# RECERTIFICATION / FOLLOW UP OASIS ASSESSMENT

**REASON FOR ASSESSMENT** ❒ **Recertification of Care** ❒ **Follow Up Date** _____/_____/_____ **Time in** _____**Out**_____

**This patient tracking sheet must be filled out at the start of care and subsequent visits when changes to demographics occur. It is to be maintained as part of the clinical record**

**(M0010) Agency Medicare Provider Number:** (Locator #5)
_____

**(M0012) Agency Medicaid Provider Number:**
_____

**Branch Identification**
(M0014) Branch State: _____ Branch ID Number: _____

**(M020) Patient ID Number** (Locator # 4)
_____

**Medical Record Number if different than M0020**
_____

**(M0030) Start of Care Date:** (Locator # 2)
_____ / _____ /_____
month day year

**(M0032) Resumption of Care Date:** ❒ NA – Not Applicable
_____ / _____ /_____
month day year

**(M0040) Patient's Name:** (Locator # 6)
_____ _____
(First) (MI)

_____ _____
(Last) (Suffix)

**Address: (Street/Apt #)**
_____

**City:**
_____

**(M0050) Patient State of Residence:** (Locator # 6)
_____

**(M0060) Patient Zip Code:** (Locator # 6)
_____-_____

**(M0063) Medicare Number:** ❒ **NA – No Medicare**
_____
Including Suffix

**(M0064) Social Security Number:** ❒ UK-Unknown or Not Available
_____-_____-_____

**(M0065) Medicaid Number:** ❒ **NA – No Medicaid**
_____

**(M0066) Birth Date:** (Locator # 8)
_____/ _____ /_____
month day year

**Patient's HI Claim No:** (Locator # 1)
❒ **1 - Same As M0063** ❒ **2 - Same as M0065**
❒ **3 - Other** _____

**(M0069) Gender:** (Locator # 9) ❒ **1- Male** ❒ **- Female**

**(M0072) Primary Referring Physician I.D.** ❒ **UK- Unknown or not available**
_____

**Phone:** (Locator # 24) _____-_____-_____

**Name:** (Locator # 24) _____ ____
**(First)** **(MI)**
_____ _____
**(Last)** **(Suffix)**

**Address: (Street/Apt #)** (Locator # 24)
_____

**City:** (Locator # 24)
_____

**State:** (Locator # 24) **Zip Code:** (Locator # 24)
_____ _____-_____

**Secondary Referring Physician I.D.** ❒ **UK- Unknown or not available**
_____

**Phone:** _____-_____-_____

**Name:** _____ ____
**(First)** **(MI)**
_____ _____
**(Last)** **(Suffix)**

**Address: (Street/Apt #)**
_____

**City:**
_____

**State:** **Zip Code:**
_____ _____-_____

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

**(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)
❒ 3 – Medicaid (traditional fee for service)
❒ 4 – Medicaid (HMO/Managed care)
❒ 5 – Worker's Compensation
❒ 6 – Title Programs (Title III, V, XX)
❒ 7 – Other government (e.g. CHAMPUS, VA, etc)
❒ 8 – Private Insurance
❒ 9 – Private HMO/Managed care
❒ 10- Self pay
❒ 11- Other (specify)_____
❒ UK-Unknown

**Person completing this form (signature/title)** _____

**PATIENT NAME –Last, First, Middle Initial**

_____ **ID #** _____

Patient Name _____ ID# _____ **(Recert)**

## CLINICAL RECORD ITEMS

**Recertification Period: (Locator # 3) From**____/____/_____ **To**____/____/____

**(MO080) Discipline of Person Completing Assessment:** ☐ 1-RN ☐ 2-PT ☐ 3-SLP/ST ☐ 4-OT

**(MO090) Date Assessment Completed:** _____/_____/_____
month day year

**(MO100) This Assessment is Currently Being Completed for the Following Reason:**

☐ 1 - Start of care-further visits planned

*** (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. At follow-up go to M0230

| | | | | | | |
|---|---|---|---|---|---|---|
| **PHYSICIAN:** Date last contacted _____/_____/_____ | | | | Date last visited _____/_____/_____ | | |
| **PRIMARY REASON FOR HOME HEALTH:** | | | | | | |
| **PRESENT ILLNESS/NURSING DIAGNOSES:** | | | | | | |
| **PERTINENT HISTORY AND/OR PREVIOUS OUTCOMES** | | | | | | |
| ☐ Hypertension | ☐ Cardiac | ☐ Diabetes | ☐ Respiratory | ☐ Osteoporosis | ☐ Fractures | ☐ Cancer (site:_____ |
| ☐ Infection | ☐ Immunosuppressed | | ☐ Open Wound | ☐ Surgeries | | |
| ☐ Other (specify) | | | | | | |
| **IMMUNIZATIONS** | ☐ Up to date | **Needs:** | ☐ Influenza | ☐ Pneumonia | ☐ Tetanus | ☐ Other |
| **PRIOR HOSPITALIZATIONS** | ☐ No | ☐ Yes | Number of times | | | |
| Reason(s)/Date(s): | | | | | | |
| **Patient has a DNRO Yes ☐ No ☐ Signed by patient and physician Yes ☐ No ☐ On appropriate form Yes ☐ No ☐** | | | | | | |

## HISTORY OF PRESENT ILLNESS

**M0230/240/246 Diagnoses, Severity Index, and Payment Diagnoses:** List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2) . Rate each condition (Column 2) using the severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) V codes (for M0230 or M0240) or E codes (for M0240 only) may be used. ICD-9-CM 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 M0246 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group.

**Code each row as follows:**

**Column 1:** Enter the description of the diagnosis.

**Column 2:** Enter the ICD-9-CM code for the diagnosis described in Column 1;
Rate the severity of 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

**Column 3:** (OPTIONAL) If a V code reported in any row in Column 2 is reported in place of a case mix diagnosis, list the appropriate case mix diagnosis (the description and the ICD-9-CM code) in the same row in Column 3. Otherwise, leave Column 3 blank in that row.

**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-CM coding guidelines, enter the diagnosis descriptions and the ICD-9-CM 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-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

Patient Name _____ ID# _____ **(Recert)**

**MO 230/240** **ORTHOPEDIC CSD + 11** **DIABETES CSD + 17** **NEUROLOGICAL CSD + 20**

| **(M0230) Primary Diagnosis & (M0240) Other Diagnoses** | | **(M0246) Case Mix Diagnoses (OPTIONAL)** | |
|---|---|---|---|
| (1) | (2) | (3) | (4) |
| | ICD-9-CM and severity rating for each condition | Complete **only if** a V code in Column 2 is reported 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 / Severity Rating | Description/ ICD-9-CM | Description/ ICD-9-CM |
| **(M0230) Primary Diagnosis** | **(V codes are allowed)** | (V or E codes NOT allowed) | (V or E codes NOT allowed) |
| a. _____ | a. ( __ __ __ . __ __ ) ☐0 ☐1 ☐2 ☐3 ☐4 | **a.** _____ ( __ __ __ . __ __ ) | a. _____ ( __ __ __ . __ __ ) |
| **(M0240) Other Diagnoses** | **(V or E codes are allowed)** | (V or E codes NOT allowed) | (V or E codes NOT allowed) |
| b. _____ | b. ( __ __ __ __ . __ __ ) ☐0 ☐1 ☐2 ☐3 ☐4 | **b.** _____ ( __ __ __ . __ __ ) | b. _____ ( __ __ __ . __ __ ) |
| c. _____ | c. ( __ __ __ __ . __ __ ) ☐0 ☐1 ☐2 ☐3 ☐4 | **c.** _____ ( __ __ __ . __ __ ) | c. _____ ( __ __ __ . __ __ ) |
| d. _____ | d. ( __ __ __ __ . __ __ ) ☐0 ☐1 ☐2 ☐3 ☐4 | **d.** _____ ( __ __ __ . __ __ ) | d. _____ ( __ __ __ . __ __ ) |
| e. _____ | e. ( __ __ __ __ . __ __ ) ☐0 ☐1 ☐2 ☐3 ☐4 | **e.** _____ ( __ __ __ . __ __ ) | e. _____ ( __ __ __ . __ __ ) |
| f. _____ | f. ( __ __ __ __ . __ __ ) ☐0 ☐1 ☐2 ☐3 ☐4 | **f.** _____ ( __ __ __ . __ __ ) | f. _____ ( __ __ __ . __ __ ) |

