

# E- Clinical OASIS C Start of Care Assessment

(M0020) Patient ID Number

DATE

TIME IN

TIME OUT

(M0030) Start of Care

(M0032) Resumption of Care Date:

(M0066) Birth Date:

Month Day Year

Month Day Year

NA - Not applicable

Month Day Year

(M0040) Patient's Name:

(First)

(MI)

(Last)

(Suffix)

(M0080) Discipline of Person Completing

(M0090) Date Assessment

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

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

Month Day Year

1 - Start of Care (further visits planned)

3 - Resumption of Care (after inpatient stay)

### CERTIFICATION PERIOD / EPISODE DATES

Month Day Year

Month Day Year

FROM

TO

Primary Physician's Name

Emergency Contact Name

Relationship

Address

Address

Phone

Physician's Phone

Physician's Fax

Emergency Physician's Name

Emergency Physician's Phone

### SENSORY STATUS

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

VACCINE:

Flu Vaccine

Other Vaccine

Comments:

(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.  
Month Day Year

M0104) Date of Referral: Indicate the date that the written or received by the HHA.  
Month Day Year

NA - No specific SOC Date ordered by physician

Date last seen by MD:

(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.

(M0140) Race / Ethnicity: 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

(M0150) Current Payment Sources for Home Care: (Mark all that apply.)

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- 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

## Patient Classification Ratings

**Class I**

Potential to be life threatening without care. Requires ongoing treatment to preserve life. Unable to evacuate/transport self. Unable to withstand any interruption in power supply. No readily available caregiver or caregiver unable to provide needed care. Requires transport to an acute care facility or specialized shelter situation. Examples: Ventilator dependent, LVAD.

**Class II**

Not immediately life threatening but patient may suffer adverse effect without service. Visits may be postponed for 24-48 hours with minimal adverse effect. Able to withstand up to 48 hour power interruption. Unable to transfer/transport self or no transportation available from caregiver. Examples: O2 dependent with severe COPD. Insulin dependent and unable to self inject, large open draining wound with potential for sepsis, IV antibiotics.

**Class III**

Low potential for adverse effect if visits are delayed 48 to 72 hours. Able to care for self or willing and able caregiver readily available. Transportation available from family, friends, volunteers, or caregiver. Examples: O2 dependent with adequate O2 supply and means to have tanks refilled. New insulin dependent diabetic who self inject and perform glucometer checks but needs phone support or further education, tube feeding.

**Class IV**

Visits may be postponed 72 hours or more with little or no adverse effects. Willing and able caregiver readily available or patient independent in most ADLs. Transportation available from family, friends, volunteers, or caregivers. Examples: Blood pressure monitoring, Foley catheter changes, personal care only.

**(M1000)** From which of the following **Inpatient Facilities** was the patient discharged during the past 14 days? **Mark all that apply:**

- |   |   |               |
|---|---|---------------|
| <input type="checkbox"/> 1 - Long-term nursing facility   | <input type="checkbox"/> 2 - Skilled nursing facility (SNF / TCU) | Comments      |
| <input type="checkbox"/> 3 - Short-stay acute hospital  | <input type="checkbox"/> 4 - Long-term care hospital (LTCH)       |               |
| <input type="checkbox"/> 5 - Inpatient rehabilitation hospital or unit (IRF)                                | <input type="checkbox"/> 6 - Psychiatric hospital or unit         |               |
| <input type="checkbox"/> 7 - Other (specify)  |   |               |
| <input type="checkbox"/> NA - Patient was not discharged from an inpatient facility ( <b>Go to M01016</b> ) |   | Dates of stay |

**(M1005) Inpatient discharge date** (most recent) Comments  
 Month Day Year  UK Unknown

**(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):

<u>Inpatient Facility Diagnosis</u>	<u>ICD-9-CM Code</u>	<u>Inpatient Facility Diagnosis</u>	<u>ICD-9-CM Code</u>
A.		D.	
B.		E.	
C.		F.	

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

<u>Inpatient Diagnosis</u>	<u>Procedure Code</u>
A.	
B.	
C.	
D.	
<input type="checkbox"/> NA - Not applicable	
<input type="checkbox"/> UK - Unknown	

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

<u>Changed Medical Regimen Diagnosis</u>	<u>ICD-9-CM Code</u>	<u>Changed Medical Regimen Diagnosis</u>	<u>ICD-9-CM Code</u>
A.		D.	
B.		E.	
C.		F.	

