

HC1314H

**Adult Physical Therapy
Re-Assessment, 485 P.O.C.
Recertification Worksheet,
and OASIS Follow-Up**

This eight-page Physical Therapy Re-Assessment, 485 Recertification, and OASIS Follow-Up form contains the MED-PASS exclusive three-forms-in-one, color-coded design.

Includes Patient Tracking Update.

Use this form as a complement to the HC1307H.

Conveniently wrapped in 100s.

100	\$49.90
500	\$44.90 per 100
1000	\$41.90 per 100

Adult Physical Therapy Re-Assessment, 485 P.O.C. Recertification Worksheet and OASIS Follow-Up

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

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

Date: _____
ASSESSMENT TIME
 IN: _____ OUT: _____

FOLLOW-UP VERSION

Items to be used at this Time Point:
 M0080-M0100, M0110, M1020-M1030, M1200, M1242, M1306, M1308, M1322-M1324, M1330-M1350, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200

7 Provider Name, Address and Telephone Number _____

2 Start of Care Date: _____
 month day year
 ___ / ___ / ___

3 Certification Period From: _____ To: _____ Patient Phone # _____

6 Patient Street Address _____ City _____

24 Primary Physician's Name _____ Address _____ Physician's Phone _____ Physician's Fax _____

Emergency Contact Name _____
 No changes since previous assessment
 Other _____

Secondary Physician's Name _____ Phone _____

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.)

<input type="checkbox"/> 0 - None; no charge for current services	<input type="checkbox"/> 4 - Medicaid (HMO/managed care)	<input type="checkbox"/> 8 - Private Insurance
<input type="checkbox"/> 1 - Medicare (traditional fee-for-service)	<input type="checkbox"/> 5 - Workers' compensation	<input type="checkbox"/> 9 - Private HMO/managed care
<input type="checkbox"/> 2 - Medicare (HMO/managed care/Advance Plan)	<input type="checkbox"/> 6 - Title programs (e.g., Title III, V, or XX)	<input type="checkbox"/> 10 - Self-pay
<input type="checkbox"/> 3 - Medicaid (traditional fee-for-service)	<input type="checkbox"/> 7 - Other government (e.g., TriCare, VA, etc.)	<input type="checkbox"/> 11 - Other (specify): _____
		<input type="checkbox"/> UK - Unknown

CLINICAL RECORD ITEMS

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

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

(M0100) This Assessment is Currently Being Completed for the Following Reason:
 Follow-Up 4 - Recertification (follow-up) reassessment [Go to M0110] 5 - Other follow-up [Go to M0110]

(M0110) Episode Timing Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?
 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: No changes since previous assessment
 Comments _____

BREASTS: No changes since previous assessment
 Comments _____

Has Medical or Treatment Regimen Changed Since Previous Assessment: (Include any Emergent Care treatment)
 0 - No
 1 - Yes, Please provide a brief summary _____

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 row 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). See OASIS-C 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 descriptions and 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 Column 3 of that 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.)	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.	Complete if a V-code is assigned under certain circumstances to Column 2 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/Symptom Control Rating	Description/ICD-9-CM	Description/ICD-9-CM
11 (M1020) Primary Diagnosis	(V-codes are allowed)	(V- or E-codes NOT 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	a. (____.____) (____.____)	a. (____.____) (____.____)
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	b. (____.____) (____.____)	b. (____.____) (____.____)
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	c. (____.____) (____.____)	c. (____.____) (____.____)
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	d. (____.____) (____.____)	d. (____.____) (____.____)
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	e. (____.____) (____.____)	e. (____.____) (____.____)
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	f. (____.____) (____.____)	f. (____.____) (____.____)
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	g. (____.____) (____.____)	g. (____.____) (____.____)
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	h. (____.____) (____.____)	h. (____.____) (____.____)

Patient/Family Knowledge and Coping Level Status Regarding Present Diagnosis:

Patient: _____ Family: _____

Changes made to Advance Directives since previous assessment:

No Yes, specify: _____

NRS (M1030) Therapies the patient receives at home: (Mark all that apply.)

