SPEECH THERAPY RECERTIFICATION/ FOLLOW-UP ASSESSMENT

INCLUDING OASIS ELEMENTS WITH PLAN OF CARE INFORMATION

DATE:_____

TIME IN:_____ **TIME OUT:**_____

(-) = 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.

Type of Visit: ❍ Skilled ❍ Skilled & Supervisory ❍ Other:_____

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

Enter Code ☐

Follow-Up

4. **Recertification (follow-up) reassessment**
5. **Other follow-up**

If M0100. coded 5, explain reason:

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 in the patient's current sequence of adjacent Medicare home health payment episodes?

Enter Code ☐

1. **Early**
2. **Later**

UK **Unknown**

NA **Not Applicable:** No Medicare case mix group to be defined by this assessment.

PATIENT CONTACTS/CAREGIVERS

Document any changes in information since the last OASIS assessment. ❑ No change since last assessment.
Contact information confirmed this vist with: ❑ Patient ❑ Caregiver

Present during this visit: ❑ Family member(s) ❑ Representative
❑ Caregiver(s) ❑ Other:_____

Does the patient have a representative? ❍ No ❍ Yes
If yes, is the person: ❍ Court declared ❍ Patient selected
Representative Name:_____
Relationship: ❍ Family ❍ Friend ❍ Other:_____
Address:_____
City:_____ State:_____ ZIP Code:_____
Phone:_____
Email:_____

Primary caregiver(s) other than patient: ❑ N/A ❑ None available
Caregiver Name:_____
Relationship: ❍ Family ❍ Friend ❍ Other:_____
Address:_____
City:_____ State:_____ ZIP Code:_____
Phone:_____
Email:_____
Paid service other than home health staff: ❍ No ❍ Yes If yes,
Company name:_____
Phone number:_____
Contact name:_____

EMERGENCY PREPAREDNESS

★ ★ ★ **PRIORITY CODE** ★ ★ ★

_____

See page 2 for Advance Directives

Emergency Contact: ❍ Representative ❍ Caregiver ❍ Other, if "Other"
Emergency Contact Name:_____
Relationship: ❍ Family ❍ Friend ❍ Other:_____
Address:_____
City:_____ State:_____ ZIP Code:_____
Phone:_____
Email:_____

Caregiver Name:_____
Relationship: ❍ Family ❍ Friend ❍ Other:_____
Address:_____
City:_____ State:_____ ZIP Code:_____
Phone:_____
Email:_____
If the caregiver(s) are not available, is there anyone who could be contacted in a critical situation? ❍ No ❍ Yes
Name:_____
Phone number:_____

Patient Name - Last, First, Middle Initial	ID #

Patient Name _____ ID # _____

Section A Administrative Information (Continued)

SUPPORTIVE ASSISTANCE/CARE PREFERENCES SUMMARY

Document any changes in information since the last OASIS assessment. ❑ No change since last assessment.

Caregiver(s) assist with ADLs, IADLs and/or medical cares? ❍ No ❍ Yes If yes:_____

Type(s) of assistance provided: ❑ No assistance ❑ Meals ❑ ADLs ❑ Transportation ❑ Supervision/Support ❑ Medications ❑ Home Maintenance ❑ Other:_____

Caregiver(s) willing to assist? ❍ Yes ❍ No ❍ Unknown If no or unknown, explain:

Does the caregiver need training to assist the patient? ❍ Yes ❍ No ❍ Unknown If no or unknown, explain:

List below the hours and days a caregiver is available to provide cares. ❑ There is no set schedule for availability

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
AM HOURS							
PM HOURS							
NIGHTS							

ADVANCE DIRECTIVES

Does the patient have an Advance Directives order? ❍ No ❍ Yes ❑ No change since last assessment.

Since the last OASIS assessment, the patient: ❑ obtained ❑ changed the item(s) checked below:

❑ An order for Advance Directives
❑ Living Will
❑ Do Cardiopulmonary Resuscitation (CPR)
❑ Do Not Resuscitate Order (DNR)
❑ Do Not Intubate Order (DNI)
❑ No Artificial Nutrition and Hydration
❑ Medical/Durable Power of Attorney Name:_____ Phone #:_____
❑ Financial Power of Attorney Name:_____ Phone #:_____
❑ State specific form(s):_____
❑ Copies on file with: ❑ PCP ❑ Other:_____

Comments:

SENSORY STATUS

Patient wears: ❑ Glasses Contacts: ❑ R ❑ L Prosthesis: ❑ R ❑ L Hearing aid: ❑ R ❑ L Other:_____

Select all areas that are affected:

What is the patient's structural (sensory) impairment: ❑ Eyes ❑ Ears ❑ Nose ❑ Mouth ❑ Throat

What is the functional impairment: ❑ Sight ❑ Hearing ❑ Smell ❑ Taste ❑ Throat

What is the activity limitation (which ADL(s)/IADL(s) do they need help with to safely complete)?

How do the skills of a therapist address the specific structural and/or functional impairment(s) and activity limitation(s) cited in steps above?

Patient Name _____ ID # _____

SPEECH/LANGUAGE EVALUATION

WFL - Within Functional Limits MIN - Minimally Impaired MOD - Moderately Impaired S - Severely Impaired U - Untested/Unable to Test

	FUNCTION EVALUATED	SCORE	COMMENTS
COGNITION	Orientation (Person/Place/Time)		
	Attention span		
	Short-term memory		
	Long-term memory		
	Judgment		
	Problem solving		
	Organization		
	Other:		
SPEECH/VOICE	Oral/Facial exam		
	Articulation		
	Prosody		
	Voice/Respiration		
	Speech intelligibility		
	Other:		
SWALLOWING	Chewing ability		
	Oral stage management		
	Pharyngeal stage management		
	Reflex time		
	Other:		
NON-ORAL COMMUNICATION	Gestures		
	Signing		
	Communication boards/cards		
	Bell/Buzzer		

	FUNCTION EVALUATED	SCORE	COMMENTS
VERBAL EXPRESSION	Augmentative methods		
	Naming		
	Appropriate ❍ Yes ❍ No		
	Complex sentences		
	Conversation		
AUDITORY COMPREHENSION	Word discrimination		
	1 step directions		
	2 step directions		
	Complex directions		
	Conversation		
	Speech reading		
READING	Letters/Numbers		
	Words		
	Simple sentences		
	Complex sentences		
	Paragraph		
WRITING	Letters/Numbers		
	Words		
	Sentences		
	Spelling		
	Formulation		
	Simple addition/subtraction		
Assessment tools used:			

REFERRAL FOR: ❑ Vision ❑ Hearing ❑ Swallowing ❑ Dentures: ❑ upper ❑ lower ❑ partial ❑ Loss of smell

❑ Other (specify) _____

Comments:

PRAGMATICS

Turn taking ❍ Yes ❍ No Comments: _____

Facial expression ❍ Yes ❍ No Comments: _____

Initiate ❍ Yes ❍ No Comments: _____

Topic maintenance ❍ Yes ❍ No Comments: _____

Eye contact ❍ Yes ❍ No Comments: _____

Response to humor ❍ Yes ❍ No Comments: _____

History of Previous Speech/Language Therapy/Outcomes:

Prior Level of Communication:

Patient Name _____ ID # _____

SPEECH/LANGUAGE EVALUATION (Continued)

Home Communicative Environment:

Prior Level of Swallowing Function:

Safe Swallowing Evaluation? ❍ No ❍ Yes; specify date, facility and M.D.

_____

Video Fluoroscopy? ❍ No ❍ Yes; specify date, facility and M.D.

