

START OF CARE (SOC)/RESUMPTION OF CARE (ROC) OASIS ASSESSMENT

REASON FOR ASSESSMENT Start of Care Resumption of Care 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 # _____

CLINICAL RECORD ITEMS

Certification Period: (Locator # 3) From ___/___/___ To ___/___/___

(MO080) Discipline of Person Completing Assessment: 1-RN 2-PT 3-SLP/ST 4-OT
 Identified Patient by 2 means Yes No

(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

HISTORY OF PRESENT ILLNESS

(MO175) From which of the following Inpatient Facilities was the patient discharged during the past 14 days? (Mark all that apply.)

- 1 - Hospital
- 2 - Rehabilitation Facility
- 3 - Skilled Nursing Facility
- 4 - Other Nursing Home
- 5 - Other (specify)
- NA - Patient was not discharged from an inpatient facility [If NA, go to MO200]

(MO180) Inpatient Discharge Date (most recent):

___/___/___ UK - Unknown
 month day year

(MO190) Inpatient Diagnoses and ICD code categories for only those conditions treated during an inpatient facility stay within the last 14 days (no surgical, E-codes, or V-codes):

Inpatient Facility Diagnoses

ICD-9-CM

- a. _____ (_____.____.)
- b. _____ (_____.____.)

(MO200) Medical or Treatment Regimen Change Within Past 14 Days: Has this patient experienced a change in medical or treatment regimen (e.g., medication, treatment, or service change due to news or additional diagnoses, etc.) within the last 14 days?

- 0 - No [If No, go to MO220]
- 1 - Yes

(MO210) List the patient's Medical Diagnoses and ICD code categories for only those conditions requiring changed medical or treatment regimen (no surgical, E-codes, or V-codes):

Changed Medical Regimen Diagnoses

ICD-9-CM

- a. _____ (_____.____.)
- b. _____ (_____.____.)
- c. _____ (_____.____.)
- d. _____ (_____.____.)

(MO220) Conditions prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions which existed prior to the inpatient stay or change in medical or treatment regimen. (Mark all that apply.)

- 1 - Urinary incontinence
- 2 - Indwelling/suprapubic catheter
- 3 - Intractable pain
- 4 - Impaired decision-making
- 5 - Disruptive or socially inappropriate behavior
- 6 - Memory loss to the extent that supervision is required
- 7 - None of the above
- NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
- UK - Unknown

HISTORY OF PRESENT ILLNESS (Cont'd.)

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.

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. (____ . ____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 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. (____ . ____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	b. _____ (____ . ____)	b. _____ (____ . ____)
c. _____	c. (____ . ____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	c. _____ (____ . ____)	c. _____ (____ . ____)
d. _____	d. (____ . ____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	d. _____ (____ . ____)	d. _____ (____ . ____)
e. _____	e. (____ . ____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	e. _____ (____ . ____)	e. _____ (____ . ____)
f. _____	f. (____ . ____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	f. _____ (____ . ____)	f. _____ (____ . ____)

Surgical Procedure: _____ Code _____ Code _____ Code _____ Code

PHYSICIAN:	Date last contacted	____ / ____ / ____	Date last visited	____ / ____ / ____
PRIMARY REASON FOR HOME HEALTH:				
PRESENT ILLNESS/NURSING DIAGNOSES:				

PATIENT HISTORY (Cont'd.)						
PERTINENT HISTORY AND/OR PREVIOUS OUTCOMES				* Describe in blank spaces below		
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Cardiac	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Fractures	<input type="checkbox"/> Cancer (site: _____)
<input type="checkbox"/> Infection	<input type="checkbox"/> Immunosuppressed	<input type="checkbox"/> Open Wound	<input type="checkbox"/> Surgeries			
<input type="checkbox"/> Other (specify)		*	*	*	*	
		*	*	*	*	
IMMUNIZATIONS	<input type="checkbox"/> Up to date	Needs:	<input type="checkbox"/> Influenza	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Other
PRIOR HOSPITALIZATIONS	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Number of times			
Reason(s)/Date(s):						
Patient has a DNRO Yes <input type="checkbox"/> No <input type="checkbox"/> Signed by patient and physician Yes <input type="checkbox"/> No <input type="checkbox"/> On appropriate form Yes <input type="checkbox"/> No <input type="checkbox"/>						

(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

(MO260) **Overall Prognosis:** BEST description of patient's overall prognosis for recovery from this episode of illness.

- 0 - Poor: little or no recovery is expected and/or further decline is imminent
- 1 - Good/Fair: partial to full recovery is expected
- UK - Unknown

(MO270) **Rehabilitative Prognosis:** BEST description of patient's prognosis for functional status.

- 0 - Guarded: minimal improvement in functional status is expected; decline is possible
- 1 - Good: marked improvement in functional status is expected
- UK - Unknown

(MO280) **Life Expectancy:** (Physician documentation is not required.)

- 0 - Life expectancy is greater than 6 months
- 1 - Life expectancy is 6 months or fewer

LIVING ARRANGEMENTS/SUPPORTIVE ASSISTANCE

(MO290) **High Risk Factors** characterizing this patient: (Mark all that apply.)

- 1 - Heavy smoking
- 2 - Obesity
- 3 - Alcohol dependency
- 4 - Drug dependency
- 5 - None of the above
- UK - Unknown

(MO300) **Current Residence:**

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

Name of facility _____

HOME ENVIRONMENT SAFETY

Safety Hazards in the Home

- | | | | | | |
|---------------------------------------------------|------------------------------|-----------------------------|-------------------------------------------|------------------------------|-----------------------------|
| Unsound structure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Unsafe functional barriers (e.g., stairs) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Unsafe placement of rugs/cords/furniture, etc. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Inadequate heating/cooling/electricity | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Inadequate sanitation/plumbing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Inadequate refrigeration | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Unsafe gas/electrical appliances or outlets | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Inadequate running water | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| No telephone available and/or unable to use phone | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Unsafe storage of supplies/equipment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Insects/rodents | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stairs inside home | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Emergency planning/fire safety

- | | | | | | |
|------------------------------------|------------------------------|-----------------------------|-----------------------------|------------------------------|-----------------------------|
| Smoke detectors | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Not two open exits | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| No plan for power failures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | O2 in use – no signs posted | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Poor handling of smoking materials | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

Oxygen back-up: Available Knows how to use Electrical/fire safety

Patient needs: **Social Work Evaluation** Yes No **Order obtained:** Yes No

Comments:

LIVING ARRANGEMENTS/SUPPORTIVE ASSISTANCE (Cont'd.)

(MO340) Patient Lives With: (Mark all that apply.)

- 1 - Lives alone
- 2 - With spouse or significant other
- 3 - With other family member
- 4 - With a friend
- 5 - With paid help (other than home care agency staff)
- 6 - With other than above

(MO350) Assisting Person(s) Other than Home Care Agency Staff: (Mark all that apply.)

