

**Comprehensive Adult Assessment,
485 P.O.C. Worksheet and Outcome and
Assessment Information Set (OASIS-C, 1/2010)**

COLOR **GREEN Ink** = OASIS Items **Grey** = PPS Indicators
KEY: **1 RED Ink** = Specific 485 Items (completed per agency policy)
BLACK Ink = Additional Comprehensive Assessment Items

Date: _____
ASSESSMENT TIME
IN: _____ OUT: _____

- START OF CARE VERSION**
(also used for Resumption of Care following Inpatient Stay)
- RESUMPTION OF CARE**
(after Inpatient Stay)

Items to be used at this Time Point:
Home Health Patient Tracking Sheet, M0080-M0110, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250 additional Comprehensive Assessment Items and specific 485 Items

PATIENT TRACKING SHEET - Fill Out at Start of Care and Update per Agency Policy

5 (M0010) CMS Certification Number: _____		(M0014) Branch State: _____	(M0016) Branch ID Number: _____
7 Provider Name, Address and Telephone Number _____ _____			
(M0018) National Provider Identifier (NPI) for the attending physician who has signed the plan of care: _____		<input type="checkbox"/> UK - Unknown or Not Available	
4 (M0020) Patient ID Number / Medical Record No.: _____		P 2 (M0030) Start of Care Date: month / day / year _____	
3 Certification Period From: _____ To: _____		P (M0032) Resumption of Care Date: month / day / year _____ <input type="checkbox"/> Not Applicable	
6 (M0040) Patient Name: (First) _____ (MI) _____ (Last) _____		Phone # _____	
Patient Street Address _____ City _____		(M0050) Patient Residence: _____	(M0060) Patient Zip Code: _____
1 (M0063) Medicare Number: (including suffix, if any) _____ <input type="checkbox"/> NA - No Medicare HI Claim No. _____		(M0064) Social Security Number: _____ <input type="checkbox"/> Unknown or Not Available Medicaid Number: _____ <input type="checkbox"/> NA - No Medicaid Effective Date: _____	
P OM 8 (M0066) Birth Date: month / day / year _____		9 (M0068) Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
24 Primary Physician's Name _____		Emergency Contact Name _____ Relationship _____	
Address _____		Phone _____	
Physician's Phone _____		Physician's Fax _____	
Secondary Physician's Name _____		Phone _____	
(M0140) Race/Ethnicity: (Mark all that apply.) <input type="checkbox"/> 1 - American Indian or Alaska Native <input type="checkbox"/> 2 - Asian <input type="checkbox"/> 3 - Black or African-American <input type="checkbox"/> 4 - Hispanic or Latino <input type="checkbox"/> 5 - Native Hawaiian or Pacific Islander <input type="checkbox"/> 6 - White			
(M0150) Current Payment Sources for Home Care: (Mark all that apply.) <input type="checkbox"/> 0 - None; no charge for current services <input type="checkbox"/> 3 - Medicare (traditional fee-for-service) <input type="checkbox"/> 6 - Title programs (e.g., Title III, V, or XX) <input type="checkbox"/> 10 - Self-pay <input type="checkbox"/> 1 - Medicare (traditional fee-for-service) <input type="checkbox"/> 4 - Medicare (managed care) <input type="checkbox"/> 7 - Other government (e.g., TriCare, VA, etc.) <input type="checkbox"/> 11 - Other (specify): _____ <input type="checkbox"/> 2 - Medicare (HMO/managed care/Advantage) <input type="checkbox"/> 5 - Workers' compensation <input type="checkbox"/> 8 - Private insurance <input type="checkbox"/> UK - Unknown <input type="checkbox"/> 9 - Private HMO/managed care			

CLINICAL RECORDING ITEMS

(M0080) Discipline of Person Completing Assessment: 1-RN 2-PT 3-SLP/SW 4-OT

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

P OM (M0100) Assessment is Currently Being Completed for the Following Reason:
 1 - Start of care (initial assessment)
 2 - Start of care - further visits planned
 3 - Resumption of care (after inpatient stay)

P OM (M0102) Date Physician-Ordered Start of Care (Resumption of Care): If the physician initiated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified. month / day / year _____ **NA - No specific SOC date ordered by physician**
 [Go to M0110, if date entered]

P OM (M0103) Date of Referral: Record the date that the written or verbal referral for initial or resumption of care was received by the HHA. month / day / year _____

(M0110) Episode Timing: Is this 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 sequence of adjacent Medicare home health payment episodes?
 1 - Early
 2 - Later
 UK - Unknown
 NA - Not Applicable: No Medicare case mix group to be defined by this assessment.

DEMOGRAPHICS AND PATIENT HISTORY

17 **ALLERGIES:** **NKA** **Allergic to:** _____

IMMUNIZATION / SCREENING TESTS	Flu	Pneumonia	Tetanus Shot	TB	Known Exposure to TB	Screening (i.e.: Cholesterol, Mammogram, Colon Cancer, PAP, PSA)	Results/Comments
	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	Type: _____ Date: _____	_____
	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	Type: _____ Date: _____	_____
	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	Type: _____ Date: _____	_____
	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	Type: _____ Date: _____	_____

BREASTS: (For both male and female) Patient Report Physical Exam
 Lumps Tenderness Discharge Pain Normal Other (specify): _____ Comments _____

Patient Name (Last, First, MI) _____ Record No. _____

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DEMOGRAPHICS AND PATIENT HISTORY (continued)

Community Agencies/Social Service Screening	Yes	No
Community Resource Info needed to manage care		
Altered affect (i.e., depression, grief, body image chg.)		
Suicide Ideation		
Suspected Abuse/Neglect, i.e.: (Please circle) unexplained bruises, inadequate food, fearful of family member, c/g exploitation of funds, sexual abuse, neglect, left unattended if needs constant supervision.		
Inadequate method to cook or shop for groceries		
MSW referral needed For? _____		
Coordinator notified		