_____

ORAL MOTOR FUNCTION

a. Labial/lip strength/ROM: _____

b. Tongue strength/ROM: _____

c. Face strength/ROM: _____

d. Diadochokinetics: _____

e. Articulation: _____

f. Loudness: _____

g. Alaryngeal speech: _____

VOCAL QUALITY

a. Prosody: _____

b. Pitch: _____

c. Resonance: _____

MOTOR SPEECH PERFORMANCE/INTELLIGIBILITY

CLINICAL SUMMARY OF COMMUNICATIVE FUNCTION

a. Auditory comprehension/tests administered/results:

b. Verbal expression/tests administered/results:

c. Other:

d. Patient/caregiver's response to Communication Assessment/findings:

Patient Name _____ ID # _____

NEUROLOGICAL STATUS

❑ **No Problem**

❑ History of a traumatic brain injury Date of injury:_____ (Type):_____

❑ History of headaches Date of last headache:_____ (Type):_____

❑ History of seizures Date of last seizure:_____ (Type):_____

❑ Aphasic: ❑ Receptive ❑ Expressive

❑ Tremors: ❑ At Rest ❑ With voluntary movement ❑ Continuous

❑ Spasms (for example; back, bladder, legs) Location:_____

Dominant side: ❍ Right ❍ Left ❑ Hemiplegia: ❍ Right ❍ Left ❑ Paraplegia ❑ Quadriplegia/Tetraplegia

Does the patient's condition affect functional ability and/or safety? ❍ No ❍ Yes If yes, explain:

COGNITIVE STATUS

Patient's cognitive function:

❍ Alert/oriented to self, person, place and time

❍ Requires prompting when stressed or conditions unfamiliar

❍ Requires some assistance to stay focused when attention needs to shift between activities

❍ Requires considerable assistance to stay focused when attention needs to shift between activities

Patient is confused: ❍ Constantly ❍ Non-responsive ❍ Never
❍ On waking or at night only ❍ During the day and evening but not consistently

Patient is anxious: ❍ None of the time ❍ Less often than daily ❍ Daily, but not constantly ❍ All the time ❍ Non-responsive

Patient has: ❑ Memory deficit ❑ Impaired decision making ❑ Disruptive behaviors: ❑ verbal ❑ physical ❑ Delusional
❑ Paranoid behaviors ❑ None of these behaviors demonstrated

Is the patient receiving psychiatric nursing services at home? ❍ No ❍ Yes

Note: *If the patient needs further cognitive assessment consider the Confusion Assessment Method (CAM) tool, another cognitive assessment or making a referral.*

MENTAL STATUS

❑ **N/A - No mental/cognitive/behavioral issues noted**

Describe the patient's mental status. Description should include their general appearance, behaviors, emotional responses, mental functioning and their overall social interaction. Include both the clinical objective observations and subjective descriptions reported during this visit. Explain any inconsistencies:

Has there been a sudden/acute change in their mental status since the last comprehensive assessment? ❍ No ❍ Yes If yes, did the change coincide with something else? For example, a medication change, a fall, the loss of a loved one or a change in their living arrangements etc.
❍ No ❍ Yes If yes, explain:

Mental status changes reported by ❑ Patient ❑ Caregiver ❑ Representative ❑ Other:_____

Note: *CMS is looking for potential issues that may complicate or interfere with the delivery of the HHA services and the patient's ability to participate in his or her own care. Consider the Brief Interview for Mental Status (BIMS) for further assessment.*

PSYCHOSOCIAL

Is the patient able to communicate their needs? ❍ Yes ❍ No If no, explain:_____

What is the patient's primary way to communicate? For example, language, sign language, etc.:_____

If the patient has a communication barrier, what has the HHA done to improve communication? For example, use an interpreter, large print literature supplied, etc.

Patient Name _____ ID # _____

PSYCHOSOCIAL (Continued)

Was anyone else present during this visit to support the patient? ❍ No ❍ Yes If yes, give name and relationship to the client:

❑ Spiritual resource:_____ Phone:_____
❑ N/A ❑ No change since last visit

Feelings/emotions the patient reports: ❑ Angry ❑ Fear ❑ Sadness ❑ Discouraged ❑ Lonely ❑ Depressed ❑ Helpless
❑ Content ❑ Happy ❑ Hopeful ❑ Motivated ❑ Other:_____
❑ N/A - Nothing reported

Sleep: ❍ Adequate ❍ Inadequate Rest: ❍ Adequate ❍ Inadequate
Frequency of naps:_____ Number of hours slept per night:_____
Explain:_____

Inappropriate reactions/behaviors toward: ❑ Caregiver(s) ❑ Clinician(s) ❑ Representative ❑ Others:_____
❍ Reported ❍ Observed ❍ N/A
Describe:

Inability to cope with altered health status as evidenced by: ❑ Lack of motivation ❑ Inability to recognize problems
❑ Unrealistic expectations ❑ Denial of problems

Evidence of: ❑ Abuse ❑ Neglect ❑ Exploitation ❑ Verbal ❑ Emotional ❑ Physical ❑ Financial
❍ Potential ❍ Actual ❍ N/A MSW referral made: ❍ No ❍ Yes
Other intervention:

Does the patient's psychosocial condition affect functional ability and/or safety (i.e., patient reports they were robbed two months ago and now they can only sleep for brief periods)? ❍ No ❍ Yes If yes, explain:

Note: *CMS is looking for potential issues that may complicate or interfere with the delivery of the HHA services and the patient's ability to participate in his or her own care. A psychosocial evaluation includes the patient's mental health, social status, and functional capacity within the community by looking at issues surrounding both a patient's psychological and social condition (for example, education and marital history).*

CARE PREFERENCES/PATIENT'S PERSONAL GOALS

Did the ❑ Patient ❑ Representative ❑ Other:_____ communicate care preferences that involve the home health services provided? For example, preferred visit times or days, etc. ❍ No ❍ Yes If yes, list preferences:

Did the ❑ Patient ❑ Representative ❑ Other:_____ communicate any specific information about personal goal(s) the patient would like to achieve from this home health admission? ❍ Yes ❍ No

If no, the ❑ Patient ❑ Representative ❑ Other:_____
❑ Do not want a personal goal(s) ❑ Already have a goal(s) they are working on at this time
❑ Other:_____

If yes, the ❑ Patient ❑ Representative ❑ Other:_____ discussed/communicated about the goal(s) with the assessing clinician and:
❍ Agreed their personal goal(s) was realistic based on the patient's health status.
❍ Agreed their personal goal(s) needed to be modified based on the patient's health status.
❍ Agreed to and identified actions/interventions the patient is willing to safely implement, so the patient will be able to meet their goal(s) by the anticipated discharge date.

❑ The ❑ Patient ❑ Representative ❑ Other:_____ helped write a measurable goal(s), understandable to all stakeholders.

❑ The ❑ Patient ❑ Representative ❑ Other:_____ was informed, appeared to understand and agreed the personal goal(s) would be added to the patient's individualized plan of care and submitted to the physician responsible for reviewing and signing the plan of care.

Document what the patient reports/says about their progress towards their personal goal(s) (if applicable) and the HHA measurable goals since prior assessment:

Patient Name _____ ID # _____

STRENGTHS/LIMITATIONS

Based upon the patient's comprehensive assessment (physical, psychosocial, cognitive, mental status and functional status):

List the patient's strengths that contributed to the progress toward their goal(s), both personal and the HHA measurable goals since prior assessment. For example, involved family, interest in returning to prior activities, cheerful attitude, cooperative, etc.

***** It is recommended that you not use checkboxes and generalized terms and restating requirements would not be adequate without corroborating documentation.***

Describe the patient's structural impairment (physical or pathophysiological impairment, e.g., fracture, MI, blindness, etc.)

Describe the patient's functional impairment (e.g., dyspnea, pain, weakness, etc.)

Does the skill(s) of a therapist address the specific structural and/or functional impairments and activity limitations cited in this section?
❍ No ❍ Yes If yes, explain:

Has there been any significant changes in strength/limitations since the last visit? ❍ No ❍ Yes If yes, explain:

Note: *CMS is looking for potential issues that may complicate or interfere with the delivery of the HHA services and the patient's ability to participate in his or her own plan of care.*

SAFETY MEASURES

❑ Bleeding precautions	❑ O_2 precautions	❑ Seizure precautions	❑ Fall precautions	❑ Aspiration precautions
❑ Siderails up	❑ Elevate head of bed	❑ 24 hr. supervision	❑ Clear pathways	❑ Lock w/c with transfers
❑ Infection control measures	❑ Walker / ❑ Cane	❑ Other: _____		

Were there any changes with the emergency preparedness plan since the last assessment? ❍ No ❍ Yes If yes, explain:

Patient Name _____ ID # _____

Primary Diagnosis & Other Diagnoses

Documentation of diagnoses has been removed from the OASIS data at recertification.

