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

OASIS RECERTIFICATION / FOLLOW-UP
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: ☐ Recertification ☐ Other Follow-Up

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: _____

Do not Resuscitate Order (DNR) information changed from previous episode:
◯ Yes ◯ No If yes, Order Obtained: ◯ Yes ◯ No
New Health care surrogate/proxy: ◯ Yes ◯ No If yes, complete:
Name/Relationship to patient: _____
Phone: _____

Evacuation Information changed from the SOC?: ◯ Yes ◯ No If yes, document registration:

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

(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: Enter Code ☐ 1 - Male 2 - Female 9

Emergency/Disaster Plan Classification Code changed from SOC: ◯ Yes ◯ No If yes, new Code: _____
(If yes complete a new Emergency/Disaster form)
New Emergency Contact from previous episode: ◯ Yes ◯ No If yes, complete:
EMERGENCY CONTACT: _____
Address: _____
Phone: _____ Relationship: _____

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

Type of Visit: ◯ Skilled ◯ Evaluation only ◯ Skilled & Evaluation ◯ Other_____

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

(M0100) This Assessment is Currently Being Completed for the Following Reason: Follow-Up
☐ 4 - Recertification (follow-up) reassessment [Go to M0110] ☐ 5- Other follow-up [Go to M0110]

(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 the patient's current sequence of adjacent Medicare home health payment episodes?
◯ 1 - Early ◯ UK - Unknown
◯ 2 - Later ◯ NA - Not Applicable: No Medicare, case mix group to be defined by this assessment.

(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.	_____	_ _ _ . _ _ _ _

☐ NA - Not Applicable (patient was not discharged from an inpatient facility)

PATIENT NAME - Last, First, Middle Initial | Med. Record #

Patient Name: _____ Med. Record # _____

PATIENT HISTORY AND DIAGNOSES (Cont'd.)

(M1021/M1023/M1025) Diagnoses, Symptom Control, and Optional Diagnoses: 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) Optional Diagnoses (OPTIONAL) (not used for payment)	
	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
11	**(M1021) Primary Diagnosis**	**V, W, X, Y codes NOT allowed**	**V, W, X, Y, Z codes NOT allowed**	**V, W, X, Y, Z codes NOT allowed**
	a. _____	a. ☐☐☐.☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	a. _____ (☐☐☐.☐☐☐☐)	a. _____ (☐☐☐.☐☐☐☐)
13	**(M1023) Other Diagnoses**	**All ICD-10–C M codes allowed**	**V, W, X, Y, Z codes NOT allowed**	**V, W, X, Y, Z codes NOT allowed**
	b. _____	b. ☐☐☐.☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	b. _____ (☐☐☐.☐☐☐☐)	b. _____ (☐☐☐.☐☐☐☐)
	c. _____	c. ☐☐☐.☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	c. _____ (☐☐☐.☐☐☐☐)	c. _____ (☐☐☐.☐☐☐☐)
	d. _____	d. ☐☐☐.☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	d. _____ (☐☐☐.☐☐☐☐)	d. _____ (☐☐☐.☐☐☐☐)
	e. _____	e. ☐☐☐.☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	e. _____ (☐☐☐.☐☐☐☐)	e. _____ (☐☐☐.☐☐☐☐)
	f. _____	f. ☐☐☐.☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	f. _____ (☐☐☐.☐☐☐☐)	f. _____ (☐☐☐.☐☐☐☐)

Surgical Procedure 12 ICD-10-CM 12

_____ (_____) Date ____/____/____

(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

Patient Name: _____ Med. Record # _____

EYES

(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 can 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.

☐ No Problem Is there any new/change in vision status from SOC, if yes explain: ◯ Yes ◯ No

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

CAREGIVER / LIVING ARRANGEMENT

Primary Caregiver/S.O. (name) _____

Phone Number (if different from patient) _____

Relationship to patient: _____

Is there any other caregiver(s) detail the specific assistance they give with medical cares, and/or ADLs:

Able to safely care for patient ◯ Yes ◯ No

Other Facility involved in care/Comments: _____

PAIN

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

- ☐ 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

QA

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)

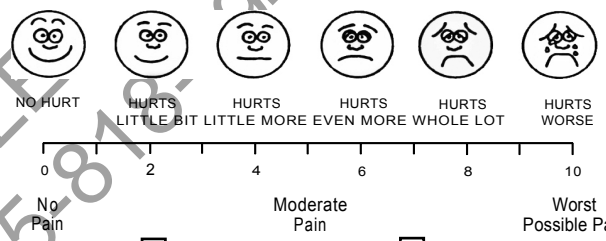
Patient complains about pain: ◯ Yes ◯ No

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 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? _____

SKIN / INTEGUMENTARY STATUS

(M1306) Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as "unstageable"? *(Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)*

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

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.)

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage:

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. Stage 2: 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 blister. Number of Stage 2 pressure ulcers [If 0 - Go to M1311 B1]	
A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Number of Stage 3 pressure ulcers.[If 0 - Go to M1311 C1]	
B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers. [If 0 - Go to M1311 D1]**	
C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	
D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device. **Number of unstageable pressure ulcers due to non-removable dressing/device. [If 0 - Go to M1311 E1]**	
D2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar. [If 0 - Go to M1311 F1]**	
E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution. [If 0 - Go to M1322]	
F2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC.	