- 1 - Relatives, friends, or neighbors living outside the home
- 2 - Person residing in the home (EXCLUDING paid help)
- 3 - Paid help
- 4 - With None of the above **[If None of the above, go to MO390]**
- UK - Unknown **[If Unknown, go to MO390]**

(MO360) Primary Caregiver taking lead responsibility for providing or managing the patient's care, providing the most frequent assistance, etc. (other than home care staff):

- 0 - No one person **[If No one person, go to MO390]**
- 1 - Spouse or significant other
- 2 - Daughter or son
- 3 - Other family member
- 4 - Friend or neighbor or community or church member
- 5 - Paid help
- UK - Unknown **[If Unknown, go to MO390]**

Primary Caregiver (name) _____
 Phone Number (if different from patient) _____
 Relationship/Health status _____
 Provides physical care _____
 Other (specify) _____

(MO370) How Often does the patient receive assistance from the primary caregiver?

- 1 - Several times during day and night
- 2 - Several times during day
- 3 - Once daily
- 4 - Three or more times per week
- 5 - One to two times per week
- 6 - Less often than weekly
- UK - Unknown

(MO380) Type of Primary Caregiver Assistance: (Mark all that apply.)

- 1 - ADL assistance (e.g., bathing, dressing, toileting, bowel/bladder, eating/feeding)
- 2 - IADL assistance (e.g., meds, meals, housekeeping, laundry, telephone, shopping, finances)
- 3 - Environmental support (housing, home maintenance)
- 4 - Psychosocial support (socialization, companionship, recreation)
- 5 - Advocates or facilitates patient's participation in appropriate medical care
- 6 - Financial agent, power of attorney, or conservator of finance
- 7 - Health care agent, conservator of person, or medical power of attorney
- UK - Unknown

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**

<input type="checkbox"/> No Problem		
<input type="checkbox"/> Glasses: R / L	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Contacts: R / L	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Ptosis
<input type="checkbox"/> Prosthesis: R / L	<input type="checkbox"/> Infections	
<input type="checkbox"/> Cataract surgery: Site _____ Date ____/____/____		
<input type="checkbox"/> Other (specify) _____		

NOSE/THROAT/MOUTH		
N O S E	T H R O A T	M O U T H
<input type="checkbox"/> No Problem <input type="checkbox"/> Congestion <input type="checkbox"/> Loss of smell <input type="checkbox"/> Other (specify) _____ _____ _____	<input type="checkbox"/> No Problem <input type="checkbox"/> Dysphagia <input type="checkbox"/> Lesions <input type="checkbox"/> Other (specify) _____ _____ _____	<input type="checkbox"/> No Problem <input type="checkbox"/> Dentures: Upper / Lower / Partial <input type="checkbox"/> Masses/Tumors <input type="checkbox"/> Ulcerations <input type="checkbox"/> Other (specify) _____ _____ _____
<input type="checkbox"/> Epistaxis <input type="checkbox"/> Sinus problem _____ _____	<input type="checkbox"/> Hoarseness <input type="checkbox"/> Sore throat _____ _____	<input type="checkbox"/> Gingivitis <input type="checkbox"/> Toothache _____ _____

EARS

(MO400) Hearing and Ability to Understand Spoken Language in patient's own language (with hearing aids if the patient usually uses them):

- 0 - No observable impairment: able to hear and understand complex or detailed instructions and extended or abstract conversation.
- 1 - With minimal difficulty, able to hear and understand most multi-step instructions and ordinary conversation. May need occasional repetition, extra time, or louder voice.
- 2 - Has moderate difficulty hearing and understanding simple, one-step instructions and brief conversation; needs frequent prompting or assistance.
- 3 - Has severe difficulty hearing and understanding simple greetings and short comments. Requires multiple repetitions, restatements, demonstrations, additional time.
- 4 - Unable to hear and understand familiar words or common expressions consistently, or patient unresponsive.

<input type="checkbox"/> No Problem <input type="checkbox"/> HOH: R / L <input type="checkbox"/> Deaf: R / L <input type="checkbox"/> Hearing aid: R / L <input type="checkbox"/> Vertigo <input type="checkbox"/> Tinnitus <input type="checkbox"/> Other (specify) _____

SPEECH/ORAL (VERBAL) EXPRESSION

(MO410) 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 is unresponsive or unable to speak.

PAIN

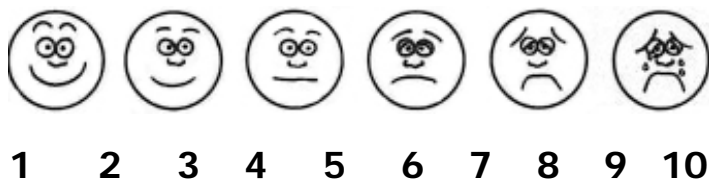
(MO420) Frequency of Pain interfering with patient's activity or movement:

- 0 - Patient has no pain or pain does not interfere with activity or movement
- 1 - Less often than 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)



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.

PAIN (Cont'd.)

No Problem

Is patient experiencing pain? Yes No Unable to communicate

Non-verbals demonstrated:

<input type="checkbox"/> Diaphoresis	<input type="checkbox"/> Grimacing	<input type="checkbox"/> Moaning/Crying
<input type="checkbox"/> Guarding	<input type="checkbox"/> Irritability	<input type="checkbox"/> Anger
<input type="checkbox"/> Tense	<input type="checkbox"/> Restlessness	<input type="checkbox"/> Change in Vital Signs
<input type="checkbox"/> Other: _____		
<input type="checkbox"/> Self-assessment	<input type="checkbox"/> 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:

<input type="checkbox"/> Aching	<input type="checkbox"/> Nagging	<input type="checkbox"/> Dull	<input type="checkbox"/> Heavy
<input type="checkbox"/> Crushing	<input type="checkbox"/> Sharp	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Throbbing
<input type="checkbox"/> Radiating	<input type="checkbox"/> Burning	<input type="checkbox"/> Tingling	<input type="checkbox"/> Cramping
<input type="checkbox"/> Other: _____			

Frequency: Occasionally Continuous Intermittent Other: _____

What makes pain worse? Movement Ambulation Other: _____

What makes pain better?

<input type="checkbox"/> Heat/Ice	<input type="checkbox"/> Massage	<input type="checkbox"/> Repositioning
<input type="checkbox"/> Medication	<input type="checkbox"/> Diversion	<input type="checkbox"/> Rest/Relaxation
<input type="checkbox"/> Other: _____		

How often is breakthrough medication needed? Never Less than daily 2-3 times/day

>3 times/day Current pain control medications adequate

Other: _____

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) _____	

INTEGUMENTARY STATUS (Cont'd.)

(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**?