If the patient diagnoses are the same from the last comprehensive assessment, SKIP THIS PAGE.

If there are changes in the diagnoses, or the order of the diagnoses, please document these changes below. These diagnoses must be captured accurately for billing purposes.

Primary Diagnosis (If changed from last assessment)

	V, W, X, Y codes NOT allowed
a. _____	a.

Other Diagnoses (If changed from last assessment)

	All ICD-10-CM codes allowed
b. _____	b.
c. _____	c.
d. _____	d.
e. _____	e.
f. _____	f.

Complete g through v per agency policy for all pertinent secondary diagnoses identified

g. _____	g.
h. _____	h.
i. _____	i.
j. _____	j.
k. _____	k.
l. _____	l.
m. _____	m.
n. _____	n.
o. _____	o.
p. _____	p.
q. _____	q.
r. _____	r.
s. _____	s.
t. _____	t.
u. _____	u.
v. _____	v.

Patient Name _____ ID # _____

Section G Functional Status

M1800. Grooming
Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).

Enter Code ☐

0. **Able to groom self unaided, with or without the use of assistive devices or adapted methods.**
1. **Grooming utensils must be placed within reach before able to complete grooming activities.**
2. **Someone must assist the patient to groom self.**
3. **Patient depends entirely upon someone else for grooming needs.**

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.

Enter Code ☐

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.

Enter Code ☐

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).

Enter Code ☐

0. **Able to bathe self in shower or tub independently, including getting in and out 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.

Enter Code ☐

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.**

M1850. Transferring
Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

Enter Code ☐

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.**

Patient Name _____ ID # _____

Section G Functional Status (Continued)

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.

Enter Code ☐

0. **Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).**
1. **With the use of a one-handed device (for example, 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 (for example, 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.**

Indications for Home Health Aides: ❍ **Yes** ❍ **No** ❍ **Refused** **Order obtained:** ❍ **Yes** ❍ **No**
Reason for need:

Indications for Occupational Therapy: ❍ **Yes** ❍ **No** ❍ **Refused** **Order obtained:** ❍ **Yes** ❍ **No**
Reason for need:

ACTIVITIES PERMITTED

❑ **No Restrictions** ❑ Complete bedrest ❑ Bathroom privileges ❑ Up as tolerated ❑ Transfer bed/chair ❑ Exercises prescribed
❑ Partial weight bearing ❑ Independent in home ❑ Crutches ❑ Cane ❑ Wheelchair ❑ Walker
❑ Other (specify):

❑ Other (specify):

FUNCTIONAL LIMITATIONS

❑ Amputation ❑ Paralysis ❑ Legally blind
❑ Bowel/Bladder (Incontinence) ❑ Endurance ❑ Dyspnea with minimal exertion
❑ Contracture ❑ Ambulation ❑ Other (specify):_____
❑ Hearing ❑ Speech ❑ Other (specify):_____

ADDITIONAL COMMENTS

Patient Name _____ ID # _____

Section GG Functional Abilities and Goals

NOTE: Code the GG tasks based on the amount of assistance needed by a helper to complete the task safely, based on the patient's innate ability and environment – NOT based on preferences or current caregiver circumstance.

Score 06-01 whenever it is possible for the task to be completed, even if the helper must complete the entire task, which would be coded as a "01". When a task can not be completed, even with the assistance of a helper, such as walking or steps, then utilize one of the "activity not attempted codes".

GG0130. Self-Care

Code the patient's usual performance at Follow-Up for each activity using the 6-point scale. If activity was not attempted at Follow-Up, code the reason.

Coding:

Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** – Patient completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

07. **Patient refused**
09. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

4. Follow-Up Performance	
Enter Codes in Boxes ↓	
☐	A. **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
☐	B. **Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from mouth, and manage denture soaking and rinsing with use of equipment.
☐	C. **Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

ADDITIONAL COMMENTS

Patient Name _____ ID # _____

Section GG Functional Abilities and Goals (Continued)

GG0170. Mobility

Code the patient's usual performance at Follow-Up for each activity using the 6-point scale. If activity was not attempted at Follow-Up, code the reason.

Coding:

Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** – Patient completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

07. **Patient refused**
09. **Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

4. Follow-Up Performance Enter Codes in Boxes ↓	
☐	A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐	B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐	C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with no back support.
☐	D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐	F. **Toilet transfer:** The ability to get on and off a toilet or commode.
☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If Follow-Up performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb).*
☐	J. **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐	L. **Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐	M. **1 step (curb):** The ability to go up and down a curb or up and down one step. *If Follow-Up performance is coded 07, 09, 10, or 88 → Skip to GG0170Q, Does patient use wheelchair and/or scooter?*
☐	N. **4 steps:** The ability to go up and down four steps with or without a rail.
☐	Q. **Does patient use wheelchair and/or scooter?** 0. **No** → *Skip to M1033, Risk for Hospitalization* 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐	R. **Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

Patient Name _____ ID # _____

MUSCULOSKELETAL

❑ **No Problem**

Current disorder(s) of musculoskeletal system (type) affecting functional activity or safety:

❑ Fracture (location):_____ ❑ Swollen, painful joints (specify):_____

Hand grips: ❍ equal ❍ unequal ❑ strong: ❑ R ❑ L ❑ weak: ❑ R ❑ L

❑ Atrophy:_____

❑ Amputation ❑ BK ❑ AK ❑ UE; ❑ R ❑ L (specify):_____

❑ Other (specify):_____

FALL RISK ASSESSMENT

Any falls reported since last OASIS assessment? ❍ No ❍ Yes (describe the fall and the severity of injuries, if applicable):

Have fall risk factors changed since prior assessment? ❍ No ❍ Yes (describe):

Complete the MAHC 10 and score as appropriate.

MAHC 10 - FALL RISK ASSESSMENT TOOL

REQUIRED CORE ELEMENTS – Assess one point for each core element "yes". *Information may be gathered from medical record, assessment and if applicable, the patient/caregiver. Beyond protocols listed below, scoring should be based on your clinical judgment.*	**POINTS**
Age 65+	
Diagnosis (3 or more co-existing) Includes only documented medical diagnosis.	
Prior history of falls within 3 months An unintentional change in position resulting in coming to rest on the ground or at a lower level.	
Incontinence Inability to make it to the bathroom or commode in timely manner. Includes frequency, urgency, and/or nocturia.	
Visual impairment Includes but not limited to, macular degeneration, diabetic retinopathies, visual field loss, age related changes, decline in visual acuity, accommodation, glare tolerance, depth perception, and night vision or not wearing prescribed glasses or having the correct prescription.	
Impaired functional mobility May include patients who need help with IADLs or ADLs or have gait or transfer problems, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination or improper use of assistive devices.	
Environmental hazards May include but not limited to, poor illumination, equipment tubing, inappropriate footwear, pets, hard to reach items, floor surfaces that are uneven or cluttered, or outdoor entry and exits.	
Poly Pharmacy (4 or more prescriptions – any type) All PRESCRIPTIONS including prescriptions for OTC meds. Drugs highly associated with fall risk include but not limited to, sedatives, anti-depressants, tranquilizers, narcotics, antihypertensives, cardiac meds, corticosteroids, anti-anxiety drugs, anticholinergic drugs, and hypoglycemic drugs.	
Pain affecting level of function Pain often affects an individual's desire or ability to move or pain can be a factor in depression or compliance with safety recommendations.	
Cognitive impairment Could include patients with dementia, Alzheimer's or stroke patients or patients who are confused, use poor judgment, have decreased comprehension, impulsivity, memory deficits. Consider patient's ability to adhere to the plan of care.	
A score of 4 or more is considered at risk for falling MAHC 10 reprinted with permission from ***Missouri Alliance for*** **HOME CARE** **TOTAL**	

Plan/Comments re: ADLs and fall risk:

Patient Name _____ ID # _____

URINARY ELIMINATION

❑ **No Problem**

(Check all applicable items) ❑ Observed ❑ Reported

❑ Urgency ❑ Frequency ❑ Burning ❑ Pain

❑ Hesitancy ❑ Increased urination at night ❑ Decreased urination

Color: ❍ Yellow/straw ❍ Amber ❍ Brown/gray ❍ Pink/red tinged

❍ Other:_____

Clarity: ❑ Clear ❑ Cloudy ❑ Sediment ❑ Mucous

Odor: ❍ No ❍ Yes

If the patient has incontinence, when does urinary incontinence occur?

