) 10. Current ability to **Plan and Prepare Light Meals** (e.g., cereal, sandwich) or reheat delivered meals:

- ☐ 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.

(M1890) 11. 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.

(M1900) 12. Prior Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to this current illness, exacerbation, or injury. Check only **ONE** box in each row.

Functional Area	Inde-pendent	Needed Some Help	Dependent
a. Self-Care (e.g., grooming, dressing, and bathing)	☐ 0	☐ 1	☐ 2
b. Ambulation	☐ 0	☐ 1	☐ 2
c. Transfer	☐ 0	☐ 1	☐ 2
d. Household tasks (e.g., light meal preparation, laundry, shopping)	☐ 0	☐ 1	☐ 2

INDICATIONS FOR HOME HEALTH AIDES:

☐ Yes ☐ No ☐ Refused

Orders obtained: ☐ Yes ☐ No

Referral to: ☐ HHA ☐ MSW ☐ PT ☐ OT ☐ ST

☐ Other ______________________________

____

____

____

____

____

____

____

(M1910) 13. Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)? *See page 20 for Fall Risk Assessment.*

- ☐ 0 - No multi-factor falls risk assessment conducted.
- ☐ 1 - Yes, and it does not indicate a risk for falls.
- ☐ 2 - Yes, and it indicates a risk for falls.

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

MEDICATIONS

(M2000) 14. Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?

- ☐ 0 - Not assessed/reviewed *(Go to M2010)*
- ☐ 1 - No problems found during review *(Go to M2010)*
- ☐ 2 - Problems found during review.
- ☐ NA - Patient is not taking any medications *(Go to M2040)*

(M2002) 15. Medication Follow-up: Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?

- ☐ 0 - No
- ☐ 1 - Yes

(M2010) 16. Patient/Caregiver High Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications.

(M2020) 17. 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.

continued on next column

M2020 17. Management of Oral Medications *continued*

- ☐ 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.

(M2030) 18. 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.

(M2040) 19. Prior Medication Management: Indicate the patient's usual ability with managing oral and injectable medications prior to this current illness, exacerbation, or injury. Check only **ONE** box in each row.

Functional Area	Inde-pendent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	☐ 0	☐ 1	☐ 2	☐ NA
b. Injectable medications	☐ 0	☐ 1	☐ 2	☐ NA

(M2100) 20. 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

(M2110) 21. 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
- ☐ UK - Unknown

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START OF CARE ASSESSMENT

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Section M: 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 ______________			
g. Syringes	☐	☐	☐
h. Miscellaneous			
Sharps container	☐	☐	☐
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) ______________	☐	☐	☐
______________	☐	☐	☐
______________	☐	☐	☐
______________	☐	☐	☐
______________	☐	☐	☐

Notes:

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START OF CARE ASSESSMENT

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Section N: Therapy Need and Plan of Care

(M2200) 1. Therapy Need and Plan of Care: 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.

(M2250) 2. Plan of Care Synopsis: (Check only **ONE** box in each row.) Does the physician-ordered plan of care include the following:

Plan / Intervention	No	Yes	Not Applicable	
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	☐ 0	☐ 1	☐ NA	Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference
b. 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
c. Falls prevention interventions	☐ 0	☐ 1	☐ NA	Patient is not assessed to be at risk for falls
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐ 0	☐ 1	☐ NA	Patient has no diagnosis or symptoms of depression
e. Intervention(s) to monitor and mitigate pain	☐ 0	☐ 1	☐ NA	No pain identified
f. Intervention(s) to prevent pressure ulcers	☐ 0	☐ 1	☐ NA	Patient is not assessed to be at risk for pressure ulcers
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	☐ 0	☐ 1	☐ NA	Patient has no pressure ulcers with need for moist wound healing

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Section O: Safety Measures for Patient's Protection BOX # 15

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: ______________________________

____

____

____

____

____

____

____

HOME ENVIRONMENT SAFETY

Safety hazards in the home:

