

RECERTIFICATION/ FOLLOW-UP ASSESSMENT INCLUDING OASIS ELEMENTS WITH PLAN OF CARE INFORMATION

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

DATE: _____

Follow OASIS items in sequence unless otherwise directed.

TIME IN: _____ TIME OUT: _____

Section A Administrative Information

M0080. Discipline of Person Completing Assessment

- Enter Code
1. RN
 2. PT
 3. SLP/ST
 4. OT

M0090. Date Assessment Completed

Month/Day/Year

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

Type of Visit: Skilled Skilled & Supervisory Other: _____

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

- Enter Code
- Follow-Up**
4. Recertification (follow-up) reassessment
 5. Other follow-up

If M0100. coded 5, explain reason:

M0110. Episode Timing

Is the Medicare home health payment episode, for which this assessment will define a case mix group, an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?

- Enter Code
1. **Early**
 2. **Later**
 - UK **Unknown**
 - NA **Not Applicable:** No Medicare case mix group to be defined by this assessment.

PATIENT CONTACTS/CAREGIVERS

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

Contact information confirmed this visit with: Patient Caregiver

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

Does the patient have a representative? No Yes

If yes, is the person: Court declared Patient selected

Representative Name: _____

Relationship: Family Friend Other: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____

Email: _____

Primary caregiver(s) other than patient: N/A None available

Caregiver Name: _____

Relationship: Family Friend Other: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____

Email: _____

Paid service other than home health staff: No Yes If yes,

Company name: _____

Phone number: _____

Contact name: _____

EMERGENCY PREPAREDNESS

★ ★ ★ PRIORITY CODE ★ ★ ★

See page 2 for
Advance Directives

Emergency Contact: Representative Caregiver Other, if "Other"

Emergency

Contact Name: _____

Relationship: Family Friend Other: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____

Email: _____

Caregiver Name: _____

Relationship: Family Friend Other: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____

Email: _____

If the caregiver(s) are not available, is there anyone who could be contacted in a critical situation? No Yes

Name: _____

Phone number: _____

Patient Name - Last, First, Middle Initial

ID #

Section A Administrative Information (Continued)

SUPPORTIVE ASSISTANCE/CARE PREFERENCES SUMMARY

Document any changes in information since the last OASIS assessment. No change since last assessment.
 Caregiver(s) assist with ADLs, IADLs and/or medical cares? No Yes If yes: _____
 Type(s) of assistance provided: No assistance Meals ADLs Transportation Supervision/Support Medications
 Home Maintenance Other: _____
 Caregiver(s) willing to assist? Yes No Unknown If no or unknown, explain:

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

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

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

ADVANCE DIRECTIVES

Does the patient have an Advance Directives order? No Yes No change since last assessment.
 Since the last OASIS assessment, the patient: obtained changed the item(s) checked below:
 An order for Advance Directives Living Will
 Do Cardiopulmonary Resuscitation (CPR) Do Not Resuscitate Order (DNR)
 Do Not Intubate Order (DNI) No Artificial Nutrition and Hydration
 Medical/Durable Power of Attorney Name: _____ Phone #: _____
 Financial Power of Attorney Name: _____ Phone #: _____
 State specific form(s): _____
 Copies on file with: PCP Other: _____
 Comments:

SENSORY STATUS

Patient wears: Glasses Contacts: R L Prosthesis: R L Hearing aid: R L Other: _____
 Select all areas that are affected:
 What is the patient's structural (sensory) impairment: Eyes Ears Nose Mouth Throat
 What is the functional impairment: Sight Hearing Smell Taste Throat
 What is the activity limitation (which ADL(s)/IADL(s) do they need help with to safely complete)?

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

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): _____

Aphasic: Receptive Expressive

Tremors: At Rest With voluntary movement Continuous

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

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

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

COGNITIVE STATUS

Patient's cognitive function:

- Alert/oriented to self, person, place and time
- Requires prompting when stressed or conditions unfamiliar
- Requires some assistance to stay focused when attention needs to shift between activities
- Requires considerable assistance to stay focused when attention needs to shift between activities

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

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

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

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

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

MENTAL STATUS

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

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

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

Mental status changes reported by Patient Caregiver Representative Other: _____

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

PSYCHOSOCIAL

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

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

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

PSYCHOSOCIAL (Continued)

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

Spiritual resource: _____ Phone: _____

N/A No change since last visit

Feelings/emotions the patient reports: Angry Fear Sadness Discouraged Lonely Depressed Helpless

