COMPREHENSIVE ADULT NURSING ASSESSMENT
INCLUDING SOC/ROC OASIS ELEMENTS WITH PLAN OF CARE INFORMATION

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

Follow OASIS items in sequence unless otherwise directed.

REASON FOR ASSESSMENT: ❍ **Start of Care** ❍ **Resumption of Care**

DATE:_____

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

This Patient Tracking Information must be filled out at start of care and per organizational policy. It is to be maintained as part of the clinical record.

Section A Administrative Information

M0018. National Provider Identifier (NPI) for the attending physician who has signed the plan of care

☐ UK – Unknown or Not Available

Physician/NPP Name:_____ (First) ____ (MI)

_____ (Last) _____ (Suffix)

Physician/NPP Address: (Street/Suite No.)

_____

City:_____ State:_____ ZIP Code:_____

Physician/NPP Phone:_____

Physician/NPP Fax:_____

Physician/NPP Email:_____

M0010. CMS Certification Number

M0014. Branch State

M0016. Branch ID Number

M0020. Patient ID Number

Medical Record Number if different from Patient ID Number:_____

M0030. Start of Care Date

Month/Day/Year

M0032. Resumption of Care Date

Month/Day/Year ☐ NA – Not Applicable

M0040. Patient Name

(First) (MI) (Last) (Suffix)

M0050. Patient State of Residence

M0060. Patient ZIP Code

–

EMERGENCY PREPAREDNESS

★ ★ ★ **PRIORITY CODE** ★ ★ ★

See page 3 for Emergency Contact, Representative and Advance Directives information.

M0064. Social Security Number

☐ UK – Unknown or Not Available

Patient Name - Last, First, Middle Initial	ID #

Patient Name _____ ID # _____

Section A Administrative Information (Continued)

M0063. Medicare Number

☐ NA – No Medicare ☐ Claim #:_____

M0065. Medicaid Number

☐ NA – No Medicaid ☐ Claim #:_____

M0069. Gender

Enter Code ☐

1. **Male**
2. **Female**

M0066. Birth Date

☐ Month/Day/Year

Answer M0069 based on how the patient self-identifies.
If the patient **does not self-identify**, referral information (including hospital or physician office clinical data), or observation and physical assessment may be used. Based on the resources mentioned above, enter a response for patient's gender.
If the patient **does self-identify** but response given is not Male or Female, patient self-identifies as:_____.
Note: M0069 will still need to be coded, based on the assessment sources listed above.

A1005. Ethnicity

Are you of Hispanic, Latino/a, or Spanish origin?

↓ Check all that apply

- ☐ A. **No, not of Hispanic, Latino/a, or Spanish origin**
- ☐ B. **Yes, Mexican, Mexican American, Chicano/a**
- ☐ C. **Yes, Puerto Rican**
- ☐ D. **Yes, Cuban**
- ☐ E. **Yes, another Hispanic, Latino, or Spanish origin**
- ☐ X. **Patient unable to respond**
- ☐ Y. **Patient declines to respond**

A1010. Race

What is your race?

↓ Check all that apply

- ☐ A. **White**
- ☐ B. **Black or African American**
- ☐ C. **American Indian or Alaska Native**
- ☐ D. **Asian Indian**
- ☐ E. **Chinese**
- ☐ F. **Filipino**
- ☐ G. **Japanese**
- ☐ H. **Korean**
- ☐ I. **Vietnamese**
- ☐ J. **Other Asian**
- ☐ K. **Native Hawaiian**
- ☐ L. **Guamanian or Charmorro**
- ☐ M. **Samoan**
- ☐ N. **Other Pacific Islander**
- ☐ X. **Patient unable to respond**
- ☐ Y. **Patient declines to respond**
- ☐ Z. **None of the above**

M0150. Current Payment Source for Home Care

↓ Check all that apply

- ☐ 0. **None;** no charge for current services
- ☐ 1. **Medicare** (traditional fee-for-service)
- ☐ 2. **Medicare** (HMO/managed care/Advantage plan)
- ☐ 3. **Medicaid** (traditional fee-for-service)
- ☐ 4. **Medicaid** (HMO/managed care)
- ☐ 5. **Workers' compensation**
- ☐ 6. **Title programs** (for example, Title III, V, XX)
- ☐ 7. **Other government** (for example, TriCare, VA)
- ☐ 8. **Private insurance**
- ☐ 9. **Private HMO/managed care**
- ☐ 10. **Self-pay**
- ☐ 11. **Other** (specify)
- ☐ UK **Unknown**

If **Current Payment Source** is coded 11, specify:

ADDITIONAL COMMENTS

End of Patient Tracking Information

Patient Name _____ ID # _____

Section A Administrative Information (Continued)

PATIENT CONTACTS/CAREGIVERS

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

❑ **ROC Assessment:** ❑ **Contact information confirmed with** ❑ **Patient** ❑ _____ ❍ **Changes documented** ❍ **No changes**

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 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:_____

SUPPORTIVE ASSISTANCE

Prior to this admission, how often did the patient receive assistance with their ADLs/IADLs, from any caregiver(s)? ❍ None received ❍ At least daily ❍ One to two times per week ❍ Three or more times per week ❍ Less often than weekly ❍ Unknown

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 a Living Will? ❍ No ❍ Yes

❑ Discussed and literature provided during this visit to the: ❑ Patient ❑ Family member ❑ Representative ❑ Caregiver

Does the patient have an order for the following Advance Directives? ❍ No ❍ Yes If yes, check all that apply:

❑ No Cardiopulmonary Resuscitation (CPR) ❑ Do Not Resuscitate (DNR)

❑ Do Not Intubate (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:_____

Patient Name _____ ID # _____

Section A Administrative Information (Continued)

A1110. Language

Enter Code ☐

A. **What is your preferred language?**

B. **Do you need or want an interpreter to communicate with a doctor or health care staff?**
0. **No**
1. **Yes**
9. **Unable to determine**

LANGUAGE BARRIER(S)

❑ **No Problem**
❑ Needs interpreter
❑ Sign language (type): _____
❑ Aphasic: ❑ Receptive ❑ Expressive

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 ☐

Start/Resumption of Care
1. **Start of care –** further visits planned
3. **Resumption of care** (after inpatient stay)

When ROC, review patient tracking information and complete M0032.

M0102. Date of Physician-ordered Start of Care (Resumption of Care)

If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.

☐ Month/Day/Year → *Skip to M0110, Episode Timing, if date entered*

☐ NA – No specific SOC/ROC date ordered by physician

If SOC/ROC was not initiated on ordered SOC/ROC date, explain circumstances:

M0104. Date of Referral

Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

☐ Month/Day/Year

If SOC/ROC was not initiated within 2 days of the referral date/discharge date, explain circumstances:

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.

A1250. Transportation *(NACHC©)*

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

↓ **Check all that apply**

☐ A. **Yes, it has kept me from medical appointments or from getting my medications**
☐ B. **Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need**
☐ C. **No**
☐ X. **Patient unable to respond**
☐ Y. **Patient declines to respond**

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Patient Name _____ ID # _____

Section A Administrative Information (Continued)

PATIENT HISTORY

PRIMARY REASON FOR HOME HEALTH ADMISSION: (review Face-to-Face)

PERTINENT HISTORY AND/OR PREVIOUS OUTCOMES:

❑ Hypertension ❑ Hypotension ❑ Cardiac ❑ Respiratory ❑ Osteoporosis ❑ Fractures ❑ Cancer (site:_____)
❑ Infection ❑ Immunosuppressed ❑ Open Wound etiology:_____
❑ Falls without injury ❑ Falls with injury ❑ Hospitalizations ❑ ER Visits ❑ Recent Surgeries
Pertinent details:

❑ Surgery ❑ Procedure(s) expected in future: ❍ No ❍ Yes If yes, explain:

VITAL SIGNS:

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

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

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

Pulse Oximetry: at rest _____% after activity _____%
(specify activity):_____

Respirations:_____ ❍ Regular ❍ Irregular ❑ Apnea periods _____ sec. ❍ Observed ❍ Reported

IMMUNIZATIONS: Within the past 12 months: ❑ Influenza (specifically this year's flu season)
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:

M1000. From which of the following **Inpatient Facilities** was the patient discharged within the past 14 days?