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

**(M1018) Conditions Prior to Medical or Treatment Regimen 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 conditions which existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**

<input type="checkbox"/> 1 - Urinary Incontinence	<input type="checkbox"/> 2 - Indwelling/suprapubic catheter	Comments
<input type="checkbox"/> 3 - Intractable pain	<input type="checkbox"/> 4 - Impaired decision-making	
<input type="checkbox"/> 5 - Disruptive or socially inappropriate behavior	<input type="checkbox"/> 6 - Memory loss to the extent that supervision required	
<input type="checkbox"/> 7 - None of the above		
<input type="checkbox"/> NA - No inpatient facility discharged and no change in medical or treatment regimen in past 14 days		
<input type="checkbox"/> UK - Unknown		

**(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>	(V-codes are allowed)	(V-codes or E-codes are allowed)	(V-codes or E-codes are allowed)
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.	b.	b.
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		

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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.
f.  <u>Diagnosis Date</u>	f. <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	f.	f.

**Surgical Procedure**

Description	<u>Diagnosis Date</u>	ICD-9-CM
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**Additional Diagnosis Code for the Plan of Care**

Description	<u>Diagnosis Date</u>	ICD-9-CM	Symptom Control Rating	<u>Exacerbation / Onset</u>
g.			<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> E <input type="checkbox"/> O
h.			<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> E <input type="checkbox"/> O
i.			<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> E <input type="checkbox"/> O
j.			<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> E <input type="checkbox"/> O
k.			<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> E <input type="checkbox"/> O
l.			<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> E <input type="checkbox"/> O
m.			<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> E <input type="checkbox"/> O
n.			<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> E <input type="checkbox"/> O

**(M1030) Therapies the patient receives at home: (Mark all that apply.)**

- |   |  |
|---|--|
| <input type="checkbox"/> 1 - Intravenous or infusion therapy (excludes TPN)   |  |
| <input type="checkbox"/> 2 - Parenteral nutrition (TPN or lipids)   |  |
| <input type="checkbox"/> 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal) |  |
| <input type="checkbox"/> 4 - None of the above  |  |

Comments

**INFUSION THERAPY**

No  Yes

Location

Appearance of Site:

IV ACCESS

Size(gauge/length)

Type of Dressing

Peripheral

Name of Catheter

**IV ACCESS**

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<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">No</td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 30%;"><input type="checkbox"/> Central</td> <td style="width: 10%;"><input type="checkbox"/> Hickman</td> <td style="width: 10%;"><input type="checkbox"/> Broviac</td> <td style="width: 10%;"><input type="checkbox"/> Groshong</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Single Lumen</td> <td><input type="checkbox"/> Double Lumen</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td colspan="4">Implanted Vascular Device</td> </tr> <tr> <td></td> <td></td> <td colspan="4">Location</td> </tr> <tr> <td></td> <td></td> <td colspan="4">Appearance of site</td> </tr> <tr> <td></td> <td></td> <td colspan="4">Type of dressing</td> </tr> </table>	No	Yes	<input type="checkbox"/> Central	<input type="checkbox"/> Hickman	<input type="checkbox"/> Broviac	<input type="checkbox"/> Groshong			<input type="checkbox"/> Single Lumen	<input type="checkbox"/> Double Lumen			<input type="checkbox"/>	<input type="checkbox"/>	Implanted Vascular Device						Location						Appearance of site						Type of dressing				<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">No</td> <td style="width: 10%; text-align: center;">Yes</td> <td colspan="4"><input type="checkbox"/> To infuse Via:</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Gravity</td> <td><input type="checkbox"/> Home Pump</td> <td><input type="checkbox"/> PCA Pump</td> <td></td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Stationary Pump</td> <td><input type="checkbox"/> TPN Portable Pump</td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td colspan="4">Type and Name of pump</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td colspan="4">Anaphylaxis Kit present</td> </tr> <tr> <td></td> <td></td> <td colspan="4">Location in home</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td colspan="4">Skilled Nurse to administer IV meds?</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td colspan="4">Patient/Caregiver to administer IV meds?</td> </tr> </table>	No	Yes	<input type="checkbox"/> To infuse Via:						<input type="checkbox"/> Gravity	<input type="checkbox"/> Home Pump	<input type="checkbox"/> PCA Pump				<input type="checkbox"/> Stationary Pump	<input type="checkbox"/> TPN Portable Pump					Type and Name of pump				<input type="checkbox"/>	<input type="checkbox"/>	Anaphylaxis Kit present						Location in home				<input type="checkbox"/>	<input type="checkbox"/>	Skilled Nurse to administer IV meds?				<input type="checkbox"/>	<input type="checkbox"/>	Patient/Caregiver to administer IV meds?			
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**(M1032) Risk for Hospitalization:** Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

