QA Quality Assurance Indicator
POC (CMS - 485) Box
SG Safety Goal

OASIS SOC / ROC, INCLUDING COMPREHENSIVE ADULT NURSING ASSESSMENT (PHYSICAL THERAPY) WITH CMS 485 (POC) INFORMATION

☐ PATIENT ID PERFORMED VIA NAME, DOB, FACE RECOGNITION AND ADDRESS BEFORE SERVICE PROVIDED SG

(M0030) **Start of Care Date:** __ __/__ __/ __ __ __ __ (month day year) 2

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

TIME IN _____ TIME OUT _____

(M0032) **Resumption of Care Date:** __ __/__ __/ __ __ __ __ (month day year)
☐ NA - Not Applicable

Certification Period: 3
From __/___/_____ To___/___/_____

DATE _____/_____/_____

(M0010) **CMS Certification Number (Provider):** _ _ _ _ _ _ 5

Agency Name: _____ 7

(M0014) **Branch Identification Branch State:** _ _ ☐ NA - Not Applicable

Phone: _____

(M0016) **Branch ID Number:** _ _ _ _ _ _ _ _ _ _

Employee's Name/Title Completing the OASIS: _____

*According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection instrument is **0938-0760**. The time required to complete this information collection is estimated to average 52.8 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.*

☐ Q5001: *Service provided in patient's home/residence*
☐ Q5002: *Service provided in ALF*
☐ Q5009: *Service provided in place not otherwise specified*

(M0018) **National Provider Identifier (NPI) for the attending physician who has signed the plan of care:**

_ _ _ _ _ _ _ _ _ _ ☐ **Unknown or Not Available**

Physician name: _____ 24

Address: _____

Phone Number: _____

PHYSICIAN: Date last contacted ___/___/_____ Date last visited ___/___/_____

Reason: _____

Other Physician (if any): _____

Address: _____

Phone Number: _____

REFERRAL SOURCE (if not from Primary Physician):

_____

Phone: _____

Fax: _____

Evacuation Form needed? Emergency Registration Completed (please document)

_____

Advance Directive/DNR Information completed on Admission Forms: ◯ Yes ◯ No

Comments: _____

(M0020) **Patient ID Number:** _ 4
(Medical Record)

(M0040) **Patient Name:** 6

_____ ___ _____ ___
(First) (M I) (Last) (Suffix)

Address: _____
6
_____

Patient Phone: _____ ☐ ALF / AFHC (circle)

(M0050) **Patient State of Residence:** _ _ Name: _____

(M0060) **Patient Zip Code:** _ _ _ _ _ _ _ _ Phone: _____

(M0063) **Medicare Number:** _
1 **(including suffix)** ☐ **N/A No Medicare**

(M0064) **Social Security Number:** _ _ _ - _ _ _ - _ _ _ _
☐ **Unknown or Not Available**

(M0065) **Medicaid Number:** _
1 ☐ **N/A No Medicaid**

(M0066) **Birth Date:** __ __/__ __/__ __ __ __ 8
month / day / year

(M0069) **Gender:** ◯ **1 - Male** ◯ **2 - Female** 9

Emergency/Disaster Plan Classification Code: _____

EMERGENCY CONTACT: _____

Address: _____

Phone: _____ Relationship: _____

OTHER: _____

(M0140) **Race/Ethnicity: (Mark all that apply.)**

☐ **1 - American Indian or Alaska Native 2 -**
☐ **Asian**
☐ **3 - Black or African-American**
☐ **4 - Hispanic or Latino**
☐ **5 - Native Hawaiian or Pacific Islander**
☐ **6 - White**

Comment: _____

Non-Discrimination statement:
It is the policy of our Agency that home health services shall be available and shall be rendered to the total population of our area of services, regardless of the recipient's race, sexual orientation, religion, age, sex, disabilities, ethnic/ cultural background, or national origin.

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

☐ **0 - None; no charge for current services**
☐ **1 - Medicare (traditional fee-for-service)**
☐ **2 - Medicare (HMO/managed care/Advantage plan)**
☐ **3 - Medicaid (traditional fee-for-service)**
☐ **4 - Medicaid (HMO/managed care)**
☐ **5 - Workers' compensation**
☐ **6 - Title programs (e.g., Title 111, V, or XX)**
☐ **7 - Other government (e.g., TriCare, VA, etc.)**
☐ **8 - Private insurance**
☐ **9 - Private HMO/managed care**
☐ **10 - Self-pay**
☐ **11 - Other (specify):** _____
☐ **UK - Unknown**

PATIENT NAME - Last, First, Middle Initial

Med. Record #

Patient Name: _____ _____ _____ Med. Record # _____

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment:
◯1-RN ◯2-PT ◯3-SLP/ST ◯4-OT

(M0090) Date Assessment Completed: __ __/__ __/__ __ __ __
month day year

(M0100) This Assessment is Currently Being Completed for the Following Reason: Start/Resumption of Care
◯1 - Start of care-further visits planned
◯3 - Resumption of care (after inpatient stay) *(complete M0032)*

(M0102) Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.

__ __/__ __/__ __ __ __ ***(Go to M0110, if date entered)***
month day year

☐ NA - No specific SOC date ordered by physician

(M0104) Date of Referral. Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

__ __/__ __/__ __ __ __
month day year

(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?
◯1 - Early
◯2 - Later
◯UK - Unknown
◯NA - Not Applicable: No Medicare case mix group to be defined by this assessment.

• Early Episode is first or second episode in a sequence of adjacent episodes.
• Later is the third episode and beyond in sequence of adjacent episodes.
(Adjacent episodes are separated by 60 days or fewer between episodes.)
Case mix adjustment *-- Adjusting payment for a beneficiary's condition and needs. OASIS items describing the patient's condition, as well as the expected therapy needs are used to determine the case-mix adjustment to the payment rate. This adjustment is the case-mix adj. Eighty case-mix groups, or Home Health Resource Groups (HHRG), are available for classification.*

PATIENT HISTORY AND DIAGNOSES

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

(M1005) Inpatient Discharge Date (most recent):
__ __/__ __/__ __ __ __ ☐ UK - Unknown
month day year

(M1011) List each Inpatient Diagnosis and ICD-10-CM code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes):

	Inpatient Facility Diagnosis	ICD-10-CM Code
a.	_____	__ __ __ . __ __ __ __
b.	_____	__ __ __ . __ __ __ __
c.	_____	__ __ __ . __ __ __ __
d.	_____	__ __ __ . __ __ __ __
e.	_____	__ __ __ . __ __ __ __
f.	_____	__ __ __ . __ __ __ __

Comments (if applicable):

(M1017) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days List the patient's Medical Diagnoses and ICD-10-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no V, W, X, Y, or Z codes or surgical codes):

	Changed Medical Regimen Diagnosis	ICD-10-CM Code
a	_____	__ __ __ . __ __ __ __
b	_____	__ __ __ . __ __ __ __
c	_____	__ __ __ . __ __ __ __
d	_____	__ __ __ . __ __ __ __
e	_____	__ __ __ . __ __ __ __
f	_____	__ __ __ . __ __ __ __

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

(MI1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions which existed prior to the inpatient stay or change in medical or treatment regimen. ***(Mark all that apply)***
☐ 1 - Urinary incontinence
☐ 2 - Indwelling/suprapubic catheter
☐ 3 - Intractable pain
☐ 4 - Impaired decision-making
☐ 5 - Disruptive or socially inappropriate behavior
☐ 6 - Memory loss to the extent that supervision required
☐ 7 - None of the above
☐ NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
☐ UK - Unknown

PROGNOSIS: 20
◯1- Poor ◯2- Guarded ◯3-Fair ◯4 Good ◯5-Excellent

Comment (if needed):

Patient Name: _____ Med. Record # _____

PATIENT HISTORY AND DIAGNOSES (Cont'd.)

(M1021/M1023/M1025) List each diagnosis for which the patient is receiving home care in Column 1, and enter its ICD-10-CM code at the level of highest specificity in Column 2 (diagnosis codes only - no surgical or procedure codes allowed). Diagnoses are listed in the order that best reflects the seriousness of each condition and supports the disciplines and services provided. Rate the degree of symptom control for each condition in Column 2. ICD-10-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a Z-code is reported in Column 2 in place of a diagnosis that is no longer active (a resolved condition), then optional item M1025 (Optional Diagnoses - Columns 3 and 4) may be completed. Diagnoses reported in M1025 will not impact payment. **Code each row according to the following directions for each column:**

Column 1: Enter the description of the diagnosis. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 2: Enter the ICD-10-CM code for the condition described in Column 1 - no surgical or procedure codes allowed. Codes must be entered at the level of highest specificity and ICD-10-CM coding rules and sequencing requirements must be followed. Note that external cause codes (ICD-10-CM codes beginning with V, W, X, or Y) may not be reported in M1021 (Primary Diagnosis) but may be reported in M1023 (Secondary Diagnoses). Also note that when a Z-code is reported in Column 2, the code for the underlying condition can often be entered in Column 2, as long as it is an active on-going condition impacting home health care.

Rate the degree of symptom control for the condition listed in Column 1. Do not assign a symptom control rating if the diagnosis code is a V, W, X, Y or Z-code. Choose one value that represents the degree of symptom control appropriate for each diagnosis using the following scale:

0 - Asymptomatic, no treatment needed at this time
1 - Symptoms well controlled with current therapy
2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring
4 - Symptoms poorly controlled; history of re-hospitalizations

Note that the rating for symptom control in Column 2 should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide.

Column 3: (OPTIONAL) There is no requirement that HHAs enter a diagnosis code in M1025 (Columns 3 and 4). Diagnoses reported in M1025 will not impact payment. Agencies may choose to report an underlying condition in M1025 (Columns 3 and 4) when:

- a Z-code is reported in Column 2 AND
- the underlying condition for the Z-code in Column 2 is a resolved condition . An example of a resolved condition is uterine cancer that is no longer being treated following a hysterectomy.

