

E-Clinical OASIS C Follow-Up Assessment

(M0020) Patient ID Number

DATE

TIME IN

TIME OUT

(M0030) Start of Care

Month Day Year

(M0032) Resumption of Care Date:

Month Day Year

NA - Not applicable

(M0066) Birth Date:

Month Day Year

(M0040) Patient's Name:

(First)

(MI)

(Last)

(Suffix)

(M0080) Discipline of Person Completing

1-RN 2-PT 3-SLP-ST 4-OT

(M0090) Date Assessment

Month Day Year

CERTIFICATION PERIOD / EPISODE DATES

Month Day Year

Month Day Year

FROM

TO

(M0100) This Assessment is Currently being completed for the Following Reason:

4 - Recertification (follow-up) reassessment [Go to M0110]

5 - Other follow-up [Go to M0110]

SENSORY STATUS

VITAL SIGNS	PULSE	<input type="checkbox"/> Apical	<input type="checkbox"/> Reg	<input type="checkbox"/> Irreg	B/P Lying Sitting Standing	Height		O2 Sat	%
		<input type="checkbox"/> Radial	<input type="checkbox"/> Reg	<input type="checkbox"/> Irreg	L	<input type="checkbox"/> Actual <input type="checkbox"/> Stated <input type="checkbox"/> Estimated		RA	
	Temp	Resp			R	Weight	<input type="checkbox"/> Actual <input type="checkbox"/> Stated <input type="checkbox"/> Estimated	O2	LPM

VACCINE: Flu Vaccine Other Vaccine

Comments:

(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

UK - Unknown

2 - Later

NA - Not Applicable: No medicare case mix group to be defined by this assessment.

(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

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(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-C M 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 Diagnosis		(M1024) Payment Diagnosis (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_CM 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
<u>M1020 Primary Diagnosis</u>	<u>(V-codes are allowed)</u>	<u>(V-codes or E-codes are allowed)</u>	<u>(V-codes or E-codes are allowed)</u>
a. _____ <u>Diagnosis Date</u>	a. <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <u>Exacerbation / Onset</u> <input type="checkbox"/> E <input type="checkbox"/> O	a.	a.
<u>M1022 Other Diagnosis</u>			
b. _____ <u>Diagnosis Date</u>	b. <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <u>Exacerbation / Onset</u> <input type="checkbox"/> E <input type="checkbox"/> O	b.	b.
c. _____ <u>Diagnosis Date</u>	c. <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <u>Exacerbation / Onset</u> <input type="checkbox"/> E <input type="checkbox"/> O	c.	c.
d. _____ <u>Diagnosis Date</u>	d. <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <u>Exacerbation / Onset</u> <input type="checkbox"/> E <input type="checkbox"/> O	d.	d.
e. _____ <u>Diagnosis Date</u>	e. <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <u>Exacerbation / Onset</u> <input type="checkbox"/> E <input type="checkbox"/> O	e.	e.

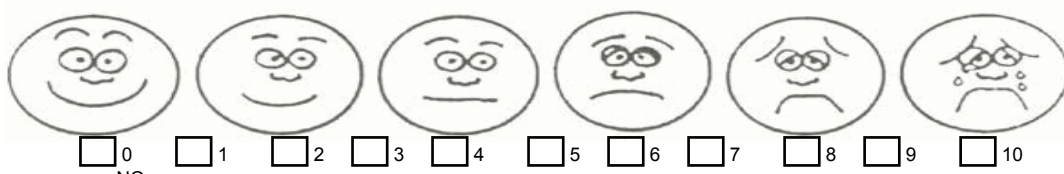
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- Limited ROM (give location)
- Bone or joint problems
- Pain or Cramps
- Redness, Warmth, Swelling
- Decreased Mobility/Endurance
- Tremors
- Amputation of
- Prosthesis/Appliance
- Device use
- Ordered
- instructed on home safety, fall precautions, Home Folder information

(M1242) Frequency of Pain Interfering with patient's activity or movement:

- 0 - Patient has no pain Comments
- 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

Wong-Baker FACES Pain Rating Scale



Brief word instructions: Point to each face using the words to describe the pain intensity. Ask the child to choose face that best describes own pain and record the appropriate number.