Content Happy Hopeful Motivated Other: _____

N/A - Nothing reported

Sleep: Adequate Inadequate Rest: Adequate Inadequate

Frequency of naps: _____ Number of hours slept per night: _____

Explain: _____

Inappropriate reactions/behaviors toward: Caregiver(s) Clinician(s) Representative Others: _____

Reported Observed N/A

Describe:

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

Unrealistic expectations Denial of problems

Evidence of: Abuse Neglect Exploitation Verbal Emotional Physical Financial

Potential Actual N/A MSW referral made: No Yes

Other intervention:

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

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

CARE PREFERENCES/PATIENT'S PERSONAL GOALS

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

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

If no, the Patient Representative Other: _____

Do not want a personal goal(s) Already have a goal(s) they are working on at this time

Other: _____

If yes, the Patient Representative Other: _____ discussed/communicated about the goal(s) with the assessing clinician and:

Agreed their personal goal(s) was realistic based on the patient's health status.

Agreed their personal goal(s) needed to be modified based on the patient's health status.

Agreed to and identified actions/interventions the patient is willing to safely implement, so the patient will be able to meet their goal(s) by the anticipated discharge date.

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

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

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

STRENGTHS/LIMITATIONS

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

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

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

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

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

Does the impairment limit the patient’s activities (climbing stairs, ambulating, making decisions, etc.)? No Yes If yes, explain:

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

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

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

SAFETY MEASURES

- Bleeding precautions
- Siderails up
- Infection control measures
- O₂ precautions
- Elevate head of bed
- Walker / Cane
- Seizure precautions
- 24 hr. supervision
- Other: _____
- Fall precautions
- Clear pathways
- Aspiration precautions
- Lock w/c with transfers

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

Primary Diagnosis & Other Diagnoses



Documentation of diagnoses has been removed from the OASIS data at recertification.
If the patient diagnoses are the same from the last comprehensive assessment, SKIP THIS PAGE.
 If there are changes in the diagnoses, or the order of the diagnoses, please document these changes below.
 These diagnoses must be captured accurately for billing purposes.

Primary Diagnosis (If changed from last assessment)

a. _____	V, W, X, Y codes NOT allowed a. <input style="width: 100%;" type="text"/>
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Other Diagnoses (If changed from last assessment)

b. _____	All ICD-10-CM codes allowed b. <input style="width: 100%;" type="text"/>
c. _____	c. <input style="width: 100%;" type="text"/>
d. _____	d. <input style="width: 100%;" type="text"/>
e. _____	e. <input style="width: 100%;" type="text"/>
f. _____	f. <input style="width: 100%;" type="text"/>

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

g. _____	g. <input style="width: 100%;" type="text"/>
h. _____	h. <input style="width: 100%;" type="text"/>
i. _____	i. <input style="width: 100%;" type="text"/>
j. _____	j. <input style="width: 100%;" type="text"/>
k. _____	k. <input style="width: 100%;" type="text"/>
l. _____	l. <input style="width: 100%;" type="text"/>
m. _____	m. <input style="width: 100%;" type="text"/>
n. _____	n. <input style="width: 100%;" type="text"/>
o. _____	o. <input style="width: 100%;" type="text"/>
p. _____	p. <input style="width: 100%;" type="text"/>
q. _____	q. <input style="width: 100%;" type="text"/>
r. _____	r. <input style="width: 100%;" type="text"/>
s. _____	s. <input style="width: 100%;" type="text"/>
t. _____	t. <input style="width: 100%;" type="text"/>
u. _____	u. <input style="width: 100%;" type="text"/>
v. _____	v. <input style="width: 100%;" type="text"/>

Section G Functional Status

M1800. Grooming

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

Enter Code

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

M1810. Current Ability to Dress Upper Body safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps.

Enter Code

0. **Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.**
1. **Able to dress upper body without assistance if clothing is laid out or handed to the patient.**
2. **Someone must help the patient put on upper body clothing.**
3. **Patient depends entirely upon another person to dress the upper body.**

M1820. Current Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes.

Enter Code

0. **Able to obtain, put on, and remove clothing and shoes without assistance.**
1. **Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.**
2. **Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.**
3. **Patient depends entirely upon another person to dress lower body.**

M1830. Bathing

Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair).