Column 4: (OPTIONAL) If a Z-code is reported in M1021/M1023 (Column 2) and the agency chooses to report a resolved underlying condition that requires multiple diagnosis codes under ICD-10-CM coding guidelines, enter the diagnosis descriptions and the ICD-10-CM codes in the same row in Columns 3 and 4. For example, if the resolved condition is a manifestation code, record the diagnosis description and ICD-10-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(M1021) Primary Diagnosis & (M1023) Other Diagnoses		(M1025) Payment Diagnoses (OPTIONAL)	
COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-10-CM and symptom, control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses.	May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved	Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code)
Description	**ICD-10-CM/ Symptom Control Rating**	Description / ICD-10-CM	Description / ICD-10-CM
(M1021) Primary Diagnosis 11	(V,W,X,Y-codes not allowed)	(V,W,X,Y,Z-codes not allowed)	(V,W,X,Y,Z-codes not allowed)
a. _____ Date ____/____/____ O/E	a. (_ _ _ _ _ _ _) ❑0 ❑1 ❑2 ❑3 ◯4	a. _____ (_ _ _ _ _ _ _)	a. _____ (_ _ _.- _ _ _)
(M1023) Other Diagnoses 13	(All ICD-10 codes are allowed)	(V,W,X,Y,Z-codes not allowed)	(V,W,X,Y,Z-codes not allowed)
b. _____ Date ____/____/____ O/E	b. (_ _ _ _ _ _ _) ❑0 ❑1 ❑2 ❑3 ◯4	b. _____ (_ _ _ _ _ _ _)	b. _____ (_ _ _.- _ _ _)
c. _____ Date ____/____/____ O/E	c. (_ _ _ _ _ _ _) ❑0 ❑1 ❑2 ◯3 ❑4	c. _____ (_ _ _ _ _ _ _)	c. _____ (_ _ _.- _ _ _)
d. _____ Date ____/____/____ O/E	d. (_ _ _ _ _ _ _) ❑0 ❑1 ❑2 ❑3 ◯4	d. _____ (_ _ _ _ _ _ _)	d. _____ (_ _ _.- _ _ _)
e. _____ Date ____/____/____ O/E	e. (_ _ _ _ _ _ _) ❑0 ❑1 ❑2 ◯3 ❑4	e. _____ (_ _ _ _ _ _ _)	e. _____ (_ _ _.- _ _ _)
f. _____ Date ____/____/____ O/E	f. (_ _ _ _ _ _ _) ❑0 ❑1 ❑2 ◯3 ❑4	f. _____ (_ _ _ _ _ _ _)	f. _____ (_ _ _.- _ _ _)

Surgical Procedure 12	ICD-10-CM 12	
_____	(_____)	Date ____/____/____
_____	(_____)	Date ____/____/____

Patient Name: _____ Med. Record # _____

PATIENT HISTORY AND DIAGNOSES (Cont'd.)

MAIN REASON FOR HOME HEALTH CARE: _____

PREVIOUS HISTORY AND/OR PREVIOUS OUTCOMES: *(Reference M1000, M1005 and M1010)*

- ☐ Diabetes
  - ◯ Insulin Dependent
  - ◯ Non Insulin Dependent
- ☐ Cardiac
- ☐ Hypertension
- ☐ Respiratory
- ☐ Osteoporosis/Osteoarthritis
- ☐ Fractures (site: _____)
- ☐ Cancer (site: _____)
- ☐ Immunosuppressed
- ☐ Gastrointestinal
- ☐ Infection
- ☐ Surgeries (site: _____)
- ☐ Open Wound (site: _____)
- ☐ Decubitus (site: _____)
- ☐ Genitourinary
- ☐ Other (specify) _____

IMMUNIZATIONS: Check if current: within last 12 months: ☐ Influenza/flu regular seasonal ☐ H1N1

Following immunization guidelines: ☐ Pneumonia ☐ Tetanus ☐ Other _____

Pending or Needed: _____

PRIOR HOSPITALIZATIONS: (in the last six months): ◯ No ◯ Yes Number of times _____

Reason (s) / Date(s): _____

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

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

(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? *(Mark all that apply)*

- ☐ 1- History of falls (2 or more falls -or any fall with an injury - in the past 12 mnonths)
- ☐ 2- Unintentional weight loss of a total of 10 punds or more in the past 12 months.
- ☐ 3- Multiple hospitalizations (2 or more in the past 12 months)
- ☐ 4- Multiple emergency department visits (2 or more) in the past 6 months.
- ☐ 5- Decline in mental, emotional, or behavioral status in the past 3 months.
- ☐ 6- Reported or observed history of dificulty complying with any medical instructions (for ex: medications, diet, exercise) in the past 3 months.
- ☐ 7- Current taking 5 or more medications.
- ☐ 8- Curerently reports exhaustation.
- ☐ 9- Other risks not listed in 1-8
- ☐ 10- None of the above

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

- ◯ 0 -The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age)
- ◯ 1 - The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
- ◯ 2 - The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.
- ◯ 3 - The patient has serious progressive conditions that could lead to death within a year.
- ◯ UK - The patient's situation is unknown or unclear.

HOMEBOUND REASON: *(Mark all that apply)* **18A**

- ☐ **Needs assist of 1-2 persons**
- ☐ Needs assistance for all activities (ADL's)
- ☐ Generalized Weakness
- ☐ Requires assistance to ambulate/Decreased Range of Motion
- ☐ Confusion, unable to go out of home alone
- ☐ Unable to safely leave home without assistance
- ☐ Mobility/Ambulatory device(s) used: _____
- ☐ Severe SOB, SOB upon exertion, amb. ____ feet
- ☐ Bedbound (Partial/Complete)
- ☐ Other (specify): _____
- ☐ Medical restrictions
- ☐ Unsteady Gait
- ☐ Psychiatric condition
- ☐ Dependent upon adaptive device(s)

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

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

Comments (if needed): _____

LIVING ARRANGEMENTS

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

Living Arrangement	Availability of Assistance: Around the Clock	Regular Daytime	Regular Nighttime	Occasional Short-term Assistance	No Assistance Available
a. Patient lives alone	◯ 01	◯ 02	◯ 03	◯ 04	◯ 05
b. Patient lives with other person(s) in the home	◯ 06	◯ 07	◯ 08	◯ 09	◯ 10
c. Patient lives in congregate situation (e.g., assisted living, residential care)	◯ 11	◯ 12	◯ 13	◯ 14	◯ 15

Patient Name: _____ Med. Record # _____

LIVING ARRANGEMENTS (Cont'd.)

Primary Caregiver (CG)/ Significant other:

Name: _____

Phone number if different from patient: _____

Relationship/health status/ability to help: _____

Make medical care decisions for the patient: ○ Yes ○ No

Any paid help, explain: _____

Other family member/(CG) available to help patient with care / safely administration of injection / procedures:

Specify: _____

Other agencies involved in care: _____

SENSORY STATUS / HEARING

(M1210) Ability to Hear (with hearing aid or hearing appliance if normally used):

- ☐ 0 - Adequate: hears normal conversation without difficulty.
- ☐ 1- Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.
- ☐ 2- Severely Impaired: absence of useful hearing.
- ☐ UK - Unable to assess hearing.

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

☐ Any ears surgery/procedure: _____
Date: _____

☐ Other (specify) _____

☐ No Problem

SENSORY STATUS / VISION

(M1200) **Vision** (with corrective lenses if the patient usually wears them):

- ○ 0 - Normal vision: sees adequately in most situations; can, see medication labels, newsprint.
- ○ 1 - Partially impaired: cannot see medication labels or newsprint, but on see obstacles in path, and the surrounding layout; can count fingers at arm's length.
- ○ 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

☐ Glasses ☐ Glaucoma ☐ Jaundice ☐ Ptosis
☐ Contacts: R / L ☐ Blurred vision ☐ Cataract R / L
☐ Prosthesis: R / L ☐ Legally Blind: R/L ☐ Other _____
☐ Infections _____
☐ Cataract surgery, Site: _____
Date: _____
☐ Other eyes surgery, Site: _____
Date: _____

Is there any function/ safety impact in the patient due to impaired vision? (explain)

☐ No Problem

SPEECH and ORAL (VERBAL) CONTENT/EXPRESSION

(M1220) **Understanding of Verbal Content** in patient's own language (with hearing aid or device if used):

- ○ 0 - Understands: clear comprehension without cues or repetitions.
- ○ 1- Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
- ○ 2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
- ○ 3 - Rarely/Never Understands.
- ○ UK - Unable to assess understanding.

(M1230) **Speech and Oral (Verbal) Expression of Language** (in patient's own language):

- ○ 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
- ○ 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
- ○ 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
- ○ 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
- ○ 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).
- ○ 5 - Patient nonresponsive or unable to speak.

(Recommended to use FLAC scale to assess pain for non-verbal patients)

NOSE

☐ Congestion ☐ Epistaxis ☐ Loss of smell ☐ Sinus problem
☐ Any nose surgery: _____
Date: _____
☐ Other (specify) _____

☐ No Problem

MOUTH

☐ Dentures: (mark) ☐ Upper ☐ Lower ☐ Partial
☐ Masses/Tumors, site: _____
☐ Gingivitis ☐ Ulcerations ☐ Toothache
☐ Any surgery/procedure: _____
Date: _____
☐ Other (specify) _____

☐ No Problem

THROAT

☐ Dysphagia ☐ Hoarseness ☐ Sore throat
☐ Lesions, explain: _____
☐ Other (specify) _____

☐ No Problem

Patient Name: _____ Med. Record # _____

PAIN

(M1240) Has this patient had a formal **Pain Assessment** using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?

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

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

- ◯ 0 - Patient has no pain
- ◯ 1 - Patient has pain that does not interfere with activity or movement
- ◯ 2 - Less often than daily
- ◯ 3 - Daily, but not constantly
- ◯ 4 -All of the time

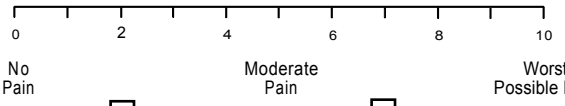
Patient complains about pain: ◯ Yes ◯ No

NON-VERBAL INDICATORS: ☐ Guarding ☐ Crying ☐ Afraid to move ☐ Moaning

Other: _____

Intensity: (using scales below)

Wong-Baker FACES **Pain Rating Scale** *



Collected using: ☐ **FACES Scale (Observed)** ☐ **0-10 Scale (patient reporting)**

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 1 hurts just a little bit. Face 2 hurts a little more. Face 3 hurts even more. Face 4 hurts a whole lot. Face 5 hurts as much as you can imagine, although you don 't have to be crying to feel this bad. Ask the person to choose which face that best describes how he is feeling.

