CARE SUMMARY INCLUDING OASIS ELEMENTS FOR

❑ TRANSFER TO INPATIENT FACILITY
❑ DEATH AT HOME

DATE_____/_____/_____

TIME IN_____ TIME OUT_____

Follow M00 numbers in sequence unless otherwise directed.

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment:

❑ 1-RN ❑ 2-PT ❑ 3-SLP/ST ❑ 4-OT

(M0090) Date Assessment Completed:

___ ___/___ ___/___ ___ ___ ___
month day year

(M0100) This Assessment is Currently Being Completed for the Following Reason: Transfer to an Inpatient Facility

❑ 6 - Transferred to an inpatient facility—patient not discharged from agency ***[Go to M1040]***

❑ 7 - Transferred to an inpatient facility—patient discharged from agency ***[Go to M1040]***

❑ 8 - Death at home ***[Go to M0903]***

(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?

❑ 0 - No

❑ 1 - Yes ***[Go to M1050]***

❑ NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. ***[Go to M1050]***

(M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason:

❑ 1 - Received from another health care provider (e.g., physician)

❑ 2 - Received from your agency previously during this year's flu season

❑ 3 - Offered and declined

❑ 4 - Assessed and determined to have medical contraindication(s)

❑ 5 - Not indicated; patient does not meet age/condition guidelines for influenza vaccine

❑ 6 - Inability to obtain vaccine due to declared shortage

❑ 7 - None of the above

(M1050) Pneumococcal Vaccine: Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge)?

❑ 0 - No

❑ 1 - Yes ***[Go to M1500]***

(M1055) Reason PPV not received: If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), state reason:

❑ 1 - Patient has received PPV in the past

❑ 2 - Offered and declined

❑ 3 - Assessed and determined to have medical contraindication(s)

❑ 4 - Not indicated; patient does not meet age/condition guidelines for PPV

❑ 5 - None of the above

CARDIOPULMONARY

(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 M2004]***

❑ 1 - Yes

❑ 2 - Not assessed ***[Go to M2004]***

❑ NA - Patient does not have diagnosis of heart failure ***[Go to M2004]***

(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.)

MEDICATIONS

(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

(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

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]***

PATIENT NAME–Last, First, Middle Initial	ID#

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Patient Name_____ ID #_____

EMERGENT CARE (Cont'd.)

(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

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

(M2400) Intervention Synopsis: (Check only **one** box in each row.) Since the previous OASIS assessment, were the following interventions BOTH included 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 not diabetic or is bilateral amputee
b. Falls prevention interventions	❑ 0	❑ 1	❑ na	Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	❑ 0	❑ 1	❑ na	Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment
d. Intervention(s) to monitor and mitigate pain	❑ 0	❑ 1	❑ na	Formal assessment did not indicate pain since the last OASIS assessment
e. Intervention(s) to prevent pressure ulcers	❑ 0	❑ 1	❑ na	Formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment
f. Pressure ulcer treatment based on principles of moist wound healing	❑ 0	❑ 1	❑ na	Dressings that support the principles of moist wound healing not indicated for this patient's pressure ulcers OR patient has no pressure ulcers with need for moist wound healing

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

- ❑ 1 - Hospital ***[Go to M2430]***
- ❑ 2 - Rehabilitation facility ***[Go to M0903]***
- ❑ 3 - Nursing home ***[Go to M2440]***
- ❑ 4 - Hospice ***[Go to M0903]***

(M2430) Reason for Hospitalization: For what reason(s) did the patient require 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 - Scheduled treatment or procedure
- ❑ 20 - Other than above reasons
- ❑ UK - Reason unknown

[Go to M0903]

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Patient Name_____ ID #_____

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY (Cont'd.)

(M2440) For what **Reason(s)** was the patient **Admitted** to a **Nursing Home**? **(Mark all that apply.)**

- ❑ 1 - Therapy services
- ❑ 2 - Respite care
- ❑ 3 - Hospice care
- ❑ 4 - Permanent placement
- ❑ 5 - Unsafe for care at home
- ❑ 6 - Other
- ❑ UK - Unknown

[Go to M0903]

SUMMARY

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

___ ___/___ ___/___ ___ ___ ___ ___
month day year

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

___ ___/___ ___/___ ___ ___ ___ ___
month day year

DISCIPLINES INVOLVED:

❑ SN ❑ PT ❑ OT ❑ ST ❑ MSW ❑ Aide ❑ Other _____

❑ All involved team members notified

Was a referral made to MSW for assistance with community resources/assistance with a living will/counseling needs (depression/suicidal ideation) and/or unsafe environment? Date_____ ❑ Yes ❑ No ❑ Refused ❑ N/A

Comment: _____

Complete this Section for either Transfer to inpatient Facility or Death at Home.

REASON FOR ADMISSION TO HOME HEALTH AND SUMMARY OF CARE TO DATE (describe condition):

_____

_____

_____

_____

_____

_____

DETAILS RELATED TO EMERGENT CARE AND/OR HOSPITALIZATION/NURSING HOME (when known):

_____

_____

_____

_____

_____

_____

Copy of summary sent/faxed (circle) Date: _____/_____/_____

To: ❑ Physician_____ ❑ Facility Name_____

Copy of current P.O.C. attached ❑ Yes ❑ No

Current medication list attached ❑ Yes ❑ No

Advance directive exists ❑ Yes ❑ No **Copy attached** ❑ Yes ❑ No

DNR ❑ Yes ❑ No **Copy attached** ❑ Yes ❑ No

SIGNATURE/DATES

X_____ _____/_____/_____
Patient/Caregiver Signature (if applicable) *Date*

X_____ _____/_____/_____
Signature/Title of Person Completing This Form *Date*

Agency Name_____ Phone #_____

OASIS INFORMATION

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

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