↓ **Check all that apply**

☐	1.	**Long-term nursing facility (NF)**
☐	2.	**Skilled nursing facility (SNF/TCU)**
☐	3.	**Short-stay acute hospital (IPPS)**
☐	4.	**Long-term care hospital (LTCH)**
☐	5.	**Inpatient rehabilitation hospital or unit (IRF)**
☐	6.	**Psychiatric hospital or unit**
☐	7.	**Other (specify)**
☐	NA	**Patient was not discharged from an inpatient facility** → *Skip to B0200, Hearing at SOC, Skip to B1300, Health Literacy at ROC*

Name of inpatient facility(ies):_____

M1005. Inpatient Discharge Date (most recent)

☐ Month/Day/Year ☐ UK – Unknown or Not Available

❑ **No inpatient admission. Note: Observation stays are NOT an inpatient stay.**

Patient Name _____ ID # _____

Section B Hearing, Speech, and Vision

B0200. Hearing

Enter Code ☐

Ability to hear (with hearing aid or hearing appliances if normally used)

0. **Adequate** – no difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty** – difficulty in some environments (e.g., when person speaks softly, or setting is noisy)
2. **Moderate difficulty** – speaker has to increase volume and speak distinctly
3. **Highly impaired** – absence of useful hearing

EARS: ❑ **No Problem** ❑ HOH: ❑ R ❑ L ❑ Deaf: ❑ R ❑ L ❑ Hearing aid: ❑ R ❑ L ❑ Vertigo ❑ Tinnitus: ❑ R ❑ L
❑ Cochlear Transplant ❑ Other (specify):_____

Does the hearing impairment interfere/impact their function/safety? ❍ No ❍ Yes If yes, explain:

B1000. Vision

Enter Code ☐

Ability to see in adequate light (with glasses or other visual appliances)

0. **Adequate** – sees fine detail, such as regular print in newspapers/books
1. **Impaired** – sees large print, but not regular print in newspapers/books
2. **Moderately impaired** – limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired** – object identification in question, but eyes appear to follow objects
4. **Severely impaired** – no vision or sees only light, colors or shapes; eyes do not appear to follow objects

EYES: ❑ **No Problem** ❑ PERRLA ❑ Pupils unequal ❑ Glasses ❑ Contacts: ❑ R ❑ L ❑ Glaucoma: ❑ R ❑ L ❑ Cataract(s): ❑ R ❑ L
❑ Scleral icterus/yellowing ❑ Blurred vision: ❑ R ❑ L ❑ Diminished peripheral vision: ❑ R ❑ L ❑ Prosthesis: ❑ R ❑ L
❑ Blind: ❑ R ❑ L ❑ Other:_____ ❑ Infections:_____
❑ Cataract surgery: (Right) Date:_____ (Left) Date:_____
Does the impaired vision interfere/impact their function/safety? ❍ No ❍ Yes If yes, explain:

NOSE: ❑ **No Problem** ❑ Congestion ❑ Epistaxis ❑ Loss of smell ❑ Sinus problem ❑ Other (specify):_____
THROAT: ❑ **No Problem** ❑ Difficulty swallowing ❑ Hoarseness ❑ Lesion(s) ❑ Sore throat
❑ Other (specify):_____
MOUTH: ❑ **No Problem** ❑ Mass(es) ❑ Tumor(s) ❑ Gingivitis ❑ Ulceration(s) ❑ Toothache ❑ Lesion(s) ❑ No Dentation
❑ Dentures: ❑ Upper ❑ Lower ❑ Partial ❑ Other (specify):_____

B1300. Health Literacy *(From Creative Commons©)*

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Enter Code ☐

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Patient declines to respond**
8. **Patient unable to respond**

LEARNING BARRIER(S):

❑ **No Problem**
❑ Mental Health Disability ❑ Psychosocial
❑ Physical ❑ Functional Cognition
❑ Unable to:
❑ Read ❑ Write

Educational level:_____

See page 4 for Language Barrier(s)

COMMUNICATION

Understanding of verbal content in patient's own language (with hearing aid or device):

❍ Understands: clear comprehension without cues or repetitions ❍ Usually Understands: Requires cues at times
❍ Sometimes Understands: Frequently requires cues to understand ❍ Rarely/Never Understands ❍ Unable to assess understanding

Speech and oral (verbal) expression of language (in patient's own language):

❍ Expresses complex ideas, feelings, and needs clearly
❍ Minimal to moderate difficulty in expressing needs. May speak in phrases or short sentences. Needs minimal or moderate prompting
❍ Unable to express basic needs. Speech nonsensical or unintelligible
❍ Patient nonresponsive or unable to speak

Patient's current ability to use the telephone safely:

❍ Able to dial (make call)
❍ Able to answer phone
❍ Must use adaptive phone to complete activity
❍ Needs helper to complete activity
❍ Helper must make call for patient
❍ Patient does not have a phone

Patient Name _____ ID # _____

Section C Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?

Attempt to conduct interview with all patients.

Enter Code

0. **No** (patient is rarely/never understood) → *Skip to C1310, Signs and Symptoms of Delirium (from CAM©)*
1. **Yes** → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code

Ask patient: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed****. Now tell me the three words."*

Number of words repeated after first attempt

0. **None**
1. **One**
2. **Two**
3. **Three**

After the patient's first attempt, repeat the words using cues *("sock, something to wear; blue, a color; bed, a piece of furniture").* You may repeat the words up to two more times.

C0300. Temporal Orientation (Orientation to year, month, and day)

Enter Code

Ask patient: *"Please tell me what year it is right now."*

A. **Able to report correct year**
   0. **Missed by > 5 years** or no answer
   1. **Missed by 2-5 years**
   2. **Missed by 1 year**
   3. **Correct**

Enter Code

Ask patient: *"What month are we in right now?"*

B. **Able to report correct month**
   0. **Missed by > 1 month** or no answer
   1. **Missed by 6 days to 1 month**
   2. **Accurate within 5 days**

Enter Code

Ask patient: *"What day of the week is today?"*

C. **Able to report correct day of the week**
   0. **Incorrect** or no answer
   1. **Correct**

C0400. Recall

Enter Code

Ask patient: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

A. **Able to recall "sock"**
   0. **No** – could not recall
   1. **Yes, after cueing** ("something to wear")
   2. **Yes, no cue required**

Enter Code

B. **Able to recall "blue"**
   0. **No** – could not recall
   1. **Yes, after cueing** ("a color")
   2. **Yes, no cue required**

Enter Code

C. **Able to recall "bed"**
   0. **No** – could not recall
   1. **Yes, after cueing** ("a piece of furniture")
   2. **Yes, no cue required**

C0500. BIMS Summary Score

Enter Score

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the patient was unable to complete the interview

Patient Name _____ ID # _____

Section C Cognitive Patterns (Continued)

C1310. Signs and Symptoms of Delirium (from CAM©)

Code **after completing** Brief Interview for Mental Status and reviewing medical record.