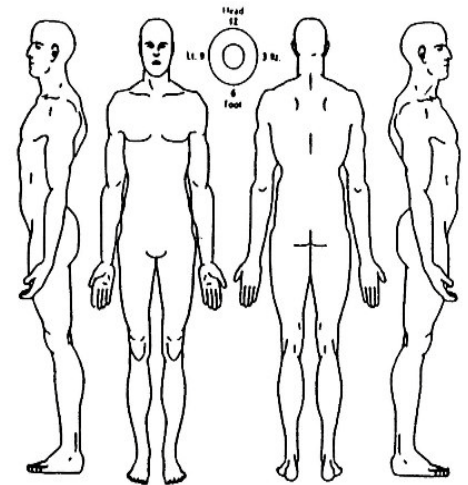
0 - No [If No, go to MO468] 1 - Yes

(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? <input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes					

CONDITION	#1	#2	#3	#4
Size (cm) (LxWxD)				
Stage				
Tunneling/ Undermining				
Odor				
Surrounding Skin				
Edema				
Stoma				
Appearance of the Wound Bed				
Drainage/ Amount	<input type="checkbox"/> None <input type="checkbox"/> Small <input type="checkbox"/> Moderate <input type="checkbox"/> Large	<input type="checkbox"/> None <input type="checkbox"/> Small <input type="checkbox"/> Moderate <input type="checkbox"/> Large	<input type="checkbox"/> None <input type="checkbox"/> Small <input type="checkbox"/> Moderate <input type="checkbox"/> Large	<input type="checkbox"/> None <input type="checkbox"/> Small <input type="checkbox"/> Moderate <input type="checkbox"/> Large
Color	<input type="checkbox"/> Clear <input type="checkbox"/> Tan <input type="checkbox"/> Serosanguineous <input type="checkbox"/> Other	<input type="checkbox"/> Clear <input type="checkbox"/> Tan <input type="checkbox"/> Serosanguineous <input type="checkbox"/> Other	<input type="checkbox"/> Clear <input type="checkbox"/> Tan <input type="checkbox"/> Serosanguineous <input type="checkbox"/> Other	<input type="checkbox"/> Clear <input type="checkbox"/> Tan <input type="checkbox"/> Serosanguineous <input type="checkbox"/> Other
Consistency	<input type="checkbox"/> Thin <input type="checkbox"/> Thick	<input type="checkbox"/> Thin <input type="checkbox"/> Thick	<input type="checkbox"/> Thin <input type="checkbox"/> Thick	<input type="checkbox"/> Thin <input type="checkbox"/> Thick

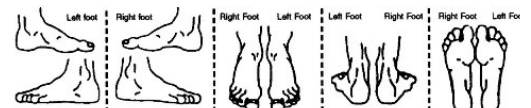
Note location of specific skin conditions/wounds by numbering appropriately on illustrations below. Proceed by completing applicable information for each numbered site on chart at left



(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

INTEGUMENTARY STATUS (Cont'd.)

(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

(MO482) Does this patient have a **Surgical Wound**?

- 0 - No [If No, go to MO490]
- 1 - Yes

(MO484) **Current Number of Observable Surgical Wounds:** (If a wound is partially closed but has more than one opening, consider each opening as a separate wound.)

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

(MO486) Does this patient have at least one **Surgical Wound that Cannot be Observed** due to the presence of a nonremovable dressing?

- 0 - No
- 1 - Yes

(Skip this Item if patient has no Surgical Wounds)

(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

Wound care done:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Soiled dressing removed
<input type="checkbox"/> Wound cleaned with (specify):	_____		
<input type="checkbox"/> Wound irrigated with (specify):	_____		
<input type="checkbox"/> Wound packed with (specify):	_____		
<input type="checkbox"/> Wound dressing applied (specify):	_____		
<input type="checkbox"/> Patient tolerated procedure well	<input type="checkbox"/> Other (specify): _____		

SYSTEMS REVIEW

Height: _____ Reported Actual Weight: _____ Reported Actual

CARDIOPULMONARY

No Problem
(Circle all applicable items)

<p>Blood Pressure:</p> <p><input type="checkbox"/> Sitting R _____ L _____</p> <p><input type="checkbox"/> Lying R _____ L _____</p> <p><input type="checkbox"/> Standing R _____ L _____</p> <p>Temperature: _____</p> <p><input type="checkbox"/> Oral <input type="checkbox"/> Axillary</p> <p><input type="checkbox"/> Rectal <input type="checkbox"/> Tympanic</p>	<p>Pulse:</p> <p><input type="checkbox"/> Apical _____ <input type="checkbox"/> Brachial _____ <input type="checkbox"/> Regular</p> <p><input type="checkbox"/> Radial _____ <input type="checkbox"/> Carotid _____ <input type="checkbox"/> Irregular</p> <p><input type="checkbox"/> Rest <input type="checkbox"/> Activity</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

CARDIOPULMONARY (Cont'd.)			
Cough: <input type="checkbox"/> Dry <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Productive: <input type="checkbox"/> Yes <input type="checkbox"/> No Thick/Thin Color: _____ Amt: _____ <input type="checkbox"/> Dyspnea: Rest/Exertion <input type="checkbox"/> Ambulation _____ feet <input type="checkbox"/> During ADL's <input type="checkbox"/> Orthopnea <input type="checkbox"/> Other: _____			
Heart Sounds: <input type="checkbox"/> Regular <input type="checkbox"/> Pacemaker: _____ <input type="checkbox"/> Irregular Date: _____ <input type="checkbox"/> Murmur Type: _____	Chest Pain: <input type="checkbox"/> Anginal <input type="checkbox"/> Sharp <input type="checkbox"/> Substernal <input type="checkbox"/> Localized <input type="checkbox"/> Ache <input type="checkbox"/> Dull <input type="checkbox"/> Postural <input type="checkbox"/> Vise-like <input type="checkbox"/> Radiating		
Respirations: <input type="checkbox"/> Rate _____ per minute <input type="checkbox"/> Regular <input type="checkbox"/> Apnea periods _____ sec. <input type="checkbox"/> Irregular <input type="checkbox"/> Cheynes Stokes	Associated with: <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Activity <input type="checkbox"/> Sweats		
Breath Sounds: <input type="checkbox"/> Clear <input type="checkbox"/> Diminished <input type="checkbox"/> Absent <input type="checkbox"/> Rales <input type="checkbox"/> Crackles <input type="checkbox"/> Wheezes <input type="checkbox"/> Rhonchi (specify) _____	Frequency/duration: _____ <input type="checkbox"/> Palpitations <input type="checkbox"/> Fatigue		
<input type="checkbox"/> Insp. Wheeze <input type="checkbox"/> RUL <input type="checkbox"/> Exp. Wheeze <input type="checkbox"/> RUL <input type="checkbox"/> RLL <input type="checkbox"/> RLL <input type="checkbox"/> LUL <input type="checkbox"/> LUL <input type="checkbox"/> LLL <input type="checkbox"/> LLL	Edema: Site: _____ <input type="checkbox"/> Right +1/+2/+3/+4 <input type="checkbox"/> Pitting +1/+2/+3/+4 <input type="checkbox"/> Left +1/+2/+3/+4 <input type="checkbox"/> Non-pitting		
<input type="checkbox"/> O2 @ _____ % LPM per _____ O2 sat. _____ % <input type="checkbox"/> Accessory muscles used <input type="checkbox"/> Other: _____	<input type="checkbox"/> Cramps <input type="checkbox"/> Capillary refill < 3 sec <input type="checkbox"/> Claudication <input type="checkbox"/> 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

NUTRITIONAL STATUS			
<input type="checkbox"/> No Problem			
(Locator #16)			
Specify Diet	<input type="checkbox"/> Increase fluids	amt.	<input type="checkbox"/> Restrict fluids
Appetite: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Anorexic Eating patterns: <input type="checkbox"/> Nausea/Vomiting Freq. _____ Amt. _____ <input type="checkbox"/> Heartburn (food tolerance) <input type="checkbox"/> Weight change: Gain/Loss lb. X wk./mo./yr. <input type="checkbox"/> Other (specify, incl. Hx) _____			
Directions: Circle each area with "yes" to assessment, then total score to determine additional risk.		YES	INTERPRETATION
Has an illness or condition that changed the kind and/or amount of food eaten.		2	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.
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	
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): _____

(MO510) Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?