(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. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 or more

(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 Patient has no pressure ulcers or no stageable pressure ulcers

(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/device) ***[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 (Observable) Stasis Ulcer:

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

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

○ 0 - No ***[Go to M1400]***
○ 1 - Yes, patient has at least one (observable) surgical wound
○ 2 - Surgical wound known but not observable due to non-removable dressing/device ***[Go to M1400]***

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

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

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.

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

Wound care done during this visit: ○ Yes ○ No

Authorization to take Photo obtained: ○ Yes ○ No

Location(s) wound site: _____

☐ Soiled dressing removed by: *(use biohazard waste box)*
☐ RN/PT ☐ Caregiver (name) _____
☐ Patient ☐ Other: _____

Technique used: ☐ Sterile ☐ Clean ☐ Correct handwashing technique followed SG

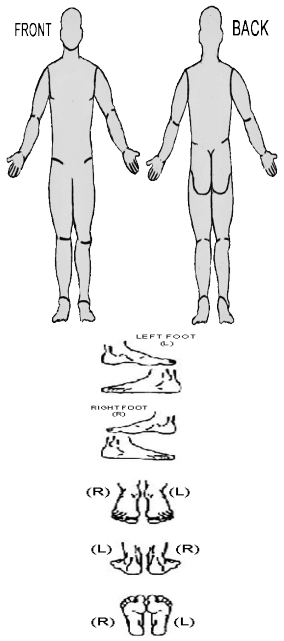
Procedure: Procedure tolerated well: ○ Yes ○ No

☐ 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

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 (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, or performing other ADLs) or with agitation
- ○ 4 - At rest (during day or night) ○ Visit Assessed ○ Patient-CG Reported

O2 therapy/precaution. fire prevention: ○ No ○ Yes, explain __ LPM: _____ SG

ENDOCRINE STATUS

Ale _____% ☐ Today's visit ☐ Patient reported ☐ Lab slip

BS _____mg/dL Date/Time: _____

☐ FBS ☐ Before meal ☐ Postprandial ☐ Random HS

☐ Blood sugar ranges_____ ☐ Patient/CG Report

Monitored by: ☐ Patient ☐ Caregiver/Family ☐ Nurse

☐ Other _____

Able to use Glucometer: _____

Monitoring Frequency: _____

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

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

○ 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)*

☐ **Disease Management Problems (explain)**

_____

_____

NUTRITIONAL STATUS

16 **DIET (Circle or check all that apply)** ☐ Controlled Carbohydrate

☐ 2 gm Sodium ☐ Low Sodium ☐ NAS ☐ NPO ☐ 1800 cal ADA

☐ Low Fat ☐ Low cholesterol Other: _____

☐ Increase fluids:_____amt. ☐ Restrict fluids_____amt.

Appetite: ○ Good ○ Fair ○ Poor ○ Anorexic ○ Nausea/Vomiting

Enteral Feedings: ☐ N/A ☐ No Problem ☐ Nasogastric

Assessment Findings: ☐ Gastrostomy ☐ Jejunostomy

Intake adequate: ○ Yes ○ No Hydration adequate: ○ Yes ○ No

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

Change in nutritional risk since last assessment: ○ Yes ○ No

Instructions/Comments: _____

_____

☐ **No Problem**

GENITOURINARY STATUS

(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]***

(Check all that apply:) ☐ Burning/pain ☐ Urgency/frequency

☐ **Incontinence:** ☐ Urinary ☐ Bowel ☐ Nocturia x _____ ☐ Hematuria

☐ Diapers/other: _____ ☐ Oliguria/anuria ☐ Hesitancy

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**

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

(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:** ☐ Urinary ☐ Bowel ☐ 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

MENTAL STATUS

☐ 1 - Oriented ☐ 3 - Forgetful ☐ 5 - Disoriented ☐ 7 - Agitated

☐ 2 - Comatose ☐ 4 - Depressed ☐ 6 - Lethargic 19

☐ 8 - Other: _____ ☐ Irritable ☐ Anxious ☐ Alert

Patient Name: _____ Med. Record # _____

ALLERGIES

17

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

FUNCTIONAL LIMITATIONS

18A

☐ 1 -Amputation ☐ 4-Hearing ☐ 7-Ambulation ☐ A -Dyspnea with
☐ 2-Bowel/Bladder (incontinence) ☐ 5-Paralysis ☐ 8-Speech
☐ 3 - Contracture ☐ 6-Endurance ☐ 9-Legally blind
☐ B- Other (specify) _____

☐ Generalized Weakness ☐ Productive cough ☐ Legs weak
☐ Arthralgia ☐ Heartburn ☐ Back Pain
☐ Dizziness ☐ Pain on ambulation ☐ Decreased Bil. breath sounds
☐ Headache ☐ Unsteady Gait ☐ Palpitations
☐ Insomnia ☐ Varicositis on lower ext. ☐ Limited Mobility
☐ Anxiety ☐ Edema in _____ ☐ Limited ROM
☐ SOB on exertion ☐ Chest pain on exertion ☐ Leg cramps
☐ Poor vision ☐ Fatigues at times ☐ Freq. Coughing episodes
☐ Needs assistance of 1 person

SG FALL RISK ASSESSMENT QA

*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
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: ☐ No risk for falls assessed
☐ Discipline already ordered. ☐ Pt has been assessed by this discipline w/in last 30 days
☐ Patient/Family refused additional discipline. ☐ Fall risk assessment will be repeated within ___ days
☐ **No other service approved by Patient's Physician**

Plan/Comments: _____

ADL/IADLs

(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, slacks, 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.
☐ 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.

