(–) = Dash is a valid response. **See the OASIS C2 Guidance Manual for the exact instructions for each specific item.**

= Look Back *Per agency policy, refer to the Look Back section for data collected at recertification to facilitate the completion of elements M1501, M1511, M2005, M2016, M2301 and M2401.*

PERFORMANCE INDICATORS:
- (O) = Outcome Measure
- (P) = Process Measure
- ($) = Reimbursement Potential
- [R] = Risk Adjustment
- [HH] = Home Health Compare
- (PA) = Potentially Avoidable Event
- ★ = 5 Star

DISCHARGE ASSESSMENT
INCLUDING OASIS ELEMENTS FOR DISCHARGE NOT TO AN INPATIENT FACILITY

DATE:_____

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

Follow OASIS items in sequence unless otherwise directed.

(M0010) CMS Certification Number:

Branch Identification **(M0014) Branch State:**

(M0016) Branch ID Number:

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

❑ **UK - Unknown or Not Available**

Physician Name:_____ (First) ___ (MI)

_____ (Last) _____ (Suffix)

Physician Phone:_____

Physician Fax:_____

Physician Email:_____

Physician Address: (Street/Suite No.)

_____

City:_____ State: ZIP Code:_____

Secondary Physician NPI #:_____

Name:_____ (First) ___ (MI)

_____ (Last) _____ (Suffix)

Phone:_____ Fax:_____

Email:_____

Address: (Street/Suite No.)

_____

City:_____ State:_____ ZIP Code:_____

Primary Care Practitioner/Practitioner's Group or other Health Care Professional responsible for providing care/services **post-discharge**

NPI #:_____ Specialty:_____

Name:_____ (First) ___ (MI)

_____ (Last) _____ (Suffix)

Phone:_____ Fax:_____

Email:_____

Address: (Street/Suite No.)

_____

City:_____ State:_____ ZIP Code:_____

(M0020) Patient ID Number:

Medical Record Number if different from Patient ID Number

_____

(M0030) Start of Care Date: month / day / year (P) [HH] (PA) ★

(M0032) Resumption of Care Date: ❑ **NA - Not Applicable** month / day / year

(M0040) Patient Name: (P) [R] [HH] (PA) ★

(First) (MI)

(Last) (Suffix)

Patient Phone:_____

Patient Email:_____

Patient Address:

_____ (Street/Apt. No.)

_____ (City)

(M0050) Patient State of Residence:

(M0060) Patient ZIP Code: -

(M0063) Medicare Number: ❑ **NA - No Medicare**

(including suffix)

(M0064) Social Security Number: ❑ **UK - Unknown or Not Available**

- -

(M0065) Medicaid Number: ❑ **NA - No Medicaid**

(M0066) Birth Date: month / day / year

Patient's HI Claim No.:

❑ 1 - Same as **M0063**

❑ 2 - Same as **M0065**

❑ 3 - Other:_____

(M0069) Gender [R]

Enter Code

1 Male

2 Female

Name of Emergency Contact:_____

Relationship:_____

Phone:_____

Address:_____

City:_____ State:_____ ZIP Code:_____

Email:_____

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment

Enter Code

1 RN 3 SLP/ST

2 PT 4 OT

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

PATIENT NAME–Last, First, Middle Initial | ID#

BRIGGS Healthcare

Patient Name_____ ID #_____

CLINICAL RECORD ITEMS (Cont'd)

Enter Code 9 only when completing this form. Discharge not to an inpatient facility.

(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)

Follow-Up
4 Recertification (follow-up) reassessment ***[Go to M0110]***
5 Other follow-up ***[Go to M0110]***

Transfer to an Inpatient Facility ◇ (P) R HH (PA)
6 Transferred to an inpatient facility–patient not discharged from agency ***[Go to M1041]***
7 Transferred to an inpatient facility–patient discharged from agency ***[Go to M1041]***

Discharge from Agency – Not to an Inpatient Facility
8 Death at home ***[Go to M2005]***
9 Discharge from agency ***[Go to M1041]***

Primary Diagnosis:_____ ICD#_____._____
Other Diagnoses: _____ ICD#_____._____
_____ ICD#_____._____
_____ ICD#_____._____
Certifying physician's prognosis:_____
_____

Does the patient have a representative to assist post-discharge?
❑ No ❑ Yes
If yes, is the person: ❑ Court declared ❑ Patient selected
Name and Title of Representative:
_____
Representative Mailing Address:
_____
_____
Phone Number(s): Work:_____
Home:_____
Cell:_____
Email:_____

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

Enter Code
0 No ***[Go to M1051]***
1 Yes

(M1046) Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season? (P) HH ★

Enter Code
1 Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)
2 Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)
3 Yes; received from another health care provider (for example, physician, pharmacist)
4 No; patient offered and declined
5 No; patient assessed and determined to have medical contraindication(s)
6 No; not indicated - patient does not meet age/condition guidelines for influenza vaccine
7 No; inability to obtain vaccine due to declared shortage
8 No; patient did not receive the vaccine due to reasons other than those listed in responses 4 – 7.