Significant Past Health History

Comments

Ability of Patient to Handle Personal Finances:
 Independent Needs Assistance Totally Dependent

P (M1000) From which of the following **Inpatient Facilities** was the patient discharged during the past 14 days? *(Mark all that apply.)*

- 1 - Long-term nursing facility (NF)
- 2 - Skilled nursing facility (SNF/TCU)
- 3 - Short-stay acute hospital (IPP S)
- 4 - Long-term care hospital (LTCH)
- 5 - Inpatient rehabilitation hospital or unit (IRF)
- 6 - Psychiatric hospital or unit
- 7 - Other (specify): _____
- NA - Patient was not discharged from an inpatient facility **[Go to M1016]**

Comments

P (M1005) Inpatient Discharge Date month day year UK - Unknown
 (most recent): ___ / ___ / _____

(M1010) List each **Inpatient Diagnosis** and ICD-9-CM code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no E-codes, or V-codes):

Inpatient Facility Diagnosis	ICD-9-CM Code	Comments
a. _____	_____	
b. _____	_____	
c. _____	_____	
d. _____	_____	
e. _____	_____	
f. _____	_____	

12 (M1012) List each **Inpatient Procedure** and the associated ICD-9-CM procedure code relevant to the plan of care. *(Check red box if Inpatient Procedure is surgical.)*

Inpatient Procedure	ICD-9-CM Code	Date	Comments
<input type="checkbox"/> a. _____	_____	___/___/___	
<input type="checkbox"/> b. _____	_____	___/___/___	
<input type="checkbox"/> c. _____	_____	___/___/___	
<input type="checkbox"/> d. _____	_____	___/___/___	
<input type="checkbox"/> NA - Not applicable			
<input type="checkbox"/> UK - Unknown			

(M1016) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-9-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no surgical, E-codes, or V-codes):

Changed Medical Regimen Diagnosis	ICD-9-CM Code	Comments
a. _____	_____	
b. _____	_____	
c. _____	_____	
d. _____	_____	
<input type="checkbox"/> NA - Not applicable - medical or treatment regimen changes within past 14 days		

(M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions which existed prior to the inpatient stay or change in medical or treatment regimen. *(Mark all that apply.)*

- 1 - Urinary incontinence
- 2 - Indwelling/suprapubic catheter
- 3 - Intractable pain
- 4 - Impaired decision-making
- 5 - Disruptive or socially inappropriate behavior
- 6 - Memory loss to the extent that supervision required
- 7 - None of the above
- NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
- UK - Unknown

Comments

Patient Name (Last, First, MI)

Record No.

DEMOGRAPHICS AND PATIENT HISTORY (continued)

NRS (M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group. Do not assign symptom control ratings for V- or E-codes.

Code each row according to the following directions for each column:

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1; Rate the degree of symptom control for the condition listed in Column 1 using the following scale:
 0 - Asymptomatic, no treatment needed at this time
 1 - Symptoms well controlled with current therapy
 2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
 3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring
 4 - Symptoms poorly controlled; history of re-hospitalizations

Note that in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any diagnosis in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4) as per ASIS-IC Guidance Manual.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-CM coding guidelines, enter the diagnosis description as the ICD-9-CM codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-CM code for the underlying condition in Columns 3 of this row and the diagnosis description and ICD-9-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided). Description	ICD-9-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses. ICD-9-CM/Symptom Control Rating	Complete if V-code is assigned under certain circumstances. Enter the ICD-9-CM code in place of a case mix diagnosis.	Complete only if the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code). Description/ICD-9-CM
11 (M1020) Primary Diagnosis	(V-codes are allowed)	(V- or E-codes are allowed)	(V- or E-codes NOT allowed)
a. _____ Date: _____ O/E	a. (_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
13 (M1022) Other Diagnoses	(V- or E-codes are allowed)	(V- or E-codes NOT allowed)	(V- or E-codes NOT allowed)
b. _____ Date: _____ O/E	b. (_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
c. _____ Date: _____ O/E	c. (_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
d. _____ Date: _____ O/E	d. (_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
e. _____ Date: _____ O/E	e. (_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
f. _____ Date: _____ O/E	f. (_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
g. _____ Date: _____ O/E	g. (_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
h. _____ Date: _____ O/E	h. (_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(_____._____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4

Patient/Family Knowledge and Coping Level Regarding Present Diagnosis.

Patient:

Family:

NRS (M1030) Therapeutic: Does the patient receive at home? (Mark all that apply.)

- 1 - Intravenous or infusion therapy (e.g., TPN)
- 2 - Parenteral nutrition (TPN or lipid)
- 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the gastrointestinal tract)
- 4 - Most of the above

Advance Directives: Yes No

- Intent: DNR Living Will
- Medical Power of Attorney
- Other: _____

Copies on File at Agency? Yes No

(M1032) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)

- 1 - Recent change in mental, emotional, or behavioral status
- 2 - Multiple hospitalizations (inpatient or SNF) in the past 12 months
- 3 - History of falls (2 or more falls or any fall with an injury-in the past year)
- 4 - Taking five or more medications
- 5 - Frailty factors, e.g., weight loss, self-reported exhaustion
- 6 - Other: _____
- 7 - More than one above

Comments

(M1034) Overall Status: Which description best fits the patient's overall status? (Check ONE)

- 0 - The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
- 1 - The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
- 2 - The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.
- 3 - The patient has serious progressive conditions that could lead to death within a year.
- UK - The patient's situation is unknown or unclear.

Comments

20 PROGNOSIS:

- Poor Fair Good

21 Is the patient DNR

- "Do Not Resuscitate"? Yes No

Patient Name (Last, First, MI)

Record No.