❍ During the day only ❍ Timed-voiding defers incontinence

❍ During the day and night ❍ Occasional stress incontinence

❍ During the night only

❑ Incontinence products/other:

_____

URINARY CATHETER: ❑ **N/A**

❍ Indwelling ❍ Suprapubic

Ostomy care managed by: ❑ Patient ❑ Caregiver ❑ Family ❑ Nurse

BOWEL ELIMINATION

❑ **No Problem**

❑ Constipation ❑ Diarrhea ❑ Hemorrhoids

❑ Last BM:_____

Abdomen: ❑ **No Problem**

❑ Tenderness ❑ Pain ❑ Distention: ❍ Hard ❍ Soft

❑ Other:

Ostomy care managed by: ❑ Patient ❑ Caregiver ❑ Family ❑ Nurse

❑ Other:_____

❑ SN referral needed due to:

Does the elimination ❑ bowel and/or ❑ bladder disorder(s) interfere/impact the patient's functional ability and/or safety? ❍ No ❍ Yes

If yes, explain:

GENITALIA

❑ **No Problem** ❑ **Not Assessed**

❑ Other:_____

❑ SN referral needed due to:_____

ADDITIONAL COMMENTS

Patient Name _____ ID # _____

ENDOCRINE

❑ **No Problem**

❑ Diabetes: ❍ Type 1 ❍ Type 2 ❍ Other diabetes_____ Date of onset:_____ ❑ Diabetic diet
❑ Oral medication ❑ Injectable medication

Was there a change in the diabetic medication since the last OASIS assessment? ❍ No ❍ Yes

If yes, medication name, dose/frequency (specify):_____

Administered by: ❑ Patient ❑ Caregiver ❑ Nurse ❑ Family ❑ Other:_____

BS _____mg/dL Date:_____ Time:_____

❑ FBS ❑ Before meal ❑ After meal ❑ Random ❑ HS

❑ Blood sugar ranges:_____ Reported by: ❑ Patient ❑ Caregiver ❑ Family

Monitored by: ❑ Patient ❑ Caregiver ❑ Family ❑ Nurse ❑ Other:_____

Frequency of monitoring:_____ Competency with use of Glucometer:_____

Section J Health Conditions

M1033. Risk for Hospitalization

Which of the following signs or symptoms characterize this patient as at risk for hospitalization?

↓ Check all that apply		
☐	1.	**History of falls (2 or more falls – or any fall with an injury – in the past 12 months)**
☐	2.	**Unintentional weight loss of a total of 10 pounds or more in the past 12 months**
☐	3.	**Multiple hospitalizations (2 or more) in the past 6 months**
☐	4.	**Multiple emergency department visits (2 or more) in the past 6 months**
☐	5.	**Decline in mental, emotional, or behavioral status in the past 3 months**
☐	6.	**Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months**
☐	7.	**Currently taking 5 or more medications**
☐	8.	**Currently reports exhaustion**
☐	9.	**Other risk(s) not listed in 1-8**
☐	10.	**None of the above**

Note: see page 13 for fall risk factors.

RISK FACTORS/HOSPITAL ADMISSION/EMERGENCY ROOM

❑ **N/A THIS VISIT**

Risk factors identified and followed up on by: ❑ Discussion ❑ Education ❑ Training

Literature given to: ❑ Patient ❑ Representative ❑ Caregiver ❑ Family Member ❑ Other:_____

List identified risk factors the patient has related to an unplanned hospital admission or an emergency department visit (e.g., smoking, alcohol, unsteady gait, etc.).

Note: *Following a patient's hospital discharge, HHA are required by CMS to include an assessment of the patient's level of risk for hospital ED visits and hospital admission. Interventions are required in the patient's plan of care. When assessing the patient, pay particular attention to patients with CHF, AMI, COPD, CABG, pneumonia, diabetes or hip and knee replacements. Consider these factors co-morbidities, multiple medications, low health literacy level, history of falls, low socioeconomic level, dyspnea, safety, confusion, chronic wounds, depression, lives alone, support system, etc.*

Patient Name _____ ID # _____

PAIN

Is patient experiencing pain? ❍ No ❍ Yes ❍ Unable to communicate

Non-verbals demonstrated: ❑ Diaphoresis ❑ Grimacing ❑ Moaning ❑ Crying ❑ Guarding ❑ Irritability ❑ Anger ❑ Tense ❑ Restlessness ❑ Change in vital signs ❑ Other: _____

❑ Self-assessment ❑ Implications: _____

If applicable (with or without pain medication) what level of discomfort/pain did the patient report is tolerable?

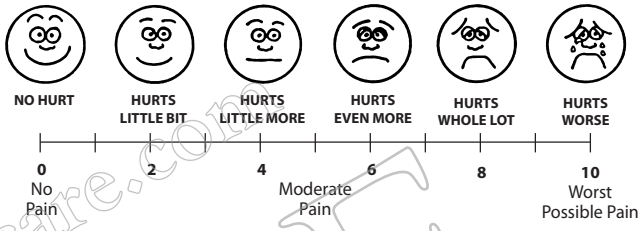
Score: _____ Assessment used: _____

Check box to indicate which pain assessment was used: ❍ **Wong-Baker** ❍ **PAINAD**

Pain Assessment	Site 1	Site 2	Site 3
Location			
Present level (0-10)			
Worst pain gets (0-10)			
Best pain gets (0-10)			
Pain description (aching, radiating, throbbing, etc.)			

Intensity: (using scales below)

Wong-Baker FACES® Pain Rating Scale**



Collected using: ❍ **FACES® Scale** ❍ **0-10 Scale (subjective reporting)**

**From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

Pain Assessment IN Advanced Dementia - PAINAD*

ITEMS	0	1	2	SCORE
Breathing Independent of Vocalization	Normal	Occasional labored breathing or short periods of hyperventilation	Noisy labored breathing, long period of hyperventilation or Cheyne-Stokes respirations	
Negative Vocalization	None	Occasional moan/groan or low level speech with a negative quality	Repeated troubled calling out, loud moaning/groaning/crying	
Facial Expression	Smiling or inexpressive	Sad/frightened/frown	Facial grimacing	
Body Language	Relaxed	Tense, distressed pacing/fidgeting	Rigid, fists clenched, knees pulled up; pulling/pushing away/striking out	
Consolability	No need to console	Distracted or reassured by voice/touch	Unable to console, distract or reassure	
****Total scores range from 0 to 10 (based on a scale of 0 to 2 for five items), with a higher score indicating more severe pain 0 = "no pain" to 10 = "severe pain").**			**TOTAL****	

Instructions: Observe the older person both at rest and during activity/with movement. For each of the items included in the PAINAD, select the score (0, 1, or 2) that reflects the current state of the person's behavior. Add the score for each item to achieve a total score. Monitor changes in the total score over time and in response to treatment to determine changes in pain. Higher scores suggest greater pain severity.

Note: Behavior observation scores should be considered in conjunction with knowledge of existing painful conditions and report from an individual knowledgeable of the person and their pain behaviors. Remember that some individuals may not demonstrate obvious pain behaviors or cues.

***Reference:** Warden, V, Hurley AC, Volicer, V. (2003). Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale. *J Am Med Dir Assoc*, 4:9-15. Developed at the New England Geriatric Research Education & Clinical Center, Bedford VAMC, MA.; Document updated 1.10.2013.