Original instructions: Explain to the person that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain. **Face 0** is very happy because he doesn't hurt at all. **Face 2** hurts a little bit. **Face 4** hurts a little more. **Face 6** hurts even more. **Face 8** hurts a whole lot. **Face 10** hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask the person to choose which face best describes how he is feeling.

Rating scale is recommended for persons age 3 years and older.

From Hockenberry MJ, Wilson D, Wilkenstein ML: Wong's Essentials of Pediatric Nursing, ed. 7, St. Louis, 2005, p.1259. Used with permission. Copyright, Mosby.

Pain Description

- Sharp Dull Other

Acceptable Level of Pain
Pain Med
Frequency Used
Effectiveness

- Instructed on Pain Medication Instructed on non-pharmacological pain reducing methods Verbalizes understanding

Behavioral Scale

Faces	<input type="checkbox"/> 0 No particular expression or smile	<input type="checkbox"/> 1 Occasional grimace or frown, withdrawn disinterested	<input type="checkbox"/> 2 Frequent to constant frown, clenched jaw, quivering chin
Legs	<input type="checkbox"/> 0 Normal Position or relaxed	<input type="checkbox"/> 1 Uneasy, restless, tense	<input type="checkbox"/> 2 Kicking, or legs drawn up
Activity	<input type="checkbox"/> 0 Lying quietly, normal position, moves easily	<input type="checkbox"/> 1 Squirming, shifting back and forth, tense	<input type="checkbox"/> 2 Arched, rigid, or jerking

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Cry	0 <input type="checkbox"/> No cry (awake or asleep)	1 <input type="checkbox"/> Moans or whimpers, occasional complaint	2 <input type="checkbox"/> Crying steadily, screams or sobs, frequent complaints
Consolability	0 <input type="checkbox"/> Content, relaxed	1 <input type="checkbox"/> Reassured by occasional touching, hugging or talking to, distractible	2 <input type="checkbox"/> Difficult to console or comfort

0 - 3 = No risk 4 - 6 = Some risk 7 - 10 = High risk

Total:

INTEGUMENTARY

- Skin Turgor** Good Fair Poor
- Skin Color** Pink Fair
 Jaundice Cyanotic
- Skin** Dry Diaphoretic Moist
 Warm Cool
- Skin** Wounds Ulcers Incision
 Ostomy Rashes Other
- Nails** Normal Problems

INFECTION CONTROL

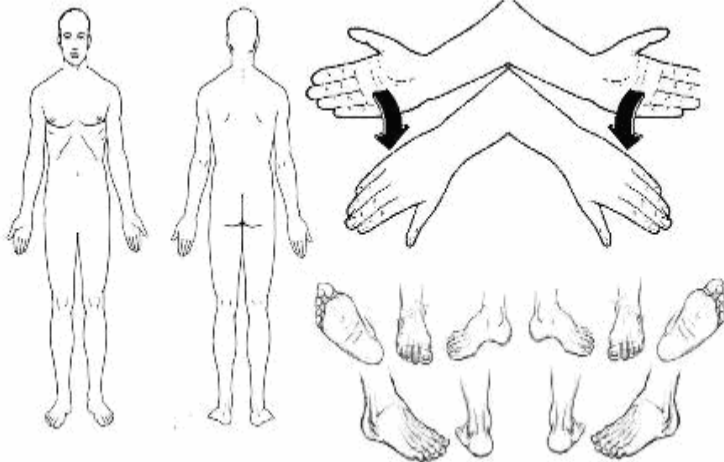
- | | | |
|--------------------------|--------------------------|--------------|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Soap |
| <input type="checkbox"/> | <input type="checkbox"/> | Paper Towels |
| <input type="checkbox"/> | <input type="checkbox"/> | Other |
- Instructed on