(M1051) Pneumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example, pneumovax)? (P) HH ★

Enter Code
0 No
1 Yes ***[Go to M1230]***

(M1056) Reason Pneumococcal Vaccine not received: If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason: (P) HH

Enter Code
1 Offered and declined
2 Assessed and determined to have medical contraindication(s)
3 Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine
4 None of the above

LIVING ARRANGEMENTS/SUPPORTIVE ASSISTANCE/CARE PREFERENCES

Primary Caregiver (other than paid home health agency)
Name:_____
Relationship to Patient:_____
Phone Number:_____
Email:_____
❑ Home visit NOT made: ❑ Patient was not available
❑ Other(s) not available:_____
❑ Contacted and had a two-way communication with:
❑ Representative ❑ Caregiver (other than home health staff)
❑ Family Member
Comment:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
❑ Home visit made
❑ Discharge discussed with: ❑ Patient ❑ Representative
❑ Other:_____ ❑ No ❑ Yes
❑ Patient independent with all care needs ADL/IADL
❑ Caregiver(s) needed post-discharge
❑ If applicable, paid service(s) (other than home health staff) that will continue post-discharge: ❑ N/A
Company Name:_____
Phone Number:_____
Contact Name:_____
Services that caregiver(s) were assisting with (ADLs, IADLs and/or medical cares):_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Name_____ ID #_____

SENSORY STATUS

(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language): ◇O R

Enter Code ☐

0 Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.

1 Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).

2 Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.

3 Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.

4 Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible).

5 Patient nonresponsive or unable to speak.

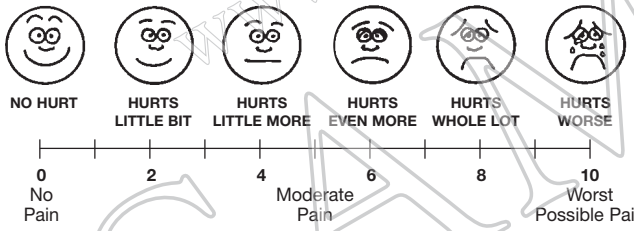
PAIN

Check box to indicate which pain assessment was used.

❑ **Wong-Baker** ❑ **PAINAD**

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 (Cont'd)

❑ **No Problem**

Is patient experiencing pain? ❑ Yes ❑ No

❑ Unable to communicate

Non-verbals demonstrated:

❑ Diaphoresis ❑ Grimacing

❑ Moaning ❑ Crying ❑ Guarding ❑ Irritability ❑ Anger

❑ Tense ❑ Restlessness ❑ Change in vital signs

❑ Other:_____

❑ Self-assessment ❑ Implications:_____

How does the pain interfere/impact their functional/activity level? (explain)

Discharge/on-going plan of care (explain):

(M1242) Frequency of Pain Interfering with patient's activity or movement: ◇O $ R HH ★

Enter Code ☐

0 Patient has no pain

1 Patient has pain that does not interfere with activity or movement

2 Less often than daily

3 Daily, but not constantly

4 All of the time

Pain Assessment IN Advanced Dementia - PAINAD*

ITEMS	0	1	2	SCORE
Breathing Independent of Vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.	
Negative Vocalization	None	Occasional moan or groan. Low level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial Expression	Smiling, or inexpressive	Sad, Frightened, Frowning.	Facial grimacing	
Body Language	Relaxed	Tense, Distressed pacing, Fidgeting.	Rigid. Fists clenched, Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or 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 Document updated 1.10.2013.

Patient Name_____ ID #_____

PAIN (Cont'd)

What makes pain worse? ❑ Movement ❑ Ambulation ❑ Immobility
❑ Other:_____
Is there a pattern to the pain? (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? ❑ Occasionally ❑ Continuously ❑ Intermittent
Current pain control medications adequate: ❑ Yes ❑ No
Comment:_____
_____
_____

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.)			

NUTRITIONAL STATUS

❑ **No Problem**

❑ NAS ❑ NPO ❑ Controlled Carbohydrate ❑ Other:_____
Nutritional requirements (diet):_____
_____
❑ Increase fluids _____ amt. ❑ Restrict fluids _____ amt.
Appetite: ❑ Good ❑ Fair ❑ Poor ❑ Anorexic
❑ Nausea ❑ Vomiting:
Frequency:_____ Amount:_____
❑ Heartburn (food intolerance)
❑ Other: _____
Nutritional Status:
Patient's nutritional approach:_____

ENDOCRINE STATUS

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

SYSTEMS REVIEW

Complete section per organizational guidelines for disciplines

Weight:_____ ❑ reported ❑ actual
A1C _____% ❑ Patient reported
❑ Lab slip Date:_____
BS _____mg/dL Date:_____ Time:_____
❑ FBS ❑ Before meal ❑ Postprandial ❑ Random ❑ HS
❑ Blood sugar ranges:_____
❑ Patient ❑ Caregiver ❑ Family Report
Monitored by: ❑ Self ❑ Caregiver ❑ Nurse ❑ Family
❑ Other:_____

SYSTEMS REVIEW (Cont'd)

❑ **No Problem**

Disease Management for:
❑ Eyes (specify):_____
_____
_____
❑ Ears (specify):_____
_____
_____
❑ Nose, throat, mouth (specify):_____
_____
❑ Other (specify):_____
_____
_____
_____

INTEGUMENTARY STATUS

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

Enter Code ☐
0 No ***[Go to M1322]***
1 Yes

(M1307) The **Oldest Stage 2 Pressure Ulcer** that is present at discharge: (Excludes healed Stage 2 Pressure Ulcers) PA

Enter Code ☐
1 Was present at the most recent SOC/ROC assessment
2 Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified:
☐☐/☐☐/☐☐☐☐ (month / day / year)
NA No Stage 2 pressure ulcers are present at discharge

Complete Braden Scale form per organizational guideline (Briggs #3166). OASIS Scoring Instructions (see page 7 of 20).