Enter Code

0. **Able to bathe self in shower or tub independently, including getting in and out of tub/shower.**
1. **With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.**
2. **Able to bathe in shower or tub with the intermittent assistance of another person:**
 - a. **for intermittent supervision or encouragement or reminders, OR**
 - b. **to get in and out of the shower or tub, OR**
 - c. **for washing difficult to reach areas.**
3. **Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.**
4. **Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.**
5. **Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.**
6. **Unable to participate effectively in bathing and is bathed totally by another person.**

M1840. Toilet Transferring

Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

Enter Code

0. **Able to get to and from the toilet and transfer independently with or without a device.**
1. **When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.**
2. **Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).**
3. **Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.**
4. **Is totally dependent in toileting.**

M1850. Transferring

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

Enter Code

0. **Able to independently transfer.**
1. **Able to transfer with minimal human assistance or with use of an assistive device.**
2. **Able to bear weight and pivot during the transfer process but unable to transfer self.**
3. **Unable to transfer self and is unable to bear weight or pivot when transferred by another person.**
4. **Bedfast, unable to transfer but is able to turn and position self in bed.**
5. **Bedfast, unable to transfer and is unable to turn and position self.**

Section G Functional Status (Continued)

M1860. Ambulation/Locomotion

Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Enter Code

- 0. **Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).**
- 1. **With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.**
- 2. **Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.**
- 3. **Able to walk only with the supervision or assistance of another person at all times.**
- 4. **Chairfast, unable to ambulate but is able to wheel self independently.**
- 5. **Chairfast, unable to ambulate and is unable to wheel self.**
- 6. **Bedfast, unable to ambulate or be up in a chair.**

Indications for Home Health Aides: Yes No Refused

Order obtained: Yes No

Reason for need:

Indications for Occupational Therapy: Yes No Refused

Order obtained: Yes No

Reason for need:

ACTIVITIES PERMITTED

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

Plan/Comments regarding ADLs:

FUNCTIONAL LIMITATIONS

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

Section GG Functional Abilities and Goals

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

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

GG0130. Self-Care

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

Coding:

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

Activities may be completed with or without assistive devices.

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

If activity was not attempted, code reason:

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

4. Follow-Up Performance	
Enter Codes in Boxes ↓	
<input style="width: 30px; height: 20px;" type="checkbox"/>	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.
<input style="width: 30px; height: 20px;" type="checkbox"/>	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.
<input style="width: 30px; height: 20px;" type="checkbox"/>	C. Toileting Hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

ADDITIONAL COMMENTS

Section GG Functional Abilities and Goals (Continued)

GG0170. Mobility 

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

Coding:

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

Activities may be completed with or without assistive devices.

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

If activity was not attempted, code reason:

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

4. Follow-Up Performance	
Enter Codes in Boxes ↓	
<input type="checkbox"/>	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.
<input type="checkbox"/>	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.
<input type="checkbox"/>	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
<input type="checkbox"/>	F. Toilet transfer: The ability to get on and off a toilet or commode.
<input type="checkbox"/>	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. <i>If Follow-Up performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb).</i>
<input type="checkbox"/>	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
<input type="checkbox"/>	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.
<input type="checkbox"/>	M. 1 step (curb): The ability to go up and down a curb or up and down one step. <i>If Follow-Up performance is coded 07, 09, 10, or 88 → Skip to GG0170Q, Does patient use wheelchair and/or scooter?</i>
<input type="checkbox"/>	N. 4 steps: The ability to go up and down four steps with or without a rail.
<input type="checkbox"/>	Q. Does patient use wheelchair and/or scooter? 0. No → Skip to M1033, Risk for Hospitalization 1. Yes → Continue to GG0170R, Wheel 50 feet with two turns
<input type="checkbox"/>	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

MUSCULOSKELETAL

No Problem

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

- Fracture (location): _____ Swollen, painful joints (specify): _____
- Contracture(s): Location _____ Contracture(s): Location _____
- Hand grips: equal unequal strong: R L weak: R L
- Motor changes: Fine Gross (specify): _____
- Weakness: UE LE (details): _____
- Atrophy: _____ Decreased ROM: _____
- Shuffling Wide-based gait Amputation BK AK UE; R L (specify): _____
- Other (specify): _____

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

FALL RISK ASSESSMENT

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

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

Complete the MAHC 10 and score as appropriate.

MAHC 10 - FALL RISK ASSESSMENT TOOL

REQUIRED CORE ELEMENTS – Assess one point for each core element “yes”.

Information may be gathered from medical record, assessment and if applicable, the patient/caregiver. Beyond protocols listed below, scoring should be based on your clinical judgment.

POINTS

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

MAHC 10 reprinted with permission from Missouri Alliance for HOME CARE

Plan/Comments re: ADLs and fall risk:

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

BOWEL ELIMINATION

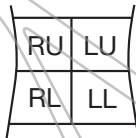
No Problem

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: _____

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

GENITALIA

No Problem **Not Assessed**

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: _____

ENDOCRINE

No Problem

Diabetes: Type 1 Type 2 Other diabetes _____ Date of onset: _____ Diabetic diet

Oral medication Injectable medication Was there a change in the diabetic medication since the last OASIS assessment?
 No Yes If yes, medication name, dose/frequency (specify): _____

Administered by: Patient Caregiver Nurse Family Other: _____

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:

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

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

Note: see page 11 for fall risk factors.