ACTIVITIES PERMITTED

18B

CMS 485 (POC):

☐ 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 (type): _____
☐ B-Walker
☐ C-No restrictions
☐ D-Other (specify) _____

Patient Name: _____ Med. Record # _____

ADL/IADLs (Cont'd.)

(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.

(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 (especifically 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.

Aide Services Offered/needed: ◯ Yes ◯ No ◯ Refused

Orders obtained: ◯ Yes ◯ No _____

MEDICATIONS

(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.

INFUSION / IV THERAPY

☐ **N/A** ☐ **Infusion / IV Therapy order obtained, verified**
☐ **Peripheral line** ☐ **Central line** ☐ **Medline catheter**

Type/brand _____
Size: _____ Gauge: _____ Length: _____
☐ Groshong ☐ Non-Groshong ☐ Tunneled ☐ Non-tunneled
Insertion site _____ Insertion date _____
Lumens: ☐ Single ☐ Double ☐ Triple
Flush solution: _____ Frequency: _____
Patent: ◯ Yes ◯ No
Injection cap change frequency _____
Dressing change frequency _____ ☐ Sterile ☐ Clean
Performed by: ☐ Patient ☐ RN ☐ Caregiver ☐ Other: _____
Site/skin condition _____
External catheter length _____
Other/Comment: _____

IV Therapy complication observed: ☐ Pain & irritation ☐ Infiltration & exravasion ☐ Occlusion/obstruction ☐ fluid overload Other: _____

PICC Specific: X-ray verification:
Circumference of arm _____ ◯ Yes ◯ No

IVAD Port Specific: Reservoir: ☐ Single ☐ Double
Huber gauge/length _____
Accessed: ◯ No ◯ Yes, date _____
Intravenous IV Port: ◯ Yes ◯ No *(vascular access device)* Flush Ordered: ◯ Yes ◯ No
Last flushed date: _____

Epidural/Intrathecal Access:
Site/skin condition _____
Infusion solution (type/volume/rate) _____
Dressing _____
Other/Comment: _____

☐ IV-Infusion Medication(s) administered: ☐ Correct handwashing technique followed SG
Drug Name: _____
Dose _____ Route _____
Frequency _____ Duration of therapy _____

☐ IV-Infusion Medication(s) administered:
Drug Name: _____
Dose _____ Route _____
Frequency _____ Duration of therapy _____

Financial ability to pay for medications: ◯ Yes ◯ No
-Unsafe Living Environment -Pt demo unsafe behavior or choices -Limited Resources -At risk and lives alone -Pt. is CG for another ◯ Yes ◯ No
Was MSW referral made? ◯ Yes ◯ No
Comment/Plan: _____

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/Fire prevention: 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
☐ HIPAA/OASIS Privacy Policy/Rules
Caregiver present during the visit: ◯ Yes ◯ No
Patient/CG able to understand instructions/teaching: ◯ Yes ◯ No Explain: _____ ☐ NEEDS FURTHER TEACHING
Comment(s): _____

Patient Name: _____ Med. Record # _____

SAFETY MEASURES / LIVING ARRANGEMENTS / SUPPORTIVE ASSISTANCE

Safety Measures: CMS485 (POC) 15

- ☐ Cast Precautions
- ☐ Change position slowly
- ☐ Coumadin/Heparin Precautions
- ☐ Do not lift, bend, stoop
- ☐ Good handwashing technique
- ☐ Oxygen Precaution/Fire prevention SG
- ☐ Practice Universal Precautions
- ☐ 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: _____

THERAPY

(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).

☐ NA - Not applicable: No case mix group defined by this assessment

☐ Physical Therapy, Total visits: _____ ☐ Speech Therapy, Total visits: _____

☐ Occupational Therapy, Total visits: _____ ☐ Other Therapy, Total visits: _____

HOMEBOUND REASON: *(Mark all that apply)*

- ☐ **Needs assist of 1-2 persons** 18A
- ☐ 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
- ☐ Dependent upon adaptive device(s)

SKILLED NURSING INTERVENTION/TEACHING

☐ **Skilled Observation / Assessment** ☐ Foley Change/Care ☐ Patient Education/teaching ☐ Wound Care / Dressing Change ☐ Prep. / Admin. Insulin ☐ Diabetic Observation / Care
☐ INJECTION ROUTE:_____ SITE: _____ MED. GIVEN: _____ DOSE: _____ REACTION: _____ ☐ Procedure/Tx well tolerated by Pt.
☐ Standard/Universal Precautions Followed ☐ Aseptic Tech. Used. ☐ Quality Control of Glucometer Performed ☐ Sharps Discarded Inside Sharps Container
☐ Correct handwashing technique followed SG ☐ Management/Evaluation Patient's Care Plan ☐ No caregiver/family available/willing to help patient with care, procedures.