Which activities are affected: (Check all that apply)

❑ Functional cognition/focus ❑ Transfers ❑ Hygiene ❑ Ambulation ❑ Dressing: ❑ upper ❑ lower ❑ Undressing: ❑ upper ❑ lower

❑ Stairs: ❑ ascend ❑ descend ❑ Eating ❑ Toileting ❑ Appetite ❑ Positional changes ❑ Other: _____

Does the pain interfere/impact the patient's functional ability and/or safety? ❍ No ❍ Yes If yes, explain:

What makes pain worse? ❑ Movement ❑ Ambulation ❑ Immobility ❑ Other: _____

Is there a pattern to the pain? ❍ No ❍ Yes If yes, explain:

What makes pain better? ❑ Heat ❑ Ice ❑ Massage ❑ Repositioning ❑ Rest ❑ Relaxation ❑ Medication ❑ Diversion ❑ Other: _____

Patient Name _____ ID # _____

PAIN (Continued)

How often is breakthrough medication needed? ❍ Never ❍ Less than daily ❍ Daily ❍ 2-3 times/day ❍ More than 3 times/day

Does the pain radiate? ❍ No ❍ Occasionally ❍ Continuously ❍ Intermittent Current pain control medications adequate: ❍ No ❍ Yes

Comments:

CARDIOPULMONARY

❑ **No problem with heart/respiratory system**

Diagnosed disorder(s) of heart/respiratory system (type):

Breath Sounds: (e.g., clear, crackles/rales, wheezes/rhonchi, diminished, absent)

Anterior: Right_____ Left_____ Posterior: Right Upper_____ Left Upper_____

Right Lower_____ Left Lower_____

❑ Labored breathing

❍ Non-smoker Has patient ever smoked in the past? ❍ No ❍ Yes If yes, date last smoked:_____

❍ Smoker - frequency: ❍ Daily ❍ Occasional ❍ Very Occasional

If daily, (include all types of products that are smoked or vaporized) how often:_____

Respiratory Treatments utilized at home: ❑ Oxygen: ❍ intermittent ❍ continuous ❑ Ventilator: ❍ continuous ❍ at night

❑ Positive airway pressure: ❑ continuous ❑ bi-level O_2 @ _____LPM via ❑ cannula ❑ mask ❑ trach O_2 saturation _____%

Trach size/type_____ Who manages? ❑ Patient ❑ RN ❑ Caregiver ❑ Family

❑ **Cough:** ❍ No ❍ Yes: ❍ Productive ❍ Non-productive describe:_____

Positioning necessary for improved breathing: ❍ No ❍ Yes, describe:_____

Heart Sounds: ❍ Regular ❍ Irregular ❑ Pacemaker: Date:_____ Last date checked:_____

Color of nail beds:_____

Circulation	N/A	Non-Pitting	Pitting	Capillary Refill
Edema Pedal Right	❍	❍	❍ +1 ❍ +2 ❍ +3 ❍ +4	❍ <3 sec ❍ >3 sec
Edema Pedal Left	❍	❍	❍ +1 ❍ +2 ❍ +3 ❍ +4	❍ <3 sec ❍ >3 sec
	❍	❍	❍ +1 ❍ +2 ❍ +3 ❍ +4	❍ <3 sec ❍ >3 sec
	❍	❍	❍ +1 ❍ +2 ❍ +3 ❍ +4	❍ <3 sec ❍ >3 sec
	❍	❍	❍ +1 ❍ +2 ❍ +3 ❍ +4	❍ <3 sec ❍ >3 sec

❑ Extremity Cramp(s) (location):_____

❑ Pain at rest:_____

❑ Dependent:_____

Respiratory Status:

Is the patient Short of Breath (SOB)? ❍ No ❍ Yes If yes, ❍ **Assessed** ❍ **Reported**

If yes, explain how/when SOB happens (i.e., patient can't walk and talk at the same time in cold weather):

Does the patient's respiratory status affect their functional ability and/or safety (i.e., patient becomes dizzy when ascending stairs)? ❍ No ❍ Yes

If yes, explain:

ADDITIONAL COMMENTS

Patient Name _____ ID # _____

VITAL SIGNS

Temperature:_____ F ❍ Oral ❍ Temporal/Forehead ❍ Rectal ❍ Axillary ❍ Tympanic

Pulse: ❑ Apical_____ ❑ Brachial_____ ❍ Regular ❍ Irregular ❑ Radial_____ ❑ Carotid_____

Respirations:_____ ❍ Regular ❍ Irregular

❑ Apnea periods _____ sec. ❍ Observed ❍ Reported

Blood Pressure:	Left	Right	Sitting/Lying	Standing
At rest				
With activity				
Post activity				

HEIGHT AND WEIGHT

Height: _____ ❍ actual ❍ reported Weight: _____ ❍ actual ❍ not weighed, reason:_____

Weight Change: ❑ N/A ❍ Gain ❍ Loss _____ lb. X _____ ❍ week ❍ month ❍ year

NUTRITIONAL STATUS

❑ **No Problem**

❑ General ❑ NAS ❑ NPO ❑ Controlled Carbohydrate ❑ Renal ❑ Other:_____

Nutritional requirements (diet):_____ ❍ Increase fluids:_____amt. ❍ Restrict fluids:_____amt.

Appetite: ❍ Good ❍ Fair ❍ Poor

Food/Environmental Allergies: ❍ **N/A**

❍ Known allergy(ies):_____

Alcohol Use: ❍ No ❍ Yes If yes, frequency: ❍ Daily ❍ Occasional ❍ Very Occasional If daily, amount per day:_____

Nutritional Approaches: Check all that apply

- ❑ Parenteral/IV feeding
- ❑ Feeding tube - nasogastric of abdominal (e.g., PEG, NG)
- ❑ Mechanically altered diet - change of texture with solids or fluids (e.g., pureed or thickened

❑ **N/A**

Directions: Check each area with "yes" to assessment, then total score to determine additional risk.	**YES**
Has an illness or condition that changed the kind and/or amount of food eaten.	❑ 2
Eats fewer than 2 meals per day.	❑ 3
Eats few fruits, vegetables or milk products.	❑ 2
Has 3 or more drinks of beer, liquor or wine almost every day.	❑ 2
Has tooth or mouth problems that make it hard to eat.	❑ 2
Does not always have enough money to buy the food needed.	❑ 4
Eats alone most of the time.	❑ 1
Takes 3 or more different prescribed or over-the-counter drugs a day.	❑ 1
Without wanting to, has lost or gained 10 pounds in the last 6 months.	❑ 2
Not always physically able to shop, cook and/or feed self.	❑ 2
TOTAL	

INTERPRETATION OF ASSESSMENT

0-2 Good
As appropriate reassess and/or provide information based on situation.

3-5 Moderate risk
Educate, refer, monitor and reevaluate based on patient situation and organization policy.

6 or more High risk
Coordinate with physician, dietitian, social service professional or nurse about how to improve nutritional health. Reassess nutritional status and educate based on plan of care.