<input type="checkbox"/>	1 - Recent decline in mental, emotional, or behavioral status	Comments
<input type="checkbox"/>	2 - Multiple hospitalizations (2 or more) in the past 12 months	
<input type="checkbox"/>	3 - History of falls (2 or more falls - or any fall with an injury - in the past year)	
<input type="checkbox"/>	4 - Taking five or more medications	
<input type="checkbox"/>	5 - Frailty indicators, e.g., weight loss, self-reported exhaustion	
<input type="checkbox"/>	6 - Other	
<input type="checkbox"/>	7 - None of the above	

**(M1034) Overall Status:** Which description best fits the patient's overall status? **(Check one)**

<input type="checkbox"/>	0 - The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age).	Comments
<input type="checkbox"/>	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).	
<input type="checkbox"/>	2 - The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.	
<input type="checkbox"/>	3 - The patient has serious progressive conditions that could lead to death within a year.	
<input type="checkbox"/>	UK - The patient's situation is unknown or unclear.	

**(M1036) Risk Factors,** either present or past, likely to affect current health status and/or outcome: **(Mark all that apply.)**

<input type="checkbox"/> 1 - Smoking	<input type="checkbox"/> 3 - Alcohol dependency	<input type="checkbox"/> 5 - None of the above	Comments
<input type="checkbox"/> 2 - Obesity	<input type="checkbox"/> 4 - Drug dependency	<input type="checkbox"/> UK - Unknown	

**Structural Barriers in the patient's environment limiting independent mobility.**

<input type="checkbox"/> None	<input type="checkbox"/> Narrow or obstructed doorways	<input type="checkbox"/> Stairs leading from inside house to outside	Comments
<input type="checkbox"/>	Stairs inside home which must be used by the patient(e.g., to get to toileting, sleeping, eating areas)	<input type="checkbox"/>	Stairs inside home which are used optionally (e.g., to get to laundry facilities)

**Safety Hazards found in the patient's current place of residence.**

<input type="checkbox"/> None	<input type="checkbox"/> Inadequate heating	<input type="checkbox"/> Inadequate stair railings	Comments
<input type="checkbox"/>	Inadequate floor, roof, or windows	<input type="checkbox"/>	Inadequate cooling
<input type="checkbox"/>	Inadequate lighting	<input type="checkbox"/>	Lack of fire safety devices
<input type="checkbox"/>	Unsafe gas/electric appliance	<input type="checkbox"/>	Unsafe floor coverings
		<input type="checkbox"/>	Other(specify)

**Sanitation Hazards found in the patient's current place of residence**

<input type="checkbox"/> None	<input type="checkbox"/> Outdoor toileting facilities only	<input type="checkbox"/> No cooking facilities	<input type="checkbox"/> Other(specify)
<input type="checkbox"/>	No running water	<input type="checkbox"/>	insects/rodents present
<input type="checkbox"/>	Contaminated water	<input type="checkbox"/>	No scheduled trash pickup
<input type="checkbox"/>	No toileting facilities	<input type="checkbox"/>	Cluttered/soiled living area

Comments

Primary Caregiver Name	Phone	Relation to patient	Able and willing to assist	Comments
<input type="checkbox"/> MSW Referral			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> MSW Referral			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> MSW Referral			<input type="checkbox"/> Yes <input type="checkbox"/> No	

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

Comments

**(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.

- Pupils PERRLA
- Glasses
- Blurred Vision
- Glaucoma
- Blind
- Cataracts
- Other

Comments

**(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.

Comments

**(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.

Comments

**(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.

Comments

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## EARS / NOSE / THROAT / MOUTH

<input type="checkbox"/> No problem Identified	Nasal Condition	Pharyngeal Condition	Mouth Condition
Hard of hearing? <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> No problem Identified	<input type="checkbox"/> No problem Identified	<input type="checkbox"/> No problem Identified
Hearing Aid? <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Altered Smell	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Sores in mouth
Ringing of ears? <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Congestion/Sinus Prob.	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Altered taste
Total deafness? <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Nose Bleed		<input type="checkbox"/> Bleeding gums
			<input type="checkbox"/> Chewing problems
Other	Other	Other	Other

<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Mucous membrane dry
<input type="checkbox"/> Tongue:red/dry/swollen
<input type="checkbox"/> Dentures
<input type="checkbox"/> Abnormal speech