PHYSICAL THERAPY INTERVENTIONS/TEACHING

☐ **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 SG ☐ Functional/Bed mobility training ☐ Teach use Assistive Device _____ ☐ Attach Plan to the assessment

OCCUPATIONAL THERAPY INTERVENTIONS/TEACHING

☐ **Evaluation /Care Plan Assessed** ☐ Fine motor coordination ☐ Independent living/ADL training (feeding, perceptual skill) ☐ Patient/Caregiver education ☐ Establish upgrade home exercise program
☐ Muscle re-education ☐ Therapeutic exercise to R / L hand to increase coordination, strength, coordination, sensation ☐ Sensory treatment, Orthotics/Splinting ☐ New/Updated Plan given to patient
☐ Perceptual motor training ☐ Falls Prevention-Safety SG ☐ Teach alternative bathing skills (unsafe use of tub/shower) ☐ Teach use Adaptive Device _____ ☐ Attach Plan to the assessment

SPEECH THERAPY INTERVENTIONS/TEACHING

☐ **Evaluation /Care Plan Assessed** ☐ Alaryngeal speech skills ☐ Teach/Develop communication skills ☐ Patient/Caregiver education ☐ Establish upgrade home program
☐ Aural rehabilitation ☐ Non-oral communication ☐ Dysphagia treatments ☐ Voice disorders ☐ Speech dysphagia instruction program ☐ New/Updated Plan given to patient
☐ Language processing ☐ Language disorders ☐ Speech articulation disorders ☐ Safe swallowing evaluation _____ ☐ Attach Plan to the assessment

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

Patient Name: _____ Med. Record # _____

PATIENT CARE COORDINATION / SUMMARY CHECKLIST

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: _____

REFERRAL TO (if needed): _____ APPROXIMATE NEXT VISIT DATE: ____/____/____

RECERTIFICATION: ◯ Yes, complete **RECERTIFICATION ORDER**, as appropriate. ◯ No, complete discharge summary/OASIS Assessment PLAN FOR NEXT VISIT _____

Verbal Recertification Order, or Verbal Modify Order (other follow-up) obtained: ◯ No ◯ Yes, specify date____/____/____ (23)

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 _____

RECERTIFICATION WORKSHEET / NEEDS

What negative findings substantiate this Patient to be recertified? ☐ N/A

_____

_____

_____

CARE SUMMARY PROVIDED DURING THIS EPISODE including progress toward goals to date, rehabilitation to potential, and understanding disease management:

_____

_____

_____

_____

_____

_____

Summary of the Services that need to be continued (State frequency in next page): ☐ N/A

- ☐ SN Comment: _____
- ☐ PT Comment: _____
- ☐ OT Comment: _____
- ☐ ST Comment: _____
- ☐ MSW Comment: _____
- ☐ Aide Comment: _____

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.**

SN - ORDERS - FREQUENCY/DURATION: _____

☐ SKILLED OBSERVATION/EVALUATION ASSESS VITAL SINGS & S/S COMPLICATIONS: _____

General ☐ INSTRUCT/EVALUATE UNDERSTANDING OF DISEASE PROCESS ☐ DETECTING COMPLICATIONS ☐ DIET/NUTRITIONAL STATUS ☐ SAFETY PRECAUTION/EMERGENCY MEASURES, MED-REGIMEN

Angina ☐ ASSESS FOR CHEST PAIN: TYPE, LOCATION, INTENSITY, DURATION & FREQUENCY ☐ I/S PAIN MANAGEMENT ☐ NOTIFY M.D. IF PAIN PERSISTS. I/S GRADUAL PROGRESS ACTIVITY INCREASE ☐ INST. DISCONTINUE ACTIVITY IF CHEST PAIN, DYSPNEA, FATIGUE OR PALPITATIONS OCCUR.

Foley Care ☐ FOLEY INSERTION _____FR. FOLEY WITH_____cc BALLON ☐ INST. S/S INFECTION ☐ CHANGE Q MONTH & PRN x3 FOR CLOGGED, LEAKING, OR ACCIDENTAL REMOVAL ☐ INST. DRESSING CHANGES _____. MONITOR FOR S/S COMPLICATIONS & NOTIFY M.D.

Wound Care ☐ MONITOR STATUS OF WOUND OR DECUBITUS (place) _____

Decubitus ☐ INST. INFECTION CONTROL MEASURES

☐ INST. GOOD NUTRITION TO FACILITATE HEALING ☐ REPORT ANY ELEVATIONS IN TEMPERATURE TO THE M.D.