DEMOGRAPHICS AND PATIENT HISTORY (continued)

- 21 Terminal Care Intervention:** Assess/Perform/Instruct Pt/Cg: **A P I**
- Spiritual, grieving & coping methods
 - s/s of impending death
 - Notification procedures for death at home

Additional Orders (specify): _____

(M1036) Risk Factors either present or past, likely to affect current health status and/or outcome: **(Mark all that apply.)**

- 1 - Smoking 3 - Alcohol dependency 5 - None of the above
- 2 - Obesity 4 - Drug dependency UK - Unknown
- Cultural/Religious/Spiritual factors that may impact care

Comments _____

LIVING ARRANGEMENTS

(M1100) Patient Living Situation: Which of the following best describes the patient's residential circumstance and availability of assistance? **(Check ONE box only.)**

Living Arrangement	Availability of Assistance				
	Around the clock	Regular daytime	Regular nighttime	Occasional/short-term assistance	No assistance available
a. Patient lives alone	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	<input type="checkbox"/> 04	<input type="checkbox"/> 05
b. Patient lives with other person(s) in the home	<input type="checkbox"/> 06	<input type="checkbox"/> 07	<input type="checkbox"/> 08	<input type="checkbox"/> 09	<input type="checkbox"/> 10
c. Patient lives in congregate situation (e.g., assisted living)	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 13	<input type="checkbox"/> 14	<input type="checkbox"/> 15

Is caregiver(s) willing to assist? Yes No Name of primary caregiver: _____

Marital Status Single Married Widowed Divorced Separated Unknown

SUPPORTIVE ASSISTANCE Names of Organizations Providing Assistance: _____

18A) FUNCTIONAL LIMITATIONS:

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

Homebound: No Yes **Reason:** Need assistance for all activities
 Physical weakness require max. assist./taxing effort to leave home
 Confusion, unable to go out alone Unable to safely leave home unassisted
 Severe S/S upon exertion Other (specify): _____

Comments _____

Safety/Sanitation Hazards affecting patient: **(Mark all that apply.)**

- Stairs No running water, plumbing
- Narrow or obstructed walkways Insects/rodents infestation
- No gas/electric appliance Cluttered/soiled living area
- Inadequate lighting, heating and cooling Other (specify): _____
- Lack of fire safety devices

Comments _____

15) SAFETY MEASURES:

- Anticoagulant Precautions Keep side rails
- O₂ Precautions Trip Pathway clear
- Slow Position Change Safety in ADLs
- Proper Position During Meals Seizure Precautions
- Use of Assistive Devices Standard Precautions/Infection Control
- Support During Transfer and Ambulation Neutropenic Precautions
- Emergency Plan Developed Fall Precautions
- Other: _____
- Instructed on safe utilities management/verb. understand
- Instructed on mobility safety/verb. understand
- Instructed on DME & electrical safety/verb. understand
- Instructed on sharps containers/verb. understand
- Instructed on proper handling of biohazard waste/verb. understand
- Instructed on medical gas safety/verb. understand
- Instructed on emergency/disaster plan/verb. understand
- Instructed on fire safety measures/verb. understand

Transfer Risk Code (Agency specific): _____

Disaster Code (Agency specific): _____

Comments _____

SENSORY STATUS

VITAL SIGNS: P/B/T: _____ (Reg) (Irreg) Height: _____
 _____ (Reg) (Irreg) Weight: _____
 _____ SP.: _____ Actual Stated

B/P: Lying _____ Sitting _____ Standing _____
 L _____
 R _____

2) Notify Physician of Temperature changes > _____ or < _____

21) Vital Signs Interventions: Assess/Perform/Instruct Pt/Cg: **A P I**

- Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings

(M1200) Vision (with corrective lenses if the patient usually wears them):

- 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.
- 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path and the surrounding layout; can count fingers at arm's length.
- 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

- WNL Blurred Vision: R L Contacts: R L
- Glasses Glaucoma: R L Cataracts: R L
- Other: _____

Comments _____

(M1210) Ability to hear (with hearing aid or hearing appliance if normally used):

- 0 - Adequate: hears normal conversation without difficulty.
- 1 - Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.
- 2 - Severely Impaired: absence of useful hearing.
- UK - Unable to assess hearing.

Comments _____

Patient Name (Last, First, MI) _____ **Record No.** _____

SENSORY STATUS (continued)

(M1220) Understanding of Verbal Content in patient's own language (with hearing aid or device if used):

- 0 - Understands: clear comprehension without cues or repetitions.
- 1 - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
- 2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
- 3 - Rarely/Never Understands
- UK - Unable to assess understanding.

Comments

EARS/NOSE/THROAT/MOUTH WNL

Hearing Loss? L R Aid Used? L R
 Ear Pain? L R

Nasal Condition:

WNL
 Congestion/Sinus Prob.
 Loss of smell
 Other: _____

Pharyngeal Condition:

WNL
 Hoarseness
 Sore throat
 Other: _____

Mouth Condition:

WNL
 Oral Mucosa Appearance Normal Problems
 Gum problems Changing dentures
 Dentures Difficulty swallowing

Other: _____
 Comments

21 EENT Interventions: Assess/Perform/Instruct Pt/Cg:

- Methods to control Disequilibrium problems
- Instillation of Ear medications
- Instillation of Ophthalmic medications

A	P	I
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments

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

- 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 (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 catatonic or unresponsive (e.g., speech nonsensical or unintelligible).
- 5 - Patient nonresponsive or unable to speak.

Comments

COMMUNICATION WNL

Limited educational background Pt. Cg.
 Reading or writing problems Pt. Cg.
 Slow learner Pt. Cg.
 Speech/language barrier Pt. Cg.
 Primary language: _____
 Interpreter needed? Pt. Cg.
 Motivated to learn? Pt. Cg.