A. **Acute Onset of Mental Status Change**

Enter Code ☐

Is there evidence of an acute change in mental status from the patient's baseline?

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

Coding:

0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

↓ Enter Codes in Boxes

☐ B. **Inattention** – Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?

☐ C. **Disorganized thinking** – Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

☐ D. **Altered level of consciousness** – Did the patient have altered level of consciousness, as indicated by any of the following criteria?

- **vigilant** – startled easily to any sound or touch
- **lethargic** – repeatedly dozed off when being asked questions, but responded to voice or touch
- **stuporous** – very difficult to arouse and keep aroused for the interview
- **comatose** – could not be aroused

Adapted from: Inouye SK, et al. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment Method. Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.

M1700. Cognitive Functioning

Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

Enter Code ☐

0. **Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.**
1. **Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.**
2. **Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.**
3. **Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.**
4. **Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium**

M1710. When Confused

(Reported or Observed Within the Last 14 Days):

Enter Code ☐

0. **Never**
1. **In new or complex situations only**
2. **On awakening or at night only**
3. **During the day and evening, but not constantly**
4. **Constantly**

NA **Patient nonresponsive**

M1720. When Anxious

(Reported or Observed Within the Last 14 Days):

Enter Code ☐

0. **None of the time**
1. **Less often than daily**
2. **Daily, but not constantly**
3. **All of the time**

NA **Patient nonresponsive**

NEUROLOGICAL STATUS

❑ **No Problem**

Diagnosed disorder(s) of neurological system (type):

❑ 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):_____

❑ 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:

Patient Name _____ ID # _____

Section D Mood

D0150. Patient Mood Interview (PHQ-2 to 9)

Say to patient: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the patient: "About how often have you been bothered by this?"
Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

	1. Symptom Presence 0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) 9. **No response** (leave column 2 blank)	2. Symptom Frequency 0. **Never or 1 day** 1. **2-6 days** (several days) 2. **7-11 days** (half or more of the days) 3. **12-14 days** (nearly every day)	1. Symptom Presence	2. Symptom Frequency
			↓ Enter Scores In ↓ Boxes	
A.	***Little interest or pleasure in doing things***		☐	☐
B.	***Feeling down, depressed, or hopeless***		☐	☐
	If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.			
C.	***Trouble falling or staying asleep, or sleeping too much***		☐	☐
D.	***Feeling tired or having little energy***		☐	☐
E.	***Poor appetite or overeating***		☐	☐
F.	***Feeling bad about yourself – or that you are a failure or have let yourself or your family down***		☐	☐
G.	***Trouble concentrating on things, such as reading the newspaper or watching television***		☐	☐
H.	***Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual***		☐	☐
I.	***Thoughts that you would be better off dead, or of hurting yourself in some way***		☐	☐

D0160. Total Severity Score

Enter Score ☐

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)

D0700. Social Isolation

How often do you feel lonely or isolated from those around you?

Enter Code ☐

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Patient declines to respond**
8. **Patient unable to respond**

Section E Behavior

M1740. Cognitive, Behavioral, and Psychiatric Symptoms that are demonstrated at least once a week (Reported or Observed):

↓ **Check all that apply**

☐	1.	**Memory deficit:** failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
☐	2.	**Impaired decision-making:** failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
☐	3.	**Verbal disruption:** yelling, threatening, excessive profanity, sexual references, etc.
☐	4.	**Physical aggression:** aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
☐	5.	**Disruptive, infantile, or socially inappropriate behavior** (excludes verbal actions)
☐	6.	**Delusional, hallucinatory, or paranoid behavior**
☐	7.	**None of the above behaviors demonstrated**

Patient Name _____ ID # _____

Section E Behavior (Continued)

M1745. Frequency of Disruptive Behavior Symptoms (Reported or Observed):
Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

Enter Code ☐

0. **Never**
1. **Less than once a month**
2. **Once a month**
3. **Several times each month**
4. **Several times a week**
5. **At least daily**

MENTAL STATUS

Has there been a sudden/acute change in their mental status? ❍ 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:_____

PSYCHOSOCIAL

❑ Spiritual ❑ Cultural implications that impact care Explain:

Spiritual resource:_____ Phone No._____

Marital status: ❍ Single ❍ Married ❍ Divorced ❍ Widower

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

❑ 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: ❍ Potential ❍ Actual ❑ Verbal ❑ Emotional ❑ Physical ❑ Financial ❑ N/A

MSW referral made: ❍ Yes ❍ No Other intervention:_____

Are there any psychosocial barriers that may affect care or recuperation? ❍ No ❍ Yes If yes, explain:

Section F Preferences for Customary Routine Activities

See page 3 for hours/days a caregiver is available to provide cares (or if there is no set schedule for availability) and types of assistance provided.

M1100. Patient Living Situation
Which of the following best describes the patient's residential circumstance and availability of assistance?

Living Arrangement	Availability of Assistance: Around the Clock	Regular Daytime	Regular Nighttime	Occasional/ Short-Term Assistance	No Assistance Available
	↓ Check only one box ↓				
A. **Patient lives alone**	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
B. **Patient lives with other person(s) in the home**	☐ 06	☐ 07	☐ 08	☐ 09	☐ 10
C. **Patient lives in congregate situation** (for example, assisted living, residential care home)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

M2102. Types and Sources of Assistance
Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.

Enter Code ☐

f. **Supervision and safety** (due to cognitive impairment)
0. **No assistance needed – patient is independent or does not have needs in this area**
1. **Non-agency caregiver(s) currently provide assistance**
2. **Non-agency caregiver(s) need training/supportive services to provide assistance**
3. **Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance**
4. **Assistance needed, but no non-agency caregiver(s) available**

Patient Name _____ ID # _____

Section F Preferences for Customary Routine Activities (Continued)

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 personal goal(s) the patient would like to achieve from this home health admission? For example, in the future they would like to shop at the mall, shop for their own food or go to a family wedding etc. ❍ No ❍ Yes

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.

❑ Other:_____ ❑ Other:_____

Resumption of Care: ❍ No change(s) ❍ Goal(s) changed

List all the patient's goal(s) and indicate if **E**-Existing, **N**-New, **M**-Modified existing or **D**-Discontinued

___ _____ ___ _____

___ _____ ___ _____

___ _____ ___ _____

___ _____ ___ _____

___ _____ ___ _____

___ _____ ___ _____

___ _____ ___ _____

___ _____ ___ _____

___ _____ ___ _____

___ _____ ___ _____

___ _____ ___ _____

___ _____ ___ _____

Note: *The IMPACT Act requires HHAs to take into account patient goal(s) and preferences in discharge and transfer planning. This process starts upon admission/resumption of care.*

STRENGTHS/LIMITATIONS

Identify the patient's strengths and weaknesses based upon the patient's comprehensive assessment (psychosocial, cognitive, mental status and functional status).

