Outcome and Assessment Information Set (OASIS-C, 1/2010)

COLOR KEY: **GREEN Ink** = OASIS Items [shaded] = PPS Indicators
BLACK Ink = Additional Comprehensive Assessment Items

Date: ____________
ASSESSMENT TIME
IN: _______OUT: _______

☐ PHYSICAL THERAPY DISCHARGE FROM AGENCY VERSION

Items to be used at this Time Point: **M0080-M0100, M1040-M1055, M1230, M1242, M1306-M1350, M1400-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2004, M2015-M2030, M2100-M2110, M2300-M2420, M0903, M0906**
Discharge Summary

Provider Name, Address and Telephone Number

Physician's Name	Address
Physician's Phone	Physician's Fax

TRACKING SHEET UPDATE - *(Complete only if changes have occurred)*

(M0050) Patient State of Residence: ___ ___

(M0060) Patient Zip Code: ___ ___ ___ ___ ___ ___ ___ ___ ___

(M0150) Current Payment Sources for Home Care: ***(Mark all that apply.)***

- ☐ 0 - None; no charge for current services
- ☐ 1 - Medicare (traditional fee-for-service)
- ☐ 2 - Medicare (HMO/managed care/Advantage plan)
- ☐ 3 - Medicaid (traditional fee-for-service)
- ☐ 4 - Medicaid (HMO/managed care)
- ☐ 5 - Workers' compensation
- ☐ 6 - Title programs (e.g., Title III, V, or ...)
- ☐ 7 - Other government (e.g., TriCare ..., etc.)
- ☐ ... - Private in...nce
- ☐ ... Private HM... ...ged care
- ☐ 1... Self-pay
- ☐ ... ...her (specify): ____________
- ☐ UK - Unknown

CLINICAL RECORD ITEMS

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

OM **(M0090) Dat... ...ssessme... ...o... ...eted:** mo... / day / year
__ __ / __ __ / __ __ __ __

P OM **(M0100) This Assessment is Currently Being Completed for the Follo... Re... ...on:**
Discharge from Agency - Not to an Inpatient Facility
☐ ...- D... ...ha... from agency **[... ...o *M1040*]**

DEMOGRAPHICS AND PATIENT HISTORY

P ⌂ OM **(M1040) Influenza Vaccine:** Did the patient receive the influe...a vaccine from yo... ag...cy for this ...r's influenza season (October 1 through March 31) during this episode of care?

- ☐ 0 - No
- ☐ 1 - Yes **[Go to *M1050*]**
- ☐ NA - Does not apply b... ...ent... episo... of care (S... /R... t... ...ansfer/ Discharge) is ...side t... ...in...nza s...on. **[Go t... ...1...]**

Comments

P ⌂ OM **(M1045) Reason Influenza Vaccine not rec...d:** If the patient ...not r... the inf...za vaccine from your agency during this episode of care, state reason:

- ☐ 1 - Received from another health care provi... (e.g., physician)
- ☐ 2 - Received from your agency previously du... this year's ...season
- ☐ 3 - Offered and declined
- ☐ 4 - Assessed and determined to h... ...ical co... ...indication(...)
- ☐ 5 - Not indicated; patient does... ...t meet a... ...ondit... guidelines ... i...za vaccine
- ☐ 6 - Inability to obtain vacci... ...ue to declared ...rtag...
- ☐ 7 - None of the above

Comments

P ⌂ OM **(M1050) Pne...ococcal V...e:** Did the pat... ... pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Dis...arge)?

- ☐ 0 - No
- ☐ 1 - Yes **[... ...1230]**

Comments

P ⌂ OM **(M... ...) Reas... PPV ...received:** If ...ent di... not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC ...ransfer/Di...arge), s... ...e reason:

- ☐ 1 - Patient ... ...d P... in the pas...
- ☐ 2 - Off... ...declin...
- ☐ 3 - A... ...and deter... ...o h... medical contraindication(s)
- ☐ 4 - N... ...dicated; patient ... meet age/condition guidelines for PPV
- ☐ 5 - None of the above

Comments

SENSO... ...ATUS

(M... ...) ...peech a... ...ral (Verbal) Expression of Language (in patient's own language):

- ☐ 0 - Ex...sses co...ex ideas, feelings, and needs clearly, completely, and easily in all ...ations ... no observable impairment.
- ☐ 1 ...inima... ...ficulty in expressing ideas and needs (may take extra time; makes occasional errors ... 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 (e.g., speech is nonsensical or unintelligible).
- ☐ 5 - Patient nonresponsive or unable to speak.