**(MO250) Therapies** the patient receives at home: **(Mark all that apply.)**

☐ 1 - Intravenous or infusion therapy (excludes TPN) **CSD +14**
☐ 2 - Parenteral nutrition (TPN or lipids) **CSD + 20**
☐ 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal) **CSD + 24**
☐ 4 - None of the above

## EYES

**(MO390) 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. **CSD + 6**
☐ 2 - Severely impaired: cannot locate objects without hearing or touching them or patient unresponsive. **CSD + 6**

☐ No Problem

☐ Glasses: R / L
☐ Contacts: R / L
☐ Prosthesis: R / L
☐ Glaucoma
☐ Blurred vision
☐ Infections
☐ Jaundice
☐ Ptosis

☐ Cataract surgery: Site _____ Date _____/_____/_____
☐ Other (specify)

## NOSE/THROAT/MOUTH

**NOSE**
☐ No Problem
☐ Congestion ☐ Epistaxis
☐ Loss of smell ☐ Sinus problem
☐ Other (specify) _____

**THROAT**
☐ No Problem
☐ Dysphagia ☐ Hoarseness
☐ Lesions ☐ Sore throat
☐ Other (specify) _____

**MOUTH**
☐ No Problem
☐ Dentures: Upper / Lower / Partial
☐ Masses/Tumors ☐ Gingivitis
☐ Ulcerations ☐ Toothache
☐ Other (specify) _____

Patient Name _____ ID# _____ **(Recert)**

## EARS

☐ No Problem

☐ HOH: R / L ☐ Deaf: R / L ☐ Hearing aid: R / L ☐ Vertigo ☐ Tinnitus

☐ Other (specify)

## PAIN

**(MO420) Frequency of Pain** interfering with patient's activity or movement:
☐ 0 - Patient has no pain or pain does not interfere with activity or movement
☐ 1 - Less often that daily
☐ 2 - Daily, but not constantly **CSD + 5**
☐ 3 - All of the time **CSD + 5**

**(MO430) Intractable Pain:** Is the patient experiencing pain that is not easily relieved, occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity?
☐ 0 - No
☐ 1 - Yes
**Intensity:** (using scales below)

**1 2 3 4 5 6 7 8 9 10**

**Medical Professionals Please Note:**
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 just 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 the face that best describes how he is feeling.

☐ No Problem

**Is patient experiencing pain?** ☐ Yes ☐ No ☐ Unable to communicate

**Non-verbals demonstrated:**
☐ Diaphoresis ☐ Grimacing ☐ Moaning/Crying
☐ Guarding ☐ Irritability ☐ Anger
☐ Tense ☐ Restlessness ☐ Change in Vital Signs
☐ Other: _____
☐ Self-assessment ☐ Implications: _____

**Pain Location:** (specify site(s)) _____

**Using Wong-Baker FACES Pain Rating Scale above:**

Present Level of Pain: _____ Worst Level of Pain: _____ Acceptable Level of Pain: _____

**Type:**
☐ Aching ☐ Nagging ☐ Dull ☐ Heavy
☐ Crushing ☐ Sharp ☐ Stabbing ☐ Throbbing
☐ Radiating ☐ Burning ☐ Tingling ☐ Cramping
☐ Other: _____

**Frequency:** ☐ Occasionally ☐ Continuous ☐ Intermittent ☐ Other: _____

**What makes pain worse?** ☐ Movement ☐ Ambulation ☐ Other: _____

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

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

Patient Name _____ ID# _____ **(Recert)**

## ENDOCRINE/HEMATOLOGY

☐ **No Problem**
(Circle all applicable items)

☐ Diabetes: Type I / Type II ☐ Diet / Oral control (specify) _____

☐ Insulin dose/frequency (specify) _____

☐ Hyperglycemia: Glycosuria / Polyuria / Polydipsia / Polyphagia

☐ Hypoglycemia: Sweats / Weak / Faint / Stupor

☐ Blood sugar range _____

Who performs blood sugars / administers insulin (Circle) ☐ Self ☐ RN ☐ PCG/family ☐ Other _____

☐ Enlarged thyroid ☐ Fatigue ☐ Intolerance to heat/cold ☐ Other _____

☐ Anemia (specify if known) _____

☐ Secondary bleed: GI / GU / GYN / unknown ☐ Hemophilia

☐ Other

## INTEGUMENTARY STATUS

☐ **No Problem**
Circle all applicable conditions listed below:

Itch / Rash / Dry / Scaling
Bruises / Ecchymosis
Incision / Wounds / Lesions
Pallor / Jaundice / Redness
Pressure Ulcer / Fistulas
Turgor: Good / Poor
Abrasions / Lacerations
Edema
Other (specify)

**(MO440)** Does this patient have a **Skin Lesion** or an **Open Wound**? This excludes "OSTOMIES."

☐ 0 - No **[If No, go to MO490]** ☐ 1 - Yes **IF M0230 IS BURN/TRAUMA DG, CSD + 21**

**(MO445)** Does this patient have a **Pressure Ulcer**?

☐ 0 - No **[If No, go to MO468]** ☐ 1 - Yes

**(MO450) Current Number of Pressure Ulcers at Each Stage:** (Circle one response for each stage.)

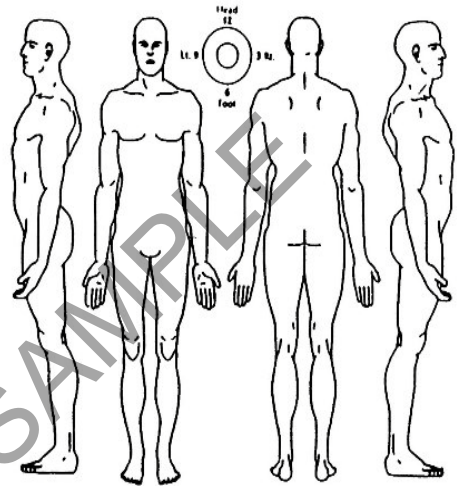
| Pressure Ulcer Stages | Number of Pressure Ulcers | | | | |
|---|---|---|---|---|---|
| a) **Stage 1:** Nonblanchable erythema of intact skin; the heralding of skin ulceration. In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators. | **0** | **1** | **2** | **3** | **4 or more** |
| b) **Stage 2:** Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater. | **0** | **1** | **2** | **3** | **4 or more** |
| c) **Stage 3:** Full-thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. | **0** | **1** | **2 CSD + 17** | **3 CSD + 17** | **4 or more CSD + 17** |
| d) **Stage 4:** Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule, etc.) | **0** | **1** | **2 CSD + 17** | **3 CSD + 17** | **4 or more CSD + 17** |

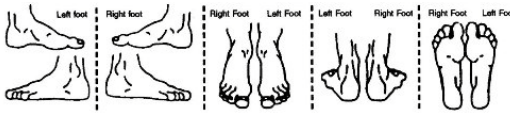
e) In addition to the above, is there at least one pressure ulcer that cannot be observed due to the presence of eschar or a nonremovable dressing, including casts? ☐ 0 - No ☐ 1 – Yes