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

(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**

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: _____

ABDOMEN (Cont'd.)

(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): _____

NEURO/EMOTIONAL/BEHAVIOR STATUS

(MO560) Cognitive Functioning: (Patient's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.)

- 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- 1 - Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.
- 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

No Problem

Headache: Location _____ Frequency _____

Aphasia: Receptive / Expressive

Motor change: Fine / Gross

Weakness: UE / LE Location _____

Tremors: Fine / Gross / Paralysis

Stuporous / Hallucinations: Visual / Auditory

Unequal pupils: R / L / PERRLA

Hand grips: Equal / Unequal (specify)
 Strong / Weak (specify)

Psychotropic drug use (specify): _____ Dose / Freq. _____

Other (specify): _____

MENTAL STATUS

(MO570) When Confused (Reported or Observed):

- 0 - Never
- 1 - In new or complex situations only
- 2 - On awakening or at night only
- 3 - During the day and evening, but not constantly
- 4 - Constantly
- NA - Patient unresponsive

MENTAL STATUS (Cont'd)

(MO580) When Anxious (Reported or Observed):

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

PSYCHOSOCIAL

No Problem

Primary Language _____

Language Barrier Needs Interpreter _____ Learning Barrier: Mental / Psychosocial / Physical / Functional

Able to read/write Educational Level _____

Angry Difficulty Coping Withdrawn Discouraged Flat affect Disorganized

Spiritual/Cultural implications that impact care (specify) _____

Spiritual resource _____ Phone No. _____

Depressed: Recent / Long term Rx _____

Due to: Lack of Motivation Inability to recognize problems Unrealistic expectations Denial of Problems

Sleep/Rest: Adequate Inadequate Explain _____

Inappropriate responses to caregivers/children Inappropriate follow-through in past Invested in "sick role"

Evidence of abuse: Potential Actual Verbal/Emotional Physical Financial

Describe objective/subjective findings _____

Other (specify) _____

(MO590) Depressive Feelings Reported or Observed in Patient: (Mark all that apply.)

- 1 - Depressed mood (e.g., feeling sad, tearful)
- 2 - Sense of failure or self-reproach
- 3 - Hopelessness
- 4 - Recurrent thoughts of death
- 5 - Thoughts of suicide
- 6 - None of the above feelings observed or reported

(MO610) Behaviors Demonstrated at Least Once a Week (Reported or Observed): (Mark all that apply.)

- 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- 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

(MO620) Frequency of Behavior Problems (Reported or Observed) (e.g., wandering episodes, self abuse, verbal disruption, physical aggression, etc.):

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

(MO630) Is this patient receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse?

- 0 - No 1 - Yes

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): _____

ADL/IADLs

For MO640 – 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.

(MO640) Grooming: Ability to tend to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make-up, teeth or denture care, fingernail care).

- | <u>Prior</u> | <u>Current</u> | |
|---------------------------------------|--------------------------|---------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - Able to groom self-unaided, with or without the used of assistive devices or adapted methods. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - Grooming utensils must be placed within reach before able to complete grooming activities. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - Someone must assist the patient to groom self. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 - Patient depends entirely upon someone else for grooming needs. |
| <input type="checkbox"/> UK - Unknown | | |

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

- | <u>Prior</u> | <u>Current</u> | |
|---------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient. FSD + 4 |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - Someone must help the patient put on upper body clothing. FSD + 4 |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 - Patient depends entirely upon another person to dress the upper body FSD + 4 . |
| <input type="checkbox"/> UK - Unknown | | |

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

- | <u>Prior</u> | <u>Current</u> | |
|---------------------------------------|--------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - Able to obtain, put on, and remove clothing and shoes without assistance. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. FSD + 4 |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - Someone must help the patient put on lower body clothing and shoes. FSD + 4 |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 - Patient depends entirely upon another person to dress the lower body. FSD + 4 |
| <input type="checkbox"/> UK – Unknown | | |

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

- | <u>Prior</u> | <u>Current</u> | |
|---------------------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - Able to bathe self in <u>shower or tub</u> independently. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - With the use of devices, is able to bathe self in shower or tub independently. |
| <input type="checkbox"/> | <input type="checkbox"/> | 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. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 - Participates in bathing self in shower or tub, <u>but</u> requires presence of another person throughout the bath for assistance or supervision. FSD + 8 |
| <input type="checkbox"/> | <input type="checkbox"/> | 4 - <u>Unable</u> to use the shower or tub and is bathed in <u>bed or bedside chair</u> . FSD + 8 |
| <input type="checkbox"/> | <input type="checkbox"/> | 5 - Unable to effectively participate in bathing and is totally bathed by another person. FSD + 8 |
| <input type="checkbox"/> UK - Unknown | | |

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

- | <u>Prior</u> | <u>Current</u> | |
|---------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - Able to get to and from the toilet independently with or without a device. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - <u>Unable</u> to get to and from the toilet but is able to use a bedside commode (with or without assistance). FSD + 3 |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 - <u>Unable</u> to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently. FSD + 3 |
| <input type="checkbox"/> | <input type="checkbox"/> | 4 - <u>Is totally dependent</u> in toileting. FSD + 3 |
| <input type="checkbox"/> 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.

- | <u>Prior</u> | <u>Current</u> | |
|---------------------------------------|--------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - Able to independently transfer. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - Transfers with minimal human assistance or with use of an assistive device. FSD + 3 . |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - <u>Unable</u> to transfer self but is able to bear weight and pivot during the transfer process. FSD + 6 |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 - <u>Unable</u> to transfer self and is <u>unable</u> to bear weight or pivot when transferred by another person. FSD + 6 |
| <input type="checkbox"/> | <input type="checkbox"/> | 4 - Bedfast, unable to transfer but is able to turn and position self in bed. FSD + 6 |
| <input type="checkbox"/> | <input type="checkbox"/> | 5 - Bedfast, unable to transfer and is <u>unable</u> to turn and position self. FSD + 6 |
| <input type="checkbox"/> 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.