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

Pain Assessment	site 1	site 2	site 3
Location / site			
New Onset/ Exacerbation			
Present level (0-10)			
Best Pain Scale 0-10 / Worst Pain Scale 0-10			
Frequency: Occasionally, Continuous Intermittent. Frequently			
Pain type: (aching, burning, radiating, neuralgia, etc)			
Feeling of pain: internal, external, acute, chronic.			
Pain is worse: morning, afternoon, evening, nights			

What makes pain worse? ☐ Sleep/Time at Bed ☐ Minimal activity ☐ Movement ☐ Ambulation ☐ Immobility ☐ Transfer

☐ Other: _____

How does the pain interfere with their functional/activity level, ADLs? (explain)

_____

_____

_____

_____

☐ **No Problem**

What relief pain? ☐ Heat ☐ Ice/unguent ☐ Change position ☐ Rest/Relaxation ☐ Medication: _____ ☐ Entertainment ☐ Massage/Therapy ☐ Walk ☐ Go to bed

☐ Other: _____

If taken medication, how often is needed? ☐ Never ☐ Less than daily ☐ Daily ☐ 2-3 times/day ☐ More than 3 times/day

Does one medication relieve pain better than another? If yes which one. _____

Pain control treatment/meds Side effect? (mark) ☐ Nausea ☐ Vomiting ☐ Sleepy ☐ Confusion ☐ Other: _____

Is there a regular pattern to the pain? (explain) _____

Does the pain radiate? ◯ Yes ◯ No

☐ Occasionally ☐ Continuously ☐ Intermittent ☐ Frequently

Current pain control medications adequate: ◯ Yes ◯ No

Comment: _____

Implications Care Plan: ◯ Yes ◯ No

Has the physician been notified by the: ☐ Patient ☐ Staff

What was the outcome? _____

ENDOCRINE STATUS

Diabetes: ☐ Type I Juvenile ☐ Type II Onset/Exacerbation date: _____

☐ Diet/Oral control (specify): _____

☐ **INSULIN** dosage, frequency, scale, explain: _____

_____ Since: _____

Administered by: ☐ Self ☐ Caregiver/Family ☐ Nurse ☐ Other _____

Any **symptoms** present (circle): ☐ Hyperglycemia, Polyuria, Glycosuria, Polydipsia ☐ Fatigue ☐ Hypoglycemia, Sweats, Weak, Faint, Stupor, Polyphagia

A1c _____ % BS _____ mg/dL Date/Time: _____

Mark: ☐ ***Today's visit*** ☐ ***Patient/Caregiver reported***

☐ FBS ☐ Before meal ☐ Postprandial ☐ Random HS ☐ Lab slip

☐ Blood sugar ranges _____ ☐ Patient/Caregiver Report

Monitored by: ☐ Self ☐ Caregiver/Family ☐ Nurse ☐ Other:

Frequency: _____ _____

Able to use Glucometer: _____

☐ **Diabetes Management Problems (explain):**

_____

_____

☐ Other Endocrine problems: _____

☐ Enlarged thyroid (hyper/hypothyroid) ☐ Intolerance to heat/cold ☐ **No Problem**

HEMATOLOGY / IMMUNOLOGIC STATUS

☐ Anemia (specify type if known): _____

☐ Bleeding problems: GI /GU /GYN /unknown ☐ Hemophilia

☐ Immunodeficiency problems (explain): _____

☐ Other: _____

_____

☐ **No Problem**

SKIN / INTEGUMENTARY STATUS

Mark all applicable skin conditions listed below:

Turgor: ◯ Good ◯ Poor

☐ Itch ☐ Rash ☐ Dry ☐ Scaling ☐ Redness

☐ Bruises ☐ Ecchymosis ☐ Pallor ☐ Jaundice

Other (specify) _____

_____

☐ **No Problem**

Patient Name: _____ Med. Record # _____

INTEGUMENTARY STATUS (Cont'd.)

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

- 0 - No assessment conducted. ***[Go to M1306]***
- 1 -Yes, based on an evaluation of clinical factors, e.g., mobility, incontinence, nutrition, etc., without use of standardized tool.
- 2 -Yes, using a standardized tool, e.g., Braden, Norton, other.

(M1302) Does this patient have a Risk of Developing Pressure Ulcers?

- 0 - No
- 1 -Yes

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

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

(Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

Wound Measurement must be performed at least every week, following the wound measuring guide, or more often if ordered by the physician. All results must be reflected in the Progress Note or Wound Record Summary (weekly) according your Policy Manual. Pressure sores/Wounds are easy to develop but very difficult to cure. Daily nursing care plays a large part in prevention. Summary Procedure for Treatment: Explain procedure to patient, Screen patient, wash area with soap and water, Apply special washing solution, if ordered, Massage the surrounding area briskly, away from the pressure sore. Massage reddened area slightly. Apply medication, if ordered. Relieve the source of pressure according to what the doctor ordered (air mattress, etc.)

Leave patient comfortable. Wash hands, follow universal/standadrd precautions and use PPE.

(M1308) Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable:
(Enter '0" if none; excludes Stage 1 pressure ulcers and healed Stage II pressure ulcers)

Stage Description - Unhealed Pressure Ulcers	Number Currently Present	*Commments (if neccessary any clarification)*
a. **Stage II:** Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough May also present as an intact or open/ruptured serum-filled blister.	_____	
b. **Stage III:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	_____	
c. **Stage IV:** Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	_____	
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device.	_____	
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	_____	
d.3 Unstageable: Suspected deep tissue injury in evolution.	_____	

Pressure Ulcers are defined as a localized area of tissue necrosis that develops when soft tissue is compressed between a bony prominence and an external surface for a prolonged period of time.Pressure Ulcers have been referred to by names, including:

Decubitus Ulcers
Bedsores
Pressure Sores
Dermal Sores

** Pressure Ulcer is always a pressure ulcer.*

Stage I: Non-blanchable erythema/redness of skin (presents as intact skin); usually over a bony prominence. In darker pigmented skin may not visible blanching, its color may differ from the sorrounding area.(Painful, firm, soft, warmth, edema, hardness or discolored skin may be indicators)

** Stages II, III, IV defined above (M1308)*

(M1320) Status of Most Problematic Pressure Ulcer (Observable):
(Exclude pressure ulcer that cannot observed due to a non-removable dressing/device)

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

(M1322) Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

0 1 2 3 4 or more

Patient Name: _____ Med. Record # _____

INTEGUMENTARY STATUS (Cont'd.)

(M1324) Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable: (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury)

- 1 -Stage I
- 2 -Stage II
- 3 -Stage III
- 4 -Stage IV
- NA - No observable pressure ulcer or unhealed pressure ulcer

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

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

(M1332) Current Number of Stasis Ulcer(s) that are observable:

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

(M1334) Status of Most Problematic Stasis Ulcer that is observable:

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

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

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

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

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

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

- 0 - No
- 1 - Yes

WOUND CARE PROCEDURE: *(Check all that apply)*

Wound care done during this visit: Yes No

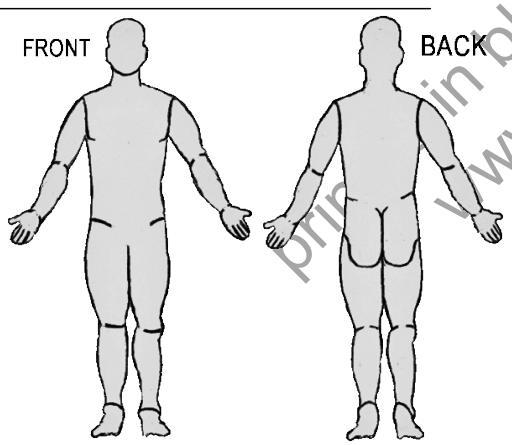
Location(s) wound site: 1 _____

2 _____

3 _____

4 _____

Authorization to take Photo obtained: Yes No



Soiled dressing removed by: *(use biohazard waste box)*

RN/PT Caregiver (name) _____

Patient Other: _____

Technique used: Sterile Clean

Procedure: Procedure tolerated well: Yes No

Wound cleaned with (specify): _____

Wound irrigated with (specify): _____

Wound packed with (specify): _____

Wound dressing/cover applied (specify): _____

Wound left open to the air: Yes No

Comments: _____

Is patient Diabetic: Yes No

DIABETIC FOOT EXAM: *(mark all that apply)*

Frequency of diabetic foot exam: Daily Twice a day Every other day Twice a week Weekly Other: _____

Done by: RN/PT Caregiver (name) _____ Patient Other: _____

Exam by RN/PT this visit: Yes No

Significant integument findings: _____

Pedal pulses: Present right / left *(please circle)* Absent right / left *(please circle)*

Observation: _____

Lack of sense of: Warm right / left *(please circle)* Cold right / left *(please circle)*

Observation: _____

Neuropathy right / left *(please circle)*

Ascending calf: Right for _____ cm Left for _____ cm

Tingling right / left *(please circle)* Burning right / left *(please circle)*

Leg hair: Present right / left *(please circle)* Absent right / left *(please circle)*

Pressure ulcer ASSESSMENT: *(mark all that apply)*

1 Size: _____ cm length _____ cm width _____ cm depth

Location: _____ Shape: Oval Round Other: _____

Exudate: Yes No Serous Serosanguineous Sanguineous

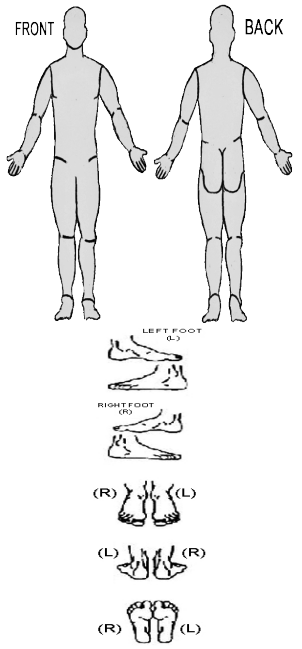
2 Size: _____ cm length _____ cm width _____ cm depth

Location: _____ Shape: Oval Round Other: _____

Exudate: Yes No Serous Serosanguineous Sanguineous

Patient Name: _____ Med. Record # _____

INTEGUMENTARY STATUS (Cont'd.)