High Risk for infection

Special Needs

HAIR

- | | | |
|--------------------------|--------------------------|-------------------------|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Hair Condition |
| <input type="checkbox"/> | <input type="checkbox"/> | Hair Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Infestation |
| <input type="checkbox"/> | <input type="checkbox"/> | Other |



- | | | |
|--------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Lesions | <input type="checkbox"/> Rash | <input type="checkbox"/> Bruises |
| <input type="checkbox"/> Scars | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Incisions |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Stasis Ulcer | <input type="checkbox"/> Pruritus |
| <input type="checkbox"/> Abrasions | <input type="checkbox"/> Masses | <input type="checkbox"/> Fistulas |
| <input type="checkbox"/> Dry/Scaling | <input type="checkbox"/> Pressure Ulcer | <input type="checkbox"/> Other |

Overall specifics and details on overall wound care

Comments on Types of Wound and Description

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as "unstageable"?

Comments

- 0 - No [Go to M1322]
- 1 - Yes

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

Stage description - unhealed pressure ulcers	Complete at SOC/ROC/FU & DC, Number Currently Present	Complete at FU and DC - Number of those listed in column 1 that were present on admission (most recent SOC/ROC)
<p>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.</p>		
<p>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.</p>		

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<input type="checkbox"/> No problem identified	<input type="checkbox"/> Pacemaker	Insertion Date	
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Fatigues easily	<input type="checkbox"/> Poor capillary refill	<input type="checkbox"/> Orthostatic Hypotension
<input type="checkbox"/> CAD	<input type="checkbox"/> TIA/CVA	<input type="checkbox"/> Long-term Anticoagulant	
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Other: (specify)		

Heart Rate:	<input type="checkbox"/> No problem identified	EDEMA:	<input type="checkbox"/> Pedal R/L	<input type="checkbox"/> Dependent	Comments
<input type="checkbox"/> Regular	<input type="checkbox"/> Irregular	<input type="checkbox"/> Reg/Irreg	<input type="checkbox"/> Pitting +1+2+3+4(site)		
<input type="checkbox"/> Tachycardia	<input type="checkbox"/> Bradycardia	<input type="checkbox"/> Arrythmia	<input type="checkbox"/> Non-pitting (site)		

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

<input type="checkbox"/> 0 - Patient is not short of breath	Comments
<input type="checkbox"/> 1 - When walking more than 20 feet, climbing stairs	
<input type="checkbox"/> 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)	
<input type="checkbox"/> 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation	
<input type="checkbox"/> 4 - At rest (during day or night)	

Respiratory No problem identified Comments

<input type="checkbox"/> Breath Sounds	<input type="checkbox"/> Cyanosis	<input type="checkbox"/> Sputum
<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Cough	<input type="checkbox"/> Orthopnea
<input type="checkbox"/> Hemoptysis	<input type="checkbox"/> Smoker	<input type="checkbox"/> O2 Usage
<input type="checkbox"/> Instructed on O2 Safety	<input type="checkbox"/> O2 Sat	<input type="checkbox"/> O2 L/Min <input type="checkbox"/> Other

(M1610) Urinary Incontinence or Urinary Catheter Presence:

<input type="checkbox"/> 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) [Go to M1620]	Comments
<input type="checkbox"/> 1 - Patient is incontinent	
<input type="checkbox"/> 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) [Go to M1620]	

URINARY Urinary Color Amount Odor Comments

<input type="checkbox"/> Hematuria	<input type="checkbox"/> Oliguria	<input type="checkbox"/> Burning	<input type="checkbox"/> Polyuria	<input type="checkbox"/> Retention: Cramping/Dysuria/Sediment
<input type="checkbox"/> Incontinence		<input type="checkbox"/> Foley Catheter		