- | <u>Prior</u> | <u>Current</u> | |
|---------------------------------------|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 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). |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - Requires use of a device (e.g., cane, walker) to walk alone <u>or</u> requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. FSD + 6 |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - Able to walk only with the supervision or assistance of another person at all times. FSD + 6 |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 - Chairfast, <u>unable</u> to ambulate but is able to wheel self independently. FSD + 9 |
| <input type="checkbox"/> | <input type="checkbox"/> | 4 - Chairfast, unable to ambulate and is <u>unable</u> to wheel self. FSD + 9 |
| <input type="checkbox"/> | <input type="checkbox"/> | 5 - Bedfast, unable to ambulate or be up in a chair. FSD + 9 |
| <input type="checkbox"/> UK - Unknown | | |

(MO710) Feeding or Eating: Ability to feed self meals and snacks. **Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.**

- | <u>Prior</u> | <u>Current</u> | |
|---------------------------------------|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - Able to independently feed self. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - Able to feed self independently but requires:
(a) meal set-up, <u>OR</u>
(b) intermittent assistance or supervision from another person, <u>OR</u>
(c) a liquid, pureed or ground meat diet. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - <u>Unable</u> to feed self and must be assisted or supervised throughout the meal/snack. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 - Able to take in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4 - <u>Unable</u> to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy. |
| <input type="checkbox"/> | <input type="checkbox"/> | 5 - Unable to take in nutrients orally or by tube feeding. |
| <input type="checkbox"/> UK - Unknown | | |

(MO720) Planning and Preparing Light Meals (e.g., cereal, sandwich) or reheat delivered meals:

- | <u>Prior</u> | <u>Current</u> | |
|---------------------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; <u>OR</u>
(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). |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - <u>Unable</u> to prepare light meals on a regular basis due to physical, cognitive, or mental limitations. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - Unable to prepare any light meals or reheat any delivered meals. |
| <input type="checkbox"/> UK - Unknown | | |

(MO730) Transportation: Physical and mental ability to SAFELY use a car, taxi, or public transportation (bus, train, subway).

- | <u>Prior</u> | <u>Current</u> | |
|---------------------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - Able to independently drive a regular or adapted care; <u>OR</u> uses a regular or handicap-accessible public bus. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - Able to ride in a car only when driven by another person; <u>OR</u> able to use a bus or handicap van only when assisted or accompanied by another person. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - <u>Unable</u> to ride in a car, taxi, bus, or van, and requires transportation by ambulance. |
| <input type="checkbox"/> UK - Unknown | | |

(MO740) Laundry: Ability to do own laundry— to carry to and from washing machine, to use washer and dryer, to wash small items by hand.

- | <u>Prior</u> | <u>Current</u> | |
|---------------------------------------|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - (a) Able to independently take care of all laundry tasks; <u>OR</u>
(b) Is physically, cognitively, and mentally able to do laundry and access facilities, but has not routinely performed laundry tasks in the past (i.e., prior to this home care admission). |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - Able to do only light laundry, such as minor hand wash or light washer loads. Due to physical, cognitive, or mental limitations, needs assistance with heavy laundry such as carrying large loads of laundry. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - <u>Unable</u> to do any laundry due to physical limitations or needs continual supervision and assistance due to cognitive or mental limitations. |
| <input type="checkbox"/> UK - Unknown | | |

(MO750) Housekeeping: Ability to safely and effectively perform light housekeeping and heavier cleaning tasks.

- | <u>Prior</u> | <u>Current</u> | |
|---------------------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - (a) Able to independently perform all housekeeping tasks; <u>OR</u>
(b) Is physically, cognitively, and mentally able to perform <u>all</u> housekeeping tasks but has not routinely participated in housekeeping tasks in the past (i.e., prior to this home care admission). |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - Able to perform only <u>light</u> housekeeping (e.g., dusting, wiping kitchen counters) tasks independently. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - Able to perform housekeeping tasks with intermittent assistance or supervision from another person. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 - <u>Unable</u> to consistently perform any housekeeping tasks unless assisted by another person throughout the process. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4 - Unable to effectively participate in any housekeeping tasks. |
| <input type="checkbox"/> UK - Unknown | | |

ADL/IADLs (Cont'd.)

(MO760) Shopping: Ability to plan for, select, and purchase items in a store and to carry them home or arrange delivery.

- | <u>Prior</u> | <u>Current</u> | |
|---------------------------------------|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - (a) Able to plan for shopping needs and independently perform shopping tasks, including carrying packages; <u>OR</u>
(b) Is physically, cognitively, and mentally able to take care of shopping, but has not done shopping in the past (i.e., prior to this home care admission). |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - Able to go shopping, but needs assistance.
(a) By self is able to do only light shopping and carry small packages, but needs someone to do occasional major shopping; <u>OR</u>
(b) <u>Unable</u> to go shopping alone, but can go with someone to assist. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - <u>Unable</u> to go shopping, but is able to identify items needed, place orders, and arrange home delivery. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 - Needs someone to do all shopping and errands |
| <input type="checkbox"/> UK - Unknown | | |

(MO770) Ability to Use Telephone: Ability to answer the phone, dial numbers, and effectively use the telephone to communicate.

- | <u>Prior</u> | <u>Current</u> | |
|---------------------------------------|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - Able to dial numbers and answer calls appropriately and as desired. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4 - <u>Unable</u> to answer the telephone at all but can listen if assisted with equipment. |
| <input type="checkbox"/> | <input type="checkbox"/> | 5 - Totally unable to use the telephone. |
| <input type="checkbox"/> | <input type="checkbox"/> | NA - Patient does not have a telephone. |
| <input type="checkbox"/> UK - Unknown | | |

Indications for Home Health Aides:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused		
Orders obtained:	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Referral to:	<input type="checkbox"/> HHA	<input type="checkbox"/> MSW	<input type="checkbox"/> PT	<input type="checkbox"/> OT	<input type="checkbox"/> ST
<input type="checkbox"/> Other:					

MEDICATIONS

(MO780) Management of Oral Medications: Patient's ability to prepare and take all prescribed 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.)**

- | <u>Prior</u> | <u>Current</u> | |
|---------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - Able to take medication(s) at the correct times if:
(a) individual dosages are prepared in advance by another person; <u>OR</u>
(b) given daily reminders; <u>OR</u>
(c) someone develops a drug diary or chart. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - <u>Unable</u> to take medication unless administered by someone else. |
| <input type="checkbox"/> | <input type="checkbox"/> | NA - No oral medications prescribed. |
| <input type="checkbox"/> UK - Unknown | | |

Financial ability to pay for medications: Yes No

(MO790) Management of Inhalant/Mist Medications: Patient's ability to prepare and take all prescribed inhalant/mist medications (nebulizers, metered dose devices) reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes all other forms of medication (oral tablets, injectable and IV medications).**

- | <u>Prior</u> | <u>Current</u> | |
|---------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - Able to independently take the correct inhalant/mist medication and proper dosage at the correct times. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - Able to take medication at the correct times if:
(a) individual dosages are prepared in advance by another person; <u>OR</u>
(b) given daily reminders. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - <u>Unable</u> to take medication unless administered by someone else. |
| <input type="checkbox"/> | <input type="checkbox"/> | NA - No inhalant/mist medications prescribed. |
| <input type="checkbox"/> UK - Unknown | | |