YES/NO

Patient Learning Preferences:

Lecture Visual Demonstrative Graphic
 Verbal Instructions Other: _____

Comments

Neurological WNL Dizziness Falls

Headache (Describe Location, Duration) _____
 Other: _____

21 Neurological Interventions: Assess/Perform/Instruct Pt/Cg:

- Changes in LOC/Neurological Status
- Communication Skills
- Seizure Precautions
- Orientation Techniques:

A	P	I
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments

21 Additional Orders (specify): _____

MUSCULOSKELETAL WNL

Limited ROM (give location) _____
 Bone or Joint problems _____
 Pain or Cramps _____
 Redness, Warmth, Swelling _____
 Decreased Mobility/Endurance/Gain _____
 Tremors _____
 Amputation of _____
 Prosthesis/Appendage _____

21 Musculoskeletal Interventions: Assess/Perform/Instruct Pt/Cg:

- Musculoskeletal Status
- Positioning body alignment techniques & ROM exercises
- Cast care
- Circulatory checks as applicable
- Adherence to appropriate activity levels

A	P	I
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Orders (specify): _____

PAIN PROFILE

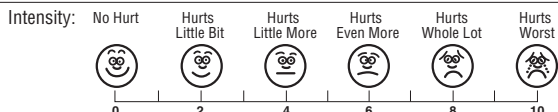
(OM) (M1231) Has this patient had a formal Pain Assessment using a standardized pain assessment tool (appropriate to patient's ability to communicate the severity of pain)?

- 0 - No standardized assessment conducted
- 1 - Yes, and does not indicate severe pain
- 2 - Yes, and indicates severe pain

(M1232) Frequency of Pain Interfering with patient's activity or movement:

- 0 - Patient has no pain that does not interfere with activity or movement
- 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

WONG-BACHMANN FACES PAIN RATING SCALE



¹ From Hockenberry MJ, Wilson D: *Wong's essentials of pediatric nursing*, ed. 8, St. Louis, 2009, Mosby. Used with permission. Copyright Mosby.

Pain Description: Sharp Dull Other: _____
 Comments

Onset Date: _____
 Pain precipitated by: _____
 Pain relieved by: _____
 History of pain management: _____
 Current pain management & effectiveness: _____
 Patient's pain goal: _____
 Progress toward pain goal: _____
 Pain site assessment: _____

See Pain Assessment/Documentation (per agency policy)
 Refer to: _____

- 21 Pain Management Interventions: Assess/Perform/Instruct Pt/Cg:**
- Intervention(s) to monitor and mitigate pain
 - _____
 - _____
 - _____

A	P	I
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name (Last, First, MI) _____ Record No. _____

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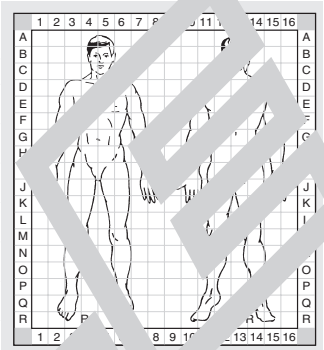
INTEGUMENTARY STATUS

Skin Turgor: Good Fair Poor Skin: Wounds Ulcers Incision Rashes Instructed on measures to control infections: Yes No
 Skin Color: Pink/WNL Pale Jaundice Cyanotic Ostomy Other: _____
 Skin: Dry Diaphoretic Warm Cool Nails: Normal Problems Yes No

Comments _____

KEY -
TYPE: 1 - Skin Lesion 4 - Surgical Wound 2 - Pressure Ulcer 5 - Other (specify) 3 - Stasis Ulcer
WOUND BED: Color: 1 - Red 3 - White 5 - Black 7 - Other (specify) 2 - Pink 4 - Gray 6 - Tan
DRAINAGE: 1 - Bloody 3 - Serous 5 - Other (specify) 2 - Serosanguous 4 - Purulent
ODOR: 1 - Foul 3 - None 2 - Sweet 4 - Other (specify)
SIZE: (LxWxD) cm U - Undermining T - Tunneling
Tissue: (List all that apply) 1 - Bloody 3 - Sloughing 5 - Eschar 7 - Weeping 9 - Other (specify) 2 - Pale 4 - Necrotic 6 - Granular 8 - Healthy
AMOUNT: 1 - None 3 - Moderate 5 - Other (specify) 2 - Scant 4 - Copious
STAGE: I II III IV
SURROUNDING SKIN: (List all that apply) 1 - Pink 3 - Red 5 - Warm 7 - Blancher 9 - Edematous 2 - White 4 - Pale 6 - Cool 8 - Shiny 10 - Other (specify)

Type	Location	Size	Wound Bed	Drainage	Amount	Odor	Stage	Surrounding Skin
	L _____ W _____ D _____ cm	<input type="checkbox"/> U <input type="checkbox"/> T	Color: _____ Tissue: _____					
	L _____ W _____ D _____ cm	<input type="checkbox"/> U <input type="checkbox"/> T	Color: _____ Tissue: _____					
	L _____ W _____ D _____ cm	<input type="checkbox"/> U <input type="checkbox"/> T	Color: _____ Tissue: _____					
	L _____ W _____ D _____ cm	<input type="checkbox"/> U <input type="checkbox"/> T	Color: _____ Tissue: _____					
	L _____ W _____ D _____ cm	<input type="checkbox"/> U <input type="checkbox"/> T	Color: _____ Tissue: _____					
	L _____ W _____ D _____ cm	<input type="checkbox"/> U <input type="checkbox"/> T	Color: _____ Tissue: _____					
	L _____ W _____ D _____ cm	<input type="checkbox"/> U <input type="checkbox"/> T	Color: _____ Tissue: _____					



P (M1300) Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers?