☐ MEASURE AND RECORD WOUND or DECUBITUS SIZE AT SOC AND AT LEAST WEEKLY THEREAFTER

☐ OPEN WOUND CARE/DRESSING: CLEANSE WOUND WITH _____, TO RINSE WITH _____ AND APPLY_____ AND PRN

☐ DECUBITUS CARE/DRESSING: CLEANSE WOUND WITH _____, TO RINSE WITH _____ AND APPLY_____ AND PRN

☐ OBSERVE AND RECORD TYPE AND AMOUNT OF DRAINAGE, COLOR, INFECTION: SWELLING, REDNESS, PAIN

Asthma / Respiratory ☐ TEACH THE PATIENT HOW TO USE A METERED-DOSE INHALER ☐ MAINTAIN EFFECTIVE AIRWAY CLEARANCE ☐ INST. DISEASE PROCESS & MAINTENANCE ☐ PROMOTE AN EFFICIENT BREATHING PATTER ☐ IMPROVE THE PT'S ABILITY TO PREVENT OR COPE WITH BREATHING DIFFICULTIES. ☐ INST. INFECTION CONTROL & PULMONARY HYGIENE ☐ INST. COMPLICATIONS IN CARDIOPULMONARY STATUS ☐ INST. PREVENTION OF COMPLICATIONS: IE: AVOID OVER-EXERTION, CHILLING, CROWDS, ETC. ☐ INSTRUCT COUGHING, DEEP BREATHING EXERCISES. ☐ INST. PATIENT TO MAINTAIN ADEQUATE REST PATTERN. ☐ INST. PACED ACTIVITY PROGRAM. ☐ EMPHASIZE THE IMPORTANCE OF ADEQUATE DAILY FLUID INTAKE

Oxygen ☐ INSTRUCT PROPER ADMINISTRATION OF OXYGEN THERAPY. INSTRUCT OXYGEN PRECAUTIONS. INSTRUCT MAINTENANCE OXYGEN EQUIPMENT.

CHF ☐ OBSERVE FOR S/S OF DECOMPENSATION SUCH AS INCREASING TACHYCARDIA, W/SUDDEN ONSET, SOB ON MIN. EXERTION, ORTHOPNEA, EXTREME ANXIETY, PROGRESSIVE CYANOSIS, GENERALIZED PALLOR AND DIAPHORESIS.

General ☐ MANAGEMENT AND EVALUATION OF A PATIENT CARE PLAN ☐ **TEACHING AND TRAINING:** DISEASE PROCESS ☐ SKIN CARE, WOUND CARE/DRESSING CHANGE, DECUBITUS CARE ☐ MEDICATION REGIMEN ☐ DIET/NUTRITION/HYDRATION ☐ COMPLICATIONS OF ENT. FEEDING AS INDICATED ☐ PAIN CONTROL MEASURES, SYMPTOM CONTROL MEASURES ☐ SINGS/SYMPTOMS OF INFECTION, ☐ SAFETY/PREVENTION OF INJURY ☐ EMERGENCY PLANS ☐ OXYGEN ADMINISTRATION

Insulin Glucometer ☐ INSTRUCT IN PREPARATION & ADMINISTRATION OF INSULIN ☐ INSTRUCT ONSET, PEAK & DURATION OF ACTION OF INSULIN ☐ INSTRUCT PROPER DISPOSAL OF SYRINGES/NEEDLES ☐ NURSE TO MONITOR BLOOD SUGAR WITH GLUCOMETER OR _____ON _____FREQUENCY, & NOTIFY M.D. OF ALTERED RESULTS ☐ TEACH GLUCOMETER OR _____ PROCEDURE & INTERPRETING RESULTS

Diabetes Mellitus ☐ INST. DISEASE PROCESS & COMMON COMPLICATIONS ☐ INST. PRESCRIBED DIET & SHOPPING ADVICE. INST. S/S HYPO/HYPERGLYCEMIA & EMERGENCY PROCEDURES ☐ INST. GOOD SKIN CARE & GOOD FOOT CARE, DAILY CARE OF TEETH. INST. DIABETIC CHART. INST. S&A TESTING & READING RESULTS ☐ INSTRUCT TO CARRY I.D. THAT INCLUDES INFORMATION REGARDING DIABETIC STATUS, NAMES & DOSAGE OF MEDS & ACTION TO TAKE IF INSULIN REACTION OCCURS ☐ INST. IMPORTANCE OF GOOD PERSONAL HEALTH HABITS, INCLUDING EXERCISE, ADEQUATE REST, SLEEP, REGULAR MED CHECK-UPS (INCLUDING PODIATRIC, OPTHAMOLOGIST & DENTIST).

Anemia ☐ INST. FOR S/S: EASY FATIGABILITY, DYSPNEA, PALPITATIONS, ANGINA TACHYCARDIA, PALLOR, DIZZINESS, JAUNDICE AND FEVER. ☐ INST. FOR G.I. DISTURBANCES. ASSESS FOR CENTRAL NERVOUS SYSTEM SYMPTOMATOLOGY ☐ OBTAIN APPROPRIATE LAB TESTS AND REPORT FINDINGS TO M.D. ☐ ADMINISTER PRESCRIBED INJECTABLE _____ USING _____ TECHNIQUE

Depression ☐ ASSESS PSYCHOLOGICAL STATUS ☐ PROVIDE SUPPORTIVE THERAPY, PROVIDE REMOTIVATION ☐ ASSESS INTERPERSONAL BEHAVIOR ☐ ASSIST PATIENT TO DEFINE PROBLEMS & SOCIAL RELATIONSHIPS. GIVE POSITIVE REINFORCEMENT ☐ ENCOURAGE PATIENT TO PERFORM PERSONAL HYGIENE & GROOMING ACTIVITIES ☐ ASSIST PATIENT TO EXPRESS REALISTIC IDEAS & PLANS. ASSIST PATIENT TO VERBALIZE FEELINGS.