## MUSCULOSKELETAL

No problem Identified

Comments

- 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

**(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)?

Comments

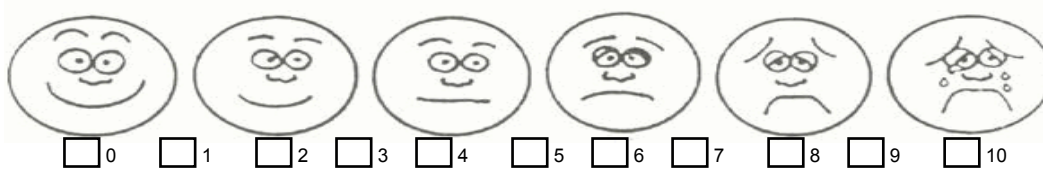
- 0 - No standardized assessment conducted
- 1 - Yes, and it does not indicate severe pain
- 2 - Yes, and it indicates severe pain

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

Comments

- 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

## 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 ven 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.

# E- Clinical OASIS C Start of Care Assessment

## 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

<b>Faces</b>	<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
<b>Legs</b>	<input type="checkbox"/> 0 Normal Position or relaxed	<input type="checkbox"/> 1 Uneasy, restless, tense	<input type="checkbox"/> 2 Kicking, or legs drawn up
<b>Activity</b>	<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
<b>Cry</b>	<input type="checkbox"/> 0 No cry (awake or asleep)	<input type="checkbox"/> 1 Moans or whimpers, occasional complaint	<input type="checkbox"/> 2 Crying steadily, screams or sobs, frequent complaints
<b>Consolability</b>	<input type="checkbox"/> 0 Content, relaxed	<input type="checkbox"/> 1 Reassured by occasional touching, hugging or talking to, distractible	<input type="checkbox"/> 2 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

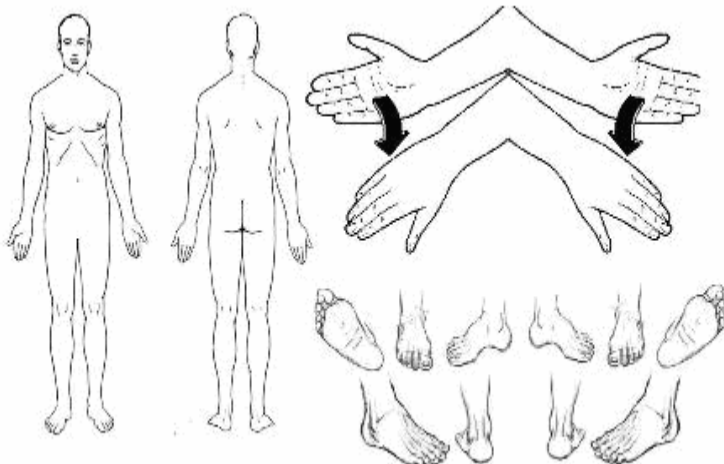
**Yes No**  
  Soap  
  Paper Towels  
  Other  
  Instructed on measures to control infection

## High Risk for infection

## Special Needs

## HAIR

**Yes No**  
  Abnormal Hair Condition  
  Hair Loss  
  Infestation  
  Other



Lesions  Rash  Bruises  
 Scars  Lacerations  Incisions  
 Redness  Stasis Ulcer  Pruritus  
 Abrasions  Masses  Fistulas  
 Dry/Scaling  Pressure Ulcer  Other

Overall specifics and details on overall wound care

Comments on Types of Wound and Description

# E- Clinical OASIS C Start of Care Assessment

**(M1300) Pressure Ulcer Assessment:** Was this patient assessed for **Risk of Developing Pressure Ulcers?**

Comments

- 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?**

Comments

- 0 - No
- 1 - Yes

**(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-epithelialized) 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)
a. <b>Stage II:</b> 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. <b>Stage III:</b> 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. <b>Stage IV:</b> 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 not stageable due to non-removable dressing or device		
d. 2 Unstageable: Known or likely but not stageable due to coverage of wound bed by slough and/or eschar.		
d. 3 Unstageable: Suspected deep tissue injury in evolution.		

**Directions for M1310 and M1312 and M1314:** If the patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the **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)

Comments

**(M1312) Pressure Ulcer Width:** Width of the same pressure ulcer; greatest width perpendicular to the length

(cm)

Comments

**(M1314) Pressure Ulcer Depth:** Depth of the same pressure ulcer; from visible surface to the deepest area

Comments

# E- Clinical OASIS C Start of Care Assessment

(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

Comments

---

**(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

Comments

---

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

- 1 - Stage I [Go to M1330 at SOC/ROC/FU]     2 - Stage II     3 - Stage III  
 4 - Stage IV     NA - No observable pressure ulcer

Comments

---

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

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

Comments

---

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

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

Comments

---

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

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

Comments

---

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

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

Comments

---

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

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

Comments

---

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

- 0 - No     1 - Yes

Comments

# E- Clinical OASIS C Start of Care Assessment

**WOUND CARE**

Wound care ordered, provide:  
 Wound cleansed with  
 Irrigated with  
 Packing with  
 Applied to wound bed  
 Dressing applied