RISK FACTORS/HOSPITAL ADMISSION/EMERGENCY ROOM

N/A THIS VISIT

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

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

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

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

PAIN

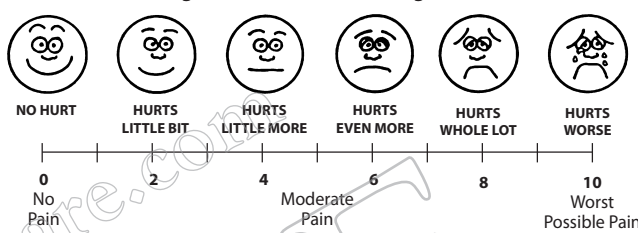
Is patient experiencing pain? No Yes Unable to communicate

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	Intensity: (using scales below)
Location				<p>Wong-Baker FACES® Pain Rating Scale**</p>  <p>0 No Pain 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worse</p> <p style="text-align: center;">Moderate Pain Worst Possible Pain</p>
Present level (0-10)				
Worst pain gets (0-10)				
Best pain gets (0-10)				
Pain description (aching, radiating, throbbing, etc.)				

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

Which activities are affected: (Check all that apply)

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

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

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

What makes pain worse? Movement Ambulation Immobility Other: _____

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

What makes pain better? Heat Ice Massage Repositioning Rest Relaxation Medication Diversion

Other: _____

VITAL SIGNS

Temperature: _____ F Oral Temporal/Forehead
 Rectal Axillary Tympanic

Pulse: Apical _____ Brachial _____ Regular Irregular
 Radial _____ Carotid _____

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

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

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

HEIGHT AND WEIGHT

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

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

NUTRITIONAL STATUS

No Problem

General NAS NPO Controlled Carbohydrate Renal Other: _____

Nutritional requirements (diet): _____ Increase fluids: _____ amt. Restrict fluids: _____ amt.

Appetite: Good Fair Poor 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: _____

Nutritional Approaches: Check all that apply
 Parenteral/IV feeding
 Feeding tube - nasogastric or abdominal (e.g., PEG, NG)
 Mechanically altered diet - change of texture with solids or fluids (e.g., pureed or thickened)

N/A

Directions: Check each area with "yes" to assessment, then total score to determine additional risk.	YES	INTERPRETATION OF ASSESSMENT
Has an illness or condition that changed the kind and/or amount of food eaten.	<input type="checkbox"/> 2	0-2 Good As appropriate reassess and/or provide information based on situation.
Eats fewer than 2 meals per day.	<input type="checkbox"/> 3	
Eats few fruits, vegetables or milk products.	<input type="checkbox"/> 2	3-5 Moderate risk Educate, refer, monitor and reevaluate based on patient situation and organization policy.
Has 3 or more drinks of beer, liquor or wine almost every day.	<input type="checkbox"/> 2	
Has tooth or mouth problems that make it hard to eat.	<input type="checkbox"/> 2	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.
Does not always have enough money to buy the food needed.	<input type="checkbox"/> 4	
Eats alone most of the time.	<input type="checkbox"/> 1	<small>Reprinted with permission by the Nutrition Screening Initiative, a project of the American Academy of Family Physicians, the American Dietetic Association and the National Council on the Aging, Inc., and funded in part by a grant from Ross Products Division, Abbott Laboratories Inc.</small>
Takes 3 or more different prescribed or over-the-counter drugs a day.	<input type="checkbox"/> 1	
Without wanting to, has lost or gained 10 pounds in the last 6 months.	<input type="checkbox"/> 2	
Not always physically able to shop, cook and/or feed self.	<input type="checkbox"/> 2	
TOTAL		