Patient Name _____ ID# _____ **(Recert)**

| CONDITION | #1 | #2 | #3 | #4 |
|---|---|---|---|---|
| Size (cm) (LxWxD) | | | | |
| Stage | | | | |
| Tunneling/ Undermining | | | | |
| Odor | | | | |
| Surrounding Skin | | | | |
| Edema | | | | |
| Stoma | | | | |
| Appearance of the Wound Bed | | | | |
| Drainage/ Amount | ☐ None ☐ Small ☐ Moderate ☐ Large | ☐ None ☐ Small ☐ Moderate ☐ Large | ☐ None ☐ Small ☐ Moderate ☐ Large | ☐ None ☐ Small ☐ Moderate ☐ Large |
| Color | ☐ Clear ☐ Tan ☐ Serosanguineous ☐ Other | ☐ Clear ☐ Tan ☐ Serosanguineous ☐ Other | ☐ Clear ☐ Tan ☐ Serosanguineous ☐ Other | ☐ Clear ☐ Tan ☐ Serosanguineous ☐ Other |
| Consistency | ☐ Thin ☐ Thick | ☐ Thin ☐ Thick | ☐ Thin ☐ Thick | ☐ Thin ☐ Thick |

Note location of specific skin conditions/wounds by numbering appropriately on illustrations below. Proceed by completing applicable information for each numbered site on chart at left






*(Skip this item if patient has no Pressure Ulcers)*

**(MO460) Stage of Most Problematic (Observable) Pressure Ulcer:**

☐ 1 - Stage 1 **CSD + 15**
☐ 2 - Stage 2 **CSD + 15**
☐ 3 - Stage 3 **CSD + 36**
☐ 4 - Stage 4 **CSD + 36**
☐ NA - No observable pressure ulcer

**(MO464) Status of Most Problematic (Observable) Pressure Ulcer:**

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

**(MO468)** Does this patient have a **Stasis Ulcer**?

☐ 0 - No **[If No, go to MO482]**
☐ 1 – Yes

**(MO470) Current Number of Observable Stasis Ulcers:**

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

**(MO474)** Does this patient have at least one **Stasis Ulcer that Cannot be Observed** due to the presence of a nonremovable dressing?

☐ 0 – No ☐ 1 – Yes *(Skip this item if patient has no Stasis Ulcers)*

**(MO476) Status of Most Problematic (Observable) Stasis Ulcer:**

☐ 1 - Fully granulating
☐ 2 - Early/partial granulation **CSD 14**
☐ 3 - Not healing **CSD + 22**
☐ NA - No observable stasis ulcer

**(MO488) Status of Most Problematic (Observable) Surgical Wound:**

☐ 1 - Fully granulating
☐ 2 - Early/partial granulation **CSD + 7**
☐ 3 - Not healing **CSD + 15**
☐ NA - No observable surgical wound

Patient Name _____ ID# _____ **(Recert)**

**Wound care done:** ☐ Yes ☐ No ☐ Soiled dressing removed
☐ **Wound cleaned with** (specify): _____
☐ **Wound irrigated with** (specify): _____
☐ **Wound packed with** (specify): _____
☐ **Wound dressing applied** (specify): _____
☐ **Other** (specify): _____
☐ **Patient tolerated procedure well**

## SYSTEMS REVIEW

**Height** _____ ☐ Reported ☐ Actual **Weigh** _____ ☐ Reported ☐ Actual

## CARDIOPULMONARY

☐ **No Problem**
**(Circle all applicable items)**

**Blood Pressure:** ☐ Sitting R _____ L _____
☐ Lying R _____ L _____
☐ Standing R _____ L _____

**Temperature:** _____ ☐ Oral ☐ Axillary ☐ Rectal ☐ Tympanic

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

**Cough:** ☐ Dry ☐ Acute ☐ Chronic ☐ Productive: ☐ Yes ☐ No Thick/Thin Color: _____ Amt: _____
☐ Dyspnea: Rest/Exertion ☐ Ambulation _____ feet ☐ During ADL's ☐ Orthopnea
☐ Other: _____

**Heart Sounds:** ☐ Regular ☐ Pacemaker:
☐ Irregular Date: _____
☐ Murmur Type: _____

**Respirations:** ☐ Rate _____ per minute
☐ Regular ☐ Apnea periods _____ sec.
☐ Irregular ☐ Cheynes Stokes

**Breath Sounds:** ☐ Clear ☐ Diminished ☐ Absent
☐ Rales ☐ Crackles ☐ Wheezes
☐ Rhonchi (specify) _____

| | | | | |
|---|---|---|---|---|
| ☐ Insp. Wheeze | ☐ RUL | ☐ Exp. Wheeze | ☐ RUL | |
| | ☐ RLL | | ☐ RLL | |
| | ☐ LUL | | ☐ LUL | |
| | ☐ LLL | | ☐ LLL | |

☐ O2 @ _____ % LPM per _____ O2 sat. _____ %
☐ Accessory muscles used
☐ Other:

**Chest Pain:** ☐ Anginal ☐ Sharp
☐ Substernal ☐ Localized
☐ Ache ☐ Dull
☐ Postural ☐ Vise-like
☐ Radiating

Associated with: ☐ Shortness of Breath ☐ Activity ☐ Sweats

Frequency/duration: _____

☐ Palpitations ☐ Fatigue

**Edema:** Site: _____
☐ Right +1/+2/+3/+4 ☐ Pitting +1/+2/+3/+4
☐ Left +1/+2/+3/+4 ☐ Non-pitting

☐ Cramps ☐ Capillary refill < 3 sec
☐ Claudication ☐ Capillary refill > 3 sec

**(MO490)** When is the patient dyspneic or noticeably **Short of Breath?**
☐ 0 - Never, patient is not short of breath
☐ 1 - When walking more that 20 feet, climbing stairs
☐ 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet) **CSD + 5**
☐ 3 - With minimal exertion (e.g., while eating, talking, or performing other ADL's) or with agitation **CSD + 5**
☐ 4 - At rest (during day or night) **CSD + 5**

☐ Observed ☐ Reported

**(MO500) Respiratory Treatments** utilized at home: **(Mark all that apply.)**
☐ 1 - Oxygen (intermittent or continuous)
☐ 2 - Ventilator (continually or at night)
☐ 3 - Continuous positive airway pressure
☐ 4 - None of the above

Patient Name _____ ID# _____ (Recert)

## NUTRITIONAL STATUS

☐ **No Problem**

**(Locator #16)**

**Specify Diet** ☐ **Increase fluids** **amt.** ☐ **Restrict fluids** **amt.**

**Appetite:** ☐ Good ☐ Fair ☐ Poor ☐ Anorexic

**Eating patterns:**

☐ Nausea/Vomiting Freq. Amt.

☐ Heartburn (food tolerance)

☐ Weight change: Gain/Loss lb. X wk./mo./yr.

☐ Other (specify, incl. Hx)

| **Directions:** Circle each area with "yes" to assessment, then total score to determine additional risk. | | **YES** |
|---|---|---|
| | Has an illness or condition that changed the kind and/or amount of food eaten. | 2 |
| | Eats fewer than 2 meals per day. | 3 |
| | Eats few fruits, vegetable or milk products. | 2 |
| | Has 3 or more drinks of beer, liquor or wine almost every day. | 2 |
| | Has tooth or mouth problems that make it hard to eat. | 2 |
| | Does not always have enough money to buy the food needed. | 4 |
| | Eats alone most of the time. | 1 |
| | Takes 3 or more different prescribed or over-the-counter drugs a day. | 1 |
| | Without wanting to, has lost or gained 10 pounds in the last 6 months. | 2 |
| | Not always physically able to shop, cook and/or feed self. | 2 |

**INTERPRETATION**

**0-2 Good.** As appropriate reassess and/or provide information based on situation.

**3-5 Moderate risk.** Educate, refer, monitor and reevaluate based on patient situation and RHC's policy.

**6 or > High risk.** Coordinate with physician, dietitian, social service professional or nurse about how to improve nutritional health. Reassess nutritional status and educate based on plan of care.