- 0 - No assessment conducted [Go to M1306]
- 1 - Yes, based on an evaluation of clinical factors, e.g., mobility, incontinence, nutrition, etc., without using a standardized tool
- 2 - Yes, using a standardized tool, e.g., Braden, Norton, other

(M1302) Does this patient have a Risk of Developing Pressure Ulcers?

- 0 - No 1 - Yes

OM (M1306) Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated "unstageable"?

- 0 - No [Go to M1322] 1 - Yes

NRS OM (M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

(Enter "0" if none; excludes Stage I pressure ulcers)

Stage Description - Unhealed Pressure Ulcers

Stage Description	Number Presently Observed
a. Stage II: 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 serum-filled blister.	<input type="checkbox"/>
b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible. Bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	<input type="checkbox"/>
c. Stage IV: Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	<input type="checkbox"/>
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device.	<input type="checkbox"/>
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	<input type="checkbox"/>
d.3 Unstageable: Suspected deep tissue injury in evolution.	<input type="checkbox"/>

Directions for M1310, M1312, and M1314: If patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the **Stage III or IV pressure ulcer with the largest surface dimension (length x width)** and record in centimeters. For Stage III or Stage IV pressure ulcers, go to M1320.

(M1310) Pressure Ulcer Length: longest length (head-to-toe) _____ | _____ | _____ (cm)

(M1312) Pressure Ulcer Width: width of the same pressure ulcer; greatest width perpendicular to the length _____ | _____ | _____ (cm)

(M1314) Pressure Ulcer Depth: Depth of the same pressure ulcer; from visible surface to deepest part _____ | _____ | _____ (cm)

(M1310) Status of Most Problematic (Observable) Pressure Ulcer:
 - Newly epithelialized - Early/partial granulation NA - No observable pressure ulcer
 - Fully granulating - Not healing

NRS OM (M1322) Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

- 0 1 2 3 4 or more

(M1324) Stage of Most Problematic Unhealed (Observable) Pressure Ulcer:
 1 - Stage I 3 - Stage III NA - No observable pressure ulcer or unhealed pressure ulcer
 2 - Stage II 4 - Stage IV

NRS (M1330) Does this patient have a Stasis Ulcer?

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

NRS (M1332) Current Number of (Observable) Stasis Ulcer(s):
 1 - One 2 - Two 3 - Three 4 - Four or more

NRS (M1334) Status of Most Problematic (Observable) Stasis Ulcer:
 0 - Newly epithelialized 1 - Fully granulating 2 - Early/partial granulation 3 - Not healing

Patient Name (Last, First, MI) _____ Record No. _____

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ELIMINATION STATUS (continued)

NRS OM (M1610) Urinary Incontinence or Urinary Catheter Presence:
 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 (i.e., external, indwelling, intermittent, suprapubic) **[Go to M1620]**

Comments

OM (M1615) When does Urinary Incontinence occur?
 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

Comments

21 Renal/Genitourinary Interventions: Assess/Perform/Instruct Pt/Cg: A P I
 Fluid intake at _____ mL per day
 Bladder training to include: _____
 Catheter care
 Ileal conduit care to include: _____
 Foley irrigation _____

Catheter change q _____ with _____
 Fr _____ mL balloon catheter
 Injections: _____
 Nurse to administer/instruct pt/cg to administer _____
 _____ (Drug) _____ (Dose) _____ (Route)
 _____ (Drug) _____ (Dose) _____ (Route)

Additional Orders (specify): _____

ENDOCRINE WNL

Polyuria/Polydipsia/Polyphagia Insulin Dependent? How Long? _____
 Neuropathy/Radiculopathy Able to draw up insulin Y N
 Urine Testing Performed Able to administer insulin Y N
 Blood Sugar Glucometer Use Most recent FBS: _____
 Oral Hypoglycemic Agent

Diabetes Thyroid Disease
 Additional Information/Notes: _____
 Comments: _____

21 Endocrine Interventions: Assess/Perform/Instruct Pt/Cg: A P I
 Use of electronic Glucose measuring device
 Diabetic care to include diet, activity, stress, foot care, skin care
 Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care
 s/s of complications of Diabetes
 s/s of Hypo/Hyperglycemia

Repetition/administration of Insulin
 Insulin syringes q _____ per Physician Order
 Monitor glucometer recordings for variations & compliance
 Notify physician of blood sugar over _____ and _____ under _____ Mg/dL
 Glucometer testing to be performed by _____ q _____

Additional Orders (specify): _____

NRS OM (M1620) Bowel Incontinence Frequency:
 0 - Very rarely or never has bowel incontinence On a daily basis
 1 - Less than once weekly 5 - More than once daily
 2 - One to three times weekly NA - Patient not on ostomy for bowel elimination
 3 - Four to six times weekly UK - Unknown

Comments

NRS (M1630) Ostomy for Bowel Elimination: Does the patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen?

0 - Patient does not have an ostomy for bowel elimination
 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.
 2 - Patient's ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

Comments

Gastrointestinal: WNL Constipation Nausea Vomiting Tenderness
 Other (specify): _____

Comments

21 Digestive/Gastrointestinal Interventions: Assess/Perform/Instruct Pt/Cg: A P I
 _____ diet compliance
 Measuring recording intake and output
 Methods to promote oral intake
 Measures to recognize dysfunction and relieve complications
 Parenteral nutrition and the care/use of equipment to include: _____
 Enteral nutrition and the care/use of equipment to include: _____
 Gastrostomy tube (specify): _____

NG tube (specify): _____
 Bowel training program _____
 Ostomy care to include: _____
 Change feeding tube _____
 using size _____ tube q _____
 Digital Exam/relieve fecal impaction; give Fleet's/SS enema as needed
 Additional Orders (specify): _____