Describe at risk intervention: N/A

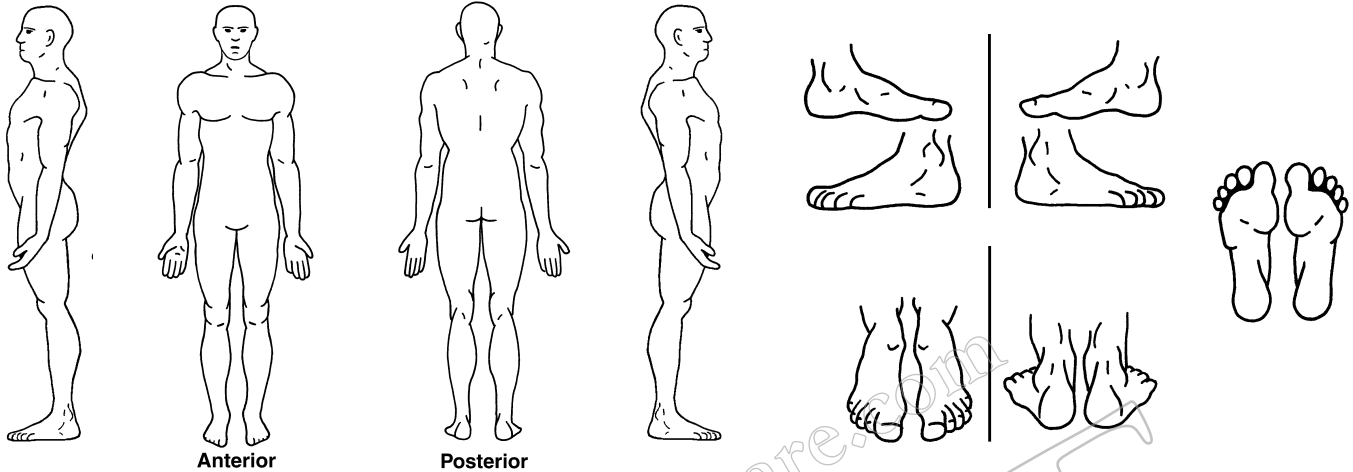
If applicable, describe safety risk: N/A

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

Section M Skin Conditions

INTEGUMENTARY STATUS



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: _____

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

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

Enter Code 0. No
 1. Yes

Section M Skin Conditions (Continued)

