OASIS START OF CARE/RESUMPTION OF CARE ASSESSMENT
SPEECH THERAPY

M Items IMPACTING HHRG SCORE

CLINICAL RECORD ITEMS

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

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

3. **(M0100)**
This Assessment is Currently Being Completed for the Following Reason:
Start/Resumption of Care
□ 1 - Start of care - further visits planned
□ 3 - Resumption of care (after inpatient stay)

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

5. **(M0104)**
Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.
__ __ / __ __ / __ __ __ __
month day year

6. **(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.

Supporting Documentation: _____

PATIENT HISTORY AND DIAGNOSIS

7. **(M1000)**
From which of the following Inpatient Facilities was the patient discharged during the past 14 days?
(Mark all that apply.)
□ 1 - Long-term nursing facility (NF)
□ 2 - Skilled nursing facility (SNF/TCU)