**Total** _____

## GENITOURINARY

☐ **No Problem**

(Circle or check all applicable items)

☐ Urgency/frequency ☐ Burning/pain ☐ Hesitancy ☐ Nocturia ☐ Hematuria ☐ Oliguria/anuria

☐ Incontinence (details if applicable) _____

☐ Diapers/other: _____

**Color:** ☐ Yellow/straw ☐ Amber ☐ Brown/gray ☐ Blood-tinged ☐ Other: _____

**Clarity:** ☐ Clear ☐ Cloudy ☐ Sediment/mucous

**Odor:** ☐ Yes ☐ No

**Urinary Diversion Device:** Type (specify): _____ Date last changed _____/_____/_____

☐ Foley inserted (date) _____ with _____ Fr _____ Cc

☐ with difficulty ☐ without difficulty

Irrigation solution: Type (specify): _____

Amount _____ cc Frequency _____

☐ Patient tolerated procedure well

☐ Other (specify):

**(MO520) Urinary Incontinence or Urinary Catheter Presence:**

☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[If No, go to MO540]**

☐ 1 - Patient is incontinent

☐ 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) **[Go to MO540]**

**(MO530) When** does **Urinary Incontinence** occur?

☐ 0 - Timed-voiding defers incontinence

☐ 1 - During the night only **CSD + 6**

☐ 2 - During the day and night **CSD + 6**

Patient Name _____ ID# _____ **(Recert)**

## ELIMINATION

☐ No Problem

☐ Flatulence ☐ Constipation/impaction ☐ Diarrhea ☐ Rectal bleeding ☐ Hemorrhoids

☐ Frequency of stools: _____ Bowel regime/program: _____ _____

☐ Laxative/Enema use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:

☐ Incontinence (details if applicable):

☐ Diapers/other:

☐ Ileostomy/colostomy site (describe skin around stoma):

☐ Other:

## ABDOMEN

☐ No Problem

☐ Tenderness ☐ Pain ☐ Distension ☐ Hard ☐ Soft ☐ Ascites ☐ Abdominal girth: _____

☐ Other: _____ NG/enteral tube (type/size) _____

**Bowel Sounds:** ☐ Active ☐ Absent ☐ Hypoactive ☐ Hyperactive x _____ Quadrants

☐ Other:

**(MO540) Bowel Incontinence Frequency:**

☐ 0 - Very rarely or never has bowel incontinence
☐ 1 - Less than once weekly
☐ 2 - One to three times weekly **CSD + 9**
☐ 3 - Four to six times weekly **CSD +9**
☐ 4 - On a daily basis **CSD + 9**
☐ 5 - More often than once daily **CSD + 9**
☐ NA - Patient has ostomy for bowel elimination
☐ UK - Unknown

**(MO550) Ostomy for Bowel Elimination:** Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen?

☐ 0 - Patient does not have an ostomy for bowel elimination.
☐ 1 - Patient's ostomy was not related to an inpatient facility stay and did not necessitate change in medical or treatment regimen. **CSD + 10**
☐ 2 - The ostomy was related to an inpatient facility stay or did necessitate change in medical or treatment regimen. **CSD + 10**

## GENITALIA

☐ **No Problem**

☐ Discharge/Drainage (describe): _____

☐ Lesions/Blisters/Masses/Cysts ☐ Inflammation ☐ Surgical alteration

☐ Prostate problem: BPH/TURP Date ____/____/____ ☐ Self-testicular exam Freq. _____

☐ Menopause ☐ Hysterectomy Date ____/____/____ Last PAP ____/____/____ Results _____

☐ Breast self-exam Freq. _____ ☐ Discharge: R / L

☐ Mastectomy: R / L Date ____/____/____ ☐ Other (specify):

## MUSCULOSKELETAL

☐ No Problem

☐ Fracture: Location _____
☐ Swollen, painful joints (specify) _____
☐ Contractures: Joint _____ Location _____
☐ Atrophy ☐ Poor conditioning
☐ Decreased ROM _____ ☐ Parasthesia _____
☐ Shuffling/Wide-based gait ☐ Weakness
☐ Amputation: BK / AK / UE; R / L (specify) _____
☐ Hemiplegia ☐ Paraplegia ☐ Quadriplegia

☐ Other (specify):

Patient Name _____ ID# _____ **(Recert)**

## ADL / IADLs

**For MO650 – MO800 Mark the level that corresponds to the patient's condition 14 days prior to start of care date. Record what the patient is *able to do*.**

**(MO650) Ability to Dress Upper Body** (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

**Current**

☐ 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. **FSD + 4**
☐ 2 - Someone must help the patient put on upper body clothing. **FSD + 4**
☐ 3 - Patient depends entirely upon another person to dress the upper body **FSD + 4**.
☐ UK - Unknown

**(MO660) Ability to Dress Lower Body** (with or without dressing aids) including undergarments, slacks, socks, or nylons, and shoes:

**Current**

☐ 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. **FSD + 4**
☐ 2 - Someone must help the patient put on lower body clothing and shoes. **FSD + 4**
☐ 3 - Patient depends entirely upon another person to dress the lower body. **FSD + 4**
☐ UK – Unknown

**(MO670) Bathing:** Ability to wash entire body. **Excludes grooming (washing face and hands only).**

**Current**

☐ 0 - Able to bathe self in shower or tub independently.
☐ 1 - With the use of devices, is able to bathe self in shower or tub independently.
☐ 2 - Able to bathe in shower or tub with the assistance of another person:
(a) for intermittent supervision or encouragement or reminders, OR **FSD + 8**
(b) to get in and out of the shower or tub, OR
(c) for washing difficult to reach areas.
☐ 3 - Participates in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision. **FSD + 8**
☐ 4 - Unable to use the shower or tub and is bathed in bed or bedside chair. **FSD + 8**
☐ 5 - Unable to effectively participate in bathing and is totally bathed by another person. **FSD + 8**
☐ UK - Unknown

**(MO680) Toileting:** Ability to get to and from the toilet or bedside commode.

**Current**

☐ 0 - Able to get to and from the toilet independently with or without a device.
☐ 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet.
☐ 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance). **FSD + 3**
☐ 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently. **FSD + 3**
☐ 4 - Is totally dependent in toileting. **FSD + 3**
☐ UK - Unknown

**(MO690) Transferring:** Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.

**Current**

☐ 0 - Able to independently transfer.
☐ 1 - Transfers with minimal human assistance or with use of an assistive device. **FSD + 3**.
☐ 2 - Unable to transfer self but is able to bear weight and pivot during the transfer process. **FSD + 6**
☐ 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person. **FSD + 6**
☐ 4 - Bedfast, unable to transfer but is able to turn and position self in bed. **FSD + 6**
☐ 5 - Bedfast, unable to transfer and is unable to turn and position self. **FSD + 6**
☐ UK - Unknown