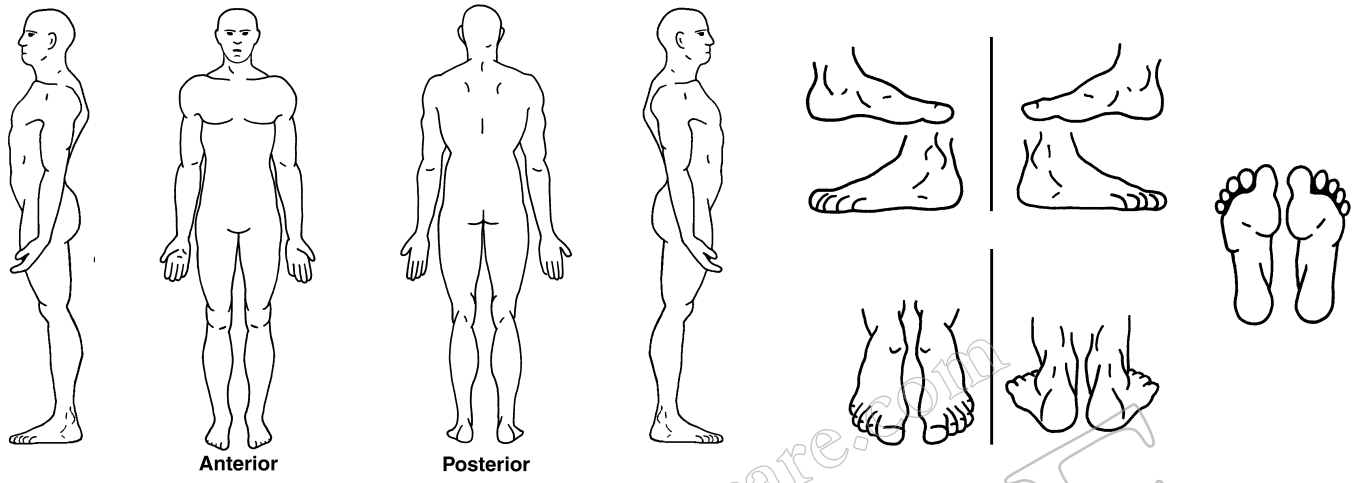
Describe at risk intervention: ❑ **N/A**

ADDITIONAL COMMENTS

Patient Name _____ ID # _____

Section M Skin Conditions

INTEGUMENTARY STATUS



DIABETIC FOOT EXAM: (Check all that apply) ❑ **N/A**

Frequency of diabetic foot exam: ❍ Daily ❍ Weekly ❍ Monthly ❍ Other:_____

Done by: ❑ Patient ❑ Caregiver (name)_____ ❑ Family ❑ RN ❑ PT ❑ Other:_____

Exam by clinician this visit: ❍ No ❍ Yes

Integument findings:

Pedal pulses: Present ❑ right ❑ left Absent ❑ right ❑ left Comment:_____

Loss of sense of: Warm ❑ right ❑ left Cold ❑ right ❑ left Comment:_____

Numbness ❑ right ❑ left Tingling ❑ right ❑ left Burning ❑ right ❑ left Leg hair: Present ❑ right ❑ left Absent ❑ right ❑ left

Comments:

Does the patient's integumentary status affect the patient's functional ability and/or safety (i.e., patient has a high risk for skin tears that could result in secondary wound infection) ❍ No ❍ Yes If yes, explain:

Does the patient appear to be at risk for acquiring any type of integumentary problem(s) based on the clinical factors (e.g., immobility, incontinence, skin thinning, impaired sensory, poor nutrition, skin disorder, poor circulation, etc.)? ❍ No ❍ Yes If yes, explain:

M1306. Does this patient have at least one **Unhealed Pressure Ulcer/Injury at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure injuries and all healed pressure ulcers/injuries)

Enter Code ☐

0. **No**
1. **Yes**

ADDITIONAL COMMENTS

Patient Name ______________________________ ID # ______________

Section M Skin Conditions (Continued)

INTEGUMENTARY STATUS (Continued)

WOUND/LESION ASSESSMENT

WOUND/LESION **Date Originally Reported ➤**	**#1** ________	**#2** ________	**#3** ________	**#4** ________	**#5** ________
Location					
Type *Include depth of infected surgical wound(s) in **Size** category below ➤	❍ Arterial ❍ Diabetic foot ulcer ❍ Malignancy ❍ Mechanical/Trauma ❍ Pressure ulcer ❍ Surgical* ❍ Dialysis access ❍ Venous stasis ulcer ❍ IV ❍ Other: ________	❍ Arterial ❍ Diabetic foot ulcer ❍ Malignancy ❍ Mechanical/Trauma ❍ Pressure ulcer ❍ Surgical* ❍ Dialysis access ❍ Venous stasis ulcer ❍ IV ❍ Other: ________	❍ Arterial ❍ Diabetic foot ulcer ❍ Malignancy ❍ Mechanical/Trauma ❍ Pressure ulcer ❍ Surgical* ❍ Dialysis access ❍ Venous stasis ulcer ❍ IV ❍ Other: ________	❍ Arterial ❍ Diabetic foot ulcer ❍ Malignancy ❍ Mechanical/Trauma ❍ Pressure ulcer ❍ Surgical* ❍ Dialysis access ❍ Venous stasis ulcer ❍ IV ❍ Other: ________	❍ Arterial ❍ Diabetic foot ulcer ❍ Malignancy ❍ Mechanical/Trauma ❍ Pressure ulcer ❍ Surgical* ❍ Dialysis access ❍ Venous stasis ulcer ❍ IV ❍ Other: ________
Size (cm) (LxWxD)					
Tunneling/Sinus Tract	length ______cm @ ______o'clock	length ______cm @ ______o'clock	length ______cm @ ______o'clock	length ______cm @ ______o'clock	length ______cm @ ______o'clock
Undermining (cm)	______cm, from ______ to ______ o'clock	______cm, from ______ to ______ o'clock	______cm, from ______ to ______ o'clock	______cm, from ______ to ______ o'clock	______cm, from ______ to ______ o'clock
Stage **(pressure ulcers only)**	Stage: ______ ❍ Unstageable ❍ Unobservable ❍ DTI	Stage: ______ ❍ Unstageable ❍ Unobservable ❍ DTI	Stage: ______ ❍ Unstageable ❍ Unobservable ❍ DTI	Stage: ______ ❍ Unstageable ❍ Unobservable ❍ DTI	Stage: ______ ❍ Unstageable ❍ Unobservable ❍ DTI
Severity of Ulcer (exclude pressure ulcers)	❑ Skin only ❑ Fatty tissue ❑ Muscle ❑ Bone ❑ Muscle necrosis ❑ Bone necrosis ❑ Other:________	❑ Skin only ❑ Fatty tissue ❑ Muscle ❑ Bone ❑ Muscle necrosis ❑ Bone necrosis ❑ Other:________	❑ Skin only ❑ Fatty tissue ❑ Muscle ❑ Bone ❑ Muscle necrosis ❑ Bone necrosis ❑ Other:________	❑ Skin only ❑ Fatty tissue ❑ Muscle ❑ Bone ❑ Muscle necrosis ❑ Bone necrosis ❑ Other:________	❑ Skin only ❑ Fatty tissue ❑ Muscle ❑ Bone ❑ Muscle necrosis ❑ Bone necrosis ❑ Other:________
Odor	❍ No ❍ Yes	❍ No ❍ Yes	❍ No ❍ Yes	❍ No ❍ Yes	❍ No ❍ Yes
Surrounding Skin	❑ Erythema ❑ Induration ❑ Maceration ❑ Normal ❑ Other:________	❑ Erythema ❑ Induration ❑ Maceration ❑ Normal ❑ Other:________	❑ Erythema ❑ Induration ❑ Maceration ❑ Normal ❑ Other:________	❑ Erythema ❑ Induration ❑ Maceration ❑ Normal ❑ Other:________	❑ Erythema ❑ Induration ❑ Maceration ❑ Normal ❑ Other:________
Edema					
Appearance of the Wound Bed	❑ Slough ________% ❑ Eschar ________% ❑ Granulation ________%	❑ Slough ________% ❑ Eschar ________% ❑ Granulation ________%	❑ Slough ________% ❑ Eschar ________% ❑ Granulation ________%	❑ Slough ________% ❑ Eschar ________% ❑ Granulation ________%	❑ Slough ________% ❑ Eschar ________% ❑ Granulation ________%
Drainage/Amount	❍ None ❍ Small ❍ Moderate ❍ Large	❍ None ❍ Small ❍ Moderate ❍ Large	❍ None ❍ Small ❍ Moderate ❍ Large	❍ None ❍ Small ❍ Moderate ❍ Large	❍ None ❍ Small ❍ Moderate ❍ Large
Color	❍ Clear ❍ Tan ❍ Serosanguineous ❍ Other	❍ 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	❍ Thin ❍ Thick
Incision Status	❍ Well Approximated ❍ Incisional separation ❍ Planned secondary Intention	❍ Well Approximated ❍ Incisional separation ❍ Planned secondary Intention	❍ Well Approximated ❍ Incisional separation ❍ Planned secondary Intention	❍ Well Approximated ❍ Incisional separation ❍ Planned secondary Intention	❍ Well Approximated ❍ Incisional separation ❍ Planned secondary Intention
Dialysis Access	❍ PD ❍ AV Graft ❍ AV Fistula Site:________	❍ PD ❍ AV Graft ❍ AV Fistula Site:________	❍ PD ❍ AV Graft ❍ AV Fistula Site:________	❍ PD ❍ AV Graft ❍ AV Fistula Site:________	❍ PD ❍ AV Graft ❍ AV Fistula Site:________
IV	❍ Peripheral ❍ PICC ❍ Central:________ # of lumens________	❍ Peripheral ❍ PICC ❍ Central:________ # of lumens________	❍ Peripheral ❍ PICC ❍ Central:________ # of lumens________	❍ Peripheral ❍ PICC ❍ Central:________ # of lumens________	❍ Peripheral ❍ PICC ❍ Central:________ # of lumens________
Date Healed					