INTEGUMENTARY STATUS (Continued)
WOUND/LESION ASSESSMENT

WOUND/LESION Date Originally Reported ▶	#1 _____	#2 _____	#3 _____	#4 _____	#5 _____
Location					
Type	<input type="radio"/> Arterial <input type="radio"/> Diabetic foot ulcer <input type="radio"/> Malignancy <input type="radio"/> Mechanical/Trauma <input type="radio"/> Pressure ulcer <input type="radio"/> Surgical* <input type="radio"/> Dialysis access <input type="radio"/> Venous stasis ulcer <input type="radio"/> IV <input type="radio"/> Other: _____	<input type="radio"/> Arterial <input type="radio"/> Diabetic foot ulcer <input type="radio"/> Malignancy <input type="radio"/> Mechanical/Trauma <input type="radio"/> Pressure ulcer <input type="radio"/> Surgical* <input type="radio"/> Dialysis access <input type="radio"/> Venous stasis ulcer <input type="radio"/> IV <input type="radio"/> Other: _____	<input type="radio"/> Arterial <input type="radio"/> Diabetic foot ulcer <input type="radio"/> Malignancy <input type="radio"/> Mechanical/Trauma <input type="radio"/> Pressure ulcer <input type="radio"/> Surgical* <input type="radio"/> Dialysis access <input type="radio"/> Venous stasis ulcer <input type="radio"/> IV <input type="radio"/> Other: _____	<input type="radio"/> Arterial <input type="radio"/> Diabetic foot ulcer <input type="radio"/> Malignancy <input type="radio"/> Mechanical/Trauma <input type="radio"/> Pressure ulcer <input type="radio"/> Surgical* <input type="radio"/> Dialysis access <input type="radio"/> Venous stasis ulcer <input type="radio"/> IV <input type="radio"/> Other: _____	<input type="radio"/> Arterial <input type="radio"/> Diabetic foot ulcer <input type="radio"/> Malignancy <input type="radio"/> Mechanical/Trauma <input type="radio"/> Pressure ulcer <input type="radio"/> Surgical* <input type="radio"/> Dialysis access <input type="radio"/> Venous stasis ulcer <input type="radio"/> IV <input type="radio"/> Other: _____
*Include depth of infected surgical wound(s) in Size category below ▼					
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: _____ <input type="radio"/> Unstageable <input type="radio"/> Unobservable <input type="radio"/> DTI	Stage: _____ <input type="radio"/> Unstageable <input type="radio"/> Unobservable <input type="radio"/> DTI	Stage: _____ <input type="radio"/> Unstageable <input type="radio"/> Unobservable <input type="radio"/> DTI	Stage: _____ <input type="radio"/> Unstageable <input type="radio"/> Unobservable <input type="radio"/> DTI	Stage: _____ <input type="radio"/> Unstageable <input type="radio"/> Unobservable <input type="radio"/> DTI
Severity of Ulcer (exclude pressure ulcers)	<input type="checkbox"/> Skin only <input type="checkbox"/> Fatty tissue <input type="checkbox"/> Muscle <input type="checkbox"/> Bone <input type="checkbox"/> Muscle necrosis <input type="checkbox"/> Bone necrosis <input type="checkbox"/> Other: _____	<input type="checkbox"/> Skin only <input type="checkbox"/> Fatty tissue <input type="checkbox"/> Muscle <input type="checkbox"/> Bone <input type="checkbox"/> Muscle necrosis <input type="checkbox"/> Bone necrosis <input type="checkbox"/> Other: _____	<input type="checkbox"/> Skin only <input type="checkbox"/> Fatty tissue <input type="checkbox"/> Muscle <input type="checkbox"/> Bone <input type="checkbox"/> Muscle necrosis <input type="checkbox"/> Bone necrosis <input type="checkbox"/> Other: _____	<input type="checkbox"/> Skin only <input type="checkbox"/> Fatty tissue <input type="checkbox"/> Muscle <input type="checkbox"/> Bone <input type="checkbox"/> Muscle necrosis <input type="checkbox"/> Bone necrosis <input type="checkbox"/> Other: _____	<input type="checkbox"/> Skin only <input type="checkbox"/> Fatty tissue <input type="checkbox"/> Muscle <input type="checkbox"/> Bone <input type="checkbox"/> Muscle necrosis <input type="checkbox"/> Bone necrosis <input type="checkbox"/> Other: _____
Odor	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Surrounding Skin	<input type="checkbox"/> Erythema <input type="checkbox"/> Induration <input type="checkbox"/> Maceration <input type="checkbox"/> Normal <input type="checkbox"/> Other: _____	<input type="checkbox"/> Erythema <input type="checkbox"/> Induration <input type="checkbox"/> Maceration <input type="checkbox"/> Normal <input type="checkbox"/> Other: _____	<input type="checkbox"/> Erythema <input type="checkbox"/> Induration <input type="checkbox"/> Maceration <input type="checkbox"/> Normal <input type="checkbox"/> Other: _____	<input type="checkbox"/> Erythema <input type="checkbox"/> Induration <input type="checkbox"/> Maceration <input type="checkbox"/> Normal <input type="checkbox"/> Other: _____	<input type="checkbox"/> Erythema <input type="checkbox"/> Induration <input type="checkbox"/> Maceration <input type="checkbox"/> Normal <input type="checkbox"/> Other: _____
Edema					
Appearance of the Wound Bed	<input type="checkbox"/> Slough _____ % <input type="checkbox"/> Eschar _____ % <input type="checkbox"/> Granulation _____ %	<input type="checkbox"/> Slough _____ % <input type="checkbox"/> Eschar _____ % <input type="checkbox"/> Granulation _____ %	<input type="checkbox"/> Slough _____ % <input type="checkbox"/> Eschar _____ % <input type="checkbox"/> Granulation _____ %	<input type="checkbox"/> Slough _____ % <input type="checkbox"/> Eschar _____ % <input type="checkbox"/> Granulation _____ %	<input type="checkbox"/> Slough _____ % <input type="checkbox"/> Eschar _____ % <input type="checkbox"/> Granulation _____ %
Drainage/Amount	<input type="radio"/> None <input type="radio"/> Small <input type="radio"/> Moderate <input type="radio"/> Large	<input type="radio"/> None <input type="radio"/> Small <input type="radio"/> Moderate <input type="radio"/> Large	<input type="radio"/> None <input type="radio"/> Small <input type="radio"/> Moderate <input type="radio"/> Large	<input type="radio"/> None <input type="radio"/> Small <input type="radio"/> Moderate <input type="radio"/> Large	<input type="radio"/> None <input type="radio"/> Small <input type="radio"/> Moderate <input type="radio"/> Large
Color	<input type="radio"/> Clear <input type="radio"/> Tan <input type="radio"/> Serosanguineous <input type="radio"/> Other	<input type="radio"/> Clear <input type="radio"/> Tan <input type="radio"/> Serosanguineous <input type="radio"/> Other	<input type="radio"/> Clear <input type="radio"/> Tan <input type="radio"/> Serosanguineous <input type="radio"/> Other	<input type="radio"/> Clear <input type="radio"/> Tan <input type="radio"/> Serosanguineous <input type="radio"/> Other	<input type="radio"/> Clear <input type="radio"/> Tan <input type="radio"/> Serosanguineous <input type="radio"/> Other
Consistency	<input type="radio"/> Thin <input type="radio"/> Thick	<input type="radio"/> Thin <input type="radio"/> Thick	<input type="radio"/> Thin <input type="radio"/> Thick	<input type="radio"/> Thin <input type="radio"/> Thick	<input type="radio"/> Thin <input type="radio"/> Thick
Incision Status	<input type="radio"/> Well Approximated <input type="radio"/> Incisional separation <input type="radio"/> Planned secondary Intention	<input type="radio"/> Well Approximated <input type="radio"/> Incisional separation <input type="radio"/> Planned secondary Intention	<input type="radio"/> Well Approximated <input type="radio"/> Incisional separation <input type="radio"/> Planned secondary Intention	<input type="radio"/> Well Approximated <input type="radio"/> Incisional separation <input type="radio"/> Planned secondary Intention	<input type="radio"/> Well Approximated <input type="radio"/> Incisional separation <input type="radio"/> Planned secondary Intention
Dialysis Access	<input type="radio"/> PD <input type="radio"/> AV Graft <input type="radio"/> AV Fistula Site: _____	<input type="radio"/> PD <input type="radio"/> AV Graft <input type="radio"/> AV Fistula Site: _____	<input type="radio"/> PD <input type="radio"/> AV Graft <input type="radio"/> AV Fistula Site: _____	<input type="radio"/> PD <input type="radio"/> AV Graft <input type="radio"/> AV Fistula Site: _____	<input type="radio"/> PD <input type="radio"/> AV Graft <input type="radio"/> AV Fistula Site: _____
IV	<input type="radio"/> Peripheral <input type="radio"/> PICC <input type="radio"/> Central: _____ # of lumens _____	<input type="radio"/> Peripheral <input type="radio"/> PICC <input type="radio"/> Central: _____ # of lumens _____	<input type="radio"/> Peripheral <input type="radio"/> PICC <input type="radio"/> Central: _____ # of lumens _____	<input type="radio"/> Peripheral <input type="radio"/> PICC <input type="radio"/> Central: _____ # of lumens _____	<input type="radio"/> Peripheral <input type="radio"/> PICC <input type="radio"/> Central: _____ # of lumens _____
Date Healed					
Comments:					