Anxiety ☐ PROVIDE SUPPORTIVE AND RELAXATION THERAPY ☐ PROVIDE FAMILY THERAPY. ASSESS INTERPERSONAL BEHAVIOR ☐ ASSIST PATIENT TO DEFINE PROBLEMS & SOCIAL RELATIONSHIPS. GIVE POSITIVE REINFORCEMENT. ☐ ASSIST PATIENT TO VERBALIZE FEELINGS.

Alzheimer's ☐ PSYCHOLOGICAL ASSESSMENT ☐ ASSESS NEUROLOGICAL STATUS ☐ IMPLEMENT AND MONITOR BOWEL REGIMEN & TEACH PROGRAM TO FAMILY ☐ SN TO MONITOR TRANQUILIZER EFFECTS GIVEN FOR SEVERE AGITATION/ANXIETY. ☐ EVALUATE FOR WEIGHT LOSS, WEIGH PATIENT Q VISIT, AND RECORDS WEIGHTS ☐ MONITOR LEVEL OF CONSCIOUSNESS ☐ ASSESS COORDINATION AND BALANCE. PROVIDE EMOTIONAL SUPPORT TO PATIENT AND FAMILY ☐ OBSERVATION AND EVALUATION OF BLADDER ELIMINATION HABITS, MANAGEMENT IF INCONTINENCE. ☐ ASSIST FAMILY IN SETTING UP ROUTINE PATIENT-CENTERED AND STRESS THE IMPORTANCE OF ADHERING.

Psychiatric ☐ PSYCH ASSESSMENT: ASSESS FOR S/S OF EPS ☐ RELAXATION TECHNIQUES ☐ DETECT AND ALLEVIATE SOMATIZED COMPLAINTS ☐ GOAL ORIENTED TASKS ☐ LIMIT SETTING MOTIVATION TECHNIQUES, IMAGERY TECHNIQUES ☐ OTHER: _____

Hypertension ☐ INST. DISEASE PROCESS AND COMMON COMPLICATIONS ☐ INST. LOW SODIUM DIET - STRESSING IMPORTANCE OF ADHERENCE ☐ MONITOR PATIENT'S BLOOD PRESSURE CLOSELY AND NOTIFY M.D OF ANY SIGNIFICANT CHANGES. ☐ INSTRUCT PT. TO AVOID OVER-THE-COUNTER COLD AND SINUS MEDS AS THEY CONTAIN VASOCONSTRICTOR ☐ INST. OF HYPERTENSIVE CRISIS ☐ MONITOR FOR S/S OF ORTHOSTATIC HYPOTENSION.

Osteoarthritis ☐ INSTRUCT PATIENT IN CONSEQUENT PHYSICAL LIMITATIONS, PLANNING AN ADEQUATE LEVEL OF DAILY ACTIVITIES ☐ TEACH PT R/E ARTHRITIS S/S OF EXACERBATION. TEACH THE IMPORTANCE OF GOOD POSTURE, PREVENT TRAUMA TO JOINTS ☐ INST. PT IN THE USE OF ASSISTIVE DEVICE AS PRESCRIBED.

AIDE - ORDERS - FREQUENCY/DURATION: _____

☐ TUB/SHOWER BATH ☐ PERSONAL CARE ☐ HAIR COMB ☐ SHAMPOO PRN ☐ MOUTH/DENTURE CARE ☐ SKIN CHECK ☐ ORAL HYGIENE ☐ TPR
☐ ASSIST TO DRESS ☐ ASSIST WITH AMBULATION ☐ PREPARE SERVE MEALS ☐ GROCERY SHOP ☐ WASH CLOTHES ☐ LIGHT HOUSEKEEPING ☐ ASSIST WITH PERSONAL CARE AND ADL'S
☐ ERRANDS ☐ NOTIFY LAST BM IF NONE FOR 3 DAYS ☐ FEET/NAILS CARE ☐ PERI CARE ☐ REPORT SIGNIFICANT FINDING TO SN ☐ STRAIGHTEN ROOM & CHANGE LINEN

PT - ORDERS - FREQUENCY/DURATION: _____

☐ EVALUATE BALANCE AND COORDINATION ☐ EVALUATE ENDURANCE, MOBILITY ☐ NEUROMUSCULAR RE-EDUCATION,
☐ PERFORM PRESCRIBED THERAPEUTIC EXERCISES ☐ NOTIFY SIGNIFICANT FINDING TO MD/AGENCY ☐ BED MOBILITY TRAINING
☐ GAIT TRAINING WITH ASSISTIVE DEVICE ☐ TEACH HOME MAINTENANCE PROGRAM AND STRENGTHENING EXERCISE
☐ EXERCISE BOTH PASSIVE AND ACTIVE EXERCISE REGIMEN ☐ TRANSFER TRAINING ☐ INSTRUCT IN SAFETY MEASURES, FALL PRECAUTIONS