Old dressing removed per:

SN  
 Patient/Caregiver

Comments

Patient tolerated wound care  
 Patient / Caregiver instructed on care provided  
 Patient / Caregiver competent/demonstrates wound care to be provided and frequency of same

**Cardiovascular**

Comments

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

**Heart Rate:**

No problem identified       Regular  
 Irregular       Tachycardia  
 Bradycardia       Reg/Irreg  
 Arrythmia

**EDEMA:**

Pedal R/L       Dependent  
 Pitting +1+2+3+4(site)  
 Non-pitting (site)

Comments

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

Comments

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.)**

Comments

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

**Respiratory**

No problem identified

Comments

Breath Sounds       Cyanosis       Sputum  
 Tracheostomy       Cough       Orthopnea  
 Hemoptysis       Smoker       O2 Usage  
 Instructed on O2 Safety       O2 Sat       O2      L/Min       Other

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

Comments

0 - No  
 1 - Yes  
 NA - Patient on prophylactic treatment  
 UK - Unknown

**(M1610) Urinary Incontinence or Urinary Catheter Presence:**

Comments

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

**URINARY**

Urinary Color

Amount

Odor

Comments

# E- Clinical OASIS C Start of Care Assessment

- |                                       |   |                                  |                                   |   |
|---------------------------------------|---|----------------------------------|-----------------------------------|---|
| <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
- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Diarrhea                                | <input type="checkbox"/> Normal                               | Per: <input type="checkbox"/> Physical Assessment | <input type="checkbox"/> No changes since previous assmnt. |
| <input type="checkbox"/> Abnormal stools: Gray/Tarry/Fresh Blood | <input type="checkbox"/> Abnormal                             | <input type="checkbox"/> Pt/Cg Reported           | Comments   |
| <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 |   |  |

- ENDOCRINE:**  No problem identified Comments
- |   |   |  |                                   |
|---|---|--|-----------------------------------|
| <input type="checkbox"/> Polyuria/Polydipsia/Polyphagia | <input type="checkbox"/> Neuropathy/Radiculopathy | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Diabetes |
|---|---|--|-----------------------------------|

- (M1615) When does Urinary Incontinence occur?** Comments
- |  |   |
|--|---|
| <input type="checkbox"/> 0 - Timed-voiding defers incontinence | <input type="checkbox"/> 1 - Occasional stress incontinence |
| <input type="checkbox"/> 2 - During the night only             | <input type="checkbox"/> 3 - During the day only            |
| <input type="checkbox"/> 4 - During the day and night          |   |

- (M1620) Bowel Incontinence Frequency:** Comments
- |  |   |
|--|---|
| <input type="checkbox"/> 0 - Very rarely or never has bowel incontinence | <input type="checkbox"/> 1 - Less than once weekly      |
| <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   | <input type="checkbox"/> 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? Comments
- |  |
|--|
| <input type="checkbox"/> 0 - Patient does not have an ostomy for bowel elimination.  |
| <input type="checkbox"/> 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen. |
| <input type="checkbox"/> 2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.                |

- (M1700) Cognitive Functioning:** Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands. Comments
- |  |
|--|
| <input type="checkbox"/> 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.   |
| <input type="checkbox"/> 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.  |
| <input type="checkbox"/> 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. |
| <input type="checkbox"/> 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.                              |
| <input type="checkbox"/> 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.  |

- (M1710) When Confused (Reported or Observed Within the Last 14 Days):** Comments
- |  |   |
|--|---|
| <input type="checkbox"/> 0 - Never                             | <input type="checkbox"/> 3 - During the day and evening, but not constantly |
| <input type="checkbox"/> 1 - In new or complex situations only | <input type="checkbox"/> 4 - Constantly                                     |
| <input type="checkbox"/> 2 - On awakening or at night only     | <input type="checkbox"/> NA - Patient nonresponsive                         |

# E- Clinical OASIS C Start of Care Assessment

**(M1720) When Anxious (Reported or Observed Within the Last 14 Days):**

Comments

- 0 - None of the time                       3 - All of the time  
 1 - Less often than daily                 NA - Patient nonresponsive  
 2 - Daily, but not constantly

**(M1730) Depression Screening:** Has the patient been screened for depression, using a standardized depression screening tool?

Comments

- 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-c Pfizer	Not at 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>

- 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.

**(M1740) Cognitive, behavioral, and psychiatric symptoms** that are demonstrated at least once a week (Reported or Observed): **(Mark all that apply.)**

Comments

- 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.  
 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.