MEDICATIONS

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

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

Comments: _____

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

Psychotropic drug use: No Yes (see med sheet)

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

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

Does the patient have special needs or problems administering any of their medications by any route? No Yes If yes, explain: _____

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 Nurse Caregiver Family Other: _____

Site/skin condition: _____

Infusion solution (type/volume/rate): _____

Pump: (type, specify): _____

Administered by: Patient Nurse Caregiver Family Other: _____

Purpose of intravenous: _____

Infusion provided during this visit? No Yes, specify: _____

Review medication profile for details

IMMUNIZATIONS

Within the past 12 months:

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

According to immunization guidelines:

Pneumonia Tetanus Shingles Hepatitis C Other: _____

Needs: _____

Last COVID-19 Vaccination:

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

Medical restrictions or personal preferences impacting immunizations: _____

REFUSED CARES

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

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

PATIENT/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:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Representative <input type="checkbox"/> Family
Diabetic: <input type="checkbox"/> Foot exam <input type="checkbox"/> Care	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Representative <input type="checkbox"/> Family
Insulin administration:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Representative <input type="checkbox"/> Family
Glucometer use:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Representative <input type="checkbox"/> Family
Nutritional management:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Representative <input type="checkbox"/> Family
Medication(s) administration: <input type="checkbox"/> Oral <input type="checkbox"/> Injected <input type="checkbox"/> Infused <input type="checkbox"/> Inhaled <input type="checkbox"/> Topical	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Representative <input type="checkbox"/> Family
Pain management:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Representative <input type="checkbox"/> Family
Oxygen use:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Representative <input type="checkbox"/> Family
Use of medical devices:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Representative <input type="checkbox"/> Family
Pressure reduction:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Representative <input type="checkbox"/> Family
Catheter care:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Representative <input type="checkbox"/> Family
Trach care:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Representative <input type="checkbox"/> Family
Ostomy care:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Representative <input type="checkbox"/> Family
Emergency Preparedness Plan:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Representative <input type="checkbox"/> Family
Infection control:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Representative <input type="checkbox"/> Family
S/S Report to agency:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Representative <input type="checkbox"/> Family
Patient's Rights:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Representative <input type="checkbox"/> Family
Other care(s):		

Teach back method used to: Educate Train Patient Caregiver Representative Family
 Patient Caregiver Representative Family educated this visit specifically for: _____
 Patient Caregiver Representative Family made aware that education training will continue during follow-up visits as needed.