BOWEL: Last BM Usual Frequency External Genitalia: Per: Physical Assessment No changes since previous assmnt. Comments

<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Normal	<input type="checkbox"/> Pt/Cg Reported
<input type="checkbox"/> Abnormal stools: Gray/Tarry/Fresh Blood	<input type="checkbox"/> Abnormal	
<input type="checkbox"/> Lax/enema use: Type		
<input type="checkbox"/> Constipation: Chronic/Acute/Occasional	<input type="checkbox"/> Ostomy: Type	
<input type="checkbox"/> Hemorrhoids: Internal/External	<input type="checkbox"/> Caregiver/Patient instructed on care	

(M1620) Bowel Incontinence Frequency:

<input type="checkbox"/> 0 - Very rarely or never has bowel incontinence	<input type="checkbox"/> 1 - Less than once weekly	Comments
<input type="checkbox"/> 2 - One to three times weekly	<input type="checkbox"/> 3 - Four to six times weekly	
<input type="checkbox"/> 4 - On a daily basis	<input type="checkbox"/> 5 - More often than once daily	
<input type="checkbox"/> 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?

Comments

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- 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.

ENDOCRINE: No problem identified Comments

Polyuria/Polydipsia/Polyphagia Neuropathy/Radiculopathy Thyroid Disease Diabetes

(M1810) Current Ability to Dress Upper Body safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

Comments

- 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) Current Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

Comments

- 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) Bathing: Current ability to wash entire body safely. **Excludes grooming (washing face and hands and shampooing hair).**

Comments

- 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) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet / commode.

Comments

- 0 - Able to get to and from the toilet and transfer 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).

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- 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) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

Comments

- 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.

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Comments

- 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.

Fall Risk Assessment			
A.	Level of Consciousness/ Mental Status	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Alert and oriented X3 Disoriented X3 at all times Intermittent confusion
B.	History of Falls (past 3 months)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	No falls 1-2 falls 3 or more falls
C.	Ambulation/ Elimination Status	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Ambulatory and continent Chair bound and requires assist with toileting Ambulatory and incontinent
D.	Vision Status	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Adequate (w/ or w/o glasses) Poor (w/ or w/o glasses) Legally Blind
E.	Gait and Balance	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have patient stand on both feet w/o any type of assist then have walk: forward, thru a doorway, then make a turn. (mark all that apply.) Normal/safe gait and balance Balance problem while standing Balance problem while walking Decreased muscular coordination Change in gait pattern when walking through doorway Jerking or unstable when making turns Requires assistance (person, furniture/walls or device)

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F.	Orthostatic Changes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	No noted drop in blood pressure between lying and standing. No change to cardiac rhythm. Drop <20mmHg in BP between lying and standing. Increase of cardiac rhythm <20. Drop >20mmHg in BP between lying and standing. Increase of cardiac rhythm >20.
G.	Medications	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Based upon the following types of medications: anesthetics, antihistamines, cathartics, diuretics, antihypertensives, antiseizure, benzodiazepines, hypoglycemics, psychotropics, sedatives/hypnotics. None of these medications taken currently or w/in past 7 days Takes 1-2 of these medications currently or w/in pst 7 days Takes 3-4 of these medications currently or w/in past 7 days Mark additional point if patient has had a change in these medications or doses in past 5 days
H.	Predisposing Diseases	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Based upon the following conditions: hypotension, vrtigo, CVA, Parkinsons disease, loss of limb(s), seizures, arthritis, osteoporosis, fractures. None present 1-2 present 3 or more present
I.	Equipment Issues	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	No risk factors noted Oxygen tubing Inappropriate or client does not consistently use assistive device Equipment needs Other

Total: 0 - 4 = No risk 5 - 9 = Some risk 10 or more = High risk

Additional Services Requested:

SN PT OT MSS AIDE Other

If no additional services requested, check reason:

Discipline already ordered
 Pt has been assessed by this discipline w/in last 30 days
 Patient refused additional discipline
 Comments

(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.** Comments

- 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.