Comments:

Patient Name _____ ID # _____

MEDICATIONS

❑ Drug Regimen Review completed. Date:_____ ❍ No change ❍ Order obtained

Check if any of the following were identified: ❑ Potential adverse effects ❑ Drug reactions ❑ Ineffective drug therapy ❑ Significant side effects ❑ Significant drug interactions ❑ Duplicate drug therapy ❑ Non-compliance with drug therapy ❑ High-risk drugs

Comments:

Financial ability to pay for medications: ❍ Yes ❍ No ❑ No change since last assessment

If no, was MSW referral made? ❍ Yes ❍ No/comment:

Medication Allergies: ❑ No known medication allergies ❑ Aspirin ❑ Penicillin ❑ Sulfa ❑ Other(s):

Does the patient have an IV? ❍ No ❍ Yes If yes, type(s):_____ | _____

If yes, number of site(s):_____ Site location(s)_____ | _____

Managed by: ❑ Patient ❑ Caregiver ❑ Nurse ❑ Family ❑ Other:_____

Does the patient require any assistance with any medication(s)? ❍ No ❍ Yes If yes, who helps and what do they do:

❑ SN referral needed due to:

IMMUNIZATIONS

Within the past 12 months:

❑ Influenza (specifically this year's flu season) ❍ No ❍ Yes

According to immunization guidelines:

❑ Pneumonia ❑ Tetanus ❑ Shingles ❑ Hepatitis C ❑ Other:_____

Needs:_____

Last COVID-19 Vaccination:

❑ Initial vaccine series ❑ Booster: ❍ 1st ❍ 2nd ❍ 3rd ❍ 4th ❍ 5th

Medical restrictions or personal preferences impacting immunizations:

_____

REFUSED CARES

Did the ❑ Patient ❑ Representative ❑ Other:_____ refuse ❑ Care(s) ❑ Service(s) since the last assessment? ❍ No ❍ Yes If yes, explain:

Are the ❑ Care(s) ❑ Service(s) they refused a significant part of the recommended plan of care? ❍ No ❍ Yes If yes, explain how:

Patient Name _____ ID # _____

PATIENT/CAREGIVER/REPRESENTATIVE/FAMILY EDUCATION AND TRAINING FOR CARE PLANNING

Check all that apply. Because several people may be involved with education and training, document details of the outcome(s) and person(s) involved per agency policy.

	Knowledge Deficit Identified	Individuals to be Instructed
Diabetic: ❑ Foot exam ❑ Care	❍ Yes ❍ No ❍ N/A	❑ Patient ❑ Caregiver ❑ Representative ❑ Family
Pain management:	❍ Yes ❍ No ❍ N/A	❑ Patient ❑ Caregiver ❑ Representative ❑ Family
Oxygen use:	❍ Yes ❍ No ❍ N/A	❑ Patient ❑ Caregiver ❑ Representative ❑ Family
Use of medical devices:	❍ Yes ❍ No ❍ N/A	❑ Patient ❑ Caregiver ❑ Representative ❑ Family
Pressure reduction:	❍ Yes ❍ No ❍ N/A	❑ Patient ❑ Caregiver ❑ Representative ❑ Family

Other care(s):

Teach back method used to: ❑ Educate ❑ Train ❑ Patient ❑ Caregiver ❑ Representative ❑ Family

❑ Patient ❑ Caregiver ❑ Representative ❑ Family educated this visit specifically for: _____

❑ Patient ❑ Caregiver ❑ Representative ❑ Family made aware that ❑ education ❑ training will continue during follow-up visits as needed.

Does the ❑ Patient ❑ Caregiver ❑ Representative ❑ Family have an action plan when disease symptoms exacerbate (e.g., when to call the homecare agency vs. emergency services)?: ❍ Yes ❍ No

After completing this section document the education and training outcome(s), per agency policy. Go to page 24 under Rehabilitation Potential/Anticipated Discharge for Plan of Care to document status of patient's anticipated discharge.

30-DAY FUNCTIONAL ASSESSMENT

Date of last speech therapy evaluation: _____

Functional task: _____ Prior functional status for the indicated task: _____

Evidence-based test used: _____ Results: _____

Current functional status for the indicated task: _____

Evidence-based test used: _____ Results: _____

Functional task: _____ Prior functional status for the indicated task: _____

Evidence-based test used: _____ Results: _____

Current functional status for the indicated task: _____

Evidence-based test used: _____ Results: _____

How have the provided interventions improved the patient's condition and/or quality of life?

Based on the reassessment, the following is recommended:

❍ Continue therapy services, patient is progressing at a normal pace

❍ Discussed lack of progress with physician, agreed to continue therapy services and change plan of care to try to effect change by performing _____.

❍ Discontinue therapy services per ❑ patient request ❑ physician request

PROFESSIONAL SERVICES WORKSHEET

Utilize this section to assist with completion of Plan of Care

ST - FREQUENCY/DURATION:

_____

❑ Evaluation and Treatment
❑ Pulse Oximetry PRN
❑ Home Safety/Falls Prevention
❑ Therapeutic Exercise
❑ Communication Training
❑ Cognitive Training
❑ Oral/Speech Management
❑ Establish/Upgrade Home Exercise Program

❑ Modality (specify frequency, duration, amount)

_____

❑ Prosthetic Training
❑ Muscle Re-Education
❑ Other: _____
❑ Other: _____
❑ Occupational Therapy to evaluate and treat
❑ Physical Therapy to evaluate and treat
❑ Nursing to evaluate and treat
❑ Medical Social Services to evaluate and treat

HOME HEALTH AIDE - FREQUENCY/DURATION:

_____

❑ Personal Care for ADL Assistance
❑ Other (specific task for HHA):

HOMEMAKER - FREQUENCY/DURATION:

_____

Patient Name _____ ID # _____

SKILLED INTERVENTIONS/INSTRUCTIONS DONE THIS VISIT (Check all applicable)

SPEECH THERAPY INTERVENTIONS/INSTRUCTIONS - Fill Out Per Organizational Policy

Treatment/Skilled Intervention Performed

❑ Education of HEP

❑ Education of Voice Disorder (specify):_____

❑ Education of Dysphagia (specify):_____

❑ Education of Expression (specify):_____

❑ Education of Cognition (specify):_____

❑ Education of Safety Precautions (specify):_____

❑ Education of proper positioning to avoid pressure ulcers/injuries (specify):

_____

Additional information (explain):

SUPERVISORY VISIT: ❍ Yes ❍ No

SUPERVISORY VISIT: ❍ Scheduled ❍ Unscheduled **STAFF:** ❍ Present ❍ Not present ❑ **AIDE** ❑ **LPN/LVN**

CARE PLAN UPDATED: ❍ No ❍ Yes **NEXT SCHEDULED SUPERVISORY VISIT:**_____

CARE PLAN FOLLOWED: ❍ Yes ❍ No, explain:

_____

IS ❑ **PATIENT** ❑ **FAMILY** ❍ **REPRESENTATIVE SATISFIED WITH CARE?** ❍ Yes ❍ No, explain:

OBSERVATION OF:

EDUCATION/TRAINING OF:

RECERTIFICATION SUMMARY

CONFINED TO HOME (homebound): ❍ No ❍ Yes, and the patient either

1. Criteria One: because of illness or injury, (must choose at least one):

❑ Dependent upon adaptive device(s)

Check all that apply: ❑ crutches ❑ canes ❑ walker ❑ wheelchair: ❑ manual ❑ motorized ❑ prosthetic limb

❑ scooter ❑ a helper ❑ other:_____

❑ Needs special transportation as indicated by:_____

❑ Needs physical assist to leave as indicated by:_____

AND/OR

❑ Leaving home is medically contraindicated due to:_____

2. Criteria Two:

❑ There exists a normal inability to leave the home as indicated by infrequent outings, consisting of:

AND

❑ Leaving home requires a considerable and taxing effort due to functional impairment caused by diagnosis, as indicated by effort such as:

_____

Patient Name _____ ID # _____

RECERTIFICATION SUMMARY (Continued)

SUMMARY OF SETBACKS/IMPROVEMENTS SINCE LAST ASSESSMENT

Patient continues to be involved with decision-making towards personal goals. The following is noted:

Improvements noted with the desired functional taks: ❑ **N/A**

Patient continues to have difficulty/no gains made with the desired functional taks: ❑ **N/A**

Continued nursing care needed in order to (expresses new goals, continue with/modify present goals, etc.): ❑ **N/A**

REHABILITATION/POTENTIAL GOALS WORKSHEET

Check goal(s) and insert information. Check box to indicate short or long term goal(s).

❑ Patient/CG will perform HEP with _____ (Independent, min assist, CGA/VC's, demo, cues) for _____ (e.g. correct technique to avoid substitution, self pacing and breathing strategies) to facilitate progressive increase of LEs strength in order to be able to _____ by _____. ❍ Short ❍ Long

❑ Patient will locate ____ visual/environmental cues to improve orientation to (location) _____ and memory skills with _____% accuracy in order to _____ by _____. ❍ Short ❍ Long

❑ Patient will independently utilize specific compensatory strategies and demonstrate compliance with HEP in at least _____% of opportunities in order to maximize orientation and memory skills to facilitate maintenance of functional gains by _____. ❍ Short ❍ Long

❑ Patient will be able to effectively communicate pain by means of _____ within _____ of _____ trials by _____. ❍ Short ❍ Long

❑ Patient will improve ability to demonstrate use of compensations with short-term memory skills with _____% accuracy to allow patient to increase safety within environment during tasks of _____ by _____. ❍ Short ❍ Long

❑ Patient will improve ability to functionally express wants and needs related to daily living with _____% accuracy to allow patient to increase functional communication such as _____ by _____. ❍ Short ❍ Long

❑ Patient will improve ability to solve complex problems with _____% accuracy to allow patient to increase safety within environment as demonstrated by _____ by _____. ❍ Short ❍ Long

❑ Patient will score _____ on _____ (MMSE, RIPA-G, MOCA, etc.) to enable the patient to _____ by _____. ❍ Short ❍ Long

❑ Other:_____ by _____. ❍ Short ❍ Long

❑ Other:_____ by _____. ❍ Short ❍ Long

ADDITIONAL COMMENTS

Patient Name _____ ID # _____

SUMMARY CHECKLIST

CARE PLAN:
❍ Reviewed ❍ Revised with involvement from: ❑ Patient ❑ Representative ❑ Caregiver ❑ **Outcome achieved**

MEDICATION STATUS: ❑ Medication regimen completed/reviewed ❑ No change ❑ Order obtained
Therapy only case: List of medications submitted to HHA RN for drug regimen review? ❍ No ❍ Yes
If yes, name of RN who reviewed medications and contacted physician, if indicated:_____
Check if any of the following were identified - see page 21:
❑ Potential adverse effects ❑ Drug reactions ❑ Ineffective drug therapy ❑ Significant side effects
❑ Significant drug interactions ❑ Duplicate drug therapy ❑ Non-compliance with drug therapy ❑ High-risk drugs
Comments:

CARE COORDINATION:
❑ Certifying Physician ❑ SN ❑ PT ❑ OT ❑ SLP ❑ MSW ❑ Aide ❑ Other (specify):_____
Was a referral made to MSW for assistance with:
❑ Community resources ❑ Living will ❑ Counseling needs ❑ Unsafe environment
❑ Other:_____
Date:_____ ❍ Yes ❍ No ❍ Refused ❍ N/A
Comments:

REFERRAL TO:_____

REASON FOR REFERRAL:

APPROXIMATE NEXT VISIT DATE:_____

PLAN FOR NEXT VISIT:_____

RECERTIFICATION: ❍ No, complete Discharge Summary ❍ Yes, complete remaining sections, as appropriate
Document the reason(s)/medical necessity that supports the continuation of services:

Note: *Medical necessity is always based on the patient's condition. Identify the skilled service and the reason this skilled service is necessary in objective terms. For example, "Wound care completed per POC to diabetic ulceration left foot. No s/s of infection, but patient remains at risk due to diabetic status." Or "Range of motion (ROM) as tolerated to lower extremities. Unsafe to teach caregiver ROM due to the patient's displaced fracture."*

Verbal Order Obtained: ❍ No ❍ Yes, specify date:_____

REHABILITATION POTENTIAL FOR ANTICIPATED DISCHARGE PLANNING

❑ Return to an independent level of care (self-care)

❑ Able to remain in residence with assistance of: ❑ Primary Caregiver ❑ Support from community agencies

❑ Restorative Potential, based on clinical objective assessment and evidence-based knowledge the patient's condition is likely to undergo functional improvement and benefit from rehabilitative care

❑ Maintenace program, patient requires a **speech therapist** to establish/perform maintenance program for patient safety at home

❑ Discussed discharge plan with: ❑ Patient ❑ Representative ❑ Other:_____

List any changes since last assessment:

Anticipated discharge status:

Patient Name _____ ID # _____

CURRENT DME/MEDICAL SUPPLIES/HCBS

DME Company:_____ Phone:_____

Oxygen Company:_____ Phone:_____

❑ Community Organizations ❑ Services:

Contact:_____ Phone:_____

Comments:

❑ **NONE USED**

SUPPLIES/EQUIPMENT:

❑ Augmentative and alternative communication device(s) (type)

❑ Bath bench

❑ Brace ❑ Orthotics (specify):

❑ Cane

❑ Commode

❑ Dressing Aid Kit/Hip Kit (e.g. reacher, long handle sponge, long handle shoe horn, etc.)

❑ Eggcrate

❑ Enteral feeding pump

SUPPLIES/EQUIPMENT (Cont'd):

❑ Grab bars: Bathroom/Other

❑ Handheld shower

❑ Hospital bed: ❑ Semi-electric

❑ Hoyer lift

❑ Knee scooter

❑ Medical alert

❑ Pressure relieving device

❑ Prosthesis: ❑ RUE ❑ RLE ❑ LUE ❑ LLE ❑ Other

SUPPLIES/EQUIPMENT (Cont'd):

❑ Raised toilet seat

❑ Reacher

❑ Special mattress overlay

❑ TENS unit

❑ Transfer equipment: ❑ Board ❑ Lift

❑ Ventilator

❑ Walker

❑ Wheelchair

❑ Other Supplies Needed:

PHYSICIAN VERBAL ORDER (Complete if applicable per agency policy)

❑ Physician (name)_____ called to report comprehensive assessment findings (including medical, nursing, rehabilitative, social and discharge planning needs).

❑ Verbal order received for home health (reasonable and necessary) skilled services. See Plan of Care or Verbal Orders.

X _____ _____ _____

Signature/Title of Person Who Received Verbal Order *Date* *Time*

X _____ _____ _____

Physician Signature for Verbal Order or see Plan of Care/Verbal Orders *Date* *Time*

SIGNATURES/DATES

X _____ _____ _____

Patient/Family Member/Caregiver/Representative (if applicable) *Date* *Time*

X _____ _____ _____

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

_____ _____

Agency Name *Phone Number*