WOUND/LESION ULCER (specify)	#1	#2	#3	#4	Diagram
Location (specify in diagram)					
Type: Pressure ulcer/Abrasion Diabetic foot ulcer Arterial / Surgical Malignancy / Incision Mechanical/Fistula Venous stasis ulcer					
Size(cm) (LengthxWidthxDepth)					
Tunneling/ Undermining (cm)					
Stage (I-II-III-IV) (pressure ulcers only)					
Odor **(Fool, normal, etc)**					
Surrounding Skin *(redness, damage, specify)*					
Stoma (Specify)					
Edema (pedal, sacral, pitting, etc)					
Appearance of the Wound Bed					
Treatment Ordered					
Drainage/Amount	○ None ○ Small ○ Moderate ○ Large	○ None ○ Small ○ Moderate ○ Large	○ None ○ Small ○ Moderate ○ Large	○ None ○ Small ○ Moderate ○ Large	Is there at least one pressure ulcer that cannot be observed due to the presence of scar or a nonremovable dressing, including casts? ○ Yes ○ No
Color	☐ Clear ☐ Tan ☐ Serosanguineous ☐ Other_____	☐ Clear ☐ Tan ☐ Serosanguineous ☐ Other_____	☐ Clear ☐ Tan ☐ Serosanguineous ☐ Other_____	☐ Clear ☐ Tan ☐ Serosanguineous ☐ Other_____	
Consistency	☐ Thin ☐ Thick	☐ Thin ☐ Thick	☐ Thin ☐ Thick	☐ Thin ☐ Thick	

FULL SYSTEMS REVIEW

Height: _____ ☐ reported ☐ actual Weight: _____ ☐ reported ☐ actual

Reported weight changes by: ☐ Patient ☐ Caregiver/Family ☐ Nurse

Gain/Loss_____lb. X _____wk./mo./yr.

VITAL SIGNS (Today's visit)

Blood Pressure: ☐ Sitting/lying R _____ L _____
☐ Standing R _____ L _____

Temperature:_____ ☐ Oral ☐ Axillary ☐ Rectal ☐ Tympanic

Pulse: ☐ Apical_____ ☐ Brachial_____ ☐ Rest ☐ Activity
☐ Radial_____ ☐ Carotid _____ ☐ Cheynes Stokes
☐ Regular ☐ Irregular

Respirations:_____ ☐ Death rattle ☐ Apnea periods -sec.
☐ Regular ☐ Irregular ☐ Accessory muscles used

CARDIOPULMONARY STATUS

Breath Sounds: ☐ Clear
☐ Crackles/rales ☐ Wheezes/rhonchi ☐ Diminished ☐ Absent

Anterior:
Right_____
Left_____

Posterior:
Right Upper_____
Right Lower_____
Left Upper_____
Left Lower_____

☐ SOB/SOBOE

☐ SOB on minimal effort/walk _____ Ft.

CARDIOPULMONARY STATUS (Cont'd.)

Chest Pain: ☐ Yes ☐ No ☐ Anginal ☐ Postural ☐ Localized ☐ Substernal
☐ Radiating to: _____
☐ Dull ☐ Ache ☐ Sharp ☐ Vise-like

Associated with: ☐ Shortness of breath/SOBOE ☐ Activity ☐ Sweats
Frequency/duration: _____
How relieved: ☐ Rest ☐ Medication: _____
☐ Other: _____

☐ **Palpitations/Arrhythmias:** ☐ Fast/accelerated ☐ Slow ☐ Fatigue

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

☐ **Cramps (site):** _____ ☐ Claudication

☐ **Capillary refill:** ☐ less than 3 sec ☐ greater than 3 sec

Disease Management Problems (explain) _____

Heart Sounds: ☐ Regular ☐ Irregular ☐ Murmur

☐ Pacemaker: Date_____ Last date checked_____
Type _____

Patient Name: _____ Med. Record # _____

CARDIOPULMONARY STATUS (Cont'd.)

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

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

☐ Today's visit assessed Reported by: ☐ Patient ☐ Caregiver/Family

(M1410) Respiratory Treatments utilized at home: **(Mark all that apply.)**

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

O_2 @ _____ LPM via cannula, mask, trach 02 saturation _____ %

☐ Fire Safety/Prevention Plan explained SG

Trach size/type _____ Who manages? ☐ Patient ☐ SN ☐ Caregiver/family/Other: _____

Intermittent treatments/SAN (C&DB, medicated inhalation treatments, etc.)

- ◯ No
- ◯ Yes, explain: _____

☐ **Cough:** ◯ No ◯ Yes: ☐ Productive, sputum color: _____ ☐ Non-productive

Worse at: ☐ morning ☐ afternoon ☐ evening ☐ sleeping time

Describe: _____

☐ **Dyspnea:** ☐ Rest ☐ During ADL's, effort ☐ Sleeping/Lying/Orthopnea

Comments: _____

Positioning necessary for improved breathing, SOB, SOB/OE:

- ◯ No
- ◯ Yes, describe: _____

GENITOURINARY STATUS

(Check all that apply:) ☐ Burning/pain ☐ Hesitancy ☐ Urgency/frequency ☐ Hematuria ☐ Oliguria/anuria ☐ Nocturia x _____ ☐ **Incontinence:** ☐ Yes ☐ No

☐ Diapers/other: _____

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

Clarity: ☐ Clear ☐ Cloudy ☐ Sediment/mucous

Odor: ☐ Yes ☐ No _____

Urinary Catheter: Type _____ Last changed on: _____

☐ Foley inserted (date) _____ with _____ French

Inflated balloon with _____ mL ☐ without difficulty ☐ Suprapubic

Irrigation solution: Type (specify): _____

Amount _____ mL Frequency _____ Returns _____

Patient tolerated procedure well ◯ Yes ◯ No

☐ Urostomy (describe skin around stoma): _____

☐ **No Problem**

GENITOURINARY STATUS (Cont'd.)

Urostomy/Foley care managed by: ☐ Patient ☐ Caregiver/Family ☐ SN

☐ Other Problem (specify) _____

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

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

(M1610) Urinary Incontinence or Urinary Catheter Presence: QA

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

(M1615) When does Urinary Incontinence occur?

- ◯ 0 - Timed-voiding defers incontinence
- ◯ 1 - Occasional stress incontinence
- ◯ 2 - During the night only
- ◯ 3 - During the day only
- ◯ 4 - During the day and night

NUTRITIONAL STATUS

16 **DIET, Nutritional requirements:** ☐ Controlled Carbohydrate ☐ 2 gm Sodium ☐ Low Sodium ☐ NAS ☐ NPO ☐ 1800 cal ADA ☐ Low Fat ☐ Low cholesterol Other: _____

☐ Increase fluids: _____ amt. ☐ Restrict fluids _____ amt.

Appetite: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Anorexic

☐ Nausea ☐ Vomiting: Frequency: _____ Amount: _____

☐ **Heartburn** (food intolerance): Frequency: _____

☐ Other: _____

Directions: Circle each area with "yes" to assessment, then total score to determine **NUTRITIONAL RISK.**	YES
Has an illness or condition that changed the kind and/or amount of food eaten.	2
Eats fewer than 2 meals per day.	3
Eats few fruits, vegetables 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	

Reprinted with permission by the Nutrition Screening Initiative, a project of the American Academy of Family Physicians, the American Dietetic Association and the National Council on the Aging, Inc. and funded in part by a grant from Ross Products Division, Abbott Laboratories, Inc.

INTERPRETATION GUIDE:

0-2 Good Recommend Recheck his/her nutritional score in **six** months

3-5 Moderate risk. See what can be done to improve the eating habits and lifestyle. Educate, refer, monitor and reevaluate based on patient situation and Agency policy. Recheck your nutritional score in **three** months

6 or more High risk. Coordinate with physician, dietitian, social services or nurse about how to boost the patient nutritional health. Reassess nutritional status and educate based on plan of care to improve his/her nutritional status.

Describe at risk intervention and plan: _____

☐ **No Problem**

Patient Name: _____ Med. Record # _____

ELIMINATION STATUS

(M1620) Bowel Incontinence Frequency:

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

(M1630) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen?

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

☐ Flatulence ☐ Constipation/impaction ☐ Last BM _____

☐ Diarrhea (Frequency): _____ Frequency of stools: _____

☐ Rectal bleeding ☐ Hemorrhoids

Bowel regime/program: _____

☐ **Incontinence:** ☐ Yes ☐ No ☐ Diapers/other: _____

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

☐ Other: _____

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

_____

_____

Elimination/Ostomy managed by: ☐ Patient ☐ Caregiver/Family ☐ SN

☐ Other _____

☐ **No Problem** ☐ Following Universal/Standard precautions

ENTERAL FEEDINGS - ACCESS DEVICE

☐ TPN ☐ Nasogastric ☐ Gastrostomy ☐ Jejunostomy

Device: ☐ Other (specify) _____

☐ IV: _____

☐ Pump: (type/specify) _____

☐ Bolus ☐ Continuous

Feedings: Type (amt./rate) _____

Flush Protocol: (amt./specify) _____

Performed by: ☐ Patient ☐ SN ☐ Caregiver ☐ Other _____

Dressing/Site care: (specify) _____

_____

Interventions /instructions/Comments _____

_____

_____

☐ Following Universal/Standard precautions ☐ N/A ☐ **No Problem**

ABDOMEN

☐ Pain (Frequency): _____

☐ Tenderness ☐ Distention ☐ Hard ☐ Soft ☐ Ascites

☐ Abdominal girth _____ cm

☐ Other: _____

☐ Bowel sounds: active / absent / hypo / hyperactive x _____ quadrants

☐ Other: _____

☐ **No Problem**

GENITALIA

☐ Discharge/Drainage: (describe) _____

_____

☐ Lesions ☐ Blisters ☐ Masses ☐ Cysts ☐ Wart

☐ Other (specify) _____

☐ Inflammation ☐ Surgical alteration: _____

☐ Prostate problem: BPH / TURP Date ____/____/____

☐ Self-testicular exam Frequency _____

☐ Menopause ☐ Hysterectomy Date ____/____/____

Date last PAP ____/____/____ Results _____

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

☐ Mastectomy: R / L Date ____/____/____

☐ Other (specify) _____ ☐ **No Problem**

NEURO / EMOTIONAL / BEHAVIOR STATUS

(M1700) Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

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

☐ Headache: Location _____ Frequency _____

☐ Migraine, Frequency: _____ ☐ PERRLA ☐ Unequal pupils: R / L (circle)

☐ Aphasia: ☐ Receptive ☐ Expressive

☐ Motor change ☐ Fine ☐ Gross Site: _____

☐ Dominant side: R / L (circle)

☐ Weakness: UE / LE Location: _____

☐ Tremors: ☐ Fine ☐ Gross ☐ Paralysis Site: _____

☐ Stuporous ☐ Hallucinations: Visual / Auditory (circle)

Hand grips: Equal / Unequal (specify) _____

Strong / Weak (specify) _____

☐ Psychotropic drug use (specify) _____

Dose/Frequency _____

☐ Other (specify) _____

_____

☐ **No Problem**

(M1710) When Confused (Reported or Observed Within the Last 14 Days)

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

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

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

Patient Name: _____ Med. Record # _____

NEURO /EMOTIONAL/ BEHAVIOR STATUS (Cont'd.)

