CARE SUMMARY INCLUDING OASIS ELEMENTS FOR

❍ TRANSFER TO INPATIENT FACILITY
❍ DEATH AT HOME ❑ No Visit Made

DATE:_____

(-) = Dash is a valid response.
See the OASIS Guidance Manual for specific item.

Follow OASIS items in sequence unless otherwise directed.

Section A Administrative Information

M0080. Discipline of Person Completing Assessment

Enter Code ☐

1. **RN**
2. **PT**
3. **SLP/ST**
4. **OT**

M0090. Date Assessment Completed

☐ Month/Day/Year

Complete M0090 using the date of the day information was last collected.

M0100. This Assessment is Currently Being Completed for the Following Reason

Enter Code ☐

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**

For DEATH AT HOME complete ONLY items:

M0080, M0090, M0100, M2005, M0906, J1800 and J1900.

Certifying Physician's Prognosis:

M0906. Discharge/Transfer/Death Date

Enter the date of the discharge, transfer, or death (at home) of the patient.

☐ Month/Day/Year

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)?

Enter Code ☐

0. **No** → *Skip to M2410, Inpatient Facility*
1. **Yes, used hospital emergency department WITHOUT hospital admission**
2. **Yes, used hospital emergency department WITH hospital admission**

UK **Unknown** → *Skip to M2410, Inpatient Facility*

M2310. Reason for Emergent Care

For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)?

↓ **Check all that apply**

☐	0.	**Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis**
☐	10.	**Hypo/Hyperglycemia, diabetes out of control**
☐	19.	**Other than above reasons**
☐	UK	**Reason unknown**

If answer is "19. Other than above reasons", specify:

M2410. To which **Inpatient Facility** has the patient been admitted?

Enter Code ☐

1. **Hospital**
2. **Rehabilitation facility**
3. **Nursing home**
4. **Hospice**

Reason for admission:

Name of facility:_____

Patient Name - Last, First, Middle Initial	ID #

Patient Name _____ ID # _____

Section A Administrative Information (Continued)

A2120. Provision of Current Reconciled Medication List to Subsequent Provider at Transfer
At the time of transfer to another provider, did your agency provide the patient's current reconciled medication list to the subsequent provider?

Enter Code ☐

0. **No – Current reconciled medication list not provided to the subsequent provider** → *Skip to J1800, Any Falls Since SOC/ROC*
1. **Yes – Current reconciled medication list provided to the subsequent provider** → Continue to A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider
2. **NA –** The agency was not made aware of this transfer timely → *Skip to J1800, Any Falls Since SOC/ROC*

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Route of Transmission	↓ Check all that apply ↓
A. **Electronic Health Record**	☐
B. **Health Information Exchange**	☐
C. **Verbal** (e.g., in-person, telephone, video conferencing)	☐
D. **Paper-based** (e.g., fax, copies, printouts)	☐
E. **Other Methods** (e.g., texting, email, CDs)	☐

Section J Health Conditions

J1800. Any Falls Since SOC/ROC, whichever is more recent (-)

Enter Code ☐

Has the patient **had any falls since SOC/ROC,** whichever is more recent?

0. **No** → *Skip to M2005, Medication Intervention*
1. **Yes** → Continue to J1900, Number of Falls Since SOC/ROC

J1900. Number of Falls Since SOC/ROC, whichever is more recent (-)

Coding:
0. **None**
1. **One**
2. **Two or more**

↓ Enter Codes in Boxes

☐	A. **No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
☐	B. **Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
☐	C. **Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Was transfer related to a fall with injury? ❍ No ❍ Yes If yes, document details of injury and circumstances surrounding injury:

Section N 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?

Enter Code ☐

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

Patient Name _____ ID # _____

Section O Special Treatment, Procedures, and Programs

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

Enter Code ☐

0. **No** → *Skip to M2401, Intervention Synopsis*
1. **Yes** → Continue to M1046, Influenza Vaccine Received

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

Enter Code ☐

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 (for example, physician, pharmacist)
4. **No;** patient offered and declined
5. **No;** patient assessed and determined to have medical contraindication(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

If answer is 8., if known, specify reason(s):

Section Q Participation in Assessment and Goal Setting

M2401. Intervention Synopsis
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? (Mark only one box in each row.)

Plan/Intervention	No	Yes	Not Applicable	
	↓ Check only one box in each row ↓			
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 AND 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.

Patient Name _____ ID # _____

PHYSICIAN TRANSFER/DEATH AT HOME SUMMARY

SUMMARY: Complete all applicable information in this section for Transfer

Admission Date:_____ Transfer Date:_____ Transfer was planned: ❍ Yes ❍ No

Reason for admission: _____

❍ N/A ❍ Reason for transfer (reference reason given on page 1):_____

❍ N/A ❍ Transferred to (facility name and address):

❑ HHA disciplines involved: ❑ SN ❑ PT ❑ OT ❑ ST ❑ MSW ❑ Aide ❑ Other:_____

All involved team members notified of transfer: ❑ SN ❑ PT ❑ OT ❑ ST ❑ MSW ❑ Aide ❑ Other:_____

❑ Appropriate physician(s) per agency policy ❑ Representative (if any) per agency policy/procedure

If not, explain:_____

❑ Additional documentation provided per agency policy/process, and/or requested by receiving provider:

❑ Copy of current plan of care

❍ Current drug profile ❍ N/A, patient was not taking any medications

❍ Copy of advance directives ❍ N/A, no advance directives

❑ Copy of transfer order

❑ Other:_____

COMPLETE FOR DEATH AT HOME ONLY

Date of death:_____ ❍ Observed by clinician ❍ Reported by:_____ Relationship to patient:_____

Person(s) present at time of death: ❍ Unknown ❍ Patient was alone

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

All involved team members were notified: ❑ SN ❑ PT ❑ OT ❑ ST ❑ MSW ❑ Aide ❑ All physicians involved in plan of care

❑ Other:_____

❍ Representative (if any) per agency policy/procedure ❍ N/A no representative ❍ N/A representative already aware

❍ If applicable, all hazardous waste pharmaceuticals were disposed of _____ per agency policy in compliance with EPA guidelines ❍ N/A patient had no hazardous waste pharmaceuticals

❍ List of drug profile provided with physician summary (per agency policy/process) ❍ N/A patient was not taking any medications

❍ **TRANSFER:** Give a brief description of the patient's care (e.g., education/training provided, care preferences, treatments, referrals, infections, wounds, unplanned ED visit or hospital admission, falls/injuries, assistive devices/equipment used etc.). Describe the patient's clinical, mental, psychosocial, cognitive, and functional status at SOC and at end of care. **(Always attach medication list.)**

❍ **DEATH AT HOME:** Summary of services provided. Explain how the agency became aware of the patient's expiration. If a visit was made, explain services provided (e.g., calling agency to cancel services). If home visit was not made, explain circumstances.

Copy of summary: ❑ **mailed** ❑ **emailed** ❑ **faxed** ❑ Facility Name:_____

To: ❑ Certifying Physician:_____ Date:_____

❑ Secondary Physician:_____ Date:_____

❑ Primary Care Provider Post-transfer/DAH:_____ Date:_____

❑ Representative (if any):_____ Date:_____

SIGNATURE/DATE

X _____ _____ _____

Person Completing This Form (signature/title) *Date* *Time*