Comments

- 0 - Never                       2 - Once a month                       4 - Several times a week  
 1 - Less than once a month                 3 - Several times each month                 5 - At least daily

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

Comments

- 0 - No                       1 - Yes

# E- Clinical OASIS C Start of Care Assessment

**(M1800) 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).

Comments

- 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) 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.
-

## E- Clinical OASIS C Start of Care Assessment

**(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).
- 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) 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.

Comments

- 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) 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.
-

# E- Clinical OASIS C Start of Care Assessment

**(M1870) Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

Comments

- 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) Current Ability to Plan and Prepare Light Meals** (e.g., cereal, sandwich) or reheat delivered meals safely:

Comments

- 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) Ability to Use Telephone:** Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.

Comments

- 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) 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.

Comments

Functional Area	Independent	Needed Some Help	Dependent
a. Self-Care (e.g., grooming, dressing, and bathing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Households tasks ( e.g., light meal, preparation, laundry, shopping )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Fall Risk Assessment**

--	--	--	--

## E- Clinical OASIS C Start of Care Assessment

<b>A.</b>	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>B.</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
<b>C.</b>	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
<b>D.</b>	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
<b>E.</b>	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)
<b>F.</b>	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.
<b>G.</b>	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
<b>H.</b>	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
<b>I.</b>	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

# E- Clinical OASIS C Start of Care Assessment

Comments

**(M1910)** 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)?

Comments

- 0 - No multi-factor falls risk assessment conducted.
- 1 - Yes, and it does not indicate a risk for falls. [Go to M2000 at SOC/ROC]
- 2 - Yes, and it indicates a risk for falls.

**(M2000) 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?

Comments

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

Comments

- 0 - No       1 - Yes

**(M2010) 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?

Comments

- 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) 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.)**

Comments

- 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
- 1 - Able to take medication(s) at the correct times if:  
(a) individual dosages are prepared in advance by another person; OR  
(b) another person develops a drug diary or chart.
- 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
- 3 - Unable to take medication unless administered by another person.
- NA - No oral medications prescribed.

# E- Clinical OASIS C Start of Care Assessment

**(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.

**(M2040) 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.

Comments

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Injectable medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

--	--	--	--	--	--	--

## E- Clinical OASIS C Start of Care Assessment

Type of Assistance	No assistance needed in this area	Caregiver(s) currently provides assistance	Caregiver(s) need training / supportive services to provide assistance	Caregiver(s) <u>not likely</u> to provide assistance	Unclear if Caregiver(s) will provide assistance	Assistance needed, but no Caregiver(s) available	Comments
<b>a. ADL Assistance</b> (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>b. IADL assistance</b> (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>c. Medication administration</b> (e.g., oral, inhaled, or injectable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>d. Medical procedures / treatments</b> (e.g., changing wound dressing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>e. Management of equipment</b> (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>f. Supervision and safety</b> (e.g., due to cognitive impairment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>g. Advocacy or facilitation</b> of patient's participation in appropriate medical care (includes transportation to or from)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**(M2110) How Often** does the patient receive **ADL or IADL assistance** from any caregiver(s) (other than home health agency staff)?

Comments

- |   |   |
|---|---|
| <input type="checkbox"/> 1 - At least daily               | <input type="checkbox"/> 4 - Received, but less often than weekly |
| <input type="checkbox"/> 2 - Three or more times per week | <input type="checkbox"/> 5 - No assistance received               |
| <input type="checkbox"/> 3 - One to two times per week    | <input type="checkbox"/> UK - Unknown*                            |

**(M2200) Therapy Need:** In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)?  
(Enter zero [ "000" ] if no therapy visits indicated.)

Comments

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.