(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.**

- | <u>Prior</u> | <u>Current</u> | |
|---------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 0 - Able to independently take the correct injectable medication and proper dosage at the correct times. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1 - Able to take injectable medication at the correct times if:
(a) individual syringes are prepared in advance by another person; <u>OR</u>
(b) given daily reminders. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2 - <u>Unable</u> to take injectable medications unless administered by someone else. |
| <input type="checkbox"/> | <input type="checkbox"/> | NA - No injectable medications prescribed. |
| <input type="checkbox"/> 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 _____

<p>_____ cc normal saline or _____ cc sterile water before / after meds before / after labs line maintenance</p>	<p>_____ cc normal saline or _____ cc sterile water before / after meds before / after labs line maintenance</p>	<p>_____ cc normal saline or _____ cc sterile water before / after meds before / after labs line maintenance</p>
<p>Flushing protocol/frequency: (Circle all that apply)</p>	<p>Flushing protocol/frequency: (Circle all that apply)</p>	<p>Flushing protocol/frequency: (Circle all that apply)</p>
<p>_____ cc heparin _____ u/ml before / after meds before / after labs line maintenance</p>	<p>_____ cc heparin _____ u/ml before / after meds before / after labs line maintenance</p>	<p>_____ cc heparin _____ u/ml before / after meds before / after labs line maintenance</p>

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 _____

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 _____

EQUIPMENT MANAGEMENT

(MO810) Patient Management of Equipment (includes ONLY oxygen, IV/infusion therapy, enteral/parenteral nutrition equipment or supplies): Patient's ability to set up, monitor and change equipment reliably and safely, add appropriate fluids or medications, clean/store/dispose of equipment or supplies using proper technique. **(NOTE: This refers to ability, not compliance or willingness.)**

- 0 - Patient manages all tasks related to equipment completely independently.
- 1 - If someone else sets up equipment (i.e., fills portable oxygen tank, provides patient with prepared solutions), patient is able to manage all other aspects of equipment.
- 2 - Patient requires considerable assistance from another person to manage equipment, but independently completes portions of the task.
- 3 - Patient is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment.
- 4 - Patient is completely dependent on someone else to manage all equipment.
- NA - No equipment of this type used in care. **[If NA, go to MO825]**

(MO820) Caregiver Management of Equipment (includes ONLY oxygen, IV/infusion therapy, enteral/parenteral nutrition, ventilator therapy equipment or supplies): Caregiver's ability to set up, monitor and change equipment reliably and safely, add appropriate fluids or medications, clean/store/dispose of equipment or supplies using proper technique. **(NOTE: This refers to ability, not compliance or willingness.)**

- 0 - Caregiver manages all tasks related to equipment completely independently.
- 1 - If someone else sets up equipment (i.e., fills portable oxygen tank, provides patient with prepared solutions), caregiver is able to manage all other aspects of equipment.
- 2 - Caregiver requires considerable assistance from another person to manage equipment, but independently completes significant portions of the task.
- 3 - Caregiver is only able to complete small portions of task (e.g., administer nebulizer treatment, clean/store/dispose of equipment or supplies).
- 4 - Caregiver is completely dependent on someone else to manage all equipment.
- NA - No caregiver
- UK - Unknown

THERAPY NEED

(MO826) 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.

Plan of Care Information

PROGNOSIS (Locator #20)				
<input type="checkbox"/> 1 – Poor	<input type="checkbox"/> 2 – Guarded	<input type="checkbox"/> 3 – Fair	<input type="checkbox"/> 4 – Good	<input type="checkbox"/> 5 – Excellent
SAFETY MEASURES (Locator #15)				
<input type="checkbox"/> 1 - Bleeding Precautions	<input type="checkbox"/> 5 - Fall precautions	<input type="checkbox"/> 9 - Elevate head of bed	<input type="checkbox"/> 13 - Lock w/c with transfers	
<input type="checkbox"/> 2 - O2 precautions	<input type="checkbox"/> 6 - Aspiration precautions	<input type="checkbox"/> 10 - 24 hour supervision	<input type="checkbox"/> 14 - Infection control measures	
<input type="checkbox"/> 3 - Seizure precautions	<input type="checkbox"/> 7 - Respiratory precautions	<input type="checkbox"/> 11 - Clear pathways	<input type="checkbox"/> 15 - Proper Storage/Disposal Medications	
<input type="checkbox"/> 4 - Diabetic precautions	<input type="checkbox"/> 8 - Siderails up	<input type="checkbox"/> 12 - Wound precautions	<input type="checkbox"/> 16 - Proper Storage/Disposal Needles /Syringes	
MENTAL STATUS				(Locator #19)
<input type="checkbox"/> 1 - Oriented	<input type="checkbox"/> 4 - Depressed	<input type="checkbox"/> 7 - Agitated		
<input type="checkbox"/> 2 - Comatose	<input type="checkbox"/> 5 - Disoriented	<input type="checkbox"/> 8 - Other		
<input type="checkbox"/> 3 - Forgetful	<input type="checkbox"/> 6 - Lethargic			
FUNCTIONAL LIMITATIONS				(Locator #18A)
<input type="checkbox"/> 1 - Amputations	<input type="checkbox"/> 6 - Endurance	<input type="checkbox"/> 11 - Pain	<input type="checkbox"/> A - Dyspnea with exertion	
<input type="checkbox"/> 2 - Bowel/Bladder (Incontinence)	<input type="checkbox"/> 7 - Ambulation	<input type="checkbox"/> 12 - General Weakness	<input type="checkbox"/> B - Other (specify)	
<input type="checkbox"/> 3 - Contracture	<input type="checkbox"/> 8 - Speech	<input type="checkbox"/> 13 - Requires assistance of		
<input type="checkbox"/> 4 - Hearing	<input type="checkbox"/> 9 - Legally blind	a person or device to leave hom		
<input type="checkbox"/> 5 - Paralysis	<input type="checkbox"/> 10- Unsteady Gait	home		
ACTIVITIES PERMITTED				(Locator #18B)
<input type="checkbox"/> 1 - Complete bedrest	<input type="checkbox"/> 5 - Exercises prescribed	<input type="checkbox"/> 9 - Cane	<input type="checkbox"/> D - Other (specify):	
<input type="checkbox"/> 2 - Bedrest/BRP	<input type="checkbox"/> 6 - Partial weight bearing	<input type="checkbox"/> A - Wheelchair		
<input type="checkbox"/> 3 - Up as tolerated	<input type="checkbox"/> 7 - Independent in home	<input type="checkbox"/> B - Walker		
<input type="checkbox"/> 4 - Transfer bed/chair	<input type="checkbox"/> 8 - Crutches	<input type="checkbox"/> C - No restrictions		
ALLERGIES				(Locator #17)
<input type="checkbox"/> None known	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa	
<input type="checkbox"/> Pollen	<input type="checkbox"/> Eggs	<input type="checkbox"/> Milk products	<input type="checkbox"/> Insect bites	
<input type="checkbox"/> Other:				