- 1 - Intravenous or infusion therapy (excludes TPN)
- 2 - Parenteral nutrition (TPN or lipids)
- 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
- 4 - None of the above

20 PROGNOSIS:

Poor Fair Good

21 Is the patient DNR

"Do Not Resuscitate"? Yes No

Comments _____

LIVING ARRANGEMENTS

Safety/Sanitation Hazards affecting patient No changes since previous assessment

15 SAFETY MEASURES:

- Anticoagulant Precautions
- O₂ Precautions
- Slow Position Change
- Proper Position During Meals
- Use of Assistive Devices
- Support During Transfer and Ambulation
- Emergency Plan Developed
- Keep Side Rails Up
- Keep Pathways Clear
- Safety in ADLs
- Seizure Precautions
- Standard Precautions/Infection Control
- Neutropenic Precautions
- Fall Precautions
- Other _____

Comments _____

- 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
- No changes since previous assessment

Comments _____

Triage/Risk Code (Agency specific): _____

Disaster Code (Agency specific): _____

Marital Status No changes to Marital Status since previous assessment

Comments _____

SUPPORTIVE ASSISTANCE

Support System/Caregiver Participation

- No changes since previous assessment
- Other: _____

Comments _____

Patient Name (Last, First, MI)

Record No.

SUPPORTIVE ASSISTANCE (continued)

SUPPORTIVE ASSISTANCE Names of Organizations/Persons Providing Assistance: _____

18A FUNCTIONAL LIMITATIONS:

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

Homebound No changes since previous assessment

Comments _____

SENSORY STATUS

VITAL SIGNS: PULSE: Apical _____ (Reg) (Irreg) Radial _____ (Reg) (Irreg) Height _____ Weight _____
 TEMP.: _____ RESP.: _____ Actual Stated
 B/P Lying _____ Sitting _____ Standing _____
 L _____ R _____

21 Notify Physician of Temperature Ranges > _____ or < _____

Known Recent Lab Results: _____

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

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

EARS / NOSE / THROAT / MOUTH No changes since previous assessment. Comments _____

(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.

Glasses Contacts: R L

No changes since previous assessment

Comments _____

Ability to Communicate No changes since previous assessment. Comments _____

NEUROLOGICAL No changes since previous assessment. Comments _____

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

- Changes in LOC/Neurological Status
- Communication Skills
- Seizure Precautions

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

- Orientation Techniques:

Additional Orders (specify): _____

PAIN PROFILE Primary Site: _____ Onset Date: _____

PA (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

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: _____

WONG-BAKER FACES[®] PAIN RATING SCALE

Intensity: No Hurt Hurts Little Bit Hurts Little More Hurts Even More Hurts Whole Lot Hurts Worst



*From Hockenberry, M., Wilson, D., Winkelstein ML: Wong's Essentials of Pediatric Nursing, ed. 7, St. Louis, 2005, p. 1259. Used with permission. Copyright, Mosby

Pain Description: Sharp Dull Other: _____

See Pain Assessment/Documentation (per agency policy)

Refer to: _____

Comments _____

21 Pain Management Interventions: Assess/Perform/Instruct Pt/Cg: **A P I**

- Intervention(s) to monitor and mitigate pain
-
-

MUSCULOSKELETAL STATUS / PHYSICAL THERAPY ASSESSMENT (PT)

POSTURE No changes since previous assessment

Comments _____

RANGE OF MOTION / MOBILITY No changes since previous assessment

Comments _____

MUSCLE STRENGTH AGAINST GRAVITY No changes since previous assessment

Comments _____

BALANCE No changes since previous assessment

Comments _____

Patient Name (Last, First, MI) _____

Record No. _____



MUSCULOSKELETAL STATUS / PHYSICAL THERAPY ASSESSMENT (continued) PT

JOINTS

No changes since previous assessment

Comments

PROSTHETIC DEVICE/ADAPTIVE EQUIPMENT

No changes since previous assessment

Comments

BED MOBILITY

No changes since previous assessment

Comments

TRANSFERS

No changes since previous assessment

Comments

ENDURANCE

No changes since previous assessment

Comments

EMOTIONAL STATUS / BEHAVIORS WHICH MAY IMPACT PLAN OF CARE

Comments

NONE IDENTIFIED AS _____

HOME STRUCTURE / HOUSEHOLD BARRIERS THAT MAY IMPACT PLAN OF CARE

Comments

NONE IDENTIFIED AS _____

PHYSICAL THERAPY ORDERS

Assess/Perform/Instruct Pt/Cg:

A P I

Assess/Perform/Instruct Pt/Cg:

A P I

- POSTURE TRAINING/EXERCISES _____
- L. E. ROM EXERCISES _____
- L. E. POSITIONING & BODY ALIGNMENT EXERCISES _____
- U. E. ROM EXERCISES _____
- U. E. POSITIONING & BODY ALIGNMENT EXERCISES _____
- UPPER BODY MUSCLE STRENGTHENING EXERCISES _____
- LOWER BODY MUSCLE STRENGTHENING EXERCISES _____
- BALANCE EXERCISES/*SITTING* _____
- BALANCE EXERCISES/*STANDING* _____

- GAIT TRAINING _____
- JOINT MOBILITY PROGRAM _____
- CAST CARE _____
- PROSTHETIC DEVICE _____
- ADAPTIVE DEVICE _____
- CIRCULATORY CHECKS AS APPLICABLE _____
- BED MOBILITY _____
- TRANSFER TECHNIQUES _____
- ENDURANCE IMPROVEMENT/STRENGTH EXERCISES _____

Additional Orders (specify): _____

INTEGUMENTARY STATUS

- INTEGUMENTARY**
- Skin Turgor: Good Fair Poor
- Skin Color: Pink Pale Jaundice Cyanotic
- Skin: Dry Diaphoretic Warm Cool
- Skin: Wounds Ulcers Incision Rashes
- Ostomy Other
- Nails: Normal Problems

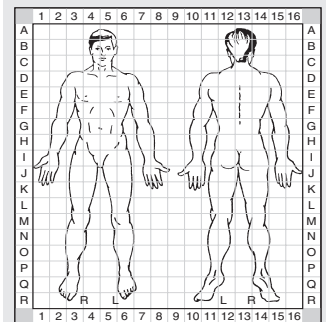
Comments

Instructed on measures to control infections: Yes No

INTEGUMENTARY STATUS LOCATOR

Key: 1 - Skin Lesion 2 - Pressure Ulcer 3 - Stasis Ulcer 4 - Surgical Wound

Type	Location	Size	Drainage	Amount	Odor	Stage	Surrounding Skin



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

Patient Name (Last, First, MI)

Record No.

INTEGUMENTARY STATUS (continued)

NRS OM (M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage: (Enter "0" if none; excludes Stage I pressure ulcers)	Complete at SOC/ROC/FU & D/C	Complete at FU & D/C	Comments
	Number Currently Present	Number of those listed in Column 1 that were present on admission (most recent SOC/ROC)	
Stage Description - Unhealed Pressure Ulcers			
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"/>	<input type="checkbox"/>	
b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device.	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	
d.3 Unstageable: Suspected deep tissue injury in evolution.	<input type="checkbox"/>	<input type="checkbox"/>	

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

(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

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]

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

OM (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]

OM (M1342) Status of Most Problematic (Observable) Surgical Wound:
 0 - Newly epithelialized 1 - Fully granulating 2 - Early/partial granulation 3 - Not healing

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

RESPIRATORY STATUS

OM (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) No changes since previous assessment

CARDIAC STATUS

No changes since previous assessment
 Comments

ELIMINATION STATUS

Urinary: No changes since previous assessment Comments

Bowel: No changes since previous assessment Comments

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]

NRS OM (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

Endocrine No changes since previous assessment Comments

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

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ELIMINATION STATUS (continued)

NRS (M1630) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days):

a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen?

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

Comments section for Ostomy for Bowel Elimination with multiple lines for text entry.

NUTRITIONAL STATUS

Nutritional Status: Significant weight loss/gain last 3 mos. Give amount: No changes since previous assessment

16 NUTRITIONAL REQUIREMENTS NEW OR CHANGED:

- Sodium Diet, Calorie ADA Diet, Bland Diet, Protein Hi Diet, Carbohydrate Hi Diet, Enteral Feeding, Bolus of, Flush with

- Mechanical (Soft, Hi-Fiber, etc.), NG Tube, Regular, PEG Tube, Supplement, Other (specify):

Comments section for Nutritional Status with multiple lines for text entry.