Definitions:

- **Unhealed:** The absence of the skin's original integrity.
- **Non-epithelialized:** The absence of the regeneration of the epidermis across a wound surface.
- **Pressure Ulcer:** A *pressure ulcer* is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear. *A number of contributing or confounding factors also are associated with pressure ulcers; the significance of these factors is yet to be elucidated.*

Patient Name_____ ID #_____

INTEGUMENTARY STATUS (Cont'd)

Definitions:

- **Newly epithelialized:**
  - Wound bed completely covered with new epithelium
  - No exudate
  - No avascular tissue (eschar and/or slough)
  - No signs or symptoms of infection
- **Fully granulating:**
  - Wound bed filled with granulation tissue to the level of the surrounding skin
  - No dead space
  - No avascular tissue (eschar and/or slough)
  - No signs or symptoms of infection
  - Wound edges are open
- **Early/partial granulation:**
  - ≥25% of the wound bed is covered with granulation tissue
  - <25% of the wound bed is covered with avascular tissue (eschar and/or slough)
  - No signs or symptoms of infection
  - Wound edges open
- **Not healing:**
  - Wound with ≥25% avascular tissue (eschar and/or slough) OR
  - Signs/symptoms of infection OR
  - Clean but non-granulating wound bed OR
  - Closed/hyperkeratotic wound edges OR
  - Persistent failure to improve despite appropriate comprehensive wound management

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage $ R PA	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 at DC Go to M1311B1]	☐
A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 at DC Go to M1311C1]	☐
B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers** [If 0 at DC Go to M1311D1]	☐
C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers due to non-removable dressing/device** [If 0 at DC Go to M1311E1	☐
D2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** [If 0 at DC Go to M1311F1]	☐
E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** [Go to M1313 (at Discharge)]	☐
F2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐

Patient Name_____ ID #_____

INTEGUMENTARY STATUS (Cont'd)

If applicable, review the *Briggs Integumentary Status Chart's* data located on the patient's recertification form(s) and refer to the algorithm to faciliate completion of M1313 pressure ulcers (location, stage and size). NOTE: Date Originally Reported will come after the most recent SOC/ROC date.

(M1313) Worsening in Pressure Ulcer Status since SOC/ROC: (H)

Instructions for a-c: Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter 0.

	Enter Number
a. Stage 2	
b. Stage 3	
c. Stage 4	

Instructions for e: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were at a Stage 1 or 2 at the most recent SOC/ROC.

	Enter Number
d. Unstageable – Known or likely but Unstageable due to non-removable dressing.	
e. Unstageable – Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	
f. Unstageable – Suspected deep tissue injury in evolution.	

OASIS ITEM Reporting Algorithm for M1313

CURRENT STAGE *at Discharge*	Look back to *most recent SOC/ROC*	PRIOR STAGE *at most recent SOC/ROC*	REPORT AS NEW OR WORSENED?
a. Stage 2 *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	• **Not present** • **Stage 1** • **Covered with a non-removable dressing/device, then documented as a Stage 1 at any home visit or Follow-Up assessment(s)**	**YES**
		• Stage 2	NO
		• Stage 3 • Stage 4	NA (Stage 3 or 4 could not become a Stage 2)
		• Covered with a non-removeable dressing/device and remains Unstageable until assessed as a Stage 2 at Discharge	NO
b. Stage 3 *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	• **Not present** • **Stage 1** • **Stage 2** • **Unstageable with documented Stage 1 and/or 2 at any home visit or Follow-Up assessment(s)**	**YES**
		• Stage 3	NO
		• Stage 4	NA (Stage 4 could not become a Stage 3)
		• Unstageable until assessed as a Stage 3 at Discharge	NO
c. Stage 4 *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	• **Not present** • **Stage 1** • **Stage 2** • **Stage 3** • **Unstageable with documented Stage 1, 2 and/or 3 at any home visit or Follow-Up assessment(s)**	**YES**
		• Stage 4 • Unstageable until assessed as a Stage 4 at Discharge	NO
d. Unstageable due to non-removeable dressing *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	• **Not present**	**YES**
		• Stage 1 • Stage 2 • Stage 3 • Stage 4 • Unstageable	NO
e. Unstageable due to slough and/or eschar *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	• **Not present** • **Stage 1** • **Stage 2**	**YES**
		• Stage 3 • Stage 4 • Unstageable	NO
f. Unstageable-suspected deep tissue injury *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	• **Not present** • **Stage 1** • **Stage 2**	**YES**
		• Stage 3 • Stage 4 • Unstageable due to slough and/or eschar	NA (Full thickness pressure ulcer could not become a sDTI)
		• Unstageable-suspected DTI or due to a non-removeable dressing/device	NO

(M1320) Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)

Enter Code

0 Newly epithelialized
1 Fully granulating
2 Early/partial granulation
3 Not healing
NA No observable pressure ulcer

(M1322) Current Number of Stage 1 Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. ($) [R]

Enter Code

0 3
1 4 or more
2

(M1324) Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable: (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.) ($) [R] (PA)

Enter Code

1 Stage 1
2 Stage 2
3 Stage 3
4 Stage 4
NA Patient has no pressure ulcers or no stageable pressure ulcers

(M1330) Does this patient have a **Stasis Ulcer**? ($) [R]

Enter Code

0 No ***[Go to M1340]***
1 Yes, patient has BOTH observable and unobservable stasis ulcers
2 Yes, patient has observable stasis ulcers ONLY
3 Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) ***[Go to M1340]***

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

Enter Code

1 One 3 Three
2 Two 4 Four or more

($) [R]

(M1334) Status of Most Problematic Stasis Ulcer that is Observable:

Enter Code

1 Fully granulating 3 Not healing
2 Early/partial granulation

($) [R] (PA)

(M1340) Does this patient have a **Surgical Wound?** (O) [R] [HH]

Enter Code

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

(M1342) Status of Most Problematic Surgical Wound that is Observable

Enter Code

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

(O) ($) [R] [HH] (PA)

Patient Name_____ ID #_____

INTEGUMENTARY STATUS (Cont'd)

OASIS SCORING INSTRUCTIONS:

- Home health agencies may adopt the NPUAP guidelines in their clinical practice and documentation. However, since CMS has adapted the NPUAP guidelines for OASIS purposes, the definitions do not perfectly align with each stage as described by NPUAP. **When discrepancies exist between the NPUAP definitions and the OASIS scoring instructions provided in the OASIS Guidance Manual and CMS Q&As, providers should rely on the CMS OASIS instructions.**
- Pressure ulcers are defined as localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.
- If pressure is not the primary cause of the lesion, do not report the wound as a pressure ulcer.
- Terminology referring to "healed" vs. "unhealed" ulcers can refer to whether the ulcer is "closed" vs. "open". Recognize, however, that Stage 1 pressure ulcers and Suspected Deep Tissue Injury (sDTI), although closed (intact skin), would not be considered healed. Unstageable pressure ulcers, whether covered with a non-removable dressing or eschar or slough, would not be considered healed.
- Stage 2 (partial thickness) pressure ulcers heal through the process of regeneration of the epidermis across a wound surface, known as "re-epithelialization."
- Stage 3 and 4 (full thickness) pressure ulcers heal through a process of granulation (filling of the wound with connective/scar tissue), contraction (wound margins contract and pull together), and re-epithelialization (covers with epithelial tissue from within wound bed and/or from wound margins). Once the pressure ulcer has fully granulated and the wound surface is completely covered with new epithelial tissue, the wound is considered closed, and will continue to remodel and increase in tensile strength. **For the purposes of scoring the OASIS, the wound is considered healed at this point, and should no longer be reported as an unhealed pressure ulcer.**
- Agencies should be aware that the patient is at higher risk of having the site of a closed pressure ulcer open up due to damage, injury, or pressure, because of the loss of tensile strength of the overlying tissue. Tensile strength of the skin overlying a closed full thickness pressure ulcer is only 80% of normal skin tensile strength. Agencies should pay careful attention that preventative measures are put into place that will mitigate the re-opening of a closed ulcer.
- Do not reverse stage pressure ulcers as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals.

DEFINITIONS – Pressure Ulcer/Injury Stages:

Stage 1 ulcers

- Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

Stage 2 ulcers

- Definition: Stage 2 pressure ulcers are characterized by partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister**.**

Stage 3 and 4 ulcers

- Definition: Stage 3 pressure ulcers are characterized by 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 or tunneling.
- Definition: Stage 4 pressure ulcers are characterized by 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.

Additional Information

- Report the number of Stage 2 or higher pressure ulcers that are present on the current day of assessment.
- If any bone, tendon or muscle or joint capsule (Stage 4 structures) is visible, the pressure ulcer should be reported as a Stage 4 pressure ulcer, regardless of the presence or absence of slough and/or eschar in the wound bed.
- A previously closed Stage 3 or Stage 4 pressure ulcer that is currently open again should be reported at its worst stage.
- If the patient has been in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, thus making it challenging to know the stage of the wound at its worst. The clinician should make every effort to contact previous providers (including patient's physician) to determine the stage of the wound at its worst. An ulcer's stage can worsen, and this item should be answered using the worst stage if this occurs.
- A muscle flap, skin advancement flap, or rotational flap (defined as full thickness skin and subcutaneous tissue partially attached to the body by a narrow strip of tissue so that it retains its blood supply) performed to surgically replace a pressure ulcer is a surgical wound. It should not be reported as a pressure ulcer on M1311.
- A pressure ulcer treated with a skin graft (defined as transplantation of skin to another site) should not be reported as a pressure ulcer and until the graft edges completely heal, should be reported as a surgical wound on M1340.
- A pressure ulcer that has been surgically debrided remains a pressure ulcer and should not be reported as a surgical wound on M1340.

Unstageable ulcers

- Definition: Pressure ulcers covered with slough and/or eschar are unstageable. Rationale: The true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. The pressure ulcer stage can be determined only when enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage.
- Pressure ulcers that are known to be present but that are Unstageable due to a dressing/device, such as a cast that cannot be removed to assess the skin underneath, should be reported as unstageable. "Known" refers to when documentation is available that states a pressure ulcer exists under the non-removable dressing/device. Examples of a non-removable dressing/device include a dressing that is not to be removed per physician's order (such as those used in negative-pressure wound therapy [NPWT], an orthopedic device, or a cast.
- Suspected deep tissue injury in evolution, which is defined as a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

Patient Name________________________ ID #______________

INTEGUMENTARY STATUS (Cont'd)

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

Wound care done during this visit: ❑ Yes ❑ No Location(s) wound site:____________________

❑ Soiled dressing removed by:

❑ Patient ❑ Caregiver (name)________________ ❑ Family ❑ RN ❑ PT ❑ Other:______________

Technique: ❑ Sterile ❑ Clean

❑ Wound cleaned with (specify):____________________

❑ Wound irrigated with (specify):____________________

❑ Wound packed with (specify):____________________

❑ Wound dressing applied (specify):____________________

Patient tolerated procedure well: ❑ Yes ❑ No

Comments:____________________

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

Frequency of diabetic foot exam____________________

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

Exam by clinician this visit: ❑ Yes ❑ No

Integument findings:____________________

____

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

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

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

Complete LEAP Diabetic Foot Screening (Briggs form 3484P) per organizational guideline

Comments:____________________

BRIGGS INTEGUMENTARY STATUS CHART

WOUND/LESION Date Originally Reported ➤	#1 ________	#2 ________	#3 ________	#4 ________	#5 ________
Location					
Type	❑ Arterial ❑ Diabetic foot ulcer ❑ Malignancy ❑ Mechanical/Trauma ❑ Pressure ulcer ❑ Surgical ❑ Venous stasis ulcer	❑ Arterial ❑ Diabetic foot ulcer ❑ Malignancy ❑ Mechanical/Trauma ❑ Pressure ulcer ❑ Surgical ❑ Venous stasis ulcer	❑ Arterial ❑ Diabetic foot ulcer ❑ Malignancy ❑ Mechanical/Trauma ❑ Pressure ulcer ❑ Surgical ❑ Venous stasis ulcer	❑ Arterial ❑ Diabetic foot ulcer ❑ Malignancy ❑ Mechanical/Trauma ❑ Pressure ulcer ❑ Surgical ❑ Venous stasis ulcer	❑ Arterial ❑ Diabetic foot ulcer ❑ Malignancy ❑ Mechanical/Trauma ❑ Pressure ulcer ❑ Surgical ❑ Venous stasis ulcer
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)**					
Date Healed					
Odor					
Surrounding Skin					
Edema					
Appearance of the Wound Bed					
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