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.*

Patient Name _____ ID # _____

Section F Preferences for Customary Routine Activities (Continued)

STRENGTHS/LIMITATIONS (Continued)

Does the patient's limitation(s) affect their safety and/or progress? ❍ No ❍ Yes If yes, explain:

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

Reason for need:

LIVING ARRANGEMENTS/SUPPORTIVE ASSISTANCE

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: _____

Is there a need for a Fall Risk Plan? ❍ No ❍ Yes **Safety plan(s) indicated?** ❍ No ❍ Yes

Comments:

Instructions/Materials Provided (Check all applicable items)

❑ Rights and Responsibilities ❑ State hotline number ❑ Advance directives ❑ Do not resuscitate (DNR)
❑ HIPAA Notice of Privacy Practices ❑ OASIS Privacy Notice ❑ Emergency planning in the event service is disrupted
❑ Agency phone number/after-hours number ❑ When to contact physician and/or agency ❑ Standard precautions/handwashing
❑ Basic home safety ❑ Disease (specify): _____
❑ Medication regimen/administration ❑ Administrator's contact information
❑ Copy of Rights & Responsibilities and transfer/discharge policies to Representative (HHA has 4 business days)
❑ Other:

EMERGENCY PREPAREDNESS CARE PLANNING

Complete this section per agency policy for applicable activities completed during this visit (check all that apply).

❑ **Emergency Priority Code** assigned to this patient is _____ based upon the comprehensive assessment of their functional, medical condition, psychosocial situation, cognitive, mental status and any significant care needs.
(**Note:** Record the code on the front of this form and other places per agency policy)

❑ Obtained the patient's emergency contact number(s) for the medical record

❑ Discussed the HHA's plans for supporting their patients during a natural or man-made disaster

❑ Discussed patient specific emergency planning options

❑ Discussed the development of the patient's individualized emergency preparedness plan of care, including self-care readiness and the procedure to follow up with the HHA in the event services are interrupted

❑ Educational materials provided to suggest/assist with emergency management/decision making priorities

❑ List of local and state approved evacuation routes and community shelters relevant to the patient's specific geographic location

❑ Written materials to restate/reinforce the emergency preparedness procedures given to the
❑ Patient ❑ Representative (if any) ❑ Caregiver ❑ Other: _____

Comments:

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.**

M1845. Toileting Hygiene
Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

Enter Code ☐

0. **Able to manage toileting hygiene and clothing management without assistance.**
1. **Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.**
2. **Someone must help the patient to maintain toileting hygiene and/or adjust clothing.**
3. **Patient depends entirely upon another person to maintain toileting hygiene.**

Patient Name _____ ID # _____

Section G Functional Status (Continued)

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.**

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.**

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):

❑ Other (specify):

Plan/Comments regarding ADLs:

Section GG Functional Abilities and Goals

GG0100. Prior Functioning: Everyday Activities

Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.

Coding:

3. **Independent** - Patient completed all the activities by themself, with or without an assistive device, with no assistance from a helper.
2. **Needed Some Help** - Patient needed partial assistance from another person to complete any activities.
1. **Dependent** - A helper completed all the activities for the patient.
8. **Unknown**
9. **Not Applicable**

↓ **Enter Codes in Boxes**

☐	A. **Self-Care:** Code the patient's need for assistance with bathing, dressing, using the toilet, and eating prior to the current illness, exacerbation, or injury.
☐	B. **Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
☐	C. **Stairs:** Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
☐	D. **Functional Cognition:** Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

Patient Name _____ ID # _____

Section GG Functional Abilities and Goals (Continued)

GG0110. Prior Device Use

Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.

↓ Check all that apply	
☐	A. **Manual wheelchair**
☐	B. **Motorized wheelchair and/or scooter**
☐	C. **Mechanical lift**
☐	D. **Walker**
☐	E. **Orthotics/Prosthetics**
☐	Z. **None of the above**

GG0130. Self-Care

Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

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**

1. SOC/ROC Performance	2. Discharge Goal	
↓ 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.
☐	☐	E. **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐	☐	F. **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐	☐	G. **Lower body dressing:** The ability to dress and undress below the waist; including fasteners; does not include footwear.
☐	☐	H. **Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Patient Name _____ ID # _____

Section GG Functional Abilities and Goals (Continued)

GG0170. Mobility

Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

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**

1. SOC/ROC Performance	2. Discharge Goal	
↓ 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.
☐	☐	G. **Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐	☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If SOC/ROC 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.
☐	☐	K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
☐	☐	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 SOC/ROC performance is coded 07, 09, 10, or 88, → Skip to GG0170P, Picking up object.*
☐	☐	N. **4 steps:** The ability to go up and down four steps with or without a rail. *If SOC/ROC performance is coded 07, 09, 10, or 88, → Skip to GG0170P, Picking up object.*
☐	☐	O. **12 steps:** The ability to go up and down 12 steps with or without a rail.

Patient Name _____ ID # _____

Section GG Functional Abilities and Goals (Continued)

GG0170. Mobility – Continued

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐	☐	P. **Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
		☐ Q. **Does the patient use wheelchair and/or scooter?** 0. **No** → *Skip to M1600, Urinary Tract Infection* 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.
		☐ RR1. **Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐	☐	S. **Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
		☐ SS1. **Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

FUNCTIONAL LIMITATIONS

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

Prior transfer ability:

Prior social activity level:

MUSCULOSKELETAL

❑ **No Problem**
Check all that apply:

Has patient had any past problems or injuries to: ❑ joints ❑ muscles ❑ bones? ❍ No ❍ Yes (note a problem could be a disease process, for example: osteoporosis, tetanus or cancer) If yes, what happened:

Treatment received:

Did the patient have any after effects/residual problems from the problem or injury reported? ❍ No ❍ Yes If yes, what happened:

Patient has pain associated with (check all that apply):
❑ joints ❑ muscles ❑ bones

Patient has (check all that apply): ❑ tingling ❑ numbness ❑ swelling ❑ contracture(s) weakness of: ❑ UE ❑ LE ❑ atrophy ❑ decreased ROM

Motor changes: ❍ No ❍ Yes If yes: ❑ fine ❑ gross

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

Has the patient had an amputation? ❍ No ❍ Yes If yes,
❑ below knee: ❑ right ❑ left ❑ above knee: ❑ right ❑ left
❑ upper extremity: ❑ right ❑ left
❑ Other:_____

When standing does the patient appear to have:
❑ Exaggerated forward curve of lumbar region
❑ Rounded upper back ❑ S shaped spine
❑ N/A patient can't stand

Does the patient's posture limit their activities? ❍ No ❍ Yes

If the patient has any of these conditions, specify what and how it affects their functional ability and/or safety:

Patient Name _____ ID # _____

Section GG Functional Abilities and Goals (Continued)

FALL RISK ASSESSMENT

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 **TOTAL**	

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Section H Bladder and Bowel

URINARY ELIMINATION

❑ **No Problem**

Diagnosed disorder(s) of urinary system (type):

(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**

Type:_____ Date last changed:_____

❑ Indwelling catheter changed this visit. Size _____ French

❑ Indwelling catheter inserted this visit. Size _____ French

❍ Single balloon ❍ Double balloon

❑ Single/anchor balloon inflated with _____ mL

❑ Second/tip balloon inflated with _____ mL

❍ Without difficulty ❍ With difficulty (explain):

Irrigation solution: Type (specify):_____

Amount_____mL Frequency_____ Returns_____

Patient tolerated procedure well ❍ No ❍ Yes

❑ Patient has suprapubic

❑ Urostomy site (describe skin around stoma):

_____

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

Patient Name _____ ID # _____

Section H Bladder and Bowel (Continued)

M1600. Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?