Comments

SAMPLE

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

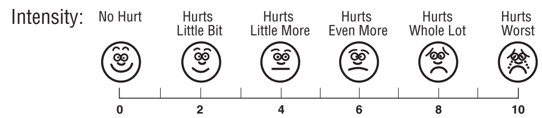
SENSORY STATUS (continued)

(OM) **(M1242) Frequency of Pain Interfering** with patient's activity or movement:

- ☐ 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**

Comments

WONG-BAKER FACES[1] PAIN RATING SCALE



[1] From Hockenberry MJ, Wilson D: Wong's essentials of pediatric nursing, ed. 8, St. Louis, ...09, Mosby. Used with permission. Copyright Mosby.

VITAL SIGNS: PULSE: ☐ Apical ____________ (Reg) (Irreg) ☐ Radial ____________ (Reg) (Irreg)
TEMP.: ____________ RESP.: ____________

Height ____________ Weight ____________ ☐ Actual ☐ Stated

B/P	Lying	Sitting	Standin
L			
R			

MUSCULOSKELETAL STATUS / PHYSICAL THERAPY ASSESSMENT (PT)

RANGE OF MOTION / MOBILITY

Joint/Segment	Movement	Range	PROM Right	PROM Left	AROM Right	AROM Left
Elbow	Flexion	0-140				
	Hyperextension	0-0				
Forearm	Pronation	0-90				
	Supination	0-90				
Wrist	Extension	0-70				
	Flexion	0-70				
	Radial Deviation	0-70				
	Ulnar Deviation	0-70				
Shoulder	Flexion	0-180				
	Abduction	0-180				
	Other					

Joint/Segment	Movement	Range	PROM Right	PROM Left	AROM Right	AROM Left
Hip	Flexion	0-120				
	Abduction	0-45				
	Internal Rot.	0-45				
	External Rot.	0-45				
Knee	Flexion	0-120				
	Extension	0				
Ankle	Flexion	45				
	Extension	0-30				
Cervical Spine	Flexion	0-45				
	Hyp...tension	...45				
	L...al Flexion	0-45				
	Ro...on					

Comments

MUSCLE STRENGTH AGAINST GRAVITY

Strength Scale: 5 = WNL 4 = Good 3 = Fair 2 = Poor 1 = Trace 0 = Abs...

- ☐ **LUE:** ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ 0
- ☐ **LLE:** ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ 0
- ☐ **Left Hand:** ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ 0
- ☐ **RUE:** ☐ 5 ☐ 4 ☐ 3 ☐ ☐ ☐ 0
- ☐ **RLE:** ☐ ☐ 4 ☐ 3 ☐ 2 ☐ ☐ 0
- ☐ **Right Hand:** ☐ 5 ☐ 4 ☐ 3 ☐ 2 1 0

...mments

BALANCE/GAIT

SITTING
☐ Altered Describe: ____________

STANDING ☐ No Deficit
☐ Altered Describe: ____________

GAIT
☐ Shuffling ☐ Unsteady ☐ Tremors

Gait Surfaces: *(Indicate highest level of functio...)*
- 4 - Navigates various surfaces without assis... device
- 3 - Navigates various surfaces with assis... device
- 2 - Navigates flat surfaces without as... device
- 1 - Navigates flat surfaces with ass... device
- 0 - Unable to navigate flat surfaces ... or withou... assistive device

BALA... GAIT
Be... core: ____________
...tti Score: ____________
...er: ____________

Gait S... ce Score: ____
...t Dis...e/Speed:
Di...ce: ______ft per s...in
☐ W... device
☐ With... vice
Speed for ...

Comments

TRANS...

...Y: 5 = Maxi... Assist 4 = Mode... Assist 3 = Minimum Assist 2 = Standby Assist 1 = Independent AD = With Assistive Device W/O AD = Without Assistive Device

- ...d Mob ______ ☐ ...D ☐ W/O AD
- ☐ Chair ______ ☐ AD ☐ W/O AD
- ☐ ______ ☐ AD ☐ W/O AD
- ...n/... of Bed ______ ☐ AD ☐ W/O AD
- ☐ Commode/Toilet ______ ☐ AD ☐ W/O AD
- ☐ ______ ☐ AD ☐ W/O AD
- ☐ Sit to Stand ______ ☐ AD ☐ W/O AD
- ☐ Tub/Shower ______ ☐ AD ☐ W/O AD
- ☐ ______ ☐ AD ☐ W/O AD

Performance Affected By: ____________

Comments

JOINTS

☐ No Def... ☐ Warm... ☐ S...
☐ Enla... ☐ P...