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

- ○ 0 - No
- ○ 1 - Yes, patient was screened using the PHQ-2* scale. (instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")

PHQ-2©*	Not at All 0-1 Day	Several Days 2-6 Days	More Than Half of the Days 7-11 Days	Nearly Every Day 12-14 Days	N/A Unable to Respond
a) Little interest or pleasure in doing things.	○ 0	○ 1	○ 2	○ 3	○ na
b) Feeling down, depressed, or hopeless?	○ 0	○ 1	○ 2	○ 3	○ na

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

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

- ☐ 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, 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

MENTAL STATUS

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

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☐ 8 - Other: _____

☐ Forgetful at times ☐ Irritable ☐ Anxious ☐ Alert ☐ **No Problem**

PSYCHOSOCIAL/SENSORY STATUS

Primary language: ○ English ○ Spanish ○ Creole ○ Russian ○ Other: _____

☐ Language barrier ☐ Needs interpreter _____
☐ Deaf ☐ Needs American Sing language interpreter
Learning barrier ☐ Mental ☐ Psychological ☐ Physical ☐ Functiona ☐ Sensory
☐ Unable to read/write Higher Educational Level: _____
☐ Spiritual /Cultural/Ethnic/Religion implications that impact care.
Explain: _____
Spiritual resource _____ Phone No. _____
☐ Sleep/Rest: ☐ Adequate ☐ Inadequate ☐ Sometimes Inadequate
Explain _____
☐ Inappropriate responses to caregivers/physician/clinician staff
☐ Inappropriate follow-through in past _____
☐ Angry ☐ Flat affect ☐ Discouraged
☐ Withdrawn ☐ Difficulty coping ☐ Disorganized
☐ Depressed: Recent/Long term ☐ Anxiety: Recent/Long term
Treatment: _____ Treatment: _____
☐ Inability to cope with altered health status/illness as evidenced by:
☐ Lack of motivation ☐ Not hope in recovery ☐ Denial of problems
☐ Unrealistic expectations ☐ Refuse to follow MD orders ☐ Inability to recognize problems
☐ **Evidence of abuse/ neglect /exploitation:** ☐ Potential ☐ Actual ☐ Physical
☐ Verbal/Emotional/Psychological ☐ Financial ☐ Abandon
☐ Intervention Describe: _____
Comments: _____
☐ **No Problem**

(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed) Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

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

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

○ 0 - No ○ 1 - Yes

NEURO / MUSCULOSKELETAL

☐ Fracture (location) _____
☐ Orthopedic cast ☐ Removable ☐ Permanent for _____ days
☐ Swollen, painful joints (specify) _____
☐ Contractures: Joint _____
Location _____
☐ Atrophy _____ Assistive Device: ☐ Wheelchair ☐ Cane
☐ Unsteady Gait ☐ Transfer Problems ☐ Walker ☐ Other: _____
☐ Decreased ROM _____ ☐ Paresthesia _____
☐ Shuffling /Wide-based gait ☐ Weakness _____
☐ Orthopedic Protesys ☐ Knee Replacement L R ☐ Other: _____
☐ Amputation: BK/AK/UE; R/L (specify) _____
_____
☐ Hemiplegia ☐ Paraplegia ☐ Quadriplegia ☐ Aphasia: Receptive / Expressive
☐ Headache: Location: _____ Frequency: _____
☐ Weakness: UE / LE Other location: _____
☐ Tremors: ☐ Fine ☐ Gross ☐ Paralysis: Total / Partial
☐ Stuporous/Hallucinations: ☐ Visual ☐ Auditory
☐ PERRLA ☐ Unequal pupils: R / L
☐ Hand Grips: ☐ Equal ☐ Unequal, specify: _____
☐ Strong ☐ Weak, specify: _____
☐ Other (specify) _____

MUSCLE STRENGTH AND RANGE OF MOTION (ROM) EVALUATION

UPPER EXTREMITIES	STRENGTH Right	STRENGTH Left	ACTION	ROM: Right Active	ROM: Right Passive	ROM: Left Active	ROM: Left Passive
Shoulder:			Flex/Extend:				
			Int.Rot./Ext.Rot.				
			Abd./Add.				
Elbow:			Flex/Extend:				
Forearm:			Sup./Pron.				
Wrist:			Flex/Extend:				
Fingers:			Flex/Extend:				
LOWER EXTREMITIES Hip:			Flex/Extend:				
			Int.Rot./Ext.Rot.				
			Abd./Add.				
Knee:			Flex/Extend:				
Ankle:			Plant./Dors.:				
Foot:			Iver./Ever.:				

SPINE Strength: _____ **Spine** ROM: _____

Manual Muscle Test (MMT) Muscle Strength:

0 Zero: no active muscle contraction.
1 Trace strength: slight muscle contraction, no motion.
2 Poor strength: unable to move against gravity
3 Fair strength: against gravity, no resistance, safety compromise
4 Good strength: against gravity with some resistance
5 Normal functional strength: against gravity, full resistance

Patient Name: _____ Med. Record # _____

FUNCTIONAL LIMITATIONS

- ☐ 1 -Amputation
- ☐ 2-Bowel/Bladder (incontinence)
- ☐ 3 - Contracture
- ☐ B- Other (specify)_____
- ☐ 4-Hearing
- ☐ 5-Paralysis
- ☐ 6-Endurance
- ☐ 7-Ambulation
- ☐ 8-Speech
- ☐ 9-Legally blind
- ☐ A -Dyspnea with 18A
- ☐ Generalized Weakness
- ☐ Arthralgia
- ☐ Dizziness
- ☐ Headache
- ☐ Insomnia
- ☐ Anxiety
- ☐ SOB on exertion
- ☐ Poor vision
- ☐ Productive cough
- ☐ Heartburn
- ☐ Pain on ambulation
- ☐ Unsteady Gait
- ☐ Varicositis on lower ext.
- ☐ Edema in _____
- ☐ Chest pain on exertion
- ☐ Fatigues at times
- ☐ Legs weak
- ☐ Back Pain
- ☐ Decreased Bil. breath sounds
- ☐ Palpitations
- ☐ Limited Mobility
- ☐ Limited ROM
- ☐ Leg cramps
- ☐ Freq. Coughing episodes
- ☐ Needs assistance of 1 person

SG FALL RISK ASSESSMENT QA

(M1910) Has this patient had a multi-factor **Fall Risk Assessment** using a standardize, validated assessment tool?

- ☐ 0 - No
- ☐ 1 - Yes, and it does not indicate a risk for falls
- ☐ 2 - Yes, and it indicates a risk for falls

*Established by the Centers for Medicare & Medicaid Services **(CMS), QualityNet** provides healthcare quality improvement news, resources and data reporting tools and applications used by healthcare providers and others.*

Patient Factors: *Circle appropriate score for each section and total score at bottom.* ***(MedQIC)***	**Score**
Level of Consciousness/ Mental Status: Disoriented X 3 at all times (M1700)	2
Level of Consciousness/ Mental Status: Intermittent confusion (M1700 - M1710)	4
History of Falls (past 3 months) 1-2 falls (M1032)	2
History of Falls (past 3 months) 3 or more falls (M1032)	4
Ambulation/ Elimination Status: Chair bound & requires assist w/ toileting (M1840)	2
Ambulation/ Elimination Status: Ambulatory & incontinent (M1610 - M1615)	4
Vision Status Poor (w/ or w/o glasses) (M1200)	2
Vision Status Poor (Legally blind) (M1200)	4
Gait and Balance (Balance problem while standing)	1
Gait and Balance (Balance problem while walking.)	1
Gait and Balance (Decreased muscular coordination.)	1
Gait and Balance (Change in gait pattern when walking through doorway)	1
Gait and Balance (Jerking or unstable when making turns.)	1
Gait and Balance (Requires assistance (person, furniture/walls or device)).	1
Orthostatic Changes (Drop<20mmHg in BP between lying and standing. Increase of cardiac rhythm <20)	2
Orthostatic Changes (Drop >20mmHg in BP between lying and standing. Increase of cardiac rhythm >20)	4
Medications (Takes 1-2 of these medications currently or w/in past 7 days)	2
Medications (Takes 3-4 of these medications currently or w/in past 7 days)	4
Medications (Mark additional point if patient has had a change in these medications or doses in past 5 days.)	1
Predisposing Diseases (1-2 present)	2
Predisposing Diseases (3 or more present)	4
Equipment Issues (Oxygen tubing)	1
Equipment Issues (Inappropriate or client does not consistently use assistive device)	1
Equipment Issues (Equipment needs:)	1
Equipment Issues (Other:)	1

SG **Implement fall precautions for a total score of 10 or greater.** **Total points:** _____

Additional service Needed:

-Impaired Mobility -History of Falls -Predisposing DX - Weakness - -Knowledge Deficit or noncompliance with activity restrictions

-Unsafe Living Environment -Pt demo unsafe behavior or choices - Limited Resources -At risk and lives alone -Pt. is CG for another

-ADL/IADL Deficits -Sensory Deficits -Decreased Cognition -Unsafe living environment -UE limitations

Order Obtained

- **Physical Therapy** ☐
- **Medical Social Services** ☐
- **Occupational Therapy** ☐

If no additional services requested, check reason:

☐ Discipline already ordered. ☐ Pt has been assessed by this discipline w/in last 30 days

☐ Patient/Family refused additional discipline. ☐ **No other service approved by Patient's Physician**

Plan/Comments: _____

ADL/IADLs

(M1800) Grooming: Current ability to tend safely to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).

- ☐ 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
- ☐ 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
- ☐ 2 - Someone must assist the patient to groom self.
- ☐ 3 - Patient depends entirely upon someone else for grooming needs.

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

- ☐ 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
- ☐ 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
- ☐ 2 - Someone must help the patient put on upper body clothing.
- ☐ 3 - Patient depends entirely upon another person to dress the upper body.

(M1820) Current **Ability to Dress Lower Body** safely (with or without) dressing aids) including undergarments, stacks, socks or nylons, shoes:

- ☐ 0 - Able to obtain, put on, and remove clothing and shoes without assistance
- ☐ 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- ☐ 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes
- ☐ 3 - Patient depends entirely upon another person to dress lower body.

(M1830) Bathing: Current ability to wash entire body safely. **Excludes grooming** (washing face, washing hands, and shampooing hair).

- ☐ 0 - Able to bathe self in shower or tub independently, including getting in and our of tub/shower.
- ☐ 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
- ☐ 2 - Able to bathe in shower or tub with the intermittent assistance of another person:
  - (a). for intermittent supervision or encouragement or reminders, OR
  - (b) to get in and out of the shower or tub, OR
  - (c) for washing difficult to reach areas.
- ☐ 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
- ☐ 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
- ☐ 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath.
- ☐ 6 - Unable to participate effectively in bathing and is bathed totally by another person.