Activities Permitted

- | | | | | |
|---|--|--|---|--|
| <input type="checkbox"/> Complete bed rest | <input type="checkbox"/> Bed rest with BRP | <input type="checkbox"/> Up as tolerated | <input type="checkbox"/> Transfer bed-chair | <input type="checkbox"/> Exercise prescribed |
| <input type="checkbox"/> Partial weight bearing | <input type="checkbox"/> Independent at home | <input type="checkbox"/> Crutches | <input type="checkbox"/> Cane | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Other (specify below) | | | |

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Mental Status

- Oriented
 Comatose
 Forgetful
 Depressed
 Disoriented
 Lethargic
 Agitated
 Other (specify Below)

(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)?

Comments

(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.

NUTRITIONAL STATUS

- | <table border="0"> <tr><th style="text-align: left;">Yes</th><th style="text-align: left;">No</th></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> | Yes | No | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <table border="0"> <tr><th style="text-align: left;">Yes</th><th style="text-align: left;">No</th></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> | Yes | No | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Functional Limitations

- Amputation
 Bowel / Bladder incontinence
 Contracture
 Hearing
 Paralysis
 Endurance
 Ambulation
 Speech
 Legally Blind
 Dyspnea with minimal exertion
 Other (specify below)

DME

- | | |
|---|--|
| <input type="checkbox"/> Bedside Commode | <input type="checkbox"/> Prosthetic Device |
| <input type="checkbox"/> Elevated Toilet Seat | <input type="checkbox"/> Leg Brace |
| <input type="checkbox"/> Tub/Shower Bench | <input type="checkbox"/> Cane |
| <input type="checkbox"/> Grab Bars | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Hospital Bed | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> Special Transferring Equipment | |
| <input type="checkbox"/> Other | |

Allergies

- NKA
 NKDA

Supplies

- | | | |
|---|---|---|
| <input type="checkbox"/> ABDs | <input type="checkbox"/> Exam Gloves | <input type="checkbox"/> NG Tube |
| <input type="checkbox"/> Ace Wrap | <input type="checkbox"/> Foley Catheter / Drainage Bags | <input type="checkbox"/> Special Dressing |
| <input type="checkbox"/> Alcohol Pads | <input type="checkbox"/> Gauze Pads | |
| <input type="checkbox"/> Chux / Underpads | <input type="checkbox"/> Insertion Kit | |
| <input type="checkbox"/> Colostomy Bag | <input type="checkbox"/> Irrigating Solution, Type | <input type="checkbox"/> Sterile Gloves |
| <input type="checkbox"/> Diabetic Supplies | <input type="checkbox"/> Irrigation Set | <input type="checkbox"/> Syringe |
| <input type="checkbox"/> Drainage Bag | <input type="checkbox"/> Kerlix Rolls | <input type="checkbox"/> Tape |
| <input type="checkbox"/> Dressing Supplies | <input type="checkbox"/> Leg Bag | <input type="checkbox"/> Wound Vac Kits |
| <input type="checkbox"/> Duoderm / Tegaderm | <input type="checkbox"/> Needles | |
| <input type="checkbox"/> Other | | |

Safety Measures

- | | | |
|---|--|---|
| <input type="checkbox"/> Safe Environment | <input type="checkbox"/> Fall Precautions | <input type="checkbox"/> Support During Transfer and Ambulation |
| <input type="checkbox"/> Emergency Plan Developed | <input type="checkbox"/> Seizure Precautions | <input type="checkbox"/> Ambulate w/in Limits of Endurance |
| <input type="checkbox"/> Adequate Safe Units | <input type="checkbox"/> Neutropenic Precautions | <input type="checkbox"/> Keep Pathways Clear |
| <input type="checkbox"/> 24 Hour Supervision | <input type="checkbox"/> Universal precautions / Infection Control | <input type="checkbox"/> Use of Assistive Device |
| <input type="checkbox"/> Safety in ADLs | <input type="checkbox"/> Infection Control | <input type="checkbox"/> Eat Meals at Regular Intervals |