NUTRITIONAL STATUS

NUTRITIONAL HEALTH SCREEN	Yes
Without reason, has lost more than 10 lbs. in the last 3 months	15
Has an illness or condition that made him/her change the type of and/or amount of food eaten	10
Has an open: <input type="checkbox"/> Decubitus <input type="checkbox"/> Ulcer <input type="checkbox"/> Burn <input type="checkbox"/> Wound	10
Eats fewer than 2 meals a day	10
Has a tooth/mouth problem which makes it hard to eat	10
Has 3 or more drinks of beer, liquor, or wine almost every day	10
Does not always have enough money to buy foods needed	10
Eats few fruits or vegetables, or milk products	5
Eats alone most of the time	5
Takes 3 or more prescribed or OTC medications a day	5
Is not always physically able to cook and/or feed self and has no caregiver to assist	5
Frequently has problems with diarrhea or constipation	5
Total Nutritional Score	

- 0 - 25 Good Nutritional Status** - provide educational information as indicated or requested by patient
- 30 - 55 Moderate Nutritional Risk** - provide educational information, appropriate dietary instructions, consult with dietician as needed, consult with physician and discuss need for dietary supplement (tablet or liquid). Continue monitoring and instructions as indicated.
- 60 - 100 High Nutritional Risk** - Report to physician and discuss need for dietary supplement (tablet or liquid), lab studies, enteral or parenteral nutrition. Provide educational information and appropriate dietary instructions. Consult with, or refer to dietician as ordered. Continue care, monitoring and instruction as indicated.

Nutritional Status Comments:

Non-compliant with prescribed Diet

Over/Under Weight by 10%

Meals Prepared by: _____

Comments: _____

16 NUTRITIONAL REQUIREMENTS NEW OR CHANGED:

DIET: Regular Mechanical (Soft, Hi-Fiber, etc.) Other: _____

Hi/Lo Sodium Gluten Free Specify: _____

Hi/Lo Protein Low/Reduced Fat _____

Hi/Lo Carbohydrate Reduced Calorie _____

Diabetic Supplement _____

NG Tube Peg Tube _____ Tube

Enteral _____ mg _____ mL/day

Pump type: _____

Flow of _____ mL/Freq _____

Flow with _____ mL/Freq _____

Other (specify): _____

NEURO/EMOTIONAL/BEHAVIORAL STATUS

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

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 (e.g., 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 consistently 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.

Comments: _____

P OM (M1710) When Confused (Reported or Observed Within the Last 14 Days):

0 - Never

1 - In new or complex situations only

2 - Daily, but not constant

3 - All of the time

NA - Patient unresponsive

Comments: _____

P OM (M1720) When Anxious (Reported or Observed Within the Last 14 Days):

0 - None of the time

1 - Less often than daily

2 - Daily, but not constant

3 - All of the time

NA - Patient unresponsive

Comments: _____

P OM (M1730) Depression Screening: Has patient been screened for depression, using a standardized depression screening tool?

0 - No

1 - Yes, patient was screened using the PHQ-2 scale. *Instructions: Use this two-question tool; Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?"*

PHQ-2*	Not at all 0 - 1 days	Several days 2 - 6 days	More than half of the days 7 - 11 days	Nearly every day 12 - 14 days	N/A Unable to respond	Comments
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA	
b) Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA	
<input type="checkbox"/> 1 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.						
<input type="checkbox"/> 3 - Yes, with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression.						

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

1 - Memory impairment: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required

2 - Judgment/decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions

3 - Verbal disturbance: yelling, threatening, excessive profanity, sexual references, etc.

4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, or performs 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

Comments: _____

OM (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.

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

Comments: _____

Patient Name (Last, First, MI) _____ Record No. _____



NEURO/EMOTIONAL/BEHAVIORAL STATUS (continued)

(M1750) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?

- 0 - No 1 - Yes

Comments

19 MENTAL STATUS:

- Oriented: Person Place Time Comatose Forgetful
 Depressed Disoriented Lethargic Agitated
 Other: _____

Additional Orders (specify): _____

21 Psychiatric/Behavioral Nursing Intervention: Assess/Perform/Instruct Pt/Cg: **A P I**

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Suicide Precautions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Grief Management | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Clock Test or Dementia Screen | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

ADL / IADLs

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

- 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.

Comments

OM (M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

- 0 - Able to get to and from the toilet and transfer independently 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 on toileting.**

Comments

OM (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:

- 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.**

Comments

OM (M1845) Toileting Hygiene: Current ability to maintain perineal hygiene safely (e.g., toilet 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).

- 0 - Able to manage toileting hygiene and clothing management without assistance.
 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/complements 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.

Comments

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

- 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, nylons, and shoes.**
 3 - **Patient depends entirely upon another person to dress lower body.**

Comments

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

- 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.**

Comments

OM (M1830) Bathing: Current ability to wash entire body of self. **Excludes grooming (washing face, washing hands, and shampooing hair).**

- 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
 1 - **With the use of one-handed device (e.g., cane, walker, crutches, hemi-walker), able to bathe self in shower or tub independently, including getting in and out of tub/shower.**
 2 - **Able to bathe in shower or tub with 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 - **Unable 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 throughout the bath.**
 6 - **Unable to participate effectively in bathing and is bathed totally by another person.**

Comments

OM (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.

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

Comments

188 ACTIVITIES PERMITTED:

- | | | |
|--|--|---|
| <input type="checkbox"/> Exercise prescribed | <input type="checkbox"/> Independent at home | <input type="checkbox"/> Cane |
| <input type="checkbox"/> Bed rest with BRP | <input type="checkbox"/> Transfer bed-chair | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Partial weight bearing |
| <input type="checkbox"/> Complete bed rest | <input type="checkbox"/> Up as tolerated | <input type="checkbox"/> Other: _____ |

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ADL / IADLs (continued)

OM (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.