Patient Name_____ ID #_____

RESPIRATORY STATUS

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

Enter Code ☐

0 Patient is not short of breath ◇ $ R HH ★
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)

VITAL SIGNS

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

Temperature:_____ ❑ Oral ❑ Axillary ❑ Rectal ❑ Tympanic

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

Respirations:_____ ❑ Regular ❑ Irregular ❑ Cheynes Stokes ❑ Death rattle ❑ Apnea periods ____sec. (❑ observed ❑ reported) ❑ Accessory muscles used

❑ Non-smoker ❑ Smoker Last smoked: _____

CARDIOPULMONARY

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_____

O_2 @ _____ LPM via ❑ cannula ❑ mask ❑ trach O_2 saturation _____%

Trach size/type _____
Who manages? ❑ Self ❑ RN ❑ Caregiver ❑ Family

Intermittent treatments (e.g., C&DB, 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 ❑ Murmur
❑ Pacemaker: Date:_____ Last date checked:_____
Type: _____

Chest Pain: ❑ Anginal ❑ Postural ❑ Localized ❑ Substernal
❑ Radiating ❑ Dull ❑ Ache ❑ Sharp ❑ Vise-like
Associated with: ❑ Shortness of breath ❑ Activity ❑ Sweats
Frequency/duration:_____
How relieved:_____
❑ Palpitations ❑ Fatigue

Edema: ❑ Pedal ❑ Right ❑ Left ❑ Sacral
❑ Dependent:_____
❑ Pitting ❑ +1 ❑ +2 ❑ +3 ❑ +4 ❑ Non-pitting
Site:_____

CARDIOPULMONARY (Cont'd)

❑ Cramps ❑ Claudication
Capillary refill: ❑ Less than 3 seconds ❑ Greater than 3 seconds
❑ **Disease Management Problems (explain):**_____

CARDIAC STATUS

(M1501) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at the time of or at any time since the most recent SOC/ROC assessment? P HH ↩

Enter Code ☐

0 No ***[Go to M1600 at DC]***
1 Yes
2 Not assessed ***[Go to M1600 at DC]***
NA Patient does not have diagnosis of heart failure ***[Go to M1600]***

(M1511) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the most recent SOC/ROC assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)** P HH ↩

❑ 0 - No action taken
❑ 1 - Patient's physician (or other primary care practitioner) contacted the same day
❑ 2 - Patient advised to get emergency treatment (for example, call 911 or go to emergency room)
❑ 3 - Implemented physician-ordered patient-specific established parameters for treatment
❑ 4 - Patient education or other clinical interventions
❑ 5 - Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)

ELIMINATION STATUS

(M1600) Has this patient been treated for a **Urinary Tract Infection** in the past 14 days? ◇ PA

Enter Code ☐

0 No NA Patient on prophylactic treatment
1 Yes

(M1610) Urinary Incontinence or Urinary Catheter Presence: ◇ $ R

Enter Code ☐

0 No incontinence or catheter (includes anuria or ostomy for urinary drainage) ***[Go to M1620]***
1 Patient is incontinent
2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) ***[Go to M1620]***

(M1615) When does **Urinary Incontinence** occur? ◇ R

Enter Code ☐

0 Timed-voiding defers incontinence
1 Occasional stress incontinence
2 During the night only
3 During the day only
4 During the day and night

(M1620) Bowel Incontinence Frequency: ◇ $ R

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

Urinary output: ❑ WNL Catheter changed:_____
Last BM:_____

Patient Name_____ ID #_____

NEURO/EMOTIONAL/BEHAVIOR STATUS

(M1700) Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands. ◇ (P) R HH

Enter Code ☐

0 Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.

1 Requires prompting (cuing, 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 ☐ ◇ (P) R HH (PA)

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): ◇ (P) R HH

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

(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week **(Reported or Observed): (Mark all that apply.)** R (PA)

❑ 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

(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 ☐ ◇ R

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

PSYCHOSOCIAL/MENTAL AND COGNITIVE STATUS

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

_____

_____

Was the patient able to communicate their needs? ❑ Yes ❑ No

If no, explain:_____

_____

_____

Primary language spoken:

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

Who are the people included in the patient's non-clinical support team? For example, family, friends, church members, social group, etc.

_____

_____

_____

_____

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widower

Number of children _____ Ages and gender:_____

_____

_____

Do children live near the patient? ❑ Yes ❑ No

❑ Spiritual resource:_____

Phone:_____

Feelings/emotions the patient reports:

❑ Angry ❑ Fear ❑ Sadness ❑ Discouraged ❑ Lonely ❑ Depressed

❑ Helpless ❑ Content ❑ Happy ❑ Hopeful ❑ Motivated

❑ Other:_____ ❑ N/A - No answer given

Describe the patient's mental status. Description should include their general appearance, behaviors, emotional responses, mental functioning and their overall demeanor. Include both the clinical objective observations and subjective descriptions reported during this visit. Consider including information collected at SOC/ROC, items M1700-1750 and M2102 in your description.