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

After completing this section document the education and training outcome(s), per agency policy. Go to page 22 under Rehabilitation Potential/Anticipated Discharge for Plan of Care to document status of patient's anticipated discharge.

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

NURSING INTERVENTIONS/INSTRUCTIONS

<input type="checkbox"/> Skilled observation & assessment <input type="checkbox"/> Foley care <input type="checkbox"/> Wound care <input type="checkbox"/> Wound dressing <input type="checkbox"/> Pressure ulcer/injury care <input type="checkbox"/> Venipuncture <input type="checkbox"/> Change: <input type="checkbox"/> NG tube <input type="checkbox"/> G tube <input type="checkbox"/> Admin. of vitamin B ₁₂ <input type="checkbox"/> Prep. <input type="checkbox"/> Admin. insulin	<input type="checkbox"/> Teach <input type="checkbox"/> Admin. <input type="checkbox"/> IVs <input type="checkbox"/> Clysis <input type="checkbox"/> Teach ostomy <input type="checkbox"/> Ileo. conduit care <input type="checkbox"/> Teach <input type="checkbox"/> Admin. tube feedings <input type="checkbox"/> Teach <input type="checkbox"/> Admin. care of trach <input type="checkbox"/> Teach care - terminally ill <input type="checkbox"/> IM injection <input type="checkbox"/> SQ injection <input type="checkbox"/> Psych. intervention <input type="checkbox"/> Observe S/S infection	<input type="checkbox"/> Diabetic observation <input type="checkbox"/> Teach diabetic care <input type="checkbox"/> Observe <input type="checkbox"/> Teach medication (N or C) <input type="checkbox"/> effects <input type="checkbox"/> side effects <input type="checkbox"/> Physiology/Disease process teaching <input type="checkbox"/> Diet teaching <input type="checkbox"/> Safety factors <input type="checkbox"/> Prenatal assessment	<input type="checkbox"/> Post-partum assessment <input type="checkbox"/> Teach care of: <input type="checkbox"/> infant <input type="checkbox"/> child <input type="checkbox"/> Pain management <input type="checkbox"/> Fall safety teaching <input type="checkbox"/> Other:
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SUPERVISORY VISIT: Yes No

SUPERVISORY VISIT: Scheduled Unscheduled **STAFF:** Present Not present AIDE LPN/LVN
CARE PLAN UPDATED: No Yes **NEXT SCHEDULED SUPERVISORY VISIT:** _____
CARE PLAN FOLLOWED: Yes No, explain:

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

OBSERVATION OF:

EDUCATION/TRAINING OF:

RECERTIFICATION SUMMARY

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

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

- Dependent upon adaptive device(s)
 Check all that apply: crutches canes walker wheelchair: manual motorized prosthetic limb
- scooter a helper other: _____
- Needs special transportation as indicated by: _____
- Needs physical assist to leave as indicated by: _____

AND/OR

- Leaving home is medically contraindicated due to: _____

2. Criteria Two:

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

AND

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

SUMMARY OF SETBACKS/IMPROVEMENTS SINCE LAST ASSESSMENT

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

Improvements noted with the desired functional taks: N/A

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

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

SUMMARY CHECKLIST

CARE PLAN:

Reviewed Revised with involvement from: Patient Representative Caregiver Outcome achieved

MEDICATION STATUS:

Medication regimen completed/reviewed - see page 19

Comments: _____

CARE COORDINATION:

Certifying Physician SN PT OT SLP MSW Aide Other (specify): _____

Was a referral made to MSW for assistance with:

Community resources Living will Counseling needs Unsafe environment

Other: _____

Date: _____ Yes No Refused N/A

Comments: _____

REFERRAL TO: _____

REASON FOR REFERRAL: _____

APPROXIMATE NEXT VISIT DATE: _____

PLAN FOR NEXT VISIT: _____

RECERTIFICATION: No, complete Discharge Summary Yes, complete remaining sections, as appropriate

Document the reason(s)/medical necessity that supports the continuation of services:

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

Verbal Order Obtained: No Yes, specify date: _____

REHABILITATION POTENTIAL FOR ANTICIPATED DISCHARGE PLANNING

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

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

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

Discussed discharge plan with: Patient Representative Other: _____

List any changes since last assessment:

Anticipated discharge status:

Patient Name _____

ID # _____

CURRENT DME/MEDICAL SUPPLIES/HCBS

DME Company: _____ Phone: _____

Oxygen Company: _____ Phone: _____

Community Organizations Services:

Contact: _____ Phone: _____

Comments:

- NONE USED**
- 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 _____

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 _____