E-Clinical OASIS C Follow-Up Assessment

- | | | |
|--|---|---|
| <input type="checkbox"/> Anticoagulant Precautions | <input type="checkbox"/> Keep Side Rails Up | <input type="checkbox"/> Proper Position During Meals |
| <input type="checkbox"/> O2 Precautions | <input type="checkbox"/> Slow Position Change | <input type="checkbox"/> Other |

Homebound	NO	YES	REASON:
<input type="checkbox"/> Bedbound	<input type="checkbox"/> Poor / limited strength	<input type="checkbox"/> Require assist with transfer	<input type="checkbox"/> Paralysis of upper / lower extremities
<input type="checkbox"/> SOB on exertion	<input type="checkbox"/> Partial weight bearing	<input type="checkbox"/> Require assist with ambulate	<input type="checkbox"/> Weakness of upper / lower extremities
<input type="checkbox"/> Wheelchair bound	<input type="checkbox"/> Poor limited endurance	<input type="checkbox"/> Poor coordination or balance	<input type="checkbox"/> Requires assistive device to ambulate
<input type="checkbox"/> Poor unsteady gait	<input type="checkbox"/> Requires assist with ADL	<input type="checkbox"/> Unable to leave home without assistance	<input type="checkbox"/> Confusion, unsafe to go out of home alone
<input type="checkbox"/> Non weight bearing	<input type="checkbox"/> Unable to tolerate sitting up	<input type="checkbox"/> Unable to negotiate uneven surfaces or steps	<input type="checkbox"/> Unable to safely leave home unassisted
<input type="checkbox"/> Ambulate		<input type="checkbox"/> Other	

CRITERIA FOR EVALUATING A PATIENT'S RISK FOLLOWING A DISASTER: (Check the category that is applicable)

<input type="checkbox"/> Category I	<input type="checkbox"/> Category II	<input type="checkbox"/> Category III
Patient's who can safely forego care or a scheduled visit without a high probability of harm or detourous effects; this category may include homemaker patients, routine supervisory visits, patient's with frequencies of one or two times a week if health status permits, or if a competent family or caregiver is present	Patients with recent exacerbation of disease process; patients requiring moderate level of skilled care that should be provided that day; patients with essential untrained families / caregivers not prepared to provide needed care	Patients / clients who cannot safely forego care and require health care intervention regardless of other conditions. Patients / clients in this category may include: highly unstable patients / clients with a high probability of inpatient admission if home care is not provided; IV therapy patients / clients with no family / caregiver or other outside support

DISCHARGE PLANS

- | | |
|--|--|
| <input type="checkbox"/> Discharge when optimal function attained with:
<input type="checkbox"/> Family Assist <input type="checkbox"/> Comm. Services <input type="checkbox"/> IHSS in weeks / visits
<input type="checkbox"/> Discharge when independent with Physician follow-up in weeks / visits
<input type="checkbox"/> Patient to continue with rehabilitation program on an outpatient basis in weeks / visits
<input type="checkbox"/> Patient of Treatment to be re-evaluated in weeks / visits | <input type="checkbox"/> Patient to remain with agency support for maintenance of:
<input type="checkbox"/> Foley Catheter
<input type="checkbox"/> Feeding Tube
<input type="checkbox"/> Insulin Administration
<input type="checkbox"/> Others |
|--|--|

SKILLED OBSERVATION: (Describe Findings / Problems)