OT - ORDERS - FREQUENCY/DURATION: _____

☐ EVALUATE PATIENT AND HOME FOR SAFETY ☐ ADL TRAINING PROGRAM ☐ MUSCLE RE-EDUCATION, BODY IMAGE TRAINING
☐ INCREASE RIGHT AND LEFT UPPER EXTREMITIES STRENGTH ☐ THERAPEUTIC EXERCISE TO (R) AND (L) HAND
☐ INCREASE STRENGTH AND COORDINATION ☐ PROPRIOCEPTION AND SENSATION.

ST - ORDERS - FREQUENCY/DURATION: _____

☐ ST FOR EVALUATION ☐ TO PROVIDE ORAL MOTOR EXERCISES INVOLVING LINGUAL AND LABIAL EXERCISES ☐ SPEECH ARTICULATION DISORDER TREATMENT
☐ IMPROVE SPEECH ☐ FACIAL SYMMETRY AND MUSCULATION ☐ IMPROVE DYSPHAGIA ☐ VOICE DISORDER TREATMENT
☐ AURAL REHABILITATION ☐ NON-ORAL COMMUNICATION ☐ LANGUAGE DISORDER TREATMENT

MSW - ORDERS - FREQUENCY/DURATION: _____

☐ MSW FOR ASSESSMENT OF SOCIAL AND EMOTIONAL FACTORS ☐ COMMUNITY RESOURCE PLANNING
☐ COUNSELING REGARDING MANAGEMENT/ADJUSTMENT TO ILLNESS ☐ LONG RANGE PLANNING AND DECISION MAKING

Patient Name: _____ Med. Record #: _____

GOALS/REHABILITATION POTENTIAL CMS485 (POC)

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

SN - GOALS

☐ **General** MR/MS _____ WILL EXHIBIT VITAL SIGNS WITHIN ACCEPTABLE RANGE AND STABILIZED DISEASE PROCESS. VERBALIZES KNOWLEDGE OF DISEASE MANAGEMENT, MEDICATIONS, SIDE EFFECTS, PRECAUTIONS, DIET, FLUIDS, TREATMENT PROGRAM, S/S NECESSITATING MEDICAL ATTENTION, EMERGENCY CARE.

☐ **Psychiatric** STABILIZATION OF PSYCHOLOGICAL STATUS WITHIN DISEASE LIMITS. TO REDUCE THE PATIENT'S ANXIETY LEVEL. DEPRESION/ANXIETY CONTROLED TROUGH MED. REGIMEN/INTERVENTIONS.

☐ **Anemia** ANEMIA CONTROLLED THROUGH MED. REGIMEN. IMPROVED HEMATOLOGIC STATUS.

☐ **Wound Care** HEALED WOUND WITHOUT INFECTION OR COMPLICATIONS. DEMONSTRATE PROPER WOUND CARE.

Decubitus ☐ HEALED DECUBITUS WITHOUT INFECTION OR COMPLICATIONS. DEMONSTRATE PROPER DECUBITUS CARE.

☐ **Alzheimer's** PT/S.O. SHOULD UNDERSTAND THE NATURE, SYMPTOMS, STAGE, AND PROGRESSION OF ALZHEIMER'S DISEASE. KNOW HOW TO RECOGNIZE PT'S OWN STRESS AND WAYS TO PREVENT OR REDUCE IT. PROMOTE SOCIAL INTERACTION AS TOLERATED BY THE PATIENT.

☐ **Asthma** DEMONSTRATE STRATEGIES TO BE USED DURING A COUGHING EPISODE. HELP THE PATIENT IDENTIFY FACTORS THAT MAY CAUSE ASTHMA ATTACKS OR CONTRIBUTE TO THEM.

☐ **Respiratory** UNDERSTAND S/S OF BRONCHITIS OR OTHER RESPIRATORY INFECTION, AND DISEASE EXACERBATION. UNDERSTAND THE DANGERS OF SMOKING, AIR AND CHEMICAL POLLUTANTS, AND RESPIRATORY INFECTION. UNDERSTAND AND PRACTICE COUGHING AND DEEP-BREATHING EXERCISES.

☐ **Catheter** DAILY COMPLIANCE W/CATHETER CARE. DECREASE RISK OF URINARY INFECTION.

☐ **Insulin** SAFELY ADMINISTERS INJECTION. COMPREHEND RATIONALE FOR AND IS ABLE TO ROTATE INJECTION SITES. COMPREHEND SAFETY FACTORS IN SYRINGE/NEEDLE DISPOSAL.

Glucometer PATIENT/CG ABLE TO MONITOR BLOOD SUGAR CORRECTLY WITHOUT ASSISTANCE. ABLE TO NOTIFY M.D. OF ALTERED/OUT OF RANGE RESULTS.