- Unsound structure ☐ Yes ☐ No
- Inadequate heating/cooling/electricity ☐ Yes ☐ No
- Inadequate sanitation/plumbing ☐ Yes ☐ No
- Inadequate refrigeration ☐ Yes ☐ No
- Unsafe gas/electrical appliances or outlets ☐ Yes ☐ No
- Inadequate running water ☐ Yes ☐ No
- Unsafe storage of supplies/equipment ☐ Yes ☐ No
- No telephone available and/or unable to use phone ☐ Yes ☐ No
- Insects/rodents ☐ Yes ☐ No
- Medications stored safely ☐ Yes ☐ No

Emergency planning/fire safety:

- Fire extinguisher ☐ Yes ☐ No
- Smoke detectors on all levels of home ☐ Yes ☐ No
  - Tested and functioning ☐ Yes ☐ No
- More than one exit ☐ Yes ☐ No
  - Plan for exit ☐ Yes ☐ No
- Plan for power failure ☐ Yes ☐ No

Oxygen use:

- Signs posted ☐ Yes ☐ No
- Handles smoking/flammables safely ☐ Yes ☐ No
- Oxygen back-up available ☐ Yes ☐ No
  - ☐ Knows how to use ☐ Electrical/fire safety

Other Precautions:

- Emergency care ☐ Yes ☐ No
- Bleeding precautions ☐ Yes ☐ No
- Medical alert devices ☐ Yes ☐ No
- Infection control measures ☐ Yes ☐ No
- Restraints ☐ Yes ☐ No
- Fall prevention ☐ Yes ☐ No
- Diabetic ☐ Yes ☐ No
- Seizure ☐ Yes ☐ No
- Sharps ☐ Yes ☐ No
- Aspiration ☐ Yes ☐ No
- 24 hour supervision ☐ Yes ☐ No
- Elevate HOB ________ degrees
- Patient able to summon help / 911 ☐ Yes ☐ No
- Patient able to call MD ☐ Yes ☐ No

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Section O: Safety Measures for Patient's Protection *continued*

Instructions/Materials Provided (Check all applicable items)

- ☐ Rights and responsibilities
- ☐ State hotline number
- ☐ Advance directives
- ☐ Do not resuscitate (DNR)
- ☐ HIPAA Notice of Privacy Practices
- ☐ OASIS Privacy Notice
- ☐ Emergency planning in the event service is disrupted
- ☐ Agency phone number/after hours number
- ☐ When to contact physician and/or agency
- ☐ Standard precautions/handwashing
- ☐ Basic home safety
- ☐ Disease (specify) ______________
- ☐ Medication regime/administration
- ☐ Other ______________

Instructions given to:

☐ Patient ☐ Caregiver (Name) ______________

Comments: ______________

Functional Limitations BOX # 18A

- ☐ 1 Amputation
- ☐ 2 Bowel/Bladder (incontinence)
- ☐ 3 Contracture
- ☐ 4 Hearing
- ☐ 5 Paralysis
- ☐ 6 Endurance
- ☐ 7 Ambulation
- ☐ 8 Speech
- ☐ 9 Legally Blind
- ☐ A Dyspnea with Minimal Exertion
- ☐ B Other (specify) ______________

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 Crutches
- ☐ 9 Cane
- ☐ A Wheelchair
- ☐ B Walker
- ☐ C No Restrictions
- ☐ D Other (specify) ______________

Section P: Homebound Reason (Check all that apply and explain)

☐ Needs assistance for all activities ☐ Residual weakness ☐ Requires assistance to ambulate: ☐ 1 person ☐ 2 people
(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): ______________

Section Q: Impressions and Skilled Interventions / Teaching Performed This Visit

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) ______________

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Section Q: Impressions and Skilled Interventions / Teaching Performed This Visit *continued*

Teaching: ____________________

Skill: ____________________

ADDITIONAL NOTES ON SKILLED CARE PROVIDED THIS VISIT

____

Section R: 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 ____________

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

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 ____________

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

DISCLIPLINE 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**

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 ______ / _____ / ______

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