Comm...ts

...OSTHE... ...ICE/AD... ...E E... ...IPMENT

- ☐ ...ne
- ☐ ...st/Splint due to: ______
- ☐ ...sthesis due to: ______
- ☐ A...tive Device ... ______
- ☐ Can... to: ______
- ☐ Walker ... ______
- ☐ Other: ______

Comments

SENSO... EFF... S ON THERAPY

- ☐ Vision
- ☐ Vertigo
- ☐ Medications
- ☐ Impaired Cognition
- ☐ Other: ______

Comments

ENDURANCE

☐ With assistive device ☐ Without assistive device

- ☐ 0 - Not troubled with breathlessness except with strenuous exercise
- ☐ 1 - Troubled by shortness of breath when hurrying on level surface or walking up a slight hill
- ☐ 2 - Walks slower than people of the same age on level surface because of breathlessness or has to stop for a breath when walking at own pace on level surface
- ☐ 3 - Usually too breathless to leave the house or breathless when dressing or undressing

Endurance Score: ________

Comments

EMOTIONAL STATUS/BEHAVIORS WHICH MAY IMPACT PLAN OF CARE

☐ None ☐ Identified as ____________

HOME STRUCTURE/HOUSEHOLD BARRIERS THAT MAY IMPACT PLAN OF CARE

☐ None ☐ Identified as ____________

INTEGUMENTARY STATUS

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

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

Comments

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

SAMPLE

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(Home Health Compare icon) = Home Health Compare (OM) = Outcome Measure Indicator (PT) = Potential Physical Therapy Indicator

(M1307) The **Oldest Non-epithelialized Stage II Pressure Ulcer** that is present at discharge

☐ 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 non-epithelialized Stage II pressure ulcers are present at discharge

Comments

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	Complete at SOC/ROC/FU & D/C: Number Currently Present	Complete at FU & D/C: Number of those listed in Column 1 that were present on admission (most recent SOC/ROC)
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.	☐	☐
b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but 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.	☐	☐
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.	☐	☐
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device.	☐	☐
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	☐	☐
d.3 Unstageable: Suspected deep tissue injury in evolution.	☐	☐

Comments

Directions for M1310, M1312, and M1314: If the 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. If no Stage III or Stage IV pressure ulcers, go to M1320.

Comments

(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)

Comments

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

Comments

(M1320) Status of Most Problematic (Observable) Pressure Ulcer:

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

Comments

NRS OM **(M1322) Current Number of Stage I 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.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Comments

(M1324) Stage of Most Problematic Unhealed (Observable) Pressure Ulcer:

☐ **1 - Stage I**
☐ **2 - Stage II**
☐ **3 - Stage III**
☐ **4 - Stage IV**
☐ NA - No observable pressure ulcer or unhealed pressure ulcer

Comments

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

☐ 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) **[Go to *M1340*]**

Comments

NRS **(M1332) Current Number of (Observable) Stasis Ulcer(s):**

☐ 1 - One ☐ 2 - Two ☐ 3 - Three ☐ 4 - Four or more

Comments

NRS **(M1334) Status of Most Problematic (Observable) Stasis Ulcer:**

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

Comments

(M1340) Does this patient have a **Surgical Wound?**

☐ 0 - No **[Go to *M1350*]**
☐ 1 - Yes, patient has at least one (observable) surgical wound
☐ 2 - Surgical wound known but not observable due to non-removable dressing **[Go to *M1350*]**

Comments

HHC NRS OM **(M1342) Status of Most Problematic (Observable) Surgical Wound:**

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

Comments

OM **(M1350)** Does this patient have a **Skin Lesion** or **Open Wound,** excluding bowel ostomy, other than those described above that is receiving intervention by the home health agency?

☐ 0 - No ☐ 1 - Yes

Comments

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

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SAMPLE

RESPIRATORY STATUS

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

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

Comments

(M1410) Respiratory Treatments utilized at home: ***(Mark all that apply.)***

- ☐ 1 - Oxygen (intermittent or continuous)
- ☐ 2 - Ventilator (continually or at night)
- ☐ 3 - Continuous/Bi-level positive airway pressure
- ☐ 4 - None of the above

Comments

CARDIAC STATUS

P **(M1500) 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 any point since the previous OASIS assessment?

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

Comments

P **(M1510) Heart Failure Follow-up:** If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? ***(Mark all that apply.)***

- ☐ 0 - No action taken
- ☐ 1 - Patient's physician (or other primary care practitioner) contacted the same day
- ☐ 2 - Patient advised to get emergency treatment (e.g., 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 (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.)