Enter Code ☐

0. **No**
1. **Yes**
NA **Patient on prophylactic treatment**
UK **Unknown**

M1610. Urinary Incontinence or Urinary Catheter Presence

Enter Code ☐

0. **No incontinence or catheter** (includes anuria or ostomy for urinary drainage)
1. **Patient is incontinent**
2. **Patient requires a urinary catheter** (specifically: external, indwelling, intermittent, or suprapubic)

BOWEL ELIMINATION

❑ **No Problem**

Diagnosed disorder(s) of GI system (type):

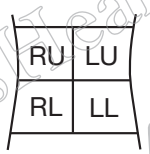
❑ Constipation ❑ Diarrhea ❑ Hemorrhoids
❑ Last BM:_____

❑ Bowel sounds: active _____
absent _____
hypoactive _____
hyperactive _____

Abdomen: ❑ **No Problem** ❑ Tenderness ❑ Pain

❑ Distention: ❍ Hard ❍ Soft ❑ Abdominal girth_____ cm

❑ Other:



❑ Frequency of stools:_____
Bowel regimen/program:
_____

❑ Laxative ❑ Enema use/frequency:_____
❑ Other:_____

❑ Involuntary incontinence (details if applicable):

❑ Incontinence products/other:
_____

❑ Ileostomy ❑ Colostomy site (describe skin around stoma):
_____

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

M1620. Bowel Incontinence Frequency

Enter Code ☐

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**
UK **Unknown**

GENITALIA

❑ **No Problem** ❑ **Not Assessed**
❑ Discharge/Drainage: (describe):_____
❑ Lesions ❑ Blisters ❑ Masses ❑ Cysts ❑ Inflammation
❑ Surgical alteration: ❍ Female to Male ❍ Male to Female
❑ Other:_____
❑ Prostate problem: ❑ BPH ❑ TURP Date:_____
❑ Self-testicular exam Frequency_____ Date last exam:_____
❑ Menopause ❑ Hysterectomy Date:_____
Date last PAP:_____ Results:_____
❑ Breast self-exam Frequency_____ Date last exam:_____
❑ Nipple discharge: ❑ R Date:_____ ❑ L Date:_____

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?

Enter Code ☐

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.**

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

Patient Name _____ ID # _____

Section I Active Diagnoses

M1021. Primary Diagnosis & M1023. Other Diagnoses

Column 1	Column 2
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

Coding Instructions

- **Column 1, Diagnoses:**
  - Enter the description of each diagnosis
  - List each diagnosis for which the patient is receiving home care
  - Diagnoses are listed in the order that best reflects the seriousness of each condition and supports the disciplines and services provided
  - Complete Column 1 from top to bottom, leaving any blank entries at the bottom.
  - Order other diagnoses (M1023) according to the degree they impact the patient's health and need for home health care, rather than the degree of symptom control.
    - For example, if a patient is receiving home health care for Type 2 Diabetes that is "controlled with difficulty" this diagnosis would be listed above a diagnosis of a fungal infection of a toenail that is being treated, even if the fungal infection is "poorly controlled."
- **Column 2, ICD-10 CM codes:**
  - For each diagnosis in Column 1, enter its ICD-10 CM code at the highest level of specificity
  - No surgical or procedure codes allowed in Column 2
  - ICD-10-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses.
  - 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 (Other Diagnoses).
  - 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.
    - See the ICD-10-CM "Official Guidelines for Coding and Reporting" for complete instructions on code assignment and sequencing related to the use of Z-codes, and use of multiple coding for a single condition (such as manifestation/etiology pairs).

M1021. Primary Diagnosis

		V, W, X, Y codes NOT allowed
a. _____	a.	☐0 ☐1 ☐2 ☐3 ☐4

M1023. Other Diagnoses

		All ICD-10-CM codes allowed
b. _____	b.	☐0 ☐1 ☐2 ☐3 ☐4
c. _____	c.	☐0 ☐1 ☐2 ☐3 ☐4
d. _____	d.	☐0 ☐1 ☐2 ☐3 ☐4
e. _____	e.	☐0 ☐1 ☐2 ☐3 ☐4
f. _____	f.	☐0 ☐1 ☐2 ☐3 ☐4

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

g. _____	g.
h. _____	h.
i. _____	i.
j. _____	j.
k. _____	k.
l. _____	l.

m-y continued on next page

Patient Name _____ ID # _____

Section I Active Diagnoses (Continued)

M1023. Other Diagnoses (Continued)	All ICD-10-CM codes allowed
m. _____	m.
n. _____	n.
o. _____	o.
p. _____	p.
q. _____	q.
r. _____	r.
s. _____	s.
t. _____	t.
u. _____	u.
v. _____	v.
w. _____	w.
x. _____	x.
y. _____	y.

PERTINENT SURGICAL PROCEDURE(S) ❑ N/A

_____ Date:_____

_____ Date:_____

_____ Date:_____

M1028. Active Diagnoses – Comorbidities and Co-existing Conditions

↓ Check all that apply

☐	1. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
☐	2. Diabetes Mellitus (DM)
☐	3. None of the above

ENDOCRINE/HEMATOLOGY

❑ **No Problem**

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

❑ Oral medication ❑ Injectable medication When did the patient first start using diabetic medication: Date:_____

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

Reports symptoms of: ❍ Hyperglycemia: ❑ Increased urination ❑ Increased thirst

❍ Hypoglycemia: ❑ Sweats ❑ Increased hunger ❑ Weak ❑ Faint ❑ Stupor

A1C _____% ❑ Patient reported ❑ Lab slip Date:_____ 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:_____

❑ **Disease Management Problems (explain):**

❑ **Other Endocrine or Hematology Issues:**

Patient Name _____ ID # _____

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

See page 33 for summary of risk factors.

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?

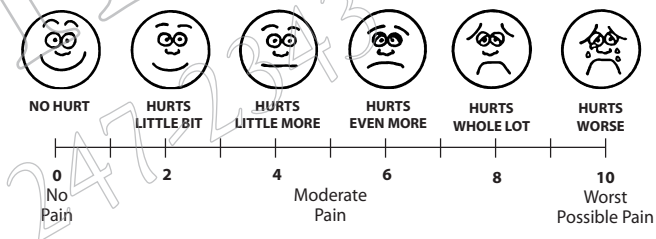
Score: _____ Assessment used: _____

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

Pain Assessment	Site 1	Site 2	Site 3
Location			
Onset			
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.

Patient Name _____ ID # _____

Section J Health Conditions (Continued)

J0510. Pain Effect on Sleep

Enter Code ☐

Ask patient: *"Over the past 5 days,* ***how much of the time has pain made it hard for you to sleep at night"***

0. **Does not apply – I have not had any pain or hurting in the past 5 days** → *Skip to M1400, Short of Breath*
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

J0520. Pain Interference with Therapy Activities

Enter Code ☐

Ask patient: *"Over the past 5 days,* ***how often have you limited your participation in rehabilitation therapy sessions due to pain?"***

0. **Does not apply – I have not received rehabilitation therapy in the past 5 days**
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

J0530. Pain Interference with Day-to-Day Activities

Enter Code ☐

Ask patient: *"Over the past 5 days,* ***how often you have limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"***

1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

PAIN (Continued)

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: _____

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

Check all pharmacological classification(s) based on the pain medication(s) the patient is receiving:

❑ Analgesics ❑ Corticosteroid ❑ Antianxiety ❑ DMARD ❑ Anticonvulsant ❑ Local anesthetics

❑ Antidepressant ❑ Narcotic ❑ Antimigraine ❑ NSAIDs ❑ Biologic ❑ Salicylate

Comment:

Patient Name _____ ID # _____

Section J Health Conditions (Continued)

CARDIOPULMONARY

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

Intermittent treatments (e.g., cough & deep breath, medicated inhalation treatments, etc.) ❍ No ❍ Yes, explain:

❑ **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:_____

❑ **Disease Management Problems (explain):**

M1400. When is the patient dyspneic or noticeably **Short of Breath?**

Enter Code ☐

0. **Patient is not short of breath**
1. **When walking more than 20 feet, climbing stairs**
2. **With moderate exertion** (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)
3. **With minimal exertion** (for example, while eating, talking, or performing other ADLs) or with agitation
4. **At rest** (during day or night)

❑ **N/A**

Shortness of Breath: ❍ Assessed ❍ Reported Explain how/when SOB happens (i.e., patient can't walk and talk at the same time in cold weather)

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

Patient Name _____ ID # _____

Section K Swallowing/Nutritional Status

M1060. Height and Weight – While measuring, if the number is X.1-X.4 round down; X.5 or greater round up.

