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

OASIS TRANSFER ASSESSMENT

☐ TRANSFER TO INPATIENT FACILITY ☐ DEATH AT HOME

Agency Name: _____

Phone: _____

DATE ____/____/____

Employee's Name/Title Completing the OASIS: _____

TIME IN _____ **TIME OUT** _____

*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 0.7 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.*

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: Transfer to an Inpatient Facility

☐ 6 - Transferred to an inpatient facility-patient not discharged from agency ***[Go to M1041]***

☐ 7 - Transferred to an inpatient facility -patient discharged from agency ***[Go to M1041]***

Discharge from Agency - Not to an Inpatient Facility:

☐ 8 - Death at home ***[Go to M0903]***

(M1041) Influenza Vaccine Data Collection Period: Does this episode of care (SOC/ROC to Transfer/Dischrage) include any dates on or between October 1 and March 31?

◯ 0 - No ***[Go to M1051]***

◯ 1 - Yes

(M1046) Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season?:

☐ 1 - Yes, received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)

☐ 2 - Yes, received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)

☐ 3 - Yes; received from another health care provider (e.g. physician, pharmacist)

☐ 4 - No; patient offered and declined.

☐ 5 - No; patient assessed and determined to have medical contra-indication(s).

☐ 6 - No; not indicated - patient does not meet age/condition guidelines for influenza vaccine

☐ 7 - No; inability to obtain vaccine due to declared shortage

☐ 8- No; patient did not receive the vaccine due to reasons other than those listed in responses 4 - 7.

(M1051) Pneumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?

◯ 0 - No ◯ 1 - Yes ***[Go to M1501]***

(M1056) Reason Pneumococcal Vaccine not received: If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason:

☐ I - Offered and declines

☐ 2 - Assessed and determined to have medical contraindication(s)

☐ 3 - Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine)

☐ 4 - None of the above

Physician name: _____

Address: _____

_____

Phone Number: _____

CARDIOPULMONARY

(M1501) 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 the time of or at any time since the most recent SOC/ROC assessment?

◯ 0 - No ***[Go to M2005]***

◯ 1 -Yes

◯ 2 - Not assessed ***[Go to M2005]***

◯ NA - Patient does not have diagnosis of heart failure ***[Go to M2005]***

(M1511) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the most recent SOC/ROC assessment, what action(s) has (have) been taken to respond? (Mark all that apply.)

☐ 0 - No action taken

☐ 1 - Patient's physician (or other primary care practitioner) contacted the same day

☐ 2 - Patient advised to get emergency treatment (e.g., call **911** or go to emergency room)

☐ 3 - Implemented physician-ordered patient-specific established parameters for treatment

☐ 4 - Patient education or other clinical interventions

☐ 5 - Obtained change in care plan orders (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.)

MEDICATIONS

(M2005) Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?

◯ 0 - No

◯ 1 -Yes

◯ 9 - NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

(M2016) Patient/Caregiver Drug Education Intervention: At the time of, or at any time since the most recent SOC/ROC assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?

◯ 0 - No

◯ 1 -Yes

◯ NA - Patient not taking any drugs

EMERGENT CARE

(M2301) Emergent Care: At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)?

◯ 0 - No ***[Go to M2401]***

◯ 1 - Yes, used hospital emergency department WITHOUT hospital admission

◯ 2 - Yes, used hospital emergency department WITH hospital admission

◯ UK - Unknown ***[Go to M2401]***

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 seek and/or receive emergent care (with or without hospitalization)? **(Mark all that apply.)**

- ☐ 1 - Improper medication administration, adverse drug reactions, 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
- ☐ 1 3 - 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

(M2401) Intervention Synopsis: (Check only one box in each row.) At the time of or at any time since the most recent SOC/ROC 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	○ 0	○ 1	○ NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee)
b. Falls prevention interventions	○ 0	○ 1	○ NA	Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	○ 0	○ 1	○ NA	Patient has no diagnosis of depression & every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the patient has: 1)no symptoms of depression; or 2)has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d. Intervention(s) to monitor and mitigate pain	○ 0	○ 1	○ NA	Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	○ 0	○ 1	○ NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	○ 0	○ 1	○ NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

(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 M0903]*** _____
- ○ 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, adverse drug reactions, 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

Patient Name: _____ Med. Record # _____

GOALS ALREADY MET or NOT MET AT TRANSFER DATE:

GOALS ALREADY MET AT TRANSFER DATE:

- ☐ PATIENT EDUCATED IN ALL MEDICATION REGIMEN, SIDE EFFECTS, ETC
- ☐ PATIENT EDUCATED IN DISEASE MANAGEMENT, TREATMENT, PROCED.
- ☐ FALL RISK ASSESSED, AND RISK DRECREASED
- ☐ OTHER: _____

GOALS NOT MET AT TRANSFER DATE:

- ☐ ABLE TO MANAGEMENT DISEASE, CARE
- ☐ FREE OF PAIN, ABLE TO MANAGEMENT PAIN
- ☐ OTHER: _____

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 glycemia ☐ 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 trough 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 _____
Staff Completing the OASIS (signature/title)

X _____
Patient Signature if required (optional)

___/___/___
Date

OASIS INFORMATION

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

TRANSFER - HOLD NOTIFICATION TO STAFF

AGENCY NAME: _____

PHONE: _____ FAX: _____

PATIENT NAME: _____ MR#: _____ DOB: _____

SOC: _____ PAYOR SOURCE: ☐ MEDICARE ☐ MEDICAID ☐ OTHER: _____

TRANSFER/HOLD DATE: _____

REASON: _____

HOSPITAL: _____ ADMISSION DATE: _____

OTHER FACILITY: _____ ADMISSION DATE: _____

LAST STAFF VISIT (NAME AND DATE)

STAFF NAME	DATE OF LAST VISIT	HOLD NOTIFICATION
SN: _____	_____	○ YES ○ NO ○ N/A
HHA: _____	_____	○ YES ○ NO ○ N/A
PT: _____	_____	○ YES ○ NO ○ N/A
OT: _____	_____	○ YES ○ NO ○ N/A
ST: _____	_____	○ YES ○ NO ○ N/A
MSW: _____	_____	○ YES ○ NO ○ N/A
OTHER: _____	_____	○ YES ○ NO ○ N/A

ABSTRACT SUMMARY REPORT *(Patient Status, Service provided up to transfer date)*

☐ ABSTRACT Summary faxed to MD on _____

☐ ABSTRACT summary faxed to In Patient Facility on: _____

☐ ABSTRACT summary delivery to patient

_____

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NAME/TILE OF PERSON MAKING REPORT: _____

SIGNATURE: _____ DATE: _____