Mental status reported by: ❑ Patient ❑ Caregiver ❑ Representative

❑ Other:_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Name_____ ID #_____

PSYCHOSOCIAL/MENTAL AND COGNITIVE STATUS (Cont'd)

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:_____

_____

_____

_____

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

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
❑ Verbal ❑ Physical disruptive behaviors ❑ Delusional
❑ Paranoid behaviors ❑ None of the above

Was the patient receiving psychiatric nursing services at home?
❑ No ❑ Yes

COMMENTS

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 A 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**

ADL/IADLs

(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). ◇ O R PA

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.

Patient Name_____ ID #_____

ADL/IADLs (Cont'd)

(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: ◇ $ R

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: ◇ $ R

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. ◇ $ R HH PA ★

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. ◇ $ R PA

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. ◇ R PA

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.

(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. ◇ $ R HH PA ★

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. ◇ P $ R HH PA ★

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.

Patient Name_____ ID #_____

ADL/IADLs (Cont'd)

(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. ◇ R PA

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.

(M1880) Current **Ability to Plan and Prepare Light Meals** (for example, cereal, sandwich) or reheat delivered meals safely: ◇ R

Enter Code ☐

0 (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR

(b) 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 (specifically: prior to this home care admission).

1 Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.

2 Unable to prepare any light meals or reheat any delivered meals.

(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate. ◇ R

Enter Code ☐

0 Able to dial numbers and answer calls appropriately and as desired.

1 Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers.

2 Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.

3 Able to answer the telephone only some of the time or is able to carry on only a limited conversation.

4 Unable to answer the telephone at all but can listen if assisted with equipment.

5 Totally unable to use the telephone.

NA Patient does not have a telephone.

ALLERGIES

Allergies: ❑ None known

❑ Aspirin ❑ Penicillin ❑ Sulfa ❑ Pollen

❑ Eggs ❑ Milk products ❑ Insect bites

❑ Other:_____

MEDICATIONS

(M2005) Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC? P

Enter Code ☐

0 No

1 Yes

9 NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

(M2016) Patient/Caregiver Drug Education Intervention: At the time of, or at any time since the most recent SOC/ROC assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur? P HH ★

Enter Code ☐

0 No

1 Yes

NA Patient not taking any drugs

(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.)** ◇ R HH PA

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.** ◇ R

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.

Does the patient have a peripheral IV line or implanted infusion device?

❑ Yes, type_____ ❑ No

Comments:_____

Patient Name_____ ID #_____

CARE MANAGEMENT

(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. R PA

Enter Code ☐

a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding)
- 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

Enter Code ☐

b. **IADL assistance** (for example, meals, housekeeping, laundry, telephone, shopping, finances)
- 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

Enter Code ☐

c. **Medication administration** (for example, oral, inhaled or injectable)
- 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

Enter Code ☐

d. **Medical procedures/ treatments** (for example, changing wound dressing, home exercise program)
- 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

Enter Code ☐

e. **Management of Equipment** (for example, oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies)
- 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

Enter Code ☐

f. **Supervision and safety** (for example, 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

Enter Code ☐

g. **Advocacy or facilitation** of patient's participation in appropriate medical care (for example, transportation to or from appointments)
- 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

EMERGENT CARE

(M2301) Emergent Care: At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)? O PA

Enter Code ☐

- 0 No ***[Go to M2401]***
- 1 Yes, used hospital emergency department WITHOUT hospital admission
- 2 Yes, used hospital emergency department WITH hospital admission
- UK Unknown ***[Go to M2401]***

(M2310) Reason for Emergent Care: For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? **(Mark all that apply.)** PA

- ❑ 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- ❑ 2 - Injury caused by fall
- ❑ 3 - Respiratory infection (for example, pneumonia, bronchitis)
- ❑ 4 - Other respiratory problem
- ❑ 5 - Heart failure (for example, fluid overload)
- ❑ 6 - Cardiac dysrhythmia (irregular heartbeat)
- ❑ 7 - Myocardial infarction or chest pain
- ❑ 8 - Other heart disease
- ❑ 9 - Stroke (CVA) or TIA
- ❑ 10 - Hypo/Hyperglycemia, diabetes out of control
- ❑ 11 - GI bleeding, obstruction, constipation, impaction
- ❑ 12 - Dehydration, malnutrition
- ❑ 13 - Urinary tract infection
- ❑ 14 - IV catheter-related infection or complication
- ❑ 15 - Wound infection or deterioration
- ❑ 16 - Uncontrolled pain
- ❑ 17 - Acute mental/behavioral health problem
- ❑ 18 - Deep vein thrombosis, pulmonary embolus
- ❑ 19 - Other than above reasons
- ❑ UK - Reason unknown

Patient Name_____ ID #_____

STRENGTHS/LIMITATIONS, EDUCATION/TRAINING, RISK FACTORS AND REFUSED CARES - RELATED TO PLAN OF CARE

List the patient's identified strengths that contributed to them meeting their goals:_____

List any ❑ Education ❑ Training that was provided for the ❑ Patient ❑ Caregiver ❑ Representative ❑ Other:_____ during this home health admission:

List the patient's identified limitations towards meeting their goals:

List any diagnosed permanent disability/impairment (physical, mental and/or cognitive limitations) the patient has:_____

What was the HHA doing/implementing to mitigate the patient's limitations?