<input type="checkbox"/> Living Arrangements	<input type="checkbox"/> Structural Barriers <input type="checkbox"/> Knowledge deficit related to: <input type="checkbox"/> Safety Hazards <input type="checkbox"/> Community Resources	<input type="checkbox"/> Financial Problems <input type="checkbox"/> Infection Control <input type="checkbox"/> Others	<input type="checkbox"/> No available, willing and able caregiver <input type="checkbox"/> Sanitation hazards
<input type="checkbox"/> Cardiovascular Status	<input type="checkbox"/> Alteration in CV status <input type="checkbox"/> Knowledge deficit related to: <input type="checkbox"/> Intake & Output <input type="checkbox"/> Others	<input type="checkbox"/> Checking Apical / Radial	<input type="checkbox"/> Wt. measurement
<input type="checkbox"/> Sensory Status	<input type="checkbox"/> Pain <input type="checkbox"/> Impaired Vision <input type="checkbox"/> Others	<input type="checkbox"/> Impaired hearing	<input type="checkbox"/> Impaired speech / Communication / Swallowing
<input type="checkbox"/> Integumentary Status	<input type="checkbox"/> Alteration in skin integrity <input type="checkbox"/> Knowledge deficit related to: <input type="checkbox"/> Wound care	<input type="checkbox"/> Potential or high risk for skin breaks <input type="checkbox"/> Skin and diabetic foot care	<input type="checkbox"/> Proper disposal of medical waste
<input type="checkbox"/> Respiratory Status	<input type="checkbox"/> Ineffective airway clearance <input type="checkbox"/> Knowledge deficit related to:		

E-Clinical OASIS C Follow-Up Assessment

	<input type="checkbox"/> Energy Conservation <input type="checkbox"/> Specific factor that precipitate an exacerbation or attack <input type="checkbox"/> O2 use / Safety precautions <input type="checkbox"/> Others
<input type="checkbox"/> Nutrition / Elimination	<input type="checkbox"/> Alteration in nutrition R/T <input type="checkbox"/> Knowledge deficit related to: <input type="checkbox"/> NGT / GT feedings <input type="checkbox"/> Aspiration precaution <input type="checkbox"/> Adequate Hydration <input type="checkbox"/> Nutrition <input type="checkbox"/> Foley catheter care <input type="checkbox"/> S/S of UTI to report <input type="checkbox"/> Others
<input type="checkbox"/> Endocrine	<input type="checkbox"/> Knowledge deficit related to <input type="checkbox"/> Diabetic Management <input type="checkbox"/> Enlarged Thyroid <input type="checkbox"/> Others
<input type="checkbox"/> Neuro / Emotional / Behavioral Status	<input type="checkbox"/> Disoriented <input type="checkbox"/> Confused <input type="checkbox"/> Behavioral problems <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed <input type="checkbox"/> Others
<input type="checkbox"/> ADL / IADL	<input type="checkbox"/> Self care deficit related to <input type="checkbox"/> Personal care <input type="checkbox"/> ADL / IADL Assistance <input type="checkbox"/> Others
<input type="checkbox"/> Musculoskeletal Status	<input type="checkbox"/> Impaired physical mobility <input type="checkbox"/> Knowledge deficit related to: <input type="checkbox"/> Proper and safe body alignment and positions <input type="checkbox"/> Others
<input type="checkbox"/> Medications	<input type="checkbox"/> Knowledge deficit related to <input type="checkbox"/> Preparation and Administration of meds <input type="checkbox"/> Action, dosage and side effects of meds <input type="checkbox"/> Others
<input type="checkbox"/> Infusion Therapy	<input type="checkbox"/> Knowledge deficit related to <input type="checkbox"/> IV administration <input type="checkbox"/> Flushing <input type="checkbox"/> Site Care / dressing change complications <input type="checkbox"/> Others
<input type="checkbox"/> Equipment Management	<input type="checkbox"/> knowledge deficit related to (specify equipment)
<input type="checkbox"/> Spiritual Status	<input type="checkbox"/> Spiritual Need <input type="checkbox"/> Love and relatedness <input type="checkbox"/> Meaning & purpose <input type="checkbox"/> Forgiveness <input type="checkbox"/> Others
<input type="checkbox"/> Others	<input type="checkbox"/> Knowledge deficit related to <input type="checkbox"/> Disease process <input type="checkbox"/> Others