Comments

ELIMINATION STATUS

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

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient on prophylactic treatment

Comments

NRS **(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

(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

NRS **(M1620) Bowel Incontinence Frequency:**

- ☐ 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

Comments

NEURO/EMOTIONAL/BEHAVIORAL STATUS

(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 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.

Comments

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

- ☐ 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

Comments

P **(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 constantly
- ☐ 3 - All of the time
- ☐ NA - Patient nonresponsive

Comments

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

- ☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- ☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- ☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- ☐ 4 - Physical aggression: aggressive or combative to self and others (e.g., 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

Comments

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

SAMPLE

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P = Process Measures   = Home Health Compare   NRS = Non Routine Supply Indicator   OM = Outcome Measure Indicator

NEURO/EMOTIONAL/BEHAVIORAL STATUS (continued)

(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

ADL / IADLs

(PT) (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

(PT) (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

(PT) (HHC) (OM) **(M1820)** Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, 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 or nylons, and shoes.**
- ☐ **3 - Patient depends entirely upon another person to dress lower body.**

Comments

(PT) (HHC) (OM) **(M1830) Bathing:** Current ability to wash entire body safely. **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 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 throughout the bath.**
- ☐ **6 - Unable to participate effectively in bathing and is bathed totally by another person.**

Comments

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

Comments

(PT) (OM) **(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.

- ☐ 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.

Comments

(PT) (HHC) (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

(PT) (HHC) (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

(PT) (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.
- (NRF) ☐ 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.
- (NRF) ☐ 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
- (NRF) ☐ 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
- (NRF) ☐ 5 - Unable to take in nutrients orally or by tube feeding.

Comments

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

ADL / IADLs (continued)

(PT) (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

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

Comments

MEDICATIONS

P (OM) **(M2004) Medication Intervention:** If there were any clinically significant medication issues since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day of the assessment to resolve clinically significant medication issues, including reconciliation?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - No clinically significant medication issues identified since the previous OASIS assessment

Comments

P (OM) **(M2015) Patient/Caregiver Drug Education Intervention:** Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects, and how and when to report problems that may occur?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient not taking any drugs

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

Comments

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)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. **IADL assistance** (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. **Medication administration** (e.g., oral, inhaled or injectable)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d. **Medical procedures/treatments** (e.g., changing wound dressing)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e. **Management of Equipment** (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
f. **Supervision and safety** (e.g., due to cognitive impairment)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
g. **Advocacy or facilitation** of patient's participation in appropriate medical care (includes transportation to or from appointments)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 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

Comments

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

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EMERGENT CARE

(M2300) Emergent Care: Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation)?

- ☐ 0 - No **[Go to *M2400*]**
- ☐ 1 - Yes, used hospital emergency department WITHOUT hospital admission
- ☐ 2 - Yes, used hospital emergency department WITH hospital admission
- ☐ UK - Unknown **[Go to *M2400*]**

Comments

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

- ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
- ☐ 2 - Injury caused by fall
- ☐ 3 - Respiratory infection (e.g., pneumonia, bronchitis)
- ☐ 4 - Other respiratory problem
- ☐ 5 - Heart failure (e.g., 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

Comments

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ON[illegible]

P **(M2400) Intervention Synopsis:** ***(Check only ONE box in each row).*** Since the previous OASIS assessm[illegible], were t[illegible] following inte[illegible]ons BOTH [illegible]cluded in the physician-ordered plan of care AND implemented?

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 [illegible] o[illegible] bilateral an[illegible]tee
b. Falls prevention interventions	☐ 0	☐ 1	☐ NA	F[illegible]al multi-factor Fall [illegible] [illegible]essment in[illegible]ates the patient was not at risk for [illegible]s since t[illegible] last OASIS [illegible]ses[illegible]ent
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐ 0	☐ 1	☐ N[illegible]	Formal [illegible]ess[illegible]nt indic[illegible]s pati[illegible] not meet criteria for depression AND patien[illegible]d no[illegible]ve dia[illegible]sis of d[illegible]ession since the last OASIS assessment
d. Intervention(s) to monitor and mitigate pain	☐ 0	☐ 1	[illegible]	Formal a[illegible]ment [illegible]not indicate pain since the last OASIS assessment
e. Intervention(s) to prevent pressure ulcers	☐ 0	[illegible]	[illegible]A	Formal assessm[illegible] indicates the patient was not at risk of pressure ulcers since [illegible]e last OASI[illegible]sessment
f. Pressure ulcer treatment based on principles of moist wound healing	[illegible]	☐ 1	☐ N[illegible]	[illegible]ssings that [illegible]pport the principles of moist wound healing not indicated for th[illegible] patient's pr[illegible]ure ulcers OR patient has no pressure ulcers with need for [illegible]o[illegible] wound [illegible]ing

