

OASIS TRANSFER ASSESSMENT

Start of Care Date: ____ / ____ / ____
month day year

TRANSFER TO INPATIENT FACILITY DEATH AT HOME

Agency Name: _____
Phone: _____

DATE ____ / ____ / ____

Employee's Name/Title Completing the OASIS: _____

TIME IN ____ TIME OUT ____

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CLINICAL RECORD ITEMS	CARDIOPULMONARY
<p>(M0080) Discipline of Person Completing Assessment:</p> <p><input type="checkbox"/> 1-RN <input type="checkbox"/> 2-PT <input type="checkbox"/> 3-SLP/ST <input type="checkbox"/> 4-OT</p> <p>(M0090) Date Assessment Completed: ____ / ____ / ____ month day year</p> <p>(M0100) This Assessment is Currently Being Completed for the Following Reason: <u>Transfer to an Inpatient Facility</u></p> <p><input type="checkbox"/> 6 - Transferred to an inpatient facility-patient not discharged from agency [Go to M1040]</p> <p><input type="checkbox"/> 7 - Transferred to an inpatient facility -patient discharged from agency [Go to M1040]</p> <p><input type="checkbox"/> 8 - Death at home [Go to M0903]</p> <p>(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes [Go to M1050]</p> <p><input type="checkbox"/> NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. [Go to M1050]</p> <p>(M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason:</p> <p><input type="checkbox"/> 1 - Received from another health care provider (e.g., physician)</p> <p><input type="checkbox"/> 2 - Received from your agency previously during this year's flu season</p> <p><input type="checkbox"/> 3 - Offered and declined</p> <p><input type="checkbox"/> 4 - Assessed and determined to have medical contraindication(s)</p> <p><input type="checkbox"/> 5 - Not indicated; patient does not meet age/condition guidelines for influenza vaccine</p> <p><input type="checkbox"/> 6 - Inability to obtain vaccine due to declared shortage</p> <p><input type="checkbox"/> 7 - None of the above</p> <p>(M1050) Pneumococcal Vaccine: Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge)?</p> <p><input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes [Go to M1500]</p> <p>(M1055) Reason PPV not received: If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), state reason:</p> <p><input type="checkbox"/> 1 - Patient has received PPV in the past</p> <p><input type="checkbox"/> 2 - Offered and declined</p> <p><input type="checkbox"/> 3 - Assessed and determined to have medical contraindication(s)</p> <p><input type="checkbox"/> 4 - Not indicated; patient does not meet age/condition guidelines for PPV</p> <p><input type="checkbox"/> 5 - None of the above</p> <p>Physician name: _____</p> <p>Address: _____</p> <p>Phone Number: _____</p>	<p>(M1500) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?</p> <p><input type="checkbox"/> 0 - No [Go to M2004]</p> <p><input type="checkbox"/> 1 -Yes</p> <p><input type="checkbox"/> 2 - Not assessed [Go to M2004]</p> <p><input type="checkbox"/> NA - Patient does not have diagnosis of heart failure [Go to M2004]</p> <p>(M1510) Heart Failure Follow-up. If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? (Mark all that apply.)</p> <p><input type="checkbox"/> 0 - No action taken</p> <p><input type="checkbox"/> 1 - Patient's physician (or other primary care practitioner) contacted the same day</p> <p><input type="checkbox"/> 2 - Patient advised to get emergency treatment (e.g., call 911 or go to emergency room)</p> <p><input type="checkbox"/> 3 - Implemented physician-ordered patient-specific established parameters for treatment</p> <p><input type="checkbox"/> 4 - Patient education or other clinical interventions</p> <p><input type="checkbox"/> 5 - Obtained change in care plan orders (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.)</p>
	MEDICATIONS
	<p>(M2004) Medication Intervention: If there were any clinically significant medication issues since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day of the assessment to resolve clinically significant medication issues, including reconciliation?</p> <p><input type="checkbox"/> 0 - No</p> <p><input checked="" type="checkbox"/> 1 -Yes</p> <p><input type="checkbox"/> NA - No clinically significant medication issues identified since the previous OASIS assessment</p> <p>(M2015) Patient/Caregiver Drug Education Intervention: Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects, and how and when to report problems that may occur?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 -Yes</p> <p><input type="checkbox"/> NA - Patient not taking any drugs</p>
	EMERGENT CARE
	<p>(M2300) Emergent Care: Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation)?</p> <p><input type="checkbox"/> 0 - No [Go to M2400]</p> <p><input type="checkbox"/> 1 - Yes, used hospital emergency department WITHOUT hospital admission</p> <p><input type="checkbox"/> 2 - Yes, used hospital emergency department WITH hospital admission</p> <p><input type="checkbox"/> UK - Unknown [Go to M2400]</p>
PATIENT NAME-Last, First, Middle Initial	Med. Record #

Patient Name: _____

Med. Record # _____

EMERGENT CARE (Cont'd.)

(M2310) Reason for Emergent Care: For what reason(s) did the patient receive emergent care (with or without hospitalization)? (Mark all that apply.)