60 DAY SUMMARY

Discipline(s)

- | | | | |
|--|---|--|-----------------|
| <input type="checkbox"/> Skilled Nurse | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Occupational Therapy | BP Range |
| <input type="checkbox"/> CHHA | <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Medical Social Worker | FBS / RBS Range |
| <input type="checkbox"/> Other | | | Other (specify) |

<p>Instructions / procedure performed</p> <input type="checkbox"/> Meds <input type="checkbox"/> Wound Care <input type="checkbox"/> Safety <input type="checkbox"/> Diabetic Management <input type="checkbox"/> Other	<p>SN Outcomes achieved:</p> <p>SN services (including HH Aide) need to continue for:</p> <input type="checkbox"/> Observation and assessment <input type="checkbox"/> Medication changes <input type="checkbox"/> Change in treatment plan <input type="checkbox"/> Foley maintenance <input type="checkbox"/> PT/PCG slowly learning <input type="checkbox"/> Personal care <input type="checkbox"/> IM/SQ injection <input type="checkbox"/> Other(specify)	<p>Recommendations</p>
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E-Clinical OASIS C Follow-Up Assessment

DISCIPLINE: frequency / duration

SN

PT/OT

CHHA

DATE / HOUR	WRITTEN SUMMARY
-------------	-----------------

<p>DIABETES MANAGEMENT</p> <p><input type="checkbox"/> DM</p> <p><input type="checkbox"/> Manifestation of DM</p> <p><input type="checkbox"/> Diabetes Type I / Type II</p> <p><input type="checkbox"/> Insulin / Oral Agent <input type="checkbox"/> Diet controlled</p> <p><input type="checkbox"/> Knowledge deficit</p> <p>Comments</p> <p>Diabetic Foot Care Teaching</p>	<p><input type="checkbox"/> Glucometer use / monitor in home</p> <p><input type="checkbox"/> FSBS range / Results</p> <p><input type="checkbox"/> Manifestations</p> <p><input type="checkbox"/> Renal <input type="checkbox"/> Neuropathy / Neurological <input type="checkbox"/> Ophthalmic</p> <p><input type="checkbox"/> Others</p> <p><input type="checkbox"/> Others</p>
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SKILLED INTERVENTION: (PROCEDURE AND TEACHING):

Pt / PCG instructed / informed on:

- | | | | |
|--|---|--|-----------------------------------|
| <input type="checkbox"/> Advance Directive | <input type="checkbox"/> County Hotline | <input type="checkbox"/> Patient's Rights and Responsibilities | <input type="checkbox"/> DC Plans |
| <input type="checkbox"/> Emergency Plan | <input type="checkbox"/> Medication Schedule | <input type="checkbox"/> Basic Home Safety Instructions | |
| <input type="checkbox"/> State hotline number | <input type="checkbox"/> Do not resuscitate (DNR) | <input type="checkbox"/> HIPAA notice of privacy practices | |
| <input type="checkbox"/> OASIS privacy notices | <input type="checkbox"/> Agency phone number / after hours number | | |
| <input type="checkbox"/> When to contact physician and / or agency | <input type="checkbox"/> Standard precautions / handwashing | | |

High Risk Medication for: Insulin Warfarin Coumadin Lovenox Arixtra

Other Intervention:

Outcome Or Response To Skilled Care Rendered

Plan for Next Visit

PROGNOSIS:

- Poor Guarded Fair
- Good Excellent

Orders:

COMMUNITY AGENCIES

- Meals on wheels** Has Needs
- Lifeline** Has Needs
- Trained Caregiver** Has Needs

Goals:

E-Clinical OASIS C Follow-Up Assessment

Overall Summary

Item 99 for the Plan of Care

Nurse's Signature and Date:	HHA USE ONLY	Checked By:	Entered By:	Transmitted By:
Name and Title		Date:	Date:	Date:

Patient's Signature

Caregiver's Signature