☐ inches	A. **Height** (in inches). Record most recent height measure since the most recent SOC/ROC
☐ pounds	B. **Weight** (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)

Only enter a height/weight that has been directly measured by agency staff. Do not enter a height/weight that is self-reported or derived from documentation from another provider setting.

If unable to weigh during this visit then:

❑ Weight within past 30 days found in documentation from:_____ is: _____ pounds

❑ Patient ❑ Caregiver reported weight is: _____ pounds

Reported weight changes: ❍ Gain ❍ Loss _____ lb. x _____ ❍ week ❍ month ❍ year

Changes are: ❍ Intentional ❍ Unintentional

Based on general appearance, the patient appears: ❍ Underweight ❍ Average ❍ Overweight ❍ Obese

NUTRITIONAL STATUS

❑ **No Problem**

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

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

Appetite: ❍ Good ❍ Fair ❍ Poor ❑ Nausea ❑ Vomiting: Frequency:_____ Amount:_____

❑ Heartburn (food intolerance) ❑ Other:_____

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

❍ Known allergy(ies):_____

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

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**

If applicable, describe safety risk: ❑ **N/A**

Patient's current ability to plan and safely prepare light meals (for example, cereal, sandwich):

❍ Able to independently plan, prepare and reheat light meals

❍ Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past

❍ Unable to prepare light meals due to physical, cognitive, or mental limitations

❍ Unable to prepare or reheat any light meals

Patient Name _____ ID # _____

Section K Swallowing/Nutritional Status (Continued)

ENTERAL FEEDINGS – ACCESS DEVICE

❑ **N/A**

❑ Nasogastric ❑ Gastrostomy ❑ Jejunostomy ❑ Other (specify):_____

❑ Pump: (type/specify):_____ ❑ Bolus ❑ Continuous

Feedings: Type (amt./rate):_____

Flush Protocol: (amt./specify):_____

Performed by: ❑ Patient ❑ Caregiver ❑ Family ❑ Other:_____

Dressing/Site care: (specify):

Interventions/Instructions/Comments:

K0520. Nutritional Approaches (A)

1. **On Admission** Check all of the nutritional approaches that apply on admission	**1. On Admission** **Check all that apply ↓**
A. **Parenteral/IV feeding**	☐
B. **Feeding tube** (e.g., nasogastric or abdominal (PEG))	☐
C. **Mechanically altered diet** – require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	☐
Z. **None of the above**	☐

M1870. Feeding or Eating

Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

Enter Code ☐

0. **Able to independently feed self.**
1. **Able to feed self independently but requires:**
   a. **meal set-up; OR**
   b. **intermittent assistance or supervision from another person; OR**
   c. **a liquid, pureed, or ground meat diet.**
2. **Unable to feed self and must be assisted or supervised throughout the meal/snack.**
3. **Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.**
4. **Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.**
5. **Unable to take in nutrients orally or by tube feeding.**

ADDITIONAL COMMENTS

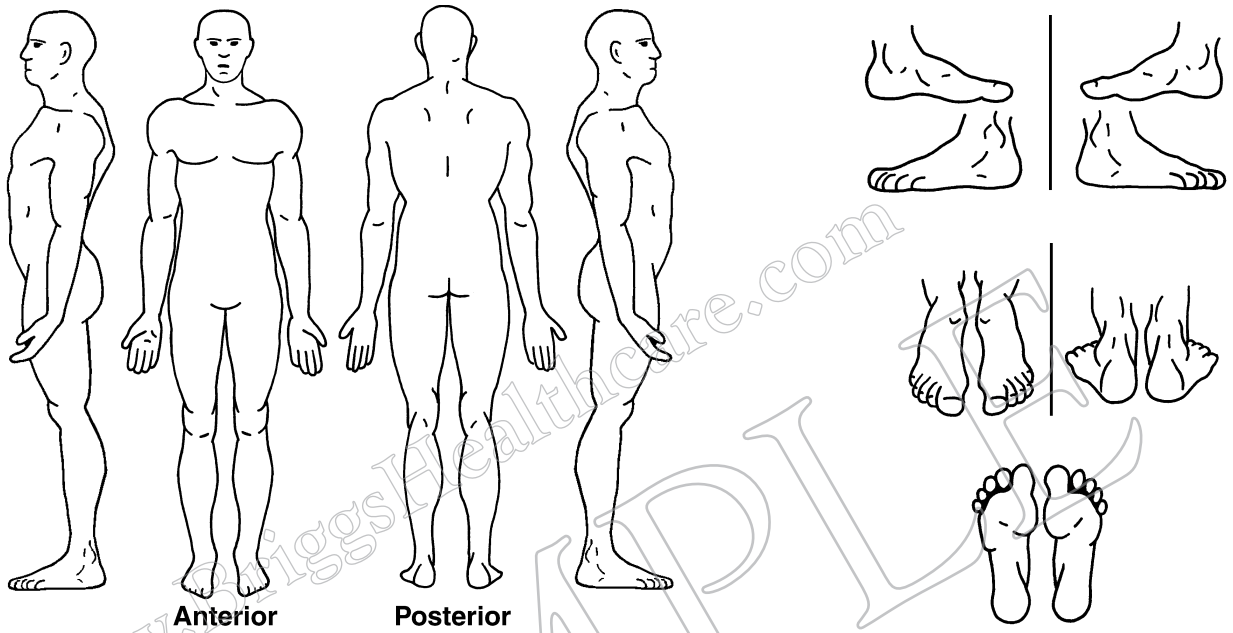
Patient Name _____ ID # _____

Section M Skin Conditions

INTEGUMENTARY STATUS

❑ **No Problem**

Check all applicable conditions: Turgor: ❍ Good ❍ Poor ❑ Itch ❑ Rash ❑ Dry ❑ Scaling ❑ Redness ❑ Bruises ❑ Ecchymosis
❑ Pallor ❑ Jaundice ❑ Weeping ❑ Other (specify):_____



WOUND CARE: (Check all that apply) ❑ **N/A**

Wound care done during this visit: ❍ No ❍ Yes Location(s) wound site:_____
❑ Soiled dressing removed by: ❍ Patient ❍ Caregiver (name)_____ ❍ Family ❍ RN ❍ PT ❍ Other:_____
Technique: ❍ Sterile ❍ Clean ❑ Hands washed: ❑ before ❑ after dressing change
❑ Wound cleaned with (specify):_____ ❑ Wound dressing applied (specify):_____
❑ Wound irrigated with (specify):_____ ❑ Dressing secured with (specify):_____
❑ Wound packed with (specify):_____ ❑ Soiled dressing properly disposed of (per agency policy)
Patient tolerated procedure well: ❍ No ❍ Yes
Comments:

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:

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 # _____

Section M Skin Conditions (Continued)

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** → *Skip to M1322, Current Number of Stage 1 Pressure Injuries*
1. **Yes**

M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Enter Number	
	A1. **Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers**
	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**
	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**
	D1. **Unstageable: Non-removable dressing/device:** Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device**
	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**
	F1. **Unstageable: Deep tissue injury** **Number of unstageable pressure injuries presenting as deep tissue injury**

M1322. Current Number of Stage 1 Pressure Injuries

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only, it may appear with persistent blue or purple hues.