**(MO700) Ambulation / Locomotion:** Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

**Current**

☐ 0 - Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).
☐ 1 - Requires use of a device (e.g., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. **FSD + 6**
☐ 2 - Able to walk only with the supervision or assistance of another person at all times. **FSD + 6**
☐ 3 - Chairfast, unable to ambulate but is able to wheel self independently. **FSD + 9**
☐ 4 - Chairfast, unable to ambulate and is unable to wheel self. **FSD + 9**
☐ 5 - Bedfast, unable to ambulate or be up in a chair. **FSD + 9**
☐ UK – Unknown

| | | | | | | |
|---|---|---|---|---|---|---|
| Indications for Home Health Aides: | ☐ Yes | ☐ No | ☐ Refused | | | |
| Orders obtained: | ☐ Yes | ☐ No | | | | |
| Referral to: | ☐ HHA | ☐ MSW | ☐ PT | ☐ OT | ☐ ST | ☐ Other: |

Patient Name _____ ID# _____ **(Recert)**

## MEDICATIONS

**(MO800) Management of Injectable Medications:** Patient's ability to prepare and take all prescribed injectable medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes IV medications.**

**Current**

☐ 0 - Able to independently take the correct injectable medication and proper dosage at the correct times.
☐ 1 - Able to take injectable medication at the correct times if:
(a) individual syringes are prepared in advance by another person; OR
(b) given daily reminders.
☐ 2 - Unable to take injectable medications unless administered by someone else.
☐ NA - No injectable medications prescribed. ☐ UK - Unknown

## ENTERAL FEEDINGS – ACCESS DEVICE

☐ **N/A**

☐ Nasogastric ☐ Gastrostomy ☐ Jejunostomy ☐ Other (specify): _____

Pump: (type/specify) _____ Feedings: ☐ Bolus ☐ Continuous

☐ Flush Protocol: (amt./specify) _____

Performed by: ☐ Self ☐ RN ☐ Cg ☐ Other _____

Dressing/Site care: (specify) _____

Additional comments _____

☐ Interventions/Instructions

## INFUSION

☐ **N/A**
☐ Peripheral: (specify) _____ ☐ PICC: (specify, size, brand) _____
☐ Central ☐ Midline Single lumen / Double lumen / Triple lumen Date of placement ____/____/____
☐ X-ray verification: ☐ Yes ☐ No
☐ Mid arm circumference _____ ☐ in/cm ☐ External catheter length _____ ☐ in/cm
☐ Hickman ☐ Groshong ☐ Jugular ☐ Subclavian
Single lumen / Double lumen / Triple lumen Date of placement ____/____/____
☐ Epidural catheter ☐ Tunneled ☐ Port Date of placement ____/____/____
☐ Implanted VAD ☐ Venous ☐ Arterial ☐ Peritoneal Date of placement ____/____/____
☐ Intrathecal ☐ Port ☐ Reservoir Date of placement ____/____/____
☐ Medication(s) ordered: (name of drug) _____ Dose _____
Route _____ Frequency _____ Duration of therapy _____
☐ Medication(s) ordered: (name of drug) _____ Dose _____
Route _____ Frequency _____ Duration of therapy _____
☐ Medication(s) ordered: (name of drug) _____ Dose _____
Route _____ Frequency _____ Duration of therapy _____
☐ Pump: (type, specify) _____ ☐ Administered by: ☐ Self ☐ PCG ☐ RN ☐ Other _____

**Flushing protocol/frequency:** (Circle all that apply)

| | | |
|---|---|---|
| _____cc normal saline or _____cc sterile water<br>before / after meds<br>before / after labs<br>line maintenance | _____cc normal saline or _____cc sterile water<br>before / after meds<br>before / after labs<br>line maintenance | _____cc normal saline or _____cc sterile water<br>before / after meds<br>before / after labs<br>line maintenance |

**Flushing protocol/frequency:** (Circle all that apply)

| | | |
|---|---|---|
| _____cc heparin _____u/ml<br>before / after meds<br>before / after labs<br>line maintenance | _____cc heparin _____u/ml<br>before / after meds<br>before / after labs<br>line maintenance | _____cc heparin _____u/ml<br>before / after meds<br>before / after labs<br>line maintenance |

Purpose of Intravenous Access: ☐ Antibiotic therapy ☐ Maintain venous access ☐ Chemotherapy
☐ Parenteral nutrition ☐ Hydration ☐ Pain control
☐ Other: (specify) _____

☐ Infusion care provided during treatment _____
☐ Dressing change: ☐ Sterile ☐ Clean Performed by: ☐ Self ☐ PCG ☐ RN ☐ Other _____
Frequency (specify) _____
Injection cap change (specify frequency) _____
Labs drawn _____
Additional comments _____
Interventions/Instructions

Patient Name _____ ID# _____ (Recert)

## APPLIANCES/AIDS/SPECIAL EQUIPMENT

☐ Brace/Orthotics (specify) _____ ☐ Transfer equipment: Board / Lift ☐ Bedside commode
☐ Grab bars: Bathroom / Other _____ ☐ Prosthesis: RUE/RLE/LUE/LLE/Other _____
☐ Hospital bed: Semi-elec./Crank/Spec. _____ Overlays _____
☐ Oxygen: HME Co. _____ HME Rep. / Phone _____
☐ Lifeline ☐ Fire Alarm ☐ Smoke Alarm ☐ Equipment needs(specify) _____
☐ Other (specify) _____
☐ Interventions/Instructions

## THERAPY NEED

**(M0826) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? (Enter zero ["000"] if no therapy visits indicated.)**

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

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



### PROGNOSIS (Locator #20)

☐ 1 – Poor ☐ 2 – Guarded ☐ 3 – Fair ☐ 4 – Good ☐ 5 – Excellent

### SAFETY MEASURES (Locator #15)

☐ 1 - Bleeding Precautions
☐ 2 - O2 precautions
☐ 3 - Seizure precautions
☐4 – Diabetic precautions
☐ 5 - Fall precautions
☐ 6 - Aspiration precautions
☐ 7 – Respiratory precautions
☐ 8 – Siderails up
☐ 9 - Elevate head of bed
☐ 10 - 24 hour supervision
☐ 11 - Clear pathways
☐ 12 – Wound precautions
☐ 13 - Lock w/c with transfers
☐ 14 - Infection control measures
☐ 15 –Proper Storage/Disposal Medications
☐ 16 –Proper Storage/Disposal Needles /Syringes

### MENTAL STATUS (Locator #19)

☐ 1 - Oriented
☐ 2 – Comatose
☐ 3 – Forgetful
☐ 4 – Depressed
☐ 5 – Disoriented
☐ 6 – Lethargic
☐ 7 - Agitated
☐ 8 - Other _____

### FUNCTIONAL LIMITATIONS (Locator #18A)

☐ 1 - Amputations
☐ 2 - Bowel/Bladder (Incontinence)
☐ 3 – Contracture
☐ 4 – Hearing
☐ 5 – Paralysis
☐ 6 – Endurance
☐ 7 – Ambulation
☐ 8 – Speech
☐ 9 - Legally blind
☐ 10- Unsteady Gait
☐ 11 – Pain
☐ 12- General Weakness
☐ 13 – Requires assistance of a person or device to leave hom home
☐ A - Dyspnea with exertion
☐ B - Other (specify) _____

### ACTIVITIES PERMITTED (Locator #18B)

☐ 1 - Complete bedrest
☐ 2 - Bedrest/BRP
☐ 3 - Up as tolerated
☐ 4 - Transfer bed/chair
☐ 5 - Exercises prescribed
☐ 6 - Partial weight bearing
☐ 7 - Independent in home
☐ 8 – Crutches
☐ 9 – Cane
☐ A – Wheelchair
☐ B – Walker
☐ C - No restrictions
☐ D - Other (specify): _____

### ALLERGIES (Locator #17)

☐ None known
☐ Pollen
☐ Other:
☐ Aspirin
☐ Eggs
☐ Penicillin
☐ Milk products
☐ Sulfa
☐ Insect bites