(M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

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

Certain abilities needed to function independently can be developed or maintained by managing symptoms or through physical or occupational therapy. Home health staff needs to evaluate the need for any special assistance devices or equipment and train patients on their use. If a patient can perform this activity with little assistance, they are more independent, self-confident, and active.

Patient Name: _____ Med. Record # _____

ADL/IADLs (Cont'd.)

(M1845) Toileting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

- 0 - Able to manage toileting hygiene and clothing management without assistance.
- 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient
- 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
- 3 - Patient depends entirely upon another person to maintain toileting hygiene.

(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

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

Transfers Bed:	☐ Independent	☐ Verbal Cues/Stand-by Assist	☐ Minimum Assist	☐ N/A
	☐ Moderate assist	☐ Maximum Assist	☐ Totally Dependent	
Transfers Wheelchair:	☐ Independent	☐ Verbal Cues/Stand-by Assist	☐ Minimum Assist	☐ N/A
	☐ Moderate assist	☐ Maximum Assist	☐ Totally Dependent	
Transfers Toilet:	☐ Independent	☐ Verbal Cues/Stand-by Assist	☐ Minimum Assist	☐ N/A
	☐ Moderate assist	☐ Maximum Assist	☐ Totally Dependent	
Transfers Tub/shower:	☐ Independent	☐ Verbal Cues/Stand-by Assist	☐ Minimum Assist	☐ N/A
	☐ Moderate assist	☐ Maximum Assist	☐ Totally Dependent	
Transfers Car/Transport:	☐ Independent	☐ Verbal Cues/Stand-by Assist	☐ Minimum Assist	☐ N/A
	☐ Moderate assist	☐ Maximum Assist	☐ Totally Dependent	
Bed Mobility: Roll/Turn	☐ Independent	☐ Verbal Cues/Stand-by Assist	☐ Minimum Assist	
	☐ Moderate assist	☐ Maximum Assist	☐ Totally Dependent	
Bed Mobility: Sit/Supine	☐ Independent	☐ Verbal Cues/Stand-by Assist	☐ Minimum Assist	☐ N/A
	☐ Moderate assist	☐ Maximum Assist	☐ Totally Dependent	
Bed Mobility: Sit/Stand Up	☐ Independent	☐ Verbal Cues/Stand-by Assist	☐ Minimum Assist	☐ N/A
	☐ Moderate assist	☐ Maximum Assist	☐ Totally Dependent	

Assist device/comments: _____

Transfer assessment Previous level: _____ Current Level: _____

☐ No significant functional problems ☐ Requires further training

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

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- 3 - Able to walk only with the supervision or assistance of another person at all times.
- 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- 5 - Chairfast, unable to ambulate and is unable to wheel self.
- 6 - Bedfast, unable to ambulate or be up in a chair.

AMBULATION/GAIT EVALUATION: Posture: _____

Endurance: _____ Muscle tone: _____

GAIT ASSESSMENT LEVEL: Distance: Level Surfaces: _____ Stairs: _____
Uneven Surfaces: _____ Other: _____
Assistance: Level Surfaces: _____ Stairs: _____
Uneven Surfaces: _____ Other: _____
Assistive Device: Level Surfaces: _____ Stairs: _____
Uneven Surfaces: _____ Other: _____
Deviations: Level Surfaces: _____ Stairs: _____
Uneven Surfaces: _____ Other: _____

Gait Quality:
- Poor/Unsteady
- Fair
- Good
- Excellent
- N/A, non-ambulatory

Comment: _____

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

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

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

- 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR
  (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
- 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- 2 - Unable to prepare any light meals or reheat any delivered meals.

(M1890) Ability to Use Telephone: Current ability to answer the phone safely including dialing numbers, and effectively using the telephone to communicate.

- ☐ 0 - Able to dial numbers and answer calls appropriately and as desired.
- ☐ 1 - Able to use a specialty adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.
- ☐ 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
- ☐ 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
- ☐ 4 - Unable to answer the telephone at all but can listen if assisted with equipment.
- ☐ 5 - Totally unable to use the telephone.
- ☐ NA - Patient does not have a telephone.

If the patient experiment: -ADL/IADL Deficit - Elimination Deficit - Impaired Mobility:
Indications for Home Health Aide may be needed:

MD Order obtained: ☐ Yes ☐ No Patient/Family: ☐ Refused

☐ N/A (Home Health Aide Services not needed) *(Please mantain coordination of care.)*

Other Services ordered: ☐ SN ☐ MSW ☐ PT ☐ OT ☐ ST

☐ Comment: _____

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

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

(M1910) See previous page 13, before the FALL RISK ASSESSMENT

ACTIVITIES PERMITTED

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

CMS 485 (POC): 18B

Patient Name: _____ Med. Record # _____

ALLERGIES

☐ None known / NKA ☐ Aspirin ☐ Eggs ☐ Insect bites 17
☐ Penicillin ☐ Sulfa ☐ Animal dander and urine ☐ Dairy/Milk products
☐ Iodine ☐ Pollens and mold spores ☐ Dust mites
☐ Other_____

MEDICATIONS SG

(M2000) Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues,eg: adverse drug reactions, ineffective drug therapy, significant side effects, drug interactions, duplicate therapy, omissions, dosage errors, or non-compliance (non-adherence)?

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

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

◯ 0 - No
◯ 1 -Yes

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

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

(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

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

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

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

MEDICATIONS

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

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	◯ 0	◯ 1	◯ 2	◯ NA
b. Injectable medications	◯ 0	◯ 1	◯ 2	◯ NA

☐ Drug/Medication review completed per Agency policy
☐ Peripheral IV line or implanted infusion devise, if yes explain. ◯ Yes ◯ No

Financial ability to pay for medications: ◯ Yes ◯ No
If any of bellow is true:
-Unsafe Living Environment -Pt demo unsafe behavior or choices -Limited Resources -At risk and lives alone -Pt. is CG for another
Social service may be required; was MSW referral made? ◯ Yes ◯ No
Comment/Plan:

WEIGHT BEARING EVALUATION/ASSISTIVE DEVICES

Weight Bearing Status (specify extremities): _____

☐ WBAT ☐ FWB ☐ PWB ☐ TDWB ☐ NWB

Weight-Bearing Radiographs (Radiographic evaluation of the foot): ◯ Yes ◯ No

Functional weight-bearing mechanics of the foot and lower extremity :

Use non-weight-bearing foot mechanics to help predict weight-bearing mechanical deficiencies : ◯ Yes ◯ No

ASSISTIVE DEVICES: ☐ Hoyer Lift
☐ Cane ☐ Quad Cane ☐ Walker ☐ Hemi Walker ☐ Wheeled Walker
☐ Wheelchair ☐ Manual ☐ Motorized ☐ Other: _____

☐ Patient able to use the assistive device ☐ Need further training

Comment: _____

Sitting Static:	Sitting Dynamic:	Standing Static:	Standing Dynamic:
◯ Poor	◯ Poor	◯ Poor	◯ Poor
◯ Fair	◯ Fair	◯ Fair	◯ Fair
◯ Good	◯ Good	◯ Good	◯ Good

BALANCE ASSESSMENT: ◯ Poor ◯ Fair ◯ Good

Tinetti: _____
BERG: _____
Timed Up and Go:: _____

Other/Comment:: _____

Dizziness/balance problems detected, if yes explain: ◯ Yes ◯ No

Patient Name: _____ Med. Record # _____

FUNCTIONAL ASSESSMENT

U- Unable (Asst. impractical) **A** - Assit'd (Prac. or 1 person)
S - Supervised (Verbal inst. only) **I** - Independent ***(circle)***

Dresses self: U - A - S - I
Feeds self: U - A - S - I
Bathes self: U - A - S - I
Sifting Balance: U - A - S - I
Standing Balance: U - A - S - I
Transfers: U - A - S - I
Bed Mobility: U - A - S - I
Bowel/Bladder Function: U - A - S - I

Gets in and out of tub/shower: U - A - S - I
Climb stairs: U - A - S - I
Use of assistive devices: U - A - S - I
Climb steps: U - A - S - I

☐ Architectural Barriers: _____

Interventions/ Instructions/ Comments/ Problems Detected:

_____

_____

CARE MANAGEMENT

(M2102) Types and Sources of Assistance: Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Exclude all care by you agency staff (Check only one box in each row.)

Type of Assistance	No Assistance Needed - patient is independent or does not have needs in this area	Non-agency Caregiver(s) currently provide assistance	Non-agency Caregiver(s) need training/ supportive services to provide assistance	Non-agency Caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance	Assistance needed, but non non-agency caregiver(s) available	Comments if needed (optional)
a. **ADL Assistance** (e.g., transfer/ambulation, bathing, dressing, toileting, eating/ feeding)	○ 0	○ 1	○ 2	○ 3	○ 4	
b. **IADL Assistance** (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	○ 0	○ 1	○ 2	○ 3	○ 4	
c. **Medication Administration** (e.g., oral, inhaled or injectable)	○ 0	○ 1	○ 2	○ 3	○ 4	
d. **Medical Procedures/ Treatments** (e.g., changing wound dressing, home exercise)	○ 0	○ 1	○ 2	○ 3	○ 4	
e. **Management of Equipment** (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)	○ 0	○ 1	○ 2	○ 3	○ 4	
f. **Supervision and Safety** (e.g., due to cognitive impairment)	○ 0	○ 1	○ 2	○ 3	○ 4	
g. **Advocacy or Facilitation** of patient's participation in appropriate medical care (includes transportation to or from appointments)	○ 0	○ 1	○ 2	○ 3	○ 4	

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

○ 1- At least daily
○ 2 - Three or more times per week
○ 3 - One to two times per week
○ 4- Received, but less often than weekly
○ 5 - No assistance received
○ UK - Unknown

APPLIANCES/ SPECIAL EQUIPMENT/ HOME MEDICAL EQUIPMENT Co.