Enter Code

0
1
2
3
4 or more

M1324. Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable

Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.

Enter Code

1. **Stage 1**
2. **Stage 2**
3. **Stage 3**
4. **Stage 4**

NA **Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries**

M1330. Does this patient have a **Stasis Ulcer?**

Enter Code

0. **No** → *Skip to M1340, Surgical Wound*
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) → *Skip to M1340, Surgical Wound*

M1332. Current Number of Stasis Ulcer(s) that are Observable

Enter Code

1. **One**
2. **Two**
3. **Three**
4. **Four or more**

M1334. Status of Most Problematic Stasis Ulcer that is Observable

Enter Code

1. **Fully granulating**
2. **Early/partial granulation**
3. **Not healing**

Patient Name _____ ID # _____

Section M Skin Conditions (Continued)

M1340. Does this patient have a **Surgical Wound?**

Enter Code ☐

0. **No** → *Skip to N0415, High-Risk Drug Classes: Use and Indication*
1. **Yes, patient has at least one observable surgical wound**
2. **Surgical wound known but not observable due to non-removable dressing/device** → *Skip N0415, High-Risk Drug Classes: Use and Indication*

M1342. Status of Most Problematic Surgical Wound that is Observable

Enter Code ☐

0. **Newly epithelialized**
1. **Fully granulating**
2. **Early/partial granulation**
3. **Not healing**

Section N Medications

N0415. High-Risk Drug Classes: Use and Indication (A)

1. **Is taking**
   Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes
2. **Indication noted**
   If Column 1 is checked, check if there is an indication noted for all medications in the drug class

	1. Is taking ↓ Check all that apply	2. Indication noted ↓ Check all that apply
A. **Antipsychotic**	☐	☐
E. **Anticoagulant**	☐	☐
F. **Antibiotic**	☐	☐
H. **Opioid**	☐	☐
I. **Antiplatelet**	☐	☐
J. **Hypoglycemic** (including insulin)	☐	☐
Z. **None of the above**	☐	

M2001. Drug Regimen Review (A)

Did a complete drug regimen review identify potential clinically significant medication issues?

Enter Code ☐

0. **No – No issues found during review** → *Skip to M2010, Patient/Caregiver High-Risk Drug Education*
1. **Yes – Issues found during review**
9. **NA – Patient is not taking any medications** → *Skip to O0110, Special Treatments, Procedures, and Programs*

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

M2003. Medication Follow-up (A)

Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

Enter Code ☐

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

❍ If yes, coded for M2001 and M2003 **OR** ❍ If yes, coded for M2001 and no for M2003
Then see: ❑ Orders ❑ Communication documentation (per agency policy)

M2010. Patient/Caregiver High-Risk Drug Education

Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?

Enter Code ☐

0. **No**
1. **Yes**
NA **Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications**

Instructed ❑ Patient ❑ Caregiver ❑ Other:_____ on high-risk drugs and associated special precautions
❑ Teaching guide given per agency policy

Patient Name _____ ID # _____

Section N Medications (Continued)

M2020. Management of Oral Medications

Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)

Enter Code ☐

0. **Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.**
1. **Able to take medication(s) at the correct times if:**
   a. **individual dosages 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 at the appropriate times**
3. **Unable to take medication unless administered by another person.**

NA **No oral medications prescribed.**

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.

Enter Code ☐

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.**

MEDICATIONS

Financial ability to pay for medications: ❍ **Yes** ❍ **No** If no, was MSW referral made? ❍ Yes ❍ No/comment:

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

INFUSION

❑ **N/A**

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

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

Total number of lumen(s):_____

Insertion date(s):_____ | _____ Flush solution/frequency:_____ | _____

Lumen(s) patent: ❍ Yes ❍ No If no, explain:_____

❑ N/A not flushed Injection cap change frequency:_____

Dressing change during visit: ❍ No ❍ Yes Dressing change frequency:_____

❑ Sterile ❑ Clean Performed by: ❑ Patient ❑ RN ❑ Caregiver ❑ Family ❑ Other:_____

Site/skin condition:_____ External catheter length _____ cm

Other:

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

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

IVAD Port Specific: Reservoir: ❍ Single ❍ Double Huber gauge/length:_____ Accessed: ❍ No ❍ Yes, date:_____

Epidural/Intrathecal Access:

Site/skin condition:_____

Infusion solution (type/volume/rate):_____

❑ Pump: (type, specify):_____

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

Patient Name _____ ID # _____

INFUSION (Continued)

Purpose of Intravenous Access: ❑ Antibiotic therapy ❑ Pain control ❑ Lab draws ❑ Chemotherapy ❑ Maintain venous access ❑ Hydration ❑ Parenteral nutrition ❑ Other:_____

❑ Infusion care provided during visit: ❍ No ❍ Yes

Interventions/Instructions/Comments:

Section O Special Treatment, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs (+) Check all of the following treatments, procedures, and programs that apply on admission.	**a. On Admission** **Check all that apply** ↓
Cancer Treatments	
A1. Chemotherapy	☐
A2. IV	☐
A3. Oral	☐
A10. Other	☐
B1. Radiation	☐
Respiratory Therapies	
C1. Oxygen Therapy	☐
C2. Continuous	☐
C3. Intermittent	☐
C4. High-concentration	☐
D1. Suctioning	☐
D2. Scheduled	☐
D3. As Needed	☐
E1. Tracheostomy care	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐
G1. Non-invasive Mechanical Ventilator	☐
G2. BiPAP	☐
G3. CPAP	☐
Other	
H1. IV Medications	☐
H2. Vasoactive medications	☐
H3. Antibiotics	☐
H4. Anticoagulation	☐
H10. Other	☐
I1. Transfusions	☐
J1. Dialysis	☐
J2. Hemodialysis	☐
J3. Peritoneal dialysis	☐
O1. IV Access	☐
O2. Peripheral	☐
O3. Mid-line	☐
O4. Central (e.g., PICC, tunneled, port)	☐
None of the Above	
Z1. None of the Above	☐

Patient Name _____ ID # _____

Section O Special Treatment, Procedures, and Programs (Continued)

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.

RISK FACTORS/HOSPITAL ADMISSION/EMERGENCY ROOM

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.). (Reference M1033 on page 22)

❑ **N/A**

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/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
Wound care:	❍ Yes ❍ No ❍ N/A	❑ Patient ❑ Caregiver ❑ Representative ❑ Family
Diabetic: ❑ Foot exam ❑ Care	❍ Yes ❍ No ❍ N/A	❑ Patient ❑ Caregiver ❑ Representative ❑ Family
Insulin administration:	❍ Yes ❍ No ❍ N/A	❑ Patient ❑ Caregiver ❑ Representative ❑ Family
Glucometer use:	❍ Yes ❍ No ❍ N/A	❑ Patient ❑ Caregiver ❑ Representative ❑ Family
Nutritional management:	❍ Yes ❍ No ❍ N/A	❑ Patient ❑ Caregiver ❑ Representative ❑ Family
Medication(s) administration: ❑ Oral ❑ Injected ❑ Infused ❑ Inhaled ❑ Topical	❍ 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
Catheter care:	❍ Yes ❍ No ❍ N/A	❑ Patient ❑ Caregiver ❑ Representative ❑ Family
Trach care:	❍ Yes ❍ No ❍ N/A	❑ Patient ❑ Caregiver ❑ Representative ❑ Family
Ostomy care:	❍ Yes ❍ No ❍ N/A	❑ Patient ❑ Caregiver ❑ Representative ❑ Family
Emergency Preparedness Plan:	❍ Yes ❍ No ❍ N/A	❑ Patient ❑ Caregiver ❑ Representative ❑ Family
Infection control:	❍ Yes ❍ No ❍ N/A	❑ Patient ❑ Caregiver ❑ Representative ❑ Family
S/S Report to agency:	❍ Yes ❍ No ❍ N/A	❑ Patient ❑ Caregiver ❑ Representative ❑ Family
Patient's Rights:	❍ Yes ❍ No ❍ N/A	❑ Patient ❑ Caregiver ❑ Representative ❑ Family