Did the ❑ Patient ❑ Representative ❑ Caregiver ❑ Family member report how the patient's limitation(s) may have affected the patient's safety and/or progress toward the goals? ❑ No ❑ Yes If yes, explain:

Did the ❑ Patient ❑ Representative ❑ Caregiver ❑ Family Member report any significant changes with the patient's condition since the last visit? ❑ No ❑ Yes If yes, explain:

List any cares/services the ❑ Patient ❑ Representative ❑ Other:_____ refused during this episode that related to/effected a significant part of the recommended care:

Did the patient have any ❑ Unplanned hospital admission ❑ Emergency department visit at any time during this home health episode? ❑ No ❑ Yes If yes, explain:_____

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

(M2401) Intervention Synopsis: (Check only **one** box in each row.) At the time of or at any time since the most recent SOC/ROC assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented? (P) HH

Plan / Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	❑ 0	❑ 1	❑ NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
b. Falls prevention interventions	❑ 0	❑ 1	❑ NA	Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	❑ 0	❑ 1	❑ NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d. Intervention(s) to monitor and mitigate pain	❑ 0	❑ 1	❑ NA	Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	❑ 0	❑ 1	❑ NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	❑ 0	❑ 1	❑ NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

Patient Name_____ ID #_____

Options 1-4, use Briggs form 3494P-18, Transfer to Inpatient Facility

(M2410) To which **Inpatient Facility** has the patient been admitted? ◇ O

Enter Code ☐

1 Hospital ***[Go to M2430]***
2 Rehabilitation facility ***[Go to M0903]***
3 Nursing home ***[Go to M0903]***
4 Hospice ***[Go to M0903]***
NA No inpatient facility admission

(M2420) Discharge Disposition: Where is the patient after discharge from your agency? **(Choose only one answer.)** ◇ O PA

Enter Code ☐

1 Patient remained in the community (without formal assistive services)
2 Patient remained in the community (with formal assistive services)
3 Patient transferred to a non-institutional hospice
4 Unknown because patient moved to a geographic location not served by this agency
UK Other unknown ***[Go to M0903]***

SKILLED CARE PROVIDED THIS VISIT

(M0903) Date of Last (Most Recent) Home Visit:

☐☐ / ☐☐ / ☐☐☐☐
month day year

(M0906) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient. P HH PA

☐☐ / ☐☐ / ☐☐☐☐
month day year

DISCHARGE STATUS

Status at Discharge:

❑ Returned to an independent level of care (self-care)
❑ Able to remain in residence with assistance of: ❑ Primary Caregiver ❑ Support from community agencies
❑ Restorative Potential - functionally improved and benefited from rehabilitative care.
❑ Discussed discharge with: ❑ Patient ❑ Representative ❑ Other:_____
List any changes since last assessment:_____

REASON FOR DISCHARGE

Note: *Check for stricter state laws where applicable. Select only one answer below.*

§ 484.50(d) The HHA may only transfer or discharge the patient from the HHA if:

❑ The discharge is necessary for the patient's welfare because the HHA and the physician who is responsible for the home health plan of care agree that the HHA can no longer meet the patient's needs, based on the patient's acuity.

❑ Patient or payer will no longer pay for the services provided by the HHA (Note: some states do not allow discharge for non-payment).

❑ The discharge is appropriate because the physician who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care in accordance with § 484.60(a)(2)(xiv) have been achieved, and the HHA and the physician who is responsible for the home health plan of care agree that the patient no longer needs the HHA's services.

❑ Patient refuses services, or elects to be transferred or discharged.

❑ HHA determines, under a policy set by the HHA for the purpose of addressing discharge for cause that meets the requirements, of paragraphs (d)(5)(i) through (d)(5)(iii), that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the HHA to operate effectively is seriously impaired.

❑ Patient dies

❑ HHA ceases to operate

Additional information (explain):_____

Patient Name_____ ID #_____

DISCHARGE REVIEW/CHECKLIST

A copy of the patient's Discharge Instructions, Briggs form #3585/2P, was provided to the:
❑ Patient ❑ Caregiver ❑ Representative ❑ Physician(s) responsible for the plan of care
❑ Primary care practitioner/practitioner's group or another health care professional responsible for providing care/services post-discharge:_____

❑ Patient ❑ Caregiver ❑ Representative ❑ Family were notified beforehand of pending discharge: ❑ No ❑ Yes Date notified:_____
❑ HHABN ❑ HHCCN given to ❑ Patient ❑ Caregiver ❑ Representative ❑ Family: ❑ N/A ❑ Yes - Date given:_____
❑ Medication reconciliation was completed per agency policy.
Pertinent findings reviewed with the ❑ Patient ❑ Caregiver ❑ Representative ❑ Family ❑ Yes ❑ No (explain):_____

❑ All patient education and/or instructions were provided for continued health needs post-discharge, per agency policy.
❑ Patient ❑ Caregiver ❑ Representative ❑ Family instructed to call physician for follow-up appointment(s), as appropriate, for follow-up care, treatments, or services: ❑ Yes ❑ No
❑ Patient ❑ Caregiver ❑ Representative ❑ Family participated with discharge planning: ❑ Yes ❑ No
❑ Patient ❑ Caregiver ❑ Representative ❑ Family verbalized awareness and independence with:
❑ Medication(s) management ❑ Medication safety ❑ Home exercise program ❑ Diet requirements ❑ Nutritional requirements
❑ Treatment(s) ❑ Safety measures ❑ Equipment ❑ Other:_____

❑ Patient ❑ Caregiver ❑ Representative ❑ Family verbalized understanding of discharge instructions: ❑ Yes ❑ No (explain):_____

Reviewed: ❑ Home safety ❑ Fall precautions ❑ Patient ❑ Caregiver ❑ Representative ❑ Family instructed: ❑ When to contact physician
❑ Standard precautions ❑ Other (describe):_____
Was a referral made to MSW for assistance with: ❑ Community resources ❑ Living will ❑ Counseling needs ❑ Unsafe environment
❑ Other:_____ Date:_____ ❑ Yes ❑ No ❑ Refused ❑ N/A
Comment:_____
Community referrals made to:
Was the patient's discharge: ❑ Expected/planned ❑ Not planned/unexpected
Was the post-discharge primary care practitioner notified of the discharge date prior to the day of discharge? ❑ Yes ❑ No
Did the ❑ patient ❑ representative communicate specific preferences related to the discharge? ❑ No ❑ Yes If yes, explain:

If no, explain:_____
Was the ❑ Patient ❑ Representative given contact information for agencies or providers that will continue to provide services, to the patient, post-discharge? ❑ Yes ❑ No If no, explain:_____
❑ Post-Discharge referrals or continuation of services (example: Meals on Wheels, Home and Community Based Waiver Services (HCBS), Senior Center, laboratory and/or outpatient therapy etc.)