☐ Brace/Orthotics (specify) _____

_____

☐ Transfer equipment: Board/Lift ☐ Bedside commode
☐ Ostomy Pliers ☐ Shower chair ☐ Scooters ☐ Hoists

☐ Prosthesis: RUE /RLE /LUE/LLE/Other_____
☐ Grab bars: Bathroom/Other_____
☐ Hospital bed: Semi-elec. /Crank/ Spec._____
☐ Lifeline ☐ Wheeled Walker ☐ Other:_____ ☐ N/A

☐ Needs (specify)_____

_____

☐ Oxygen: HME Co._____
☐ Fire Prevention/Safety Program in place, Patient instructed SG
HME Rep._____ Phone_____ ☐ N/A
☐ Organizations providing Home Medical Equipment (HME):

_____

Phone_____ ☐ N/A

Patient Name: _____ Med. Record # _____

SAFETY MEASURES / LIVING ARRANGEMENTS / SUPPORTIVE ASSISTANCE

Safety Measures: CMS485-POC 15

- ☐ Cast Precautions
- ☐ Change position slowly
- ☐ Coumadin/Heparin Precautions
- ☐ Bleeding Precautions
- ☐ Good handwashing technique
- ☐ Oxygen Precaution/Fire prevention SG
- ☐ Practice Universal Precautions
- ☐ Do not lift, bend, stoop
- ☐ Respiratory Precautions
- ☐ Diabetic Precautions
- ☐ Wound/Decubitus precautions
- ☐ Adequate lighting
- ☐ Prevent Cardiac Overload
- ☐ Prevent Falls and Injuries SG
- ☐ Safe Ambulation
- ☐ Prev. Infection Complications
- ☐ Seizure Precautions
- ☐ Suicide precautions
- ☐ Support due functional limitation
- ☐ Teach coping skills
- ☐ Safe storage/disposal syringes
- ☐ G.I. Precautions
- ☐ G.U. Precautions
- ☐ Safe Transfers
- ☐ SAN Precautions
- ☐ Catheter Care
- ☐ Provide Emotional Support
- ☐ Emergency Plan
- ☐ Cardiac Precautions
- ☐ Maintain Safe/clear Environment
- ☐ Maintain Good Skin care
- ☐ Clear pathways
- ☐ Correct handwashing technique SG
- ☐ Check bathroom, floor/stairs for safety hazards
- ☐ Psycho-social, behavior precautions
- ☐ Other: _____

HOME ENVIRONMENT SAFETY

Safety hazards in the home: (check all that apply)

SG	Fire alarm/smoke detector /Fire extinguish	○Y ○N
	Inadequate heating/ cooling/ electricity / lighting	○Y ○N
	Hurricane, Disaster Emergency supplies/kits	○Y ○N
	First aid box/Emergency Equipment or Supplies	○Y ○N
SG	Unsafe gas/electrical appliances or electrical outlets	○Y ○N
	Inadequate running water, plumbing problems	○Y ○N
	Unsafe storage of supplies/ equipment/ HME	○Y ○N
	No telephone available and/or unable to use the phone	○Y ○N
	Pest problems, Insects/rodents	○Y ○N
SG	Medications stored safely, clearly-easy use, check interactions	○Y ○N
	Emergency planning, Exit Plan in place, more than one exit	○Y ○N
	Enough Ventilation	○Y ○N
	Safe Beds/Chairs, clear pathways	○Y ○N
	Able to follow directions in case of Emergency	○Y ○N
SG	Slippery Floors, Ashtrays (if a smoker)	○Y ○N
	Plan for power failure, emergency lights, flashlights, etc.	○Y ○N
	Relevant medical appliances, if applicable (wheelchair, O_2, Monitors, etc.)	○Y ○N
	Hurricane Shutter , Disaster Plan	○Y ○N

Oxygen use: Signs posted ○Y ○N ○Oxygen Precautions explained

Follow smoking /flammables safety precautions: ○Y ○N SG

Oxygen back-up: ☐Available ☐Knows/ Instructed how to use

Plan/Comments: _____

Instructions/Information Provided, Sign Up package (Check all that apply):

- ☐ Patient Rights and responsibilities
- ☐ State hotline/ABUSE number
- ☐ Advance directives information
- ☐ Emergency Plan, classification, instructions
- ☐ Agency phone numbers, address
- ☐ Client Information Handbook
- ☐ Pain Management info
- ☐ Standard precautions /handwashing/ Infection Control SG
- ☐ Admission criteria, Information for Home visit, Services, Frequency
- ☐ Diabetes Control, other disease management information
- ☐ Care Plans ☐ Local Resources Guide ☐ Mission, ownership information
- ☐ Fall Prevention Program SG ☐ Other: _____
- ☐ Do not resuscitate (DNR) (if applicable)
- ☐ Service Agreement/Contract
- ☐ OASIS/HIPAA Privacy Notice, Confidentiality
- ☐ Medication sheet, reconciliated/checked SG
- ☐ Home safety guidelines
- ☐ Alzheimer's, Sensory impairments info
- ☐ Grievance Procedures

THERAPY AND PLAN OF CARE

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

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

- ☐ Physical Therapy, Total visits: _____
- ☐ Speech Therapy, Total visits: _____
- ☐ Occupational Therapy, Total visits: _____
- ☐ Other Therapy, Total visits: _____
- ☐ NA - Not applicable: No case mix group defined by this assessment.

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

Plan/Intervention	No	Yes	Not Applicable	
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	○0	○1	○NA	Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	○0	○1	○NA	Patient is not diabetic or is missing lower legs due to congenital or acquiered condition (bilateral amputee)
c. Falls prevention interventions	○0	○1	○NA	Fall risk assessment indicates patient has no risk for falls
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment and/or physician notified that patient screened positive for depression	○0	○1	○NA	Patient has no diagnosis or symptoms of depression and depression screening indicates 1)no symptoms 2) has some symptoms but doesn't meet criteria for further evaluation of depression based on screening tool used.
e. Intervention(s) to monitor and mitigate pain	○0	○1	○NA	Pain assessment indicates patient has no pain
f. Intervention(s) to prevent pressure ulcers	○0	○1	○NA	Patient ulcer risk assessment (clinical or formal) indicates not risk of developing pressure ulcers
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	○0	○1	○NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated

Patient Name: _____ Med. Record # _____

PATIENT CARE COORDINATION

CARE PLAN: ☐ Reviewed with patient involvement **CARE COORDINATION:** ☐ Physician ☐ SN ☐ PT ☐ OT ☐ ST ☐ MSW ☐ Aide ☐ Other (specify):

MEDICATION RECORD: ☐ Medication Form completed/reviewed/updated (10) ☐ No change ☐ Order obtained _____

(SG) **Medication Management**, Check all that applies/identified: ☐ Potential adverse effects/drug reactions ☐ Ineffective drug therapy ☐ Significant side effects ☐ Significant drug interactions ☐ Non-compliance with drug orders ☐ Duplicate drug therapy

Explain: _____

☐ Expected Outcome: _____

DISCHARGE PLANNING DISCUSSED/EXPLAINED? ◯ Yes ◯ No ☐ Patient unable to perform own Wound Care due to _____ ☐ Patient unable to Insuline/Injection self administration due to _____

☐ No S/O or C/G able/willing for wound care/Insulin-Injection administration at this time: _____

DME SUPPLIES

☐ Saline/NSS (14)
☐ 2x2's
☐ 4x4's
☐ ABD's
☐ Telfa
☐ Tape
☐ Cotton tipped applicators
☐ Wound cleanser
☐ Wound gel
☐ Drain sponges
☐ Gloves:
☐ Sterile ☐ Non-sterile
☐ Hydrocolloids
☐ Kerlix size _____
☐ Nu-gauze
☐ Transparent dressings
☐ Ointment
_____
☐ Colostomy Supplies
☐ Thermometer
☐ Red Box (Biohazard)
☐ Sharp Container

☐ Injection caps
☐ IV start kit
☐ IV pole
☐ IV tubing
☐ Alcohol swabs
☐ Angiocatheter size _____
_____
☐ Peroxide
☐ Extension tubings
☐ Central line dressing
☐ Infusion pump
☐ Batteries size _____
_____
☐ Syringes size _____
_____
☐ Duoderm
☐ Betadine Solution
☐ Ace band size
☐ MEFIX 2X11 YD (EA)
☐ MICROPORE TAPE 2"
☐ SOFTWICK 4X4

☐ Abd Pads
☐ Underpads, size:
_____
☐ External catheters
☐ Urinary bag/pouch
☐ Ostomy pouch (brand, size)
_____
☐ Ostomy wafer (brand, size)
_____
☐ Stoma adhesive tape
☐ Skin protectant
_____
FOLEY/CATH SUPPLIES:
☐ _____ Fr catheter kit (tray, bag, foley)
☐ Leg Straps Cath
☐ Straight catheter
☐ Irrigation tray
☐ Saline/NSS ☐ Texas Cath
☐ Acetic acid
☐ Other _____
_____
_____
_____

☐ ALCOHOL PREP PADS
☐ Chemstrips
☐ Syringes
☐ COTTON TIP APP
☐ DUODERM CFG
☐ HY-TAPE 2"
☐ INSERTION TRAY 5CC
☐ INSULIN SYRINGE ___ CC
☐ SYRINGES
_____
☐ Glucometer
_____
☐ Enema supplies
☐ Feeding tube:
type _____ size _____
☐ Suture removal kit
☐ Staple removal kit
☐ Steri strips
☐ TRIPLE ANTIBIOTIC 30GR
☐ VASELINE GAUZE 3X9
☐ KLING 4
_____

☐ Side Rails
☐ Bathbench
☐ Cane ☐ Quad Cane
☐ Commode
☐ Special mattress overlay
_____
☐ Pressure relieving device
_____
☐ Eggcrate
☐ Hospital bed
☐ Hoyer lift
☐ Enteral feeding pump
☐ Nebulizer
☐ Oxygen concentrator
_____
☐ Suction machine
☐ Ventilator
☐ Walker
☐ Wheelchair
☐ Tens unit
☐ Other _____
_____
_____
_____

PATIENT/CAREGIVER INSTRUCTIONS-TEACHING

Check all that applies:

Patient/caregiver(CG) independent with:

Wound/Decubitus care: ◯ Yes ◯ No ◯ N/A
Diabetic management/care: ◯ Yes ◯ No ◯ N/A
Insulin administration: ◯ Yes ◯ No ◯ N/A
Glucometer use/calibration: ◯ Yes ◯ No ◯ N/A
Nutritional management/Diet: ◯ Yes ◯ No ◯ N/A
Trach care: ◯ Yes ◯ No ◯ N/A
Ostomy care: ◯ Yes ◯ No ◯ N/A
Foley care: ◯ Yes ◯ No ◯ N/A