- 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.

Comments

OM (M1880) Current Ability to Plan and Prepare Light Meals (e.g., cereal, sandwich) or reheat delivered meals safely:

- 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 (i.e., 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

Comments

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

- 0 - Able to dial numbers and answer calls appropriately and as desired.
- 1 - Able to use a specially adapted telephone (i.e. large numbers on the dial, teletype phone for the hearing and call transfer 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. Is able to carry on only a limited conversation.
- 4 - Unable to answer the telephone but can listen to calls with equipment.
- 5 - Totally unable to use the telephone.
- NA - Patient does not have a telephone.

Comments

(M1900) Functional Activities of Daily Living: Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury. (Check only **OM** in each row.)

Functional Area	Independent	Needed Some Help	Dependent
a. Activities of daily living (e.g., grooming, dressing, and bathing)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. Ambulation	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. Transfer	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. Household tasks (e.g., light meal preparation, laundry, shopping)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2

Comments

Patient Name (Last, First, MI)

Fall Risk Assessment	Assess <u>one point</u> for each core element "Yes"	Points
Age 65+		
Diagnosis (3 or more co-existing)	Assess for hypotension.	
Prior history of falls within 3 months	Fall Definition, "An unintentional change in position resulting in coming to rest on the ground or a lower level."	
Incontinence	Inability to make it to the bathroom or in a timely manner. Includes frequent urgency and/or nocturia.	
Visual impairment	Includes macular degeneration, diabetic retinopathy, visual field loss, age related changes, cataracts, 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, ADLs or have transfer problems, arthritis, pain, fear, falling not problems, impaired sensation, impaired coordination or improper use of assistive devices.	
Environmental hazards	May include poor illumination, equipment blocking, inappropriate footwear, hard transitions, floor surfaces that are uneven or cluttered, outdoor entry and exit.	
Poly Pharmacy (4 or more prescriptions)	Drugs not associated with fall risk include but not limited to sedatives, anti-emetics, tranquilizers, narcotic analgesics, cardiac meds, corticosteroids, chemotherapy drugs, anticholinergic drugs, and hypoglycemic drugs.	
Pain affecting mobility or function	Pain often affects an individual's desire or ability to move. 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 <u>one or more</u> is considered at risk for falling		TOTAL

Functional Reach Assessment

Score _____ seconds

Functional Reach Assessment Score _____ inches

Comments

P (M1910) Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?

- 0 - No multi-factor falls risk assessment conducted.
- 1 - Yes, and it does not indicate a risk for falls.
- 2 - Yes, and it indicates a risk for falls.

Comments

21 Fall Prevention Interventions: Assess/Perform/Instruct Pt/Cg: **A P I**

Fall Prevention

Additional Orders (specify): _____

Record No.



MEDICATIONS

(M2000) Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?

- 0 - Not assessed/reviewed [Go to M2010]
- 1 - No problems found during review [Go to M2010]
- 2 - Problems found during review
- NA - Patient is not taking any medications [Go to M2040]

Comments

(OM) (M2002) Medication Follow-up: Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?

- 0 - No
- 1 - Yes

Comments

(OM) (M2010) Patient/Caregiver High Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?

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

Comments

(OM) (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.)**

- 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.

Comments

(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.**

- 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 injections.
- 3 - Unable to take injectable medication unless administered by another person.
- NA - No injectable medications prescribed.

Comments

(M2040) Prior Medication Management: Indicate the patient's current ability with managing oral and injectable medications prior to the current illness, event, or injury. **(Check only ONE box in each row.)**

Functional Area	Independent	Needs Some Help	Dependent	Not Applicable
a. Oral medication	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> NA
b. Injectable medication	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> NA

Comments

10 MEDICATIONS:

DOSE/FREQUENCY: _____ See Medication Profile

Note: See Med Profile Addendum for Drug Regimen Review per Agency Policy

- Implement and instruct on Medication Regimen, including dosage, side effects, name, route, frequency, desired action & adverse reactions.
- Assess Medication Compliance/Adherence Set-up _____

2 High Tech/Special Procedures Assess/Perform/Instruct Pt/Cg: **A P I**

<input type="checkbox"/> Administer IV _____ at rate of _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Change Huber needle 1 x week and PRN using sterile technique	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> _____ Pump / Gravity (circle one)		<input type="checkbox"/> Access port 1 x a month and PRN to flush with _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Change Huber _____ 2 hours and PRN for infiltration/infection	<input type="checkbox"/> <input type="checkbox"/>	_____	
<input type="checkbox"/> Flush _____ with _____ mL of normal Saline q _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Port dressing change q _____ and PRN using sterile technique	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Flush Huber _____ mL of _____ units/mL Heparin flush q _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> PICC Line (specify): _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Use SASH (Saline Antibiotic Saline Heparin) protocol	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> On _____ pump/equipment	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> s/s of infiltration and emergency procedures	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	(specify): _____	
<input type="checkbox"/> Change _____ catheter dressing _____ x a week using sterile techniques with alcohol/betadine	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Change tubing q _____ and PRN	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Change injection cap q _____ and PRN	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Additional Orders (specify): _____	
<input type="checkbox"/> Flush _____ catheter with _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	

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Patient Name (Last, First, MI) _____ Record No. _____

CARE MANAGEMENT

(M2100) Types and Sources of Assistance: Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. (Check only ONE box in each row.)

Type of Assistance	No assistance needed in this area	Caregiver(s) currently provide assistance	Caregiver(s) need training/supportive services to provide assistance	Caregiver(s) not likely to provide assistance	Unclear if Caregiver(s) will provide assistance	Assistance needed, but no Caregiver(s) available
a. ADL assistance (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c. Medication administration (e.g., oral, inhaled or injectable)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d. Medical procedures/treatments (e.g., changing wound dressing)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
e. Management of equipment (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
f. Supervision and safety (e.g., due to cognitive impairment)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
g. Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from appointments)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Comments

(M2110) How often does the patient receive **ADL or IADL assistance** from any caregiver(s) (other than home health agency staff)?