## SKILLED INTERVENTIONS/INSTRUCTIONS Locator # 21 Skilled Nursing (SN) Orders & Treatments

**(Mark all applicable with an "X". Circle appropriate item(s) separated "/".)**

### NURSING INTERVENTIONS/INSTRUCTIONS

| General | General | General | Neuro |
|---|---|---|---|
| ☑ **GAOO** Frequency & duration of service are subject to change according to the patient condition, patient request and physician orders | ☑ **G00B** SN to perform skilled assessment & observation of vital signs, Cardiovascular, Respiratory, Gastrointestinal, Genito-urinary, Musculoskeletal, & Integumentary, & Endocrine Systems, hydration & nutrition status, home safety, response to treatment and compliance to Plan of Care. Instruct/ evaluate understanding of disease process, detecting complications, diet /nutritional status, safety precautions/ emergency measures, medication regimen. Observe /teach medication (n or c) effects/ side/e | ☐ **GA01A** Weigh patient Q _____<br>☐ **GA01B** Measure abdominal girth Q _____<br>☐ **GANUT.** SN to assess nutritional status/hydration status. Instruct in _____diet & measures to ❒ prevent weight loss ❒ prevent weight gain. ❒ Maintain adequate hydration | ☐ **GACVALAT** SN to assess for late effect of CVA: Hemiplegia; flaccid paralysis; Aphasia; Visual Disturbances, Nystagmus, Tinnitus, Dysphagia; B/B incontinence. |

Patient Name _____ ID# _____ **(Recert)**

☐ **Psychiatric**
**GA01C** Assess mental & emotional status. Assess for s/s/ of complications & tolerance to medications. Provide therapeutic interventions to decrease anxiety & depression, promote verbalization of feelings, improve insight, promote medication compliance. Provide therapeutic interventions to promote reality testing, decrease acting out on hallucinations/delusions, improve orientation. Instruct pt/cg in disease process, medication actions/s/e, s/s to report to MD.

☐ **Cardiopulmonary**
**GACORPUL** SN to assess for clinical manifestations of Pulmonary heart disease such as increasing dyspnea and fatigue fatigue. progressive dyspnea (orthopnea, paroxysmal nocturnal dyspnea), chronic cough, distended neck veins, peripheral edema, headache, confusion.

☐ **Cardiopulmonary**
**GACOPDI** SN to instruct pt/ pcg to avoid respiratory irritants, monitoring & prevention of respiratory infections, deep breathing & coughing exercises, energy conservation techniques.

☐ **Cardiopulmonary**
**A10** Chest Physiotherapy (including postural drainage)

☐ **Telemedicine**
**TM** Monitor patient via telemedicine for the following:
- ❒ B/P and Pulse
- ❒ Pulseoximetry
- ❒ Blood glucose
- ❒ Weight

☐ **Wound**
**GA04A** SN to assess surgical wound status, drainage, pain, color, dressing. Instruct patient/caregiver to report any of the above observations to MD/SN.

☐ **Wound**
**GA04** Open Wound care/dressing (specify wound care order)
_____ ___
_____
_____
_____

☐ **Wound**
**GA05** Decubitus Care Stage 1,2,3,4 (specify stage/location and wound care order)
_____
_
_____
_
_____
_
_____
_

☐ **GI/GU**
**GA02** Foley insertion _____fr foley with _____ml balloon, change q month & PRN x 3 for clogged, leaking, or accidental removal.
☐ **GA03** Bladder instillation: irrigate foley with _____ml of _____ Q _____
☐ **GA09** Bowel/Bladder Training Digital exam with manual removal/ Enema

☐ **Pain**
**GA21** SN to assess pain by using scale 0-10 or Wong-Baker Faces Rating Scale & to instruct patient to take pain medication as ordered by MD. Take medications at least _____ hour before (therapy /exercise/ treatment) to be able to ambulate & to tolerate exercises/treatment prescribed by (MD/PT).

☐ **Ostomy**
☐ **G 15** Teach/perform Ostomy/ Ileo-Conduit Care
☐ **GA18** Teach/ Administer Gastrostomy Care & feedings. SN to teach/instruct proper GT care: flush with _____ ml water before & after each feeding/medication administration. Flush GT with _____ml water every _____ hrs.

☐ **Injections**
**GA11** SN to administer subcutaneous injection of Vitamin B 12 _____ Q _____.
☐ **GA13** Administer other IM/ Subcutaneous _____ Q _____.

☐ **Labs**
**GAO6A** SN to perf orm venipuncture & draw labs for_____ Q_____. Notify physician of results.

☐ **Diabetes**
**GADM** SN to instruct patient/ caregiver on early s/s of hypoglycemia, including hunger, shakiness, palpitations, weakness, headache, irritability, nervousness, and visual disturbances; s/s of hyperglycemia and possible Ketoacidosis, including fatigue, malaise, flushed face, nausea and vomiting, marked thirst, fruity breath, and changes in mentation.

☐ **Diabetes**
**GADMO** SN to report FBS > 250 MG/DL/ RBS > 350 MG/DL;FBS/RBS < 60 MG/DL and any signs and symptoms of Hypo/Hyperglycemia.
☐ **GADM01** Blood glucose level Q SN visit

☐ **Diabetes**
**GADM1** SN to teach PT/Caregiver preparation of insulin & subcutaneous administration using proper aseptic technique w/ correct dosage & frequency, rotation of site, needle precaution & disposal.
☐ **GADM2** Prepare/Administer subcutaneous injection of _____ Insulin _____ Units Q_____.

☐ **Diabetes**
**GADM3** SN to instruct/demonstrate to PT/cg ability in checking /monitoring/ recording/machine use & calibration. Validate PT/caregiver's skill.
☐ **GADM4** SN to instruct PT/ PCG Insulin preparation, using aseptic technique, administer subcut - aneous injection, site rotation. Proper disposal of sharps.

☐ **Infusion**
**G00INFUS** SN to prepare and administer prescribed medication: _____ dose _____. Route_____ duration: _____ As directed by MD and to assess response to_____ Therapy given and to notify MD if condition worsens or if pt fails to improve

☐ **Infusion**
☐ **G06INFUS SN** to insert peripheral venous access & rotate site every 48 – 72 hours & as needed
☐ **G02INFUS** SN to check for S/SX of phlebitis or infiltration each visit & before initiating, during IV therapy & assess for redness, swelling

☐ **Infusion**
**G04INFUS** SN to flush catheter using SASH protocol: flush with _____ml Normal Saline before and after each intravenous medication administration, then administer _____ ml Heparin _____units per ml.
☐ **A06B** May draw labs from _____ Q _____ If _____is used to draw labs, flush with 20 ml Normal Saline and Heparinize with _____ ml Heparin _____ units per ml.

☐ **Infusion**
☐ **GO5INFUS** Administer/ instruct in infusion of _____in_____ml of _____ over _____ minutes And _____ in _____ml _____ ver_____minutes every_____for_____days
☐ **GA14D** SN may administer medications in anaphylactic kit per agency protocol

☐ **G03INFUS** SN to instruct/perform admin of _____ _____ml/mg in ____ml to be given over _____min/hr, at___ ml/hr Q_____ hr, for duration of_____days/wks.
Other therapy:_____
SN to assess response to specific prescribed therapy and notify MD if condition worsens or fails to improve. SN to instruct pt./cg on purpose of prescribed IV therapy in relation to disease process, and expected response to therapy versus s/s of poor response.