Medication management: Administration: ☐ Oral ☐ Injection ☐ IV-Infused ☐ Inhaled

Physician follow up visits/appointments: ◯ Yes ◯ No ◯ N/A
Oxygen use/precautions: (SG) ◯ Yes ◯ No ◯ N/A
Use of home medical equipment/devices: ◯ Yes ◯ No ◯ N/A
Pain Management/Home prescribed exercises: ◯ Yes ◯ No ◯ N/A
Activities of Daily Living/Personal Care: ◯ Yes ◯ No ◯ N/A
Elimination, Incontinence management ◯ Yes ◯ No ◯ N/A

Patient/CG education/teaching this visit for:
☐ MEDICATION _____
☐ DISEASE PROCESS /COMPLICATIONS _____
☐ S/S OF _____
☐ ILEAL CONDUIT/OSTOMY ☐ SKIN/FOOT CARE
☐ DIET, FLUIDS _____ ☐ INFECTION CONTROL

OTHER INSTRUCTIONS GIVEN: _____

Does the patient/CG have a plan when disease symptoms exacerbate (e.g., when to call the nurse/Agency vs. emergency **911**): ◯ Yes ◯ No

☐ Short/Long term therapy goals explained to patient

Caregiver present during the visit: ◯ Yes ◯ No ◯ N/A

Patient/CG able to understand instructions/teaching: ◯ Yes ◯ No Explain: _____ ☐ NEEDS FURTHER TEACHING

Comment(s): _____

SKILLED CARE PROVIDED THIS VISIT

☐ **Evaluation /Care Plan Assessed** ☐ Balance training/activities ☐ Teach hip safety precautions ☐ Patient/Caregiver education ☐ Establish upgrade home exercise program
☐ Pulmonary Physical Therapy Services ☐ Ultrasound/Electrotherapy ☐ Therapeutic exercise ☐ Prosthetic training ☐ Transfer training ☐ New/Updated Plan given to patient
☐ Gait/Ambulation training ☐ TENS/ Falls Prevention-Safety ☐ Functional/Bed mobility training ☐ Teach use Assistive Device _____ ☐ Attach Plan to the assessment

_____
_____
_____
_____

Patient Name: _____ Med. Record # _____

Orders by discipline (optional) To complete CMS485 (POC)

21 **Included as reference only, your Professional Staff must review/update/personalized/approve the orders.**

PT - ORDERS - FREQUENCY/DURATION: _____

- ☐ EVALUATE BALANCE AND COORDINATION
- ☐ EVALUATE ENDURANCE, MOBILITY
- ☐ NEUROMUSCULAR RE-EDUCATION
- ☐ PERFORM PRESCRIBED THERAPEUTIC EXERCISES
- ☐ STRENGTHENING EXERCISE
- ☐ EXERCISE BOTH PASSIVE AND ACTIVE EXERCISE REGIMEN
- ☐ INSTRUCT IN FALL PRECAUTIONS
- ☐ PULSE OXIMETRY PRN
- ☐ HOME SAFETY PROGRAM
- ☐ OTHER: _____
- ☐ NOTIFY SIGNIFICANT FINDING TO MD/AGENCY
- ☐ BED MOBILITY TRAINING
- ☐ GAIT TRAINING WITH ASSISTIVE DEVICE
- ☐ TEACH HOME MAINTENANCE PROGRAM
- ☐ TRANSFER TRAINING
- ☐ INSTRUCT IN SAFETY MEASURES
- ☐ MODALITY (SPECIFY FREQUENCY, DURATION, AMOUNT): _____
- ☐ PROSTHETIC TRAINING

AIDE - ORDERS - FREQUENCY/DURATION: _____ ☐ N/A

- ☐ TUB/SHOWER BATH
- ☐ PERSONAL CARE
- ☐ HAIR COMB
- ☐ ORAL HYGIENE
- ☐ TPR
- ☐ ASSIST TO DRESS
- ☐ WASH CLOTHES
- ☐ LIGHT HOUSEKEEPING
- ☐ ASSIST WITH PERSONAL CARE AND ADL'S
- ☐ PERI CARE
- ☐ REPORT SIGNIFICANT FINDING TO AGENCY/CASE MANAGER
- ☐ SHAMPOO PRN
- ☐ MOUTH/DENTURE CARE
- ☐ SKIN CHECK/CARE
- ☐ ASSIST WITH AMBULATION
- ☐ PREPARE SERVE MEALS
- ☐ GROCERY SHOP
- ☐ ERRANDS
- ☐ NOTIFY LAST BM IF NONE FOR 3 DAYS
- ☐ FEET/NAILS CARE (DO NOT CUT)
- ☐ STRAIGHTEN ROOM & CHANGE LINEN
- ☐ OTHER: _____

☐ **NURSE TO EVALUATE AND TREAT:** _____

☐ **OT TO EVALUATE AND TREAT:** _____

☐ **ST TO EVALUATE AND TREAT:** _____

☐ **MSW TO EVALUATE AND TREAT:** _____

☐ **OTHER SERVICE NEEDED:** _____

Patient Name: _____ Med. Record #: _____

GOALS/REHABILITATION POTENTIAL CMS485 (POC)

22 **Included as reference only, your Professional Staff must review/update/personalize/approve the goals.**

PT - GOALS

- ☐ GAIT PATTERN, ENDURANCE, STRENGTH AND BALANCE WILL IMPROVE WITHIN ____ WEEKS
- ☐ PATIENT WILL DEMONSTRATE CORRECT BODY MECHANICS WITHIN _____ WEEKS
- ☐ PATIENT AND/OR CG WILL COMPREHEND AND DEMONSTRATE HOME EXERCISE PROGRAM WITHIN _____ WEEKS.
- ☐ PATIENT WILL EXPERIENCE A DECREASE IN PAIN
- ☐ DEMONSTRATE EFFECTIVE PAIN MANAGEMENT WITHIN ___ WEEKS
- ☐ ABLE TO COMPLY WITH EXERCISES: BOTH PASSIVE AND ACTIVE EXERCISE REGIMEN
- ☐ DEMONSTRATE EFFECTIVE FALL PREVENTION PROGRAM WITHIN _____ WEEKS
- ☐ IMPROVE THE USE OF ASSISTIVE DEVICE: _____ WITHIN _____ WEEKS
- ☐ MAINTAIN/COMPLY WITH HOME SAFETY PROGRAM
- ☐ IMPROVE BED MOBILITY TO INDEPENDENT WITHIN _____ WEEKS
- ☐ IMPROVE BED MOBILITY TO _____ ASSIST WITHIN _____ WEEKS
- ☐ IMPROVE TRANSFERS TO _____ ASSIST USING _____ WITHIN _____ WEEKS
- ☐ INDEPENDENT WITH TRANSFER SKILLS WITHIN _____ WEEKS
- ☐ PATIENT WILL AMBULATE WITH _____ (device) FOR _____ FT WITH _____ ASSIST WITHIN ____ WEEKS
- ☐ PATIENT WILL BE ABLE TO CLIMB STAIRS/UNEVEN SURFACES WITH _____ (device) WITH _____ ASSIST WITHIN ____ WEEKS
- ☐ INCREASE STRENGTH OF ☐RUE ☐LUE ☐RLE ☐LLE WITHIN ____ WEEKS TO ALLOW PATIENT TO PERFORM THE FOLLOWING ACTIVITIES: _____.
- ☐ INCREASE RANGE OF MOTION (ROM) OF _____ JOINT TO _____ DEGREE FLEXION AND _____ DEGREE EXTENSION IN ____ WEEKS TO ALLOW PATIENT TO PERFORM THE FOLLOWING ACTIVITY: _____.
- ☐ IMPROVE RANGE OF MOTION (ROM) WNL WITHIN _____ WEEKS
- ☐ IMPROVE FUNCTIONALITY, BALANCE AND COORDINATION WNL WITHIN _____ WEEKS
- ☐ OTHER: _____

AIDE - GOALS

- ☐ GOOD/FAIR RETURN TO PREVIOUS LEVEL OF ADLS INDEPENDENTLY.
- ☐ FAIR-TO BE ABLE TO CARRY OUT MINIMAL ADLS WITH AVAILABLE HOME SUPPORT.
- ☐ WILL NOT BE ABLE TO CARRY OUT ADLS WITHOUT MAXIMUM SUPPORT.
- ☐ GOOD/FAIR RETURN TO PREVIOUS LEVEL OF PERSONAL CARE
- ☐ RETURN TO INDEPENDENT AMBULATION. BE SAFE IN SELF CARE.
- ☐ PATIENT WILL BE ABLE TO FUNCTION WITH ASSISTANCE OF CAREGIVER WITHIN HE/SHE CURRENT LIMITATIONS AT HOME.
- ☐ PATIENT IS ABLE TO FUNCTION INDEPENDENTLY WITHIN HIS/HER CURRENT LIMITATIONS AT HOME.

DISCHARGE PLANNING DISCUSSED WITH PATIENT: ◯ **Yes** ◯ **No** **REHAB POTENTIAL:** ◯ **Poor** ◯ **Fair** ◯ **Good** ◯ **Excellent**

- ☐ WILL DISCHARGE THE PATIENT WITHIN ____ WEEKS, WHEN PATIENT AND/OR CAREGIVER IS/ARE ABLE TO DEMONSTRATE KNOWLEDGE OF DISEASE MANAGEMENT, S/S COMPLICATIONS. PATIENT IS ABLE TO FUNCTION INDEPENDENTLY WITHIN HIS/HER CURRENT LIMITATION AT HOME.
- ☐ RETURN TO INDEPENDENT LEVEL OF SELF CARE.
- ☐ ABLE TO REMAIN SAFELY IN RESIDENCE WITH ASSISTANT OF _____
- ☐ WHEN PATIENT AND/OR CG KNOWLEDGEABLE ABOUT WHEN TO NOTIFY PHYSICIAN
- ☐ ABLE TO REMAIN IN HOME/RESIDENCE/ALF WITH ASSISTANCE OF PRIMARY CAEGIVER/SUPPORT AT HOME ABLE TO UNDERSTAND MEDICATION REGIMEN, AND CARE RELATED TO HIS/HER DISEASE. WILL BE DISCHARGE WHEN MAXIMUM FUNCTIONAL POTENTIAL REACHED.
- ☐ ABLE TO UNDERSTAND MEDICATION REGIME AND CARE RELATED TO DISEASE
- ☐ DISCHARGE WHEN MAXIMUM FUNCTIONAL POTENTIAL REACHED
- ☐ OTHER: _____

SIGNATURE/DATES

X _____ Staff Completing the OASIS (signature/title)

X _____ Patient Signature if required / optional if itinerary is used

_____/_____/_____ Date

OASIS INFORMATION

QA Date Reviewed:_____/_____/_____ **Data Entry Date & Locked:**_____/_____/_____ **Date Submitted:**_____/_____/_____