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) |  |   |  |

# E- Clinical OASIS C Start of Care Assessment

**Mental Status**

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

<p style="text-align: center;"><b>Warning Signs of Poor Nutritional Health</b></p> <p>Client <span style="float: right;">Circle and Total</span></p> <p>-Has an illness or condition that made him/her change the kind and/or amount of food he/she eats..... <input type="checkbox"/> 2</p> <p>-Eats fewer than 2 meals per day..... <input type="checkbox"/> 3</p> <p>-Eats few fruits and vegetables, or milk products.. <input type="checkbox"/> 2</p> <p>-Has 3 or more drinks of beer, liquor or wine almost every day..... <input type="checkbox"/> 2</p> <p>-Has tooth or mouth problems that make it hard for him/her to eat..... <input type="checkbox"/> 2</p> <p>-Doesn't always have enough money to buy the food he/she needs..... <input type="checkbox"/> 4</p> <p>-Takes 3 or more different prescribed or over-the-counter drugs a day..... <input type="checkbox"/> 1</p> <p>-Eats alone most of the time..... <input type="checkbox"/> 1</p> <p>-Without wanting to, has lost or gained 10 lbs. in the last six months..... <input type="checkbox"/> 2</p> <p>-Is not always physically able to shop, cook and/or feed him/herself..... <input type="checkbox"/> 2</p> <p>3-6 = Some Risk 7 or more = High Risk....Total: <input style="width: 40px;" type="text"/></p> <p>If High Risk (7 or more), Care Coordinator contacted about referral to physician or nutritionist?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No, reason</p> <p><b>COMMUNITY AGENCIES</b></p> <p><b>Meals on wheels</b>    <input type="checkbox"/> Has    <input type="checkbox"/> Needs</p> <p><b>Lifeline</b>    <input type="checkbox"/> Has    <input type="checkbox"/> Needs</p> <p><b>Trained Caregiver</b>    <input type="checkbox"/> Has    <input type="checkbox"/> Needs</p>	<p style="text-align: center;"><b>Yes No SLEEP</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Disturbance of Sleep/Rest Pattern</p> <p><input type="checkbox"/> <input type="checkbox"/> Uses sleeping aides</p> <p><input type="checkbox"/> <input type="checkbox"/> Other</p> <hr/> <p style="text-align: center;"><b>Yes No NEURO</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> <input type="checkbox"/> Convulsions</p> <p><input type="checkbox"/> <input type="checkbox"/> Change in level of consciousness</p> <p><input type="checkbox"/> <input type="checkbox"/> Aphasia/Speech Problem</p> <hr/> <p style="text-align: center;"><b>Yes No NAIL</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal nail condition</p> <p><input type="checkbox"/> <input type="checkbox"/> Ingrown</p> <p><input type="checkbox"/> <input type="checkbox"/> Fungus</p> <p><input type="checkbox"/> <input type="checkbox"/> Clubbing</p> <p><input type="checkbox"/> <input type="checkbox"/> Capillary refill</p> <p><input type="checkbox"/> <input type="checkbox"/> Poor nail care</p> <p><input type="checkbox"/> <input type="checkbox"/> Other</p> <hr/> <p style="text-align: center;"><b>SPIRITUAL / CULTURAL NEEDS</b></p> <p><input type="checkbox"/> Religion</p> <p><input type="checkbox"/> No religious affiliation</p> <p><input type="checkbox"/> Spiritual Need:</p> <p style="padding-left: 20px;"><input type="checkbox"/> Love and relatedness</p> <p style="padding-left: 20px;"><input type="checkbox"/> Meaning and Purpose</p> <p style="padding-left: 20px;"><input type="checkbox"/> Forgiveness</p> <p style="padding-left: 20px;"><input type="checkbox"/> Other</p>	<p style="text-align: center;"><b>Yes No NA REPRODUCTION</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abnormal vaginal discharge</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abnormal Breast/Nipples</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abnormal Penis/Scrotum/Testicles</p> <hr/> <p style="text-align: center;"><b>Yes No LEARNING</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Slow to respond</p> <p><input type="checkbox"/> <input type="checkbox"/> Altered Comprehension</p> <p><input type="checkbox"/> <input type="checkbox"/> Lacks knowledge of health care needs</p> <p><input type="checkbox"/> <input type="checkbox"/> Poor Retention</p> <p><input type="checkbox"/> <input type="checkbox"/> Illiterate</p> <p><input type="checkbox"/> <input type="checkbox"/> Other</p> <hr/> <p style="text-align: center;"><b>Yes No NUTRITIONAL STATUS</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Anorexia</p> <p><input type="checkbox"/> <input type="checkbox"/> Overweight/Underweight</p> <p><input type="checkbox"/> <input type="checkbox"/> Recent weight Gain/Loss</p> <p><input type="checkbox"/> <input type="checkbox"/> Cachexia</p> <p><input type="checkbox"/> <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> <input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> <input type="checkbox"/> Fluid/Electrolyte Imbalance</p> <p><input type="checkbox"/> <input type="checkbox"/> NG Tubes(specify feeding)</p> <p><input type="checkbox"/> <input type="checkbox"/> Gastrostomy Tube(specify)</p> <p><input type="checkbox"/> <input type="checkbox"/> Fluid Restriction</p> <p><input type="checkbox"/> <input type="checkbox"/> Prescribed Diet</p> <p><input type="checkbox"/> <input type="checkbox"/> Dietary Restrictions/Allergies</p> <p><input type="checkbox"/> <input type="checkbox"/> Other</p>
---	--	--