Provider Name/Service Type	Referral (R) / Continued (C)	Contact Name	Phone Number
	❑ R ❑ C		
	❑ R ❑ C		
	❑ R ❑ C		
	❑ R ❑ C		

Certifying Physician (print name):_____ Phone:_____ Fax:_____
Date physician notified of discharge:_____ Method of notification:_____
Copy of medication reconciliation included with summary: ❑ Yes ❑ No (explain):_____
Comments:_____

SIGNATURE/DATES

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

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

OASIS INFORMATION

Date Reviewed_____ **Date Entered & Locked**_____ **Date Transmitted**_____

Patient Name_____ ID #_____

PHYSICIAN DISCHARGE SUMMARY (Include skilled care provided this visit and analysis of findings)

Dear Doctor_____ This Discharge Summary is for your records.
Thank you for allowing us to care for your patient.

DISCIPLINES INVOLVED AND NOTIFIED OF DISCHARGE:

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

List services provided during this admission. Include services from providers outside the agency (e.g., Meals on Wheels, Waiver Services):

_____

_____

Complete this Section for Discharge Purposes (Unless Summary is written elsewhere)

Patient Name: (Last, first, middle initial) _____

Reason for initial referral/diagnosis:_____

Certification period:_____ to _____ SOC date:_____ Discharge date:_____

Insurance:_____ Last primary physician visit date:_____

Discipline(s) discharging: ❑ SN ❑ PT ❑ OT ❑ SLP ❑ MSW ❑ Aide ❑ Other_____ ❑ Other _____

If applicable, services that will continue or start: _____

Emergency contact name:_____ Relationship:_____ Phone:_____

Was the discharge planned? ❑ Yes ❑ No If not explain:_____

Reason for Discharge (recorded on page 16)_____

_____

_____

_____

If planned, was a verbal order obtained from certifying physician? ❑ Yes Specify date:_____ ❑ No If no, explain:_____

_____

_____

_____

The members of the patient's HHA disciplinary team, other than physician(s), were notified about discharge? ❑ Yes ❑ No If no, explain:_____

_____

_____

_____

List all physicians involved in the plan of care, who issued orders, other than the physician who signed the plan of care:

Physician Name 1:_____ NPI #:_____

Address:_____

Phone Number:_____ Fax Number:_____

Email Address:_____

Physician Name 2:_____ NPI #:_____

Address:_____

Phone Number:_____ Fax Number:_____

Email Address:_____

Note: *§ 484.60(d)(1) and (2) HHAs must assure communication with all physicians involved in the plan of care, and integrate orders from all physicians involved in the plan of care to assure the coordination of all services and interventions provided to the patient.*

❑ **Post-Discharge** *Provide a completed discharge summary to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge.*

Contact Information for Post-Discharge Provider:

Physician Name or Group Name:_____ NPI # (if applicable):_____

Phone Number:_____ Fax Number:_____

Email:_____

Address (Street/Suite No.):_____

City:_____ State:_____ Zip:_____

Other:_____

_____

_____

Patient Name_____ ID #_____

PHYSICIAN DISCHARGE SUMMARY (Cont'd)

Standard § 484.60(e) *Care planning, coordination of services, and quality of care,* include the following information:

Give a brief description of the patient's HHA care. (Examples: education and training provided to facilitate a timely discharge, care preferences, treatments, referrals, infections, wounds, ED visit or hospital admission, medications, falls/injuries, assistive devices/equipment used, patient's motivation to participate in the plan of care, care/services that were refused that significantly effected the plan of care, the patient's progress towards goal(s) including their personal goal(s), areas where the patient will continue to have post-discharge needs etc.):

SIGNATURE/DATE

X _____ _____ _____

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

_____ _____

Agency Name *Phone Number*

Patient Name_____ ID #_____

PHYSICIAN DISCHARGE SUMMARY (Cont'd)

Describe the patient's clinical, mental, psychosocial, cognitive, and functional status at the **start of care** addressed in the plan of care. (Reference Start of Care/Resumption of Care):

Describe the patient's clinical, mental, psychosocial, cognitive; and functional status at the **end of care** addressed in the plan of care:

List any recommendations for follow-up care:

❑ Included – the patient's current drug profile (per agency policy/process) ❑ N/A patient is not taking any medication

❑ Included – the patient's current individualized plan of care (per agency policy/process)

❑ Included – the patient's current emergency preparedness plan (per agency policy/process)

❑ Included – Advance Directives (including DNR)

❑ Provide (per agency policy/process) any additional documentation that would assist in the continuity of post-discharge care, or that was requested by the receiving practitioner or facility. List documentation provided:

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

To: ❑ Certifying Physician:_____ Date:_____

❑ Secondary Physician:_____ Date:_____

❑ Primary Care Provider Post-discharge:_____ Date:_____

❑ Representative (if any):_____ Date:_____

SIGNATURES/DATES

X _____ _____ _____

Certifying Physician (signature) - **Obtain signature for receipt of discharge summary** (if applicable, per agency policy) *Date* *Time*

X _____ _____ _____

Clinician (signature/title) *Date* *Time*

_____ _____

Agency Name *Phone Number*

ORIGINAL — Clinical Record

(Provide copy to Physician per agency policy)