Comments

(M2410) To which **Inpatient Facility** has t[illegible] patient been admitt[illegible]

- ☐ 1 - Hospital
- ☐ 2 - Rehabilitation facility **[Go to *M0903*]**
- ☐ [illegible] - Nursing ho[illegible]e
- ☐ [illegible] - Hospice **[**[illegible] ***M0903*]**
- [illegible]A - No inpatient facility admission

Comments

(M2420) Discharge Disposition: [illegible]e is the [illegible]ient after d[illegible]e from [illegible]ur agency?
(Choose only ONE answer.)

- ☐ 1 - Patient remained in the co[illegible]unity (wi[illegible]t for[illegible] assistive s[illegible]ice[illegible]
- ☐ 2 - Patient remained in the [illegible]munity (with [illegible]al a[illegible]tive servic[illegible]
- ☐ 3 - Patient transferred t[illegible]on-institutional hosp[illegible]
- ☐ 4 - Unknown because patient moved to a geographic location not served by this agency
- ☐ UK - Other unknown

[Go to *M0903*]

Comments

(M0903) Date of Last (M[illegible] Recent) [illegible]m[illegible]isit:
mont[illegible] *da[illegible]* [illegible]
__ __ / __ __ / __ __ __ __

P **(M[illegible]) Discharge/Transfer/Death Date:** Enter the date of the discharge, transfer, or death (at home) of the patient.
month *day* *year*
__ __ / __ __ / __ __ __ __

SKILLE[illegible]ERVICES PR[illegible]DED T[illegible]S VISIT:

SKILLED TEACHI[illegible]ROVIDED T[illegible] VISIT:

Patient S[illegible]e (optional per HHA policy & procedure):	Patient Name	Record No.

Nursing Signature/Discipline and Date:	HHA USE ONLY	Checked By	Entered By	Transmitted By
		Date	Date	Date

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DISCHARGE SUMMARY

Admission Date: ____________________ **Discharge Date:** ____________________

Reason for discharge: ☐ Care completed ☐ To hospital ☐ To nursing home ☐ Moved out of area ☐ Deceased ☐ Refused/Request ☐ Noncompliant

Condition on Discharge

Vital Signs (optional per HHA Policies & Procedures): ____________________

Physical/Psychosocial Status: ____________________

Current Status: ☐ Independent ☐ Dependent ☐ Needs assist ☐ Need[illegible]perv[illegible]n ☐ [illegible]ired

Care Summary (care given, intervention, progress, regress including therapies): ____________________

Specific discharge instructions given: ____________________

Goals not met & reasons: ____________________

Continuing symptoms management needs (i.e., [illegible], N[illegible]dy[illegible]ea, [illegible]): ____________________

Resource information provided to patient [illegible] continuing [illegible]ds: ____________________

Outcomes:

☐ Goals met ☐ Condition improve[illegible] ☐ Stabilized ☐ Improved kn[illegible]dge[illegible] self care m[illegible]agement ☐ I[illegible]proved functio[illegible] st[illegible] ☐ I[illegible]ved independe[illegible] ☐ Lack of progress ☐ Deterioration of status ☐ Other: ____________________

Resource[illegible]ngoing: ☐ N[illegible] ☐ Me[illegible] on W[illegible] ☐ State program ☐ Other (specify): ____________________

[illegible]ischarge i[illegible]uctions? ☐ Yes ☐ No
Able to [illegible]? ☐ Yes ☐ No If no, what action was taken: ____________________
Cou[illegible] use me[illegible]llow u[illegible]nd Pt/Cg verbalizes understanding? ☐ Yes ☐ No
In[illegible]d to call agenc[illegible] for future home care needs? ☐ Yes ☐ No

Living A[illegible]ements a[illegible]ischarge: ☐ O[illegible] ☐ Relative home ☐ Nursing home ☐ Other (specify): ____________________

☐ [illegible]scharge [illegible]m Home Health Care
Privat[illegible]ty services offered
☐ [illegible]ician notified
☐ All disciplines notified and discontinued
☐ Report given to institution or agency assuming care w/notification of Advance Directive status
☐ Office scheduler notified
☐ Order and summary completed
☐ Medication Profile Provided (per agency policy)
☐ Other: ____________________

SAMPLE

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

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

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