☐ **Diabetes Mellitus** DISCHARGE PT WHEN BLOOD SUGARS ARE WITHIN THE NORMAL FOR PATIENT RANGE. KNOW THE ACCEPTABLE RANGE FOR BLOOD SUGAR LEVEL. COMPLY WITH DIET RESTRICTIONS..

☐ **Fracture** RETURN TO SELF-MANAGEMENT OF HEALED FRACTURED.

☐ **CHF** KNOW ABOUT SIGNS, SYMPTOMS, AND PRECIPITATING CAUSES OF CHF. KNOW HOW TO TAKE THE PULSE AND KNOW TO CONSULT THE DOCTOR BEFORE CONTINUING MEDICATION IF THE PULSE RHYTHM CHANGES. KNOW TO AVOID SMOKING AND SMOKY ENVIRONMENTS AND PERSONS WITH INFECTIONS, ESPECIALLY RESPIRATORY INFECTIONS.

☐ **Hypertension** UNDERSTAND THAT HYPERTENSION IS A CHRONIC DISEASE REQUIRING LIFE LONG TREATMENT. EXHIBIT BLOOD PRESSURE READINGS CONSISTENTLY WITHIN NORMAL OR SPECIFIED RANGE. DEMONSTRATE ADHERENCE TO A LOW-SALT, LOW-FAT DIET.

☐ **Angina** HELP THE PATIENT ACHIEVE PAIN RELIEVE AND REDUCE ANGINA EPISODES. UNDERSTAND THE CAUSE OF ANGINA PECTORIS AND POSSIBLE PRECIPITATING FACTORS FOR AN ATTACK. IDENTIFY PERSONAL STRESSORS THAT MAY CONTRIBUTE TO THE PROBLEM AND BEGIN ELIMINATING OR MINIMIZING THEM. KNOW WAYS TO REDUCE THE FREQUENCY OF ANGINA EPISODES.

☐ **Osteoarthritis** INCREASED PAIN RELIEF. INCREASED STRENGTH AND ENDURANCE. COMPREHEND AND DEMONSTRATE HOME EXERCISE.

AIDE - GOALS

☐ GOOD 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.

☐ 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.

PT - GOALS

☐ GAIT PATTERN, ENDURANCE, STRENGTH AND BALANCE WILL IMPROVE AND PATIENT WILL DEMONSTRATE CORRECT BODY MECHANICS W/IN 4-6 WKS. PT/CG WILL COMPREHEND AND DEMONSTRATE HOME EXERCISE PROGRAM WITHIN 4-6 WKS.

☐ GAIT PATTERN, ENDURANCE, STRENGTH AND BALANCE WILL IMPROVE AND PT WILL DEMONSTRATE CORRECT BODY MECHANICS WITHIN _____ WEEKS.

☐ PATIENT WILL EXPERIENCE A DECREASE IN PAIN

☐ PT/CG WILL COMPREHEND AND DEMONSTRATE HOME EXERCISE PROGRAM WITHIN _____ WEEKS.

OT - GOALS

☐ OT: PATIENT WILL EXHIBIT IMPROVEMENT IN COPING IN ADL'S/IADL'S/ MUSCLE USE/MOTOR COORDINATION/NEURO RESPONSE/USE OF ORTHOTIC/ SPLINTING AND/OR EQUIPMENT.

ST - GOALS

☐ PATIENT WILL DEMONSTRATE FUNCTIONAL COMMUNICATIONS, EXHIBIT MAXIMUM VERBAL AND SENTENCE FORMULATION AND COMPREHENSION WITHIN DISEASE LIMITS WITHIN ____ WEEKS.

☐ PATIENT WILL DEMONSTRATE APPROPRIATE USE OF FUNCTIONAL VERBAL/NON-VERBAL COMMUNICATIONS SYSTEMS WITHIN _____ WEEKS.

☐ PATIENT WILL DEMONSTRATE IMPROVED READING/WRITING, USE OF GESTURES/NUMBERS WITHIN ____ WEEKS.

☐ PATIENT WILL DEMONSTRATE IMPROVED SWALLOWING/CHEWING/ORAL/MOTOR CONTROL WITHIN ____ WEEKS.

MSW - GOALS

☐ PATIENT WILL HAVE ADEQUATE SUPPORT TO REMAIN IN HOME WITH ASSISTANCE OF COMMUNITY RESOURCES FOR FINANCIAL, TRANSPORTATION AND PERSONAL CARE ASSISTANCE WITHIN ____ WEEKS.

☐ PSYCHOSOCIAL EVALUATION WILL BE PERFORMED. PT/CG WILL BE COUNSELED REGARDING MANAGEMENT & ADJUSTMENT TO ILLNESS /LONG TERM PLANNING AND DECISION MAKING. APPROPRIATE COMMUNITY RESOURCE REFERRALS WILL BE MADE.

DISCHARGE PLANNING DISCUSSED WITH PATIENT: ◯ **Yes** ◯ **No**

☐ WILL DISCHARGE THE PATIENT WITHIN 60 DAYS 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.

REHAB POTENTIAL: ◯ **Poor** ◯ **Fair** ◯ **Good** ◯ **Excellent**

☐ 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.

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:**_____/_____/_____

RECERT/FOLLOW-UP