TRANSFER TO INPATIENT FACILITY

(Page 1 of 2)

Client's Name:

Client Record No.

A. DEMOGRAPHIC/GENERAL INFORMATION - Update Patient Tracking Sheet as needed.

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

2. **(M0090) Date Assessment Completed:**
   __ __ – __ __ – __ __ __ __
   m m d d y y y y

3. **(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)

Follow-Up
- 4 - Recertification (follow-up) reassessment
- 5 - Other follow-up

Transfer to an Inpatient Facility
- ☐ **6 - Transferred to an inpatient facility—patient not discharged from agency**
- ☐ **7 - Transferred to an inpatient facility—patient discharged from agency**

Discharge from Agency — Not to an Inpatient Facility
- 8 - Death at home
- 9 - Discharge from agency

B. EMERGENT CARE

1. **(M0830) Emergent Care:** Since the last time OASIS data were collected, has the patient utilized any of the following services for emergent care (other than home care agency services)? **(Mark all that apply.)**
   - ☐ 0 - No emergent care services **[If no emergent care, go to *Section C #1 - Inpatient Facility*]**
   - ☐ 1 - Hospital emergency room (includes 23-hour holding)
   - ☐ 2 - Doctor's office emergency visit/house call
   - ☐ 3 - Outpatient department/clinic emergency (includes urgicenter sites)
   - ☐ UK - Unknown **[If UK, go to *Section C #1 - Inpatient Facility*]**

2. **(M0840) Emergent Care Reason:** For what reason(s) did the patient/family seek emergent care? **(Mark all that apply.)**
   - ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
   - ☐ 2 - Nausea, dehydration, malnutrition, constipation, impaction
   - ☐ 3 - Injury caused by fall or accident at home
   - ☐ 4 - Respiratory problems (e.g., shortness of breath, respiratory infection, tracheobronchial obstruction)
   - ☐ 5 - Wound infection, deteriorating wound status, new lesion/ulcer
   - ☐ 6 - Cardiac problems (e.g., fluid overload, exacerbation of CHF, chest pain
   - ☐ 7 - Hypo/Hyperglycemia, diabetes out of control
   - ☐ 8 - GI bleeding, obstruction
   - ☐ 9 - Other than above reasons
   - ☐ UK - Reason unknown

C. INPATIENT FACILITY ADMISSION OR DISCHARGE FROM HOME CARE

1. **(M0855)** To which **Inpatient Facility** has the patient been admitted?
   - ☐ 1 - Hospital **[Go to *#2 - Hospital Reason*]**
   - ☐ 2 - Rehabilitation facility **[Go to *#5 - Most Recent Home Visit Date*]**
   - ☐ 3 - Nursing home **[Go to *#4 - Reason Admitted Nursing Home*]**
   - ☐ 4 - Hospice **[Go to *#5 - Most Recent Home Visit Date*]**

2. **(M0890)** If the patient was admitted to an acute care **Hospital**, for what **Reason** was he/she admitted?
   - ☐ 1 - Hospitalization for emergent (unscheduled) care
   - ☐ 2 - Hospitalization for urgent (scheduled within 24 hours of admission) care
   - ☐ 3 - Hospitalization for elective (scheduled more than 24 hours before admission) care
   - ☐ UK - Unknown

3. **(M0895) Reason for Hospitalization: (Mark all that apply.)**
   - ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
   - ☐ 2 - Injury caused by fall or accident at home
   - ☐ 3 - Respiratory problems (SOB, infection, obstruction)
   - ☐ 4 - Wound or tube site infection, deteriorating wound status, new lesion/ulcer
   - ☐ 5 - Hypo/Hyperglycemia, diabetes out of control
   - ☐ 6 - GI bleeding, obstruction
   - ☐ 7 - Exacerbation of CHF, fluid overload, heart failure
   - ☐ 8 - Myocardial infarction, stroke
   - ☐ 9 - Chemotherapy
   - ☐ 10 - Scheduled surgical procedure
   - ☐ 11 - Urinary tract infection
   - ☐ 12 - IV catheter-related infection
   - ☐ 13 - Deep vein thrombosis, pulmonary embolus
   - ☐ 14 - Uncontrolled pain
   - ☐ 15 - Psychotic episode
   - ☐ 16 - Other than above reasons

4. **(M0900)** 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

5. **(M0903) Date of Last (Most Recent) Home Visit:**

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

   __ __ – __ __ – __ __ __ __
   m m d d y y y y

7. Was the patient **Discharged** from the **Agency?**
   - ☐ No **[If No, STOP here]**
   - ☐ Yes **[If Yes, go to *Section D*]**

D. SUMMARY OF CARE PROVIDED DURING HOME CARE EPISODE

1. Identified Problem	Interventions	Current Status

2. Overall Status at Discharge:

Copy of Summary to ☐ Referral Source ☐ Attending Physician

Date of Assessment: _____ Signature of Assessor: _____