OMB #0938-1279

TRANSFER

(M0010) CMS Certification Number: 367549 (M0014) Branch State: OH (M0016) Branch ID Number: N/A

Patient Identifiers: ☐ **Facial Recognition** ☐ **Patient Address** ☐ **DOB (month/day year)** __ __ /__ __ /__ __ __ __ **UHHC#** ____________

(M0020) Patient ID Number: __

(M0030) Start of Care Date: __ __ /__ __ /__ __ __ __
month / day / year

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

(M0040) Patient Name:

__ __
(First) (M I) (Last) (Suffix)

Patient Address: ____

(M0060) Patient ZIP Code: __ __ __ __ __ __ __ __ __

(M0063) Medicare Number: __ __ __ __ __ __ __ __ __ __ __ __ ☐ NA – No Medicare
(including suffix)

(M0064) Social Security Number: __ __ __ - __ __ - __ __ __ __ ☐ UK – Unknown or Not Available

(M0065) Medicaid Number: __ __ __ __ __ __ __ __ __ __ __ __ __ ☐ NA – No Medicaid

Payor Source: ____

(M0066) Birth Date: __ __ /__ __ /__ __ __ __
month / day / year

(M0069) Gender:
- ☐ 1 - Male
- ☐ 2 - Female

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment:

☐ 1-RN ☐ 2-PT ☐ 3-SLP/ST ☐ 4-OT

Discipline Signature: ____

Team Leader: ____

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

(M0100) This Assessment is Currently Being Completed for the Following Reason:

☐ 6 – Transferred to an inpatient facility—patient not discharged from agency [Go to M1041]

☐ 7 – Transferred to an inpatient facility—patient discharged from agency [Go to M1041]

Transfer to an Inpatient Facility ------------------------ Transferred to an inpatient facility—patient not discharged from an agency Transferred to an inpatient facility—patient discharged from agency	M0080-M0100, M1041-M1056, M1500, M1510, M2004, M2015, M2300-M2410, M2430, M0903, M0906

PATIENT HISTORY AND DIAGNOSES

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

- ☐ 0 - No [Go to M1051]
- ☐ 1 - Yes

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

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

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

- ☐ 0 - No
- ☐ 1 - Yes [Go to M1500]

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

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

CARDIAC STATUS

(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 the time of or at any time 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 at the time of or at any time 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 (for example, call 911 or go to emergency room)
- ☐ 3 - Implemented physician-ordered patient-specific established parameters for treatment
- ☐ 4 - Patient education or other clinical interventions
- ☐ 5 - Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)

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

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - No clinically significant medication issues identified at the time of or at any time since the previous OASIS

(M2015) Patient/Caregiver Drug Education Intervention: At the time of, or at any time 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, adverse drug reactions, and significant 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: At the time of or at any time since the previous OASIS assessment has the patient utilized a hospital emergency department (includes holding/observation status)?

- ☐ 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]

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

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

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

(M2400) Intervention Synopsis: (Check only **one** box in each row.) At the time of or at any time 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 missing lower legs due to congenital or acquired condition (bilateral amputee).
b. Falls prevention interventions	☐0	☐1	☐NA	Every standardized, validated multifactor fall risk assessment conducted at or since the last OASIS assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐0	☐1	☐NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the last OASIS assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d. Intervention(s) to monitor and mitigate pain	☐0	☐1	☐NA	Every standardized, validated pain assessment conducted at or since the last OASIS assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	☐0	☐1	☐NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the last OASIS assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	☐0	☐1	☐NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

(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 M0903]
- ☐ 4 - Hospice [Go to M0903]
- ☐ NA - No inpatient facility admission [Omit “NA” option on TRN]

(M2430) Reason for Hospitalization: For what reason(s) did the patient require hospitalization? **(Mark all that apply.)**

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

(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