NEURO/EMOTIONAL/BEHAVIORAL STATUS

ORIENTED/COGNITIVE STATUS No changes since previous assessment Other: Comments

PSYCHOLOGICAL STATUS No changes since previous assessment Comments

- 19 MENTAL STATUS: Oriented: Person, Place, Time, Comatose, Forgetful, Agitated, Depressed, Disoriented, Lethargic, Other:

Comments section for Oriented/Cognitive Status

Comments section for Psychological Status

Comments section for Mental Status

ADL / IADLs

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

No changes since previous assessment Other: 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.

OM (M1800) 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.

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.

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.

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.

ADL/IADLs Comments

Comments section for ADL/IADLs with multiple lines for text entry.

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.

Patient Name (Last, First, MI)

Record No.

ADL / IADLs (continued)

- 18B ACTIVITIES PERMITTED: Complete bed rest, Up as tolerated, Exercise prescribed, Independent at home, Cane, Walker, Bed rest with BRP, Transfer bed-chair, Partial weight bearing, Crutches, Wheelchair, Other:

Indicate changes in the following areas:

- Feeding/Eating, Meal Plan/Preparation, Transportation, Laundry, Housekeeping, Shopping, Telephone Use, Other:

Comments

MEDICATIONS

Patient's ability to manage oral medication No changes since previous assessment, Other, 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.

10 MEDICATIONS: DOSE/FREQUENCY/ROUTE: See Medication Profile Note: See Med Profile for Drug Regimen Review per agency policy.

- 21 Implement and Instruct Medication Regimen, including dosage, side effects, name, route, frequency, desired action & adverse reactions. Assess Medication Compliance/Med Set-up

THERAPY NEED

(OM) (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.

NRS 14 DME AND SUPPLIES

- DME: Bedside Commode, Cane, Elevated Toilet Seat, Grab Bars, Hospital Bed, Tub/Shower Bench, Wheelchair, Walker, Other:
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, Irrigation Set, Kerlix Rolls, Leg Bag, Needles, NG Tube, Sterile Gloves, Syringe, Tape, Other (specify):

21 ORDERS FOR DISCIPLINE AND TREATMENTS

- Implement and Instruct Standard Precautions/Infection Control
Management of disease process to include:
HHA Visit Frequency to assist w/personal care/ADL's/light housekeeping as needed
PCA/R - Personal Care Aide/Respite Waiver Passport (circle one)
Skilled Nursing to consult, evaluate and treat
Skilled Nursing Visit Frequency
Physical Therapy Visit Frequency
Occupational Therapy Visit Frequency
OT to consult, evaluate and treat
ST to consult, evaluate and treat
Speech Therapy Visit Frequency
MSW to evaluate and assess for needs
Medical Social Worker Visit Frequency

21 Dietitian evaluation Review Nutritional Risk Factors to determine need for further Nutrition Assessment by qualified H.C. professional.

Patient Name (Last, First, MI)

Record No.



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 _____ diet, as evidenced by compliance with diet plan within _____ period of time.
- The patient's home environment will be clean & 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.
- Rehabilitation potential: _____
- Other: _____
- Other: _____

SPECIFIC PHYSICAL THERAPY GOALS

Short-Term:

Long-Term:

Patient/Caregiver's Expectations:

- 22 Discharge Plans** Patient to be discharged when skilled care no longer needed Other (specify): _____
- Patient to be discharged to the care of: Self Caregiver Other: _____

- Patient Strengths:** Motivated Learner Strong Support System Absence of Multiple Disease Diagnosis Enhanced Socioeconomic Status Other: _____
- Conclusions:** Skilled Intervention Needed Skilled Instruction Needed No Skilled Service Needed Other: _____

ADDITIONAL COMMENTS/NOTES: **21** 60-Day Summary

Aide Supervision (optional)

- Present on this visit? Yes No
- Aide following care plan? Yes No
- Courteous and polite? Yes No
- Report changes in patient status to HHA? Yes No
- Patient satisfied with care? Yes No
- Changes made to aide care plan? Yes No
- Additional instruction given during visit? Yes No

Signature: _____

SKILLED SERVICES PROVIDED THIS VISIT AND PATIENT RESPONSE:

Patient Signature (optional per HHA policy & procedure): _____

Patient Name _____

Record No. _____

23 PT's 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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