**(M2250) 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	Comments

# E- Clinical OASIS C Start of Care Assessment

a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient is not diabetic or is bilateral amputee
c. Falls prevention interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient has no diagnosis or symptoms of depression
e. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No pain identified
f. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient has no pressure ulcers with need for moist wound healing

### Functional Limitations

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

### DME

- Bedside Commode   
  Prosthetic Device  
 Elevated Toilet Seat   
  Leg Brace  
 Tub/Shower Bench   
  Cane  
 Grab Bars   
  Walker  
 Hospital Bed   
  Wheelchair  
 Special Transferring Equipment  
 Other

### Supplies

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

### Allergies

- NKA   
  NKDA

### Safety Measures

- Safe Environment   
  Fall Precautions   
  Ambulate w/in Limits of Endurance  
 Emergency Plan Developed   
  Seizure Precautions   
  Keep Pathways Clear  
 Adequate Safe Units   
  Neutropenic Precautions   
  Use of Assistive Device  
 24 Hour Supervision   
  Universal precautions / Infection Control   
  Eat Meals at Regular Intervals  
 Safety in ADLs   
  Keep Side Rails Up   
  Proper Position During Meals  
 Anticoagulant Precautions   
  Slow Position Change   
  Other  
 O2 Precautions   
  Support During Transfer and Ambulation

Homebound   
 NO   
 YES   
**REASON:**

# E- Clinical OASIS C Start of Care Assessment

- |   |  |   |  |
|---|--|---|--|
| <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"/> <b>Category I</b>  Patient's who can safely forego care or a scheduled visit without a high probability of harm or deleterious 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	<input type="checkbox"/> <b>Category II</b>  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	<input type="checkbox"/> <b>Category III</b>  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
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**DISCHARGE PLANS**

- |   |  |
|---|--|
| <input type="checkbox"/> Discharge when optimal function attained with:<br><input type="checkbox"/> Family Assist <input type="checkbox"/> Comm. Services <input type="checkbox"/> IHSS in _____ weeks / _____ visits | <input type="checkbox"/> Patient to remain with agency support for maintenance of:<br><input type="checkbox"/> Foley Catheter<br><input type="checkbox"/> Feeding Tube<br><input type="checkbox"/> Insulin Administration<br><input type="checkbox"/> Others |
| <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  |  |

**ADVANCE DIRECTIVES:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Living Will       | <input type="checkbox"/> Organ donor      | <input type="checkbox"/> Copies on file           |
| <input type="checkbox"/> Do no resuscitate | <input type="checkbox"/> Education needed | <input type="checkbox"/> Funeral arrangement made |
| <input type="checkbox"/> Comments          |   |   |

**SKILLED OBSERVATION: (Describe Findings / Problems)**

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

# E- Clinical OASIS C Start of Care Assessment

<input type="checkbox"/> Respiratory Status	<input type="checkbox"/> Ineffective airway clearance <input type="checkbox"/> Knowledge deficit related to: <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

<b>DIABETES MANAGEMENT</b> <input type="checkbox"/> DM <input type="checkbox"/> Manifestation of DM <input type="checkbox"/> Diabetes Type I / Type II <input type="checkbox"/> Insulin / Oral Agent <input type="checkbox"/> Diet controlled <input type="checkbox"/> Knowledge deficit  Comments  Diabetic Foot Care Teaching	<input type="checkbox"/> Glucometer use / monitor in home <input type="checkbox"/> FSBS range / Results <input type="checkbox"/> Manifestations <input type="checkbox"/> Renal <input type="checkbox"/> Neuropathy / Neurological <input type="checkbox"/> Ophthalmic <input type="checkbox"/> Others <input type="checkbox"/> Others
---	--

**SKILLED INTERVENTION: ( PROCEDURE AND TEACHING ):**

# E- Clinical OASIS C Start of Care Assessment

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

	Date & Time:	Outcome
T. C. to MD to inform assessment results & approve the plan		
T. C. to Supervisor to report assessment & request other disciplines needed		
Discipline    Frequency / Duration	Document Reason	
SN	SN needed but refused:	
PT	PT needed but refused:	
OT	OT needed but refused:	
ST	ST needed but refused:	
MSW	MSW needed but refused:	
CHHA	CHHA needed but refused:	

**PROGNOSIS:**

- Poor       
  Guarded       
  Fair       
  Good       
  Excellent

**Orders:**

**Goals:**

**Overall Summary**

**Item 99 for Plan of Care**

# E- Clinical OASIS C Start of Care Assessment

Nurse's Signature and Date:

Name and Title

**HHA  
USE  
ONLY**

Checked By:

Date:

Entered By:

Date:

Transmitted By:

Date:

**Patient's Signature**

**Caregiver's Signature**