Other care(s):

Patient Name _____ ID # _____

Section O Special Treatment, Procedures, and Programs (Continued)

PATIENT/CAREGIVER/REPRESENTATIVE/FAMILY EDUCATION AND TRAINING FOR CARE PLANNING (Continued)

❑ Patient ❑ Caregiver ❑ Representative ❑ Family needs further ❑ education ❑ training with items checked "Yes" on previous page

_____

❑ Patient ❑ Caregiver ❑ Representative ❑ Family educated this visit for:
❑ Wound care ❑ Diabetic foot exam ❑ Diabetic care ❑ Insulin administration ❑ Glucometer use ❑ Nutritional management
❑ Medication(s) administration: ❑ Oral ❑ Injected ❑ Infused ❑ Inhaled ❑ Topical
❑ Pain management ❑ Oxygen use ❑ Use of medical devices ❑ Catheter care ❑ Trach care ❑ Ostomy care
❑ Emergency Preparedness Plan ❑ Infection control ❑ S/S Report to agency ❑ Patient's Rights

❑ 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 nurse vs. emergency services): ❍ No ❍ Yes

Agency admission packet given, per agency policy, to ❑ Patient ❑ Representative ❑ Family ❑ Other:_____

Comment(s):

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

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

CARE COORDINATION

CARE PLAN: Collaboration with: ❑ Patient ❑ Caregiver ❑ Representative ❑ Family involvement

Check all items that apply were completed at SOC/ROC according to agency policy.

❑ Primary diagnosis identified (M1021) (The primary diagnosis is defined as the chief reason for home care and related to the Plan of Care. Must relate to all HHA skilled services.)
❑ All pertinent secondary diagnoses identified.
❑ Homebound status, medical necessity as supported by the assessment data and additional documentation
❑ Drug regimen review completed
❑ Any identified medication issues were addressed and followed-up ❑ Outcome documented in communication note ❑ Order received

Assessment findings problems/issues (Check all areas that apply):
❑ Sensory status ❑ Pain ❑ Endocrine/Hematology ❑ Integumentary Status ❑ Cardiopulmonary Status
❑ Nutritional Status (includes nutritional approaches) ❑ Urinary Elimination ❑ Bowel Elimination ❑ Neuro/Emotional/Behavioral Status (includes functional cognition, confusion, anxiety, behaviors, psychiatric symptoms, depression and mental status) ❑ Psychosocial ❑ Fall Risk
❑ Musculoskeletal ❑ Functional Limitations (includes mobility and completion ADL/IADLs) ❑ Safety issues

Additional areas assessed during the SOC:
❑ Coping mechanisms ❑ Level of comprehension/understanding ❑ Motivation ❑ Identified strengths/limitations
❑ Non-paid caregiver availability ❑ Family support ❑ Friends and/or community support ❑ Living arrangements (includes safety)
❑ Care preferences ❑ Personal goals (patient's expectation of home health services' outcome at discharge)
❑ Risk for: ❑ (re)hospitalization ❑ Avoidable ED use ❑ Interventions to avoid: ❑ (re)hospitalization ❑ ED use
❑ Coordination of services and/or resources to meet problem/issue needs ❑ Emergency Preparedness Plan

Additional care coordination and communication with certifying physician at SOC/ROC:
❑ Findings of comprehensive assessment reported ❑ Reported additional findings not included in referral
❑ Medication issues identified and resolution (see narratives and/or orders)
❑ Verification of additional diagnosis(es)
List additional diagnosis(es):_____
❑ Verification of rehabilitation potential for anticipated discharge ❑ Approval of additional interventions on POC

Other Services involved: ❑ 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

Care Coordination comment space on next page

Patient Name _____ ID # _____

Section O Special Treatment, Procedures, and Programs (Continued)

CARE COORDINATION (Continued)

Comments:

CURRENT DME/MEDICAL SUPPLIES

DME Company:_____ Phone:_____
Oxygen Company:_____ Phone:_____
❑ Community Organizations ❑ Services:

Contact:_____ Phone:_____
Comments:

❑ **NONE USED**

WOUND CARE:
❑ 2x2's
❑ 4x4's
❑ ABD's
❑ Cotton tipped applicators
❑ Drain sponges
❑ Hydrocolloids
❑ Kerlix size_____
❑ Nu-gauze
❑ Saline
❑ Tape
❑ Transparent dressings
❑ Wound cleanser
❑ Wound gel
❑ Other

IV SUPPLIES:
❑ Alcohol swabs
❑ Angiocatheter size_____
❑ Batteries size_____
❑ Central line dressing
❑ Extension tubings
❑ Infusion pump
❑ Injection caps

IV SUPPLIES (Cont'd):
❑ IV pole
❑ IV start kit
❑ IV tubing
❑ Syringes size_____
❑ Tape
❑ Other

URINARY/OSTOMY:
❑ External catheters
❑ Ostomy pouch (brand, size)
_____
❑ Ostomy wafer (brand, size)
_____
❑ Skin protectant
❑ Stoma adhesive tape
❑ Underpads
❑ Urinary bag ❑ Pouch
❑ Other

CATHETER SUPPLIES:
❑ Acetic acid
❑ _____ Fr catheter kit (tray, bag, foley)

CATHETER SUPPLIES (Cont'd):
❑ Irrigation tray
❑ Saline
❑ Straight catheter
❑ Other

DIABETIC:
❑ Chemstrips
❑ Syringes
❑ Other

MISCELLANEOUS:
❑ Enema supplies
❑ Feeding tube: type_____ size_____
❑ Gloves: ❑ Sterile ❑ Non-sterile
❑ Med Box
❑ Staple removal kit
❑ Steri strips
❑ Suture removal kit
❑ Other

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
❑ Grab bars: Bathroom/Other

❑ Handheld shower
❑ Hospital bed: ❑ Semi-electric
❑ Hoyer lift
❑ Knee scooter
❑ Medical alert
❑ Nebulizer

SUPPLIES/EQUIPMENT (Cont'd):
❑ Oxygen concentrator
❑ Pressure relieving device
_____
❑ Prosthesis: ❑ RUE ❑ RLE ❑ LUE ❑ LLE ❑ Other

❑ Raised toilet seat
❑ Reacher
❑ Special mattress overlay
_____
❑ Suction machine
❑ TENS unit
❑ Transfer equipment: ❑ Board ❑ Lift
❑ Ventilator
❑ Walker
❑ Wheelchair
❑ Other Supplies Needed

Patient Name _____ ID # _____

Section O Special Treatment, Procedures, and Programs (Continued)

HOMEBOUND AND ASSESSMENT SUMMARY (Include skilled care provided this visit and analysis of findings)

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:

_____

Skilled care provided? ❍ No ❍ Yes If yes, explain care provided and patient response:

Plan for next visit:

Comments:

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*