- 1 - At least daily
- 2 - Three or more times per week
- 3 - One to two times per week
- 4 - Received, but less often than weekly
- 5 - No assistance received
- UK - Unknown

THERAPY NEED AND PLAN OF CARE

(M2200) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational and speech-language pathology visits combined)? (Enter zero ["000"] if no therapy visits indicated.) (_____) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).

NA - Not Applicable: No case mix group defined by this assessment.

(M2250) Plan of Care Synopsis: (Check only ONE box in each row.) Does the physician-ordered plan of care include the following:

Plan / Intervention	Yes	Not Applicable	
a. Patient-specific parameters for notifying physician of change in vital signs or other clinical findings	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient is not diabetic or is bilateral amputee
c. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient is not assessed to be at risk for falls
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient has no diagnosis or symptoms of depression
e. Intervention(s) to monitor and manage pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA No pain identified
f. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient is not assessed to be at risk for pressure ulcers
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested by physician	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient has no pressure ulcers with need for moist wound healing

Comments

NRS 14 HOME AND SUPPLIES

- DMEPOS:**
- Bedside Commode
 - Cane
 - Elevator Toilet Seat
 - Grab Bars
 - Hospital Bed
 - Tub/Shower Bench
 - Walker
 - Chair
- SUPPLIES:**
- ABDs
 - Ace Wrap
 - Alcohol Pads
 - Chux/Underpads
 - Diabetic Supplies
 - Drainage Bag
 - Dressing Supplies
 - Duoderm
 - Exam Gloves
 - Foley Catheter
 - Gauze Pads
 - Insertion Kit
 - Irrigating Solution, Type: _____
 - Irrigation Set
 - Kerlix Rolls
 - Leg Bag
 - Needles
 - NG Tube
 - Sterile Gloves
 - Syringe
 - Tape
 - Other (specify): _____

21 OTHERS FOR DISCIPLINE AND TREATMENTS


- SNR (speech) frequency _____
- Assess VS & all body systems, knowledge of disease process and its associated care and treatment, med regimen knowledge, and s/s complications necessitating medical attention.
- Venipuncture for: _____
- Other: _____
- Implement and Instruct Standard Precautions/Infection Control
- Management of disease process to include: _____

Patient Name (Last, First, MI)

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21 ORDERS FOR DISCIPLINE AND TREATMENTS (continued)

- HHA Visit Frequency _____ to assist w/personal care/ADLs/light housekeeping as needed
- ROM (Range of Motion) PCA/R - Personal Care Aide/Respite Waiver Passport (circle one)
- Physical Therapy Visit Frequency _____ Speech Therapy Visit Frequency _____
- PT to consult, evaluate and treat ST to consult, evaluate and treat
- Occupational Therapy Visit Frequency _____ Medical Social Worker Visit Frequency _____
- OT to consult, evaluate and treat MSW to evaluate and assess for needs
- Dietitian evaluation Review Nutritional Risk Factors  to determine need for further Nutrition Assessment by qualified H.C. professional.

22 GOALS/REHABILITATION POTENTIAL/DISCHARGE PLANS

- The patient's safety will be enhanced throughout the home care service as evidenced by _____ within _____ period of time.
- The patient/caregiver will verbalize understanding of (disease process) _____ and all aspects of associated care within _____ period of time.
- The patient/caregiver will verbalize understanding of medications as evidenced by recall of action/dose/side effects within _____ period of time.
- The patient/caregiver will verbalize understanding of _____ diet as evidenced by compliance with diet plan within _____ period of time.
- The patient's skin and mucous membranes will remain intact for this cert period.
- The patient's weight will be maintained between _____ and _____ for this cert period.
- The patient's _____ lab value will be within normal limits per physician assessment and patient's compliance with meds/diet this cert period.
- The patient's pain will be controlled and managed at the patient's own comfort level as verbalized by the patient/caregiver within _____ period of time.
- The patient's _____ catheter _____ tube will remain patent for this cert period.
- The patient's _____ infection will resolve as evidenced by _____ within _____ period of time.
- The patient's _____ site will be decreased in size to _____ color _____ % in cert period.
- The patient's home environment will be clean and safe, as evidenced by _____ within _____ period of time.
- The patient's hygiene and personal care needs will be met this cert period with the assistance of the home health aide.
- The patient will reach maximum functional potential, as evidenced by _____ within _____ period of time.
- The patient will have psycho/social needs met, as evidenced by _____ within _____ period of time.
- Endpoint of daily visits _____
- Other: _____
- Other: _____

Rehabilitation potential: _____ Other: _____

Discharge Plans Patient to be discharged when skilled care no longer needed Other (specify): _____

Patient to be discharged to the caregiver: Self Caregiver Other: _____

Patient Strengths: Motivated Learner Strong Support System Absence of Multiple Disease Diagnosis Enhanced Socioeconomic Status Other: _____

Conclusions: Skilled Intervention Needed Skilled Intervention Needed No Skilled Service Needed Other: _____

PATIENT / CAREGIVER'S EXPECTATIONS: _____

NURSING DIAGNOSIS: _____ **SKILLED SERVICES PROVIDED THIS VISIT AND PATIENT RESPONSE:** _____

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Patient Signature (per HHA policy & procedure): _____ Patient Name _____ Record No. _____

23 Nursing Signature/Discipline and Date of verbal SOC where applicable:	HHA USE ONLY	Checked By	Entered By	Transmitted By
	Date	Date	Date	Date

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