SN to instruct pt./cg on common versus reportable drug /therapy side effects Assess pt/cg ability & willingness to (flushing, set & med. Preparation, pump operation) independently, using aseptic technique.
perform infusion therapy procedures
SN TO instruct/perform aseptic VAD flushing regimen: NS_____ml before & after infusion, NS 20ml after Blood draws. Heparin _____mls of 100/10units after 2nd NS flush and blood draws. SN to instruct/perform aseptic infusion set preparation

☐ Change gravity/pump tubing Q_____hr.
Change extension set & injection cap Q week and after blood draw. Change infusion bag Q _____hr. Change pump batteries Q ___days. SN to perform/instruct pt./cg in aseptic preparation or reconstitution of infusate. SN to perform /instruct pt./cg in delivery mode. Delivery mode: IV push/Intermittent gravity/ Continuous gravity /Syringe pump / Ambulatory pump
Stationary pump / PCA

☐ **GO7INFUS** SN to perform/instruct in dressing changes weekly and PRN as follows: under aseptic technique cleanse with 3 alcohol swabs followed by 3 povidone iodine swabs or one alcohol prep swab followed by chloraprep & apply sterile occlusive transparent dressing.
☐ **GO8INFUS** SN to change PRN adaptor cap, extension tubing or non coring (huber type) needle weekly & PRN. Change adaptor cap whenever blood is drawn into the cap

Patient Name _____ ID# _____ **(Recert)**

## AIDE INTERVENTIONS/INSTRUCTIONS

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **G00** Frequency & duration of service are subject to change according to the patient condition, patient request & physician orders | | **GF1** Tub/Shower/Bath | | **F2** Partial/Complete bed bath | | **F4** Personal Care /ADL |
| | **F6** Catheter care | | **F8** Assist w/ambulation | | **GF10** Exercises | | **GF 11** Prepare a meal |
| | **GF12** Grocery Shop | | **GF 13** Wash Clothes | | **GF14** Light Housekeeping | | **GF15** Assist w/ Toileting |
| | **GF15A** Feeding | | **GF15B** I & O | | **GF15C** Empty Urinary Drainage Bags | | **GF15D** Transfers |
| | **GF15E** Positioning | | **GF15F** Urine Testing | | **GF15G** TPR | | |

## MEDICAL SOCIAL SERVICES INTERVENTIONS/INSTRUCTIONS

| | | | | | |
|---|---|---|---|---|---|
| | **GO0** Frequency & duration of service are subject to change according to the patient condition, physician orders & planning & decision making | | **GE1** MSW assessment of social and emotional factors related to the patient's illness, need for care response to treatment and adjustment to care, followed by care plan development. | ☐<br>☐ | **GE2** Counseling for long-range planning and decision making<br>**GE2B** Assist patient to develop a daily life schedule |
| | **GE3** MSW to promote community centered service(s), education, advocacy, referral and linkage. | | **GE4** MSW to establish goals oriented intervention directed toward management of terminal illness, reaction/adjustment to illness, strengthening family/support system, conflict resolution related to chronicity of illness. | | **MSW** MSW to evaluate/ assess social/ emotional factors, home situation, family situations, financial/ community resources. |

## SKILLED CARE PROVIDED THIS VISIT

## ANALYSIS OF FINDINGS

**HOMEBOUND REASON:**

☐ Needs assistance for all activities ☐ Residual weakness ☐ Requires assistance to ambulate

☐ Confusion, unable to go out of home alone ☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exertion

☐ Dependent upon adaptive device(s) ☐ Medical restrictions ☐ Other (specify) _____

| SERVICES | ORDER FOR DISCIPLINE TREATMENTS (AMOUNT/FREQUENCY/DURATION) | PROJECTED # OF OF VISITS |
|---|---|---|
| ☐ SN | | |
| ☐ PT | | |
| ☐ OT | | |
| ☐ ST | | |
| ☐ MSS | | |
| ☐ Aide | | |
| ☐ Other | | |
| | **Total number of projected visits** | |
| | | |

Patient Name _____ ID# _____ **(Recert)**

**(Locator #22)**

## GOALS SKILLED NURSING General

| | | | | | |
|---|---|---|---|---|---|
| | **GP01** Pt/SO will verbalize knowledge of disease management, medications, side effects, precautions, diet, fluids, treatment program, s/s necessitating medical attention, emergency care in _____weeks. | | **GP02** Pt/SO will verbalize proper emergency management procedures & safety measures within two (2) weeks. Home will be free of hazards | ☐<br>☐<br>☐ | **GP2** Will demonstrate evidence of wound healing within 3-4 wks.<br>**03** Will achieve weight range of _____ to _____ within _____weeks. Prior weight_____<br>**GP03** Endpoint for daily visits will be _____ |
| | **GP04** Pt/SO will demonstrate proper biohazardous waste/ syringe/ needle **(circle one)** disposal in _____weeks. | | **GP5** Pt will exhibit improved nutritional status in accordance with disease process within _____weeks. | | **GP07** Pt/SO will verbalize action &S/E of _____ within _____weeks. |
| | **04** Will eat ____ % average of meals _____ X per day in _____ wks.<br>**05** Will have no evidence of falls, injury or skin breakdown during Tx. plan. | | **06** Will take all meds as ordered without demonstrating untoward side effects or drug interaction within 2 wks. | | **07** Will verbalize understanding of medication actions/side effects by_____. |
| | **GWOUND** PT's wound will exhibit the following signs of healing by _____: wound edges showing induration , tender, with epithelization, & granulation; absence of odor, exudate and necrotic tissue. By_____ absence of swelling, pain < 4/10 in scale/warmth on the surrounding tissues of the wound. absence of further skin breakdown. By _____ PT/CG will verbalize compliance to medically prescribed regimen, understanding of medication action, adverse reaction, side effect, & understand disease process: identify critical s/sx of potential complications. | ☐<br>☐<br>☐ | **08** Resume ADL status within _____ weeks (prior ADL function_____).<br>**09** Will verbalize understanding of symptoms or significant problems to report to MD in _____weeks.<br>**12** Will verbalize understanding / demonstrate compliance with safety precautions within 2-4 weeks. | ☐<br>☐<br>☐<br>☐ | **11** Pt/SO will verbalize understanding of post operative limitations within _____ weeks.<br>**11A** Pt/SO will demonstrate ability to perform ostomy care as ordered.<br>**11B** Pt/SO will verbalize s/s of wound infection within _____weeks.<br>**G13** Pt will verbalize measures to maintain blood pressure within acceptable range within _____weeks. |
| | **14** Patient will demonstrate bowel / bladder continence within __ Wks. using bowel / bladder program. | ☐<br>☐ | **15** Pt will verbalize appropriate reporting regarding chest pain within _____weeks.<br>**15A** Pt will verbalize methods to decrease lung congestion within _____ weeks. | ☐<br>☐ | **16** Will increase functional activity by demonstrating ability to ____ within __ wks.<br>**16 A** Pt will verbalize methods for prevention or edema & when to report edema to physician |
| ☐<br>☐ | **17** Resolution of _____ infection with antibiotic therapy within __ wks.<br>**18** Pt will verbalize methods to decrease episodes of SOB & activities to perform that will not increase SOB within _____ weeks. | ☐<br>☐ | **19** Edema will resolve in __ wks<br>**19A** Pt will verbalize understanding of increased circulation to extremity as evidenced by reduced pain, decreased redness & edema of the area, warm skin & palpable peripheral pulses in ____weeks | ☐<br>☐ | **20** Pt will maintain patency of _____ throughout treatment plan<br>**21** Will verbalize ways to decrease SOB in __ wks. |
| | **22** Will verbalize or show evidence of adjustment to & coping with _____ within 4-6 wks. | | **CARPUL** PT's Cardiopulmonary status will be stabilized as evidence by absence of cough, crackles, decreased sob/absence of sob, increased tolerance to activity. | | **GP1** Pt/S.O. will have knowledge of and or demonstrate safe transfers & ambulation with/with/without device |
| | **GP2** Pt/S.O. will have knowledge of and or demonstrate exercises to increase strength & endurance | | **GP3** Pt/S.O. will have knowledge of and or demonstrate transfer technique & use of a special device | ☐<br>☐ | **GP4** Pt/S.O. will comprehend & verbalize injury prevention techniques<br>**GP5** Pt/S.O. will comprehend/verbalize/demonstrate a home exercise program |
| **Endocrine** | | | | | |
| | **GP24** Pt/SO will verbalize S/S of hypo/ hyperglycemia & procedure to follow for each within _____weeks. | | **GINSULIN** Pt/SO will be able to prepare & administer insulin using proper technique as verified by return demonstration | | **GP25** Pt/SO will verbalize understanding of importance of maintaining blood sugar between _____&_____ within _____ weeks. |
| | **GP26** Pt/SO will verbalize proper foot care procedures within _____ weeks. | | | | |
| **Psychiatric** | | | | | |
| | **GP28** Pt will exhibit signs of stabilization of psychiatric status within disease process within _____ weeks. | | **GP29** Pt will return to previous lifestyle activities, socialization &/or participation in community activities within _____weeks. | | |
| **Foley Care / Nasogastric Tube** | | | | | |
| | **GP30** Pt/SO will demonstrate independence in foley catheter/nasogastric (**circle one)** tube care within ____weeks. | | **GP31** Pt/SO will verbalize S/S UTI | | **GP32** Urinary incontinence/retention (**circle one)** will be managed by patent foley catheter for this certification period |
| **Metastatic Illness/ Pain/Equipment** | | | | | |
| ☐<br>☐ | **GP33** Pt will exhibit pain controlled with medications within disease limits within _____weeks.<br>**GPAIN** By the end of Plan of Care, pt will report relief of pain, perform activities of daily living with minimal assistance. Pt/pcg will be able to verbalize measures to relieve pain and prevent of repeated attacks. | ☐<br>☐ | **GP34** Pt/SO will verbalize and demonstrate proper equipment usage & troubleshooting within ____weeks<br>**PAIN** PT's pain will be controlled within an acceptable range of 0-2/10. PT will demonstrate pain management techniques such as relaxation, energy conservation, creative imagery by _____. | | **CHEMO2** By ___, PT/ PCG will verbalize understanding of management of symptoms & S/ SX that require immediate medical attention. PT/ PCG will verbalize understanding & demonstrate compliance with measures to prevent infection/ bleeding, measures to minimize fatigue, promote nutrition, & measures to minimize stomatitis. PT will be afebrile, with no signs of infection. PT will be free of s/sx of dehydration & will be free of significant weight loss ( > 2 lbs/ week). |
| **Injection / Infusion Therapy** | | | | | |
| | **GP35** Pt/SO will demonstrate use of specific sites of injection that are appropriate for their lifestyle within_____weeks | | **GP36** Pt/SO will demonstrate how to safely administer injection within _____ weeks. | | **GP37** Pt/SO will demonstrate proper flush technique within_____weeks |
| | **GP38** will verbalize understanding of S/S of vascular access complications w/in ____weeks. | | **GP39** will demonstrate proper sterile IV access site care within _____weeks. | | **GP40** will demonstrate proper administration of IV medication within _____weeks |

Patient Name _____ ID# _____ **(Recert)**

## Home Health Aide Goals

- ☐ Resume ADL status within ____ wks.(prior ADL function _____).
- ☐ The Patient's needs for personal care and ADL's will be met by the HHA during the certification period.
- ☐ Patient/caregiver will be able to perform ADLS within restriction of the patient's condition.

**Goals/Rehabilitation Potential & Discharge Plans** _____

Discussed with patient? ☐ Yes ☐ No if ,no reason _____

## REHABILITATION POTENTIAL/DISCHARGE PLANS

| | | | | | |
|---|---|---|---|---|---|
| | **RPF** will be able to participate more effectively with ADL's once *** is controlled; & debilitating effects corrected with medication regimen. | | **RPG** Good with PT able to return to previous level of activity & improvement in functional status in accordance with pt's endurance level. | | **RPG1** Good for PT to be able to follow the plan of care/treatment regimen, & be able to self manage her/his condition . |
| | **RPGU** Guarded with minimal improvement in functional status expected & decline is possible. | | **DC** Discharge Plan: TO D/C Pt when above goals met under care of caregiver and MD follow-up. | | **DC1** Will discharge Pt as soon as able and willing caregiver will assume responsibilities and will be under the care of MD. |
| | **GD/C**Plan to discharge to self in a safe environment with minimal assistance from CG, under the supervision of MD when all goals have been met. | | **GDP** Pt to be discharged when Pt/S.O. able to verbalize understanding of disease management & s/s of complications | ☐<br>☐ | **GDPA** Pt will be discharged when Pt is able to function with assistance of caregiver within current limitations at home<br>**GDPI** Pt will be discharged when Pt is able to function independently within current limitations at home |

## DME SUPPLIES (Locator #14)

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

**IV SUPPLIES:**
- ☐ IV start kit
- ☐ IV pole
- ☐ IV tubing
- ☐ Alcohol swabs
- ☐ Angiocatheter size _____
- ☐ Tape
- ☐ Extension tubings
- ☐ Injection caps
- ☐ Central line dressing
- ☐ Infusion pump
- ☐ Batteries size _____
- ☐ Syringes size _____
- ☐ Other _____

**URINARY/OSTOMY:**
- ☐ Underpads
- ☐ External catheters
- ☐ Urinary bag/pouch
- ☐ Ostomy pouch (brand, size) _____
- ☐ Ostomy wafer (brand, size) _____
- ☐ Stoma adhesive tape
- ☐ Skin protectant
- ☐ Other

**FOLEY SUPPLIES:**
- ☐ _____ Fr catheter kit (tray, bag, foley)
- ☐ Straight catheter
- ☐ Irrigation tray
- ☐ Saline
- ☐ Acetic acid
- ☐ Other _____

**DIABETIC SUPPLIES:**
- ☐ Chemstrips
- ☐ Syringes
- ☐ Glucometer
- ☐ Other _____

**MISCELLANEOUS:**
- ☐ Enema supplies
- ☐ Feeding tube:
  Type _____ Size _____
- ☐ Suture removal kit
- ☐ Staple removal kit
- ☐ Steri strips
- ☐ Other _____

**SUPPLIES/EQUIPMENT:**
- ☐ Bathbench
- ☐ Cane
- ☐ Commode
- ☐ Special mattress overlay _____
- ☐ Pressure relieving device _____
- ☐ Eggcrates
- ☐ Hospital bed
- ☐ Hoyer lift
- ☐ Enteral feeding pump
- ☐ Nebulizer
- ☐ Oxygen concentrator
- ☐ Suction machine
- ☐ Ventilator
- ☐ Walker
- ☐ Wheelchair
- ☐ Tens unit
- ☐ Other_____

## SUMMARY CHECKLIST

**CARE COORDINATION:** ☐ Physician ☐ PT ☐ OT ☐ ST ☐ MSW ☐ SN ☐ Aide ☐ Other (specify)

## SIGNATURE/DATES

X _____ _____/_____/_____

*Patient/Caregiver (if applicable)* *Date*

X _____ _____/_____/_____

*Person Completing This Form (signature/title)* *Date*

## OASIS INFORMATION

**Date Reviewed** _____/_____/_____ **Initial** _____ **Date Entered/Locked** ____/____/_____**Initial** _____