- 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
- 2 - Injury caused by fall
- 3 - Respiratory infection (e.g., pneumonia, bronchitis)
- 4 - Other respiratory problem
- 5 - Heart failure (e.g., fluid overload)
- 6 - Cardiac dysrhythmia (irregular heartbeat)
- 7 - Myocardial infarction or chest pain
- 8 - Other heart disease
- 9 - Stroke (CVA) or TIA
- 10 - Hypo/Hyperglycemia, diabetes out of control
- 11 - GI bleeding, obstruction, constipation, impaction
- 12 - Dehydration, malnutrition
- 13 - Urinary tract infection
- 14 - IV catheter-related infection or complication
- 15 - Wound infection or deterioration
- 16 - Uncontrolled pain
- 17 - Acute mental/behavioral health problem
- 18 - Deep vein thrombosis, pulmonary embolus
- 19 - Other than above reasons _____
- UK - Reason unknown

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

(M2400) Intervention Synopsis: (Check only one box in each row.) Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

Plan/intervention	No	Yes	Not Applicable
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Patient is not diabetic or is bilateral amputee
b. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment
d. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Formal assessment did not indicate pain since the last OASIS assessment
e. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment
f. Pressure ulcer treatment based on principles of moist wound healing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Dressings that support the principles of moist wound healing not indicated for this patient's pressure ulcers OR patient has no pressure ulcers with need for moist wound healing

(M2410) To which Inpatient Facility has the patient been admitted?

- 1 - Hospital [Go to M2430] _____
- 2 - Rehabilitation facility [Go to M0903] _____
- 3 - Nursing home [Go to M2440] _____
- 4 - Hospice [Go to M0903] _____

(M2430) Reason for Hospitalization: For what reason(s) did the patient require hospitalization? (Mark all that apply.)

- 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
 - 2 - Injury caused by fall
 - 3 - Respiratory infection (e.g., pneumonia, bronchitis)
 - 4 - Other respiratory problem
 - 5 - Heart failure (e.g., fluid overload)
 - 6 - Cardiac dysrhythmia (irregular heartbeat)
 - 7 - Myocardial infarction or chest pain
 - 8 - Other heart disease
 - 9 - Stroke (CVA) or TIA
 - 10 - Hypo/Hyperglycemia, diabetes out of control
 - 11 - GI bleeding, obstruction, constipation, impaction
 - 12 - Dehydration, malnutrition
 - 13 - Urinary tract infection
 - 14 - IV catheter-related infection or complication
 - 15 - Wound infection or deterioration
 - 16 - Uncontrolled pain
 - 17 - Acute mental/behavioral health problem
 - 18 - Deep vein thrombosis, pulmonary embolus
 - 19 - Scheduled treatment or procedure
 - 20 - Other than above reasons _____
 - UK - Reason unknown
- [Go to M0903]

Transfer

Patient Name: _____ Med. Record # _____

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY (Cont'd.)

(M2440) For what Reason(s) was the patient Admitted to a Nursing Home? (Mark all that apply.)

- 1 - Therapy services
 - 2 - Respite care
 - 3 - Hospice care
 - 4 - Permanent placement
 - 5 - Unsafe for care at home
 - 6 - Other _____
 - UK - Unknown
- [Go to M0903]**

CARE SUMMARY

(M0903) Date of Last (Most Recent) Home Health Visit:

____ / ____ / ____
month / day / year

(M0906) Discharge /Transfer/ Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.

____ / ____ / ____
month / day / year

DISCIPLINES/SERVICES INVOLVED:

- SN PT OT ST MSW Aide Other _____
- All involved team members notified of Patient Transfer or Death Home Health Services **ON HOLD** communication in Chart
- Was a referral made to MSW for assistance with community resources/assistance with a counseling needs (depression/ suicidal inclination), living will/DNR, and/or safety environment problems? Date _____ Yes No Refused N/A
- Comment: _____

REASON FOR ADMISSION TO HOME HEALTH AND SUMMARY OF CARE TO TRANSFER/DEATH DATE (describe condition):

- Compromise Health Status Hospital D/C Cardiovascular complication Altered Endocrine Status Other (document):

DETAILS RELATED TO EMERGENT CARE AND/OR HOSPITALIZATION/ NURSING HOME TRANSFER (when known):

- Patient's complaints of: Chest Pain Hyper/Hypo glycoemia CVA/Stroke High Blood Pressure Other (document):

- Physician Notified of Transfer/Death:** Yes No **Date:** ____ / ____ / ____ Patient's Physician authorized transfer
- Copy of current P.O.C. attached** Yes No Transfer through Emergency Services/Ambulance/911 Family/Caregiver
- Current medication list attached** Yes No Other (explain): _____
- Advance directive exists** Yes No **Copy attached** Yes No
- DNR** Yes No **Copy attached** Yes No

SIGNATURE/DATES

X _____ X _____ _____
Staff Completing the OASIS (signature/title) Patient Signature if required / optional if itinerary is used Date

OASIS INFORMATION

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

TRANSFER - HOLD NOTIFICATION TO STAFF

AGENCY NAME: _____

PHONE: _____ FAX: _____

PATIENT NAME: _____ MR#: _____

SOC: _____ PAYOR SOURCE: MEDICARE MEDICAID OTHER: _____

TRANSFER/HOLD DATE: _____

REASON: _____

HOSPITAL: _____ ADMISSION DATE: _____

OTHER FACILITY: _____ ADMISSION DATE: _____

LAST STAFF VISIT (NAME AND DATE)

<u>STAFF NAME</u>	<u>DATE OF LAST VISIT</u>	<u>HOLD NOTIFICATION</u>
SN: _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
HHA: _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
PT: _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
OT: _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
ST: _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
MSW: _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
OTHER: _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

NAME OF PERSON MAKING REPORT: _____

SIGNATURE: _____

DATE: _____