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
<input checked="" type="checkbox"/> GA00 Frequency & duration of service are subject to change according to the patient condition, patient request and physician orders	<input checked="" type="checkbox"/> GO0B 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	<input type="checkbox"/> GA01A Weigh patient Q _____ <input type="checkbox"/> GA01B Measure abdominal girth Q _____ <input type="checkbox"/> GANUT. SN to assess nutritional status/hydration status. Instruct in _____ diet & measures to <input type="checkbox"/> prevent weight loss <input type="checkbox"/> prevent weight gain. <input type="checkbox"/> Maintain adequate hydration	<input type="checkbox"/> GACVALAT SN to assess for late effect of CVA: Hemiplegia; flaccid paralysis; Aphasia; Visual Disturbances, Nystagmus, Tinnitus, Dysphagia; B/B incontinence.
<input type="checkbox"/> 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.	<input type="checkbox"/> 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.	<input type="checkbox"/> Cardiopulmonary GACOPDI SN to instruct pt/ pcg to avoid respiratory irritants, monitoring & prevention of respiratory infections, deep breathing & coughing exercises, energy conservation techniques.	<input type="checkbox"/> Cardiopulmonary A10 Chest Physiotherapy (including postural drainage) <input type="checkbox"/> Telemedicine TM Monitor patient via telemedicine for the following: <input type="checkbox"/> B/P and Pulse <input type="checkbox"/> Pulseoximetry <input type="checkbox"/> Blood glucose <input type="checkbox"/> Weight
<input type="checkbox"/> 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.	<input type="checkbox"/> Wound GA04 Open Wound care/dressing (specify wound care order) _____ _____ _____ _____	<input type="checkbox"/> Wound GA05 Decubitus Care Stage 1,2,3,4 (specify stage/location and wound care order) _____ _____ _____ _____	<input type="checkbox"/> GI/GU GA02 Foley insertion _____fr foley with _____ml balloon, change q month & PRN x 3 for clogged, leaking, or accidental removal. <input type="checkbox"/> GA03 Bladder instillation: irrigate foley with _____ml of _____ Q _____ <input type="checkbox"/> GA09 Bowel/Bladder Training Digital exam with manual removal/ Enema
<input type="checkbox"/> 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).	<input type="checkbox"/> Ostomy G 15 Teach/perform Ostomy/ Ileo-Conduit Care <input type="checkbox"/> 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.	<input type="checkbox"/> Injections GA11 SN to administer subcutaneous injection of Vitamin B 12 _____ Q _____ <input type="checkbox"/> GA13 Administer other IM/ Subcutaneous _____ Q _____	<input type="checkbox"/> Labs GA06A SN to perf orm venipuncture & draw labs for _____ Q _____. Notify physician of results.
<input type="checkbox"/> 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.	<input type="checkbox"/> 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. <input type="checkbox"/> GADM01 Blood glucose level Q SN visit	<input type="checkbox"/> 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. <input type="checkbox"/> GADM2 Prepare/Administer subcutaneous injection of _____ Insulin _____ Units Q _____	<input type="checkbox"/> Diabetes GADM3 SN to instruct/demonstrate to PT/cg ability in checking /monitoring/ recording/machine use & calibration. Validate PT/caregiver's skill. <input type="checkbox"/> GADM4 SN to instruct PT/ PCG Insulin preparation, using aseptic technique, how to administer subcutaneous injection, site rotation. Proper disposal of sharps.
<input type="checkbox"/> Infusion GO0INFUS 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	<input type="checkbox"/> Infusion GO6INFUS SN to insert peripheral venous access & rotate site every 48 – 72 hours & as needed <input type="checkbox"/> GO2INFUS SN to check for S/SX of phlebitis or infiltration each visit & before initiating, during IV therapy & assess for redness, swelling	<input type="checkbox"/> Infusion GO4INFUS 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. <input type="checkbox"/> AO6B 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.	<input type="checkbox"/> Infusion GO5INFUS Administer/ instruct in infusion of _____ in _____ml of _____ over _____ minutes And _____ in _____ml _____ ver _____ minutes every _____for _____days <input type="checkbox"/> GA14D SN may administer medications in anaphylactic kit per agency protocol

(Locator #22)

GOALS SKILLED NURSING General

<p>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.</p>	<p>GP02 Pt/SO will verbalize proper emergency management procedures & safety measures within two (2) weeks. Home will be free of hazards</p>	<p><input type="checkbox"/> GP2 Will demonstrate evidence of wound healing within 3-4 wks. <input type="checkbox"/> GP3 Will achieve weight range of _____ to _____ within _____ weeks. Prior weight _____ <input type="checkbox"/> GP03 Endpoint for daily visits will be _____</p>
<p>GP04 Pt/SO will demonstrate proper <u>biohazardous waste/ syringe/ needle</u> (circle one) disposal in _____ weeks.</p>	<p>GP5 Pt will exhibit improved nutritional status in accordance with disease process within _____ weeks.</p>	<p>GP07 Pt/SO will verbalize action &S/E of _____ within _____ weeks.</p>
<p>04 Will eat _____ % average of meals _____ X per day in _____ wks. 05 Will have no evidence of falls, injury or skin breakdown during Tx. plan.</p>	<p>06 Will take all meds as ordered without demonstrating untoward side effects or drug interaction within 2 wks.</p>	<p>07 Will verbalize understanding of medication actions/side effects by _____.</p>
<p>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.</p>	<p><input type="checkbox"/> 08 Resume ADL status within _____ weeks (prior ADL function _____). <input type="checkbox"/> 09 Will verbalize understanding of symptoms or significant problems to report to MD in _____ weeks. <input type="checkbox"/> 12 Will verbalize understanding / demonstrate compliance with safety precautions within 2-4 weeks.</p>	<p><input type="checkbox"/> 11 Pt/SO will verbalize understanding of post operative limitations within _____ weeks. <input type="checkbox"/> 11A Pt/SO will demonstrate ability to perform ostomy care as ordered. <input type="checkbox"/> 11B Pt/SO will verbalize s/s of wound infection within _____ weeks. <input type="checkbox"/> G13 Pt will verbalize measures to maintain blood pressure within acceptable range within _____ weeks.</p>
<p>14 Patient will demonstrate bowel / bladder continence within _____ Wks. using bowel / bladder program.</p>	<p><input type="checkbox"/> 15 Pt will verbalize appropriate reporting regarding chest pain within _____ weeks. <input type="checkbox"/> 15A Pt will verbalize methods to decrease lung congestion within _____ weeks.</p>	<p><input type="checkbox"/> 16 Will increase functional activity by demonstrating ability to _____ within _____ wks. <input type="checkbox"/> 16 A Pt will verbalize methods for prevention or edema & when to report edema to physician</p>
<p><input type="checkbox"/> 17 Resolution of _____ infection with antibiotic therapy within _____ wks. <input type="checkbox"/> 18 Pt will verbalize methods to decrease episodes of SOB & activities to perform that will not increase SOB within _____ weeks.</p>	<p><input type="checkbox"/> 19 Edema will resolve in _____ wks <input type="checkbox"/> 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</p>	<p><input type="checkbox"/> 20 Pt will maintain patency of _____ throughout treatment plan <input type="checkbox"/> 21 Will verbalize ways to decrease SOB in _____ wks.</p>
<p>22 Will verbalize or show evidence of adjustment to & coping with _____ within 4-6 wks.</p>	<p>CARPUL PT's Cardiopulmonary status will be stabilized as evidence by absence of cough, crackles, decreased SOB/absence of SOB, increased tolerance to activity.</p>	<p>GP1 Pt/S.O. will have knowledge of and or demonstrate safe transfers & ambulation with/with/without device</p>
<p>GP2 Pt/S.O. will have knowledge of and or demonstrate exercises to increase strength & endurance</p>	<p>GP3 Pt/S.O. will have knowledge of and or demonstrate transfer technique & use of a special device</p>	<p><input type="checkbox"/> GP4 Pt/S.O. will comprehend & verbalize injury prevention techniques <input type="checkbox"/> GP5 Pt/S.O. will comprehend/verbalize/demonstrate a home exercise program</p>
Endocrine		
<p>GP24 Pt/SO will verbalize S/S of hypo/hyperglycemia & procedure to follow for each within _____ weeks.</p>	<p>INSULIN Pt/SO will be able to prepare & administer insulin using proper technique as verified by return demonstration</p>	<p>GP25 Pt/SO will verbalize understanding of importance of maintaining blood sugar between _____ & _____ within _____ weeks.</p>
<p>GP26 Pt/SO will verbalize proper foot care procedures within _____ weeks.</p>		
Psychiatric		
<p>GP28 Pt will exhibit signs of stabilization of psychiatric status within disease process within _____ weeks.</p>	<p>GP29 Pt will return to previous lifestyle activities, socialization &/or participation in community activities within _____ weeks.</p>	
Foley Care/Nasogastric Tube		
<p>GP30 Pt/SO will demonstrate independence in <u>foley catheter/nasogastric</u> (circle one) tube care within _____ weeks.</p>	<p>GP31 Pt/SO will verbalize S/S UTI</p>	<p>GP32 Urinary <u>incontinence/retention</u> (circle one) will be managed by patent foley catheter for this certification period</p>
Metastatic Illness/ Pain/Equipment		
<p><input type="checkbox"/> GP33 Pt will exhibit pain controlled with medications within disease limits within _____ weeks. <input type="checkbox"/> 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.</p>	<p><input type="checkbox"/> GP34 Pt/SO will verbalize and demonstrate proper equipment usage & troubleshooting within _____ weeks <input type="checkbox"/> 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 _____.</p>	<p>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).</p>
Injection/Infusion Therapy		
<p>GP35 Pt/SO will demonstrate use of specific sites of injection that are appropriate for their lifestyle within _____ weeks</p>	<p>GP36 Pt/SO will demonstrate how to safely administer injection within _____ weeks.</p>	<p>GP37 Pt/SO will demonstrate proper flush technique within _____ weeks</p>
<p>GP38 will verbalize understanding of S/S of vascular access complications w/in _____ weeks.</p>	<p>GP39 will demonstrate proper sterile IV access site care within _____ weeks.</p>	<p>GP40 will demonstrate proper administration of IV medication within _____ weeks</p>

Home Health Aide Goals	
<input type="checkbox"/> Resume ADL status within ____ wks. (prior ADL function _____). <input type="checkbox"/> The Patient's needs for personal care and ADL's will be met by the HHA during the certification period. <input type="checkbox"/> Patient/caregiver will be able to perform ADLS within restriction of the patient's condition.	
Goals/Rehabilitation Potential & Discharge Plans _____	
Discussed with patient? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> GDPA Pt will be discharged when Pt is able to function with assistance of caregiver within current limitations at home <input type="checkbox"/> GDPI Pt will be discharged when Pt is able to function independently within current limitations at home

DME SUPPLIES (Locator #14)

WOUND CARE: <input type="checkbox"/> 2x2's <input type="checkbox"/> 4x4's <input type="checkbox"/> ABD's <input type="checkbox"/> Cotton tipped applicators <input type="checkbox"/> Wound cleanser <input type="checkbox"/> Wound gel <input type="checkbox"/> Drain sponges <input type="checkbox"/> Gloves: <input type="checkbox"/> Sterile <input type="checkbox"/> Non-sterile <input type="checkbox"/> Hydrocolloids <input type="checkbox"/> Kerlix size _____ <input type="checkbox"/> Nu-guaze <input type="checkbox"/> Saline <input type="checkbox"/> Tape <input type="checkbox"/> Transparent dressings <input type="checkbox"/> Other _____ _____ _____	IV SUPPLIES: <input type="checkbox"/> IV start kit <input type="checkbox"/> IV pole <input type="checkbox"/> IV tubing <input type="checkbox"/> Alcohol swabs <input type="checkbox"/> Angiocatheter size _____ <input type="checkbox"/> Tape <input type="checkbox"/> Extension tubings <input type="checkbox"/> Injection caps <input type="checkbox"/> Central line dressing <input type="checkbox"/> Infusion pump <input type="checkbox"/> Batteries size _____ <input type="checkbox"/> Syringes size _____ <input type="checkbox"/> Other _____ _____ _____	FOLEY SUPPLIES: <input type="checkbox"/> _____ Fr catheter kit (tray, bag, foley) <input type="checkbox"/> Straight catheter <input type="checkbox"/> Irrigation tray <input type="checkbox"/> Saline <input type="checkbox"/> Acetic acid <input type="checkbox"/> Other _____ _____ _____
		SUPPLIES/EQUIPMENT: <input type="checkbox"/> Bathbench <input type="checkbox"/> Cane <input type="checkbox"/> Commode <input type="checkbox"/> Special mattress overlay <input type="checkbox"/> Pressure relieving device <input type="checkbox"/> Eggcrates <input type="checkbox"/> Hospital bed <input type="checkbox"/> Hoyer lift <input type="checkbox"/> Enteral feeding pump <input type="checkbox"/> Nebulizer <input type="checkbox"/> Oxygen concentrator <input type="checkbox"/> Suction machine <input type="checkbox"/> Ventilator <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Tens unit <input type="checkbox"/> Other _____ _____ _____
		DIABETIC SUPPLIES: <input type="checkbox"/> Chemstrips <input type="checkbox"/> Syringes <input type="checkbox"/> Glucometer <input type="checkbox"/> Other _____ _____ _____
	URINARY/OSTOMY: <input type="checkbox"/> Underpads <input type="checkbox"/> External catheters <input type="checkbox"/> Urinary bag/pouch <input type="checkbox"/> Ostomy pouch (brand, size) _____ <input type="checkbox"/> Ostomy wafer (brand, size) _____ <input type="checkbox"/> Stoma adhesive tape <input type="checkbox"/> Skin protectant <input type="checkbox"/> Other _____	MISCELLANEOUS: <input type="checkbox"/> Enema supplies <input type="checkbox"/> Feeding tube: Type _____ Size _____ <input type="checkbox"/> Suture removal kit <input type="checkbox"/> Staple removal kit <input type="checkbox"/> Steri strips <input type="checkbox"/> Other _____ _____ _____

SUMMARY CHECKLIST

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

SIGNATURE/DATES

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

X _____ Date _____/_____/_____
Person Completing This Form (signature/title)

OASIS INFORMATION

Date Reviewed _____/_____/_____ Initial _____ Date Entered/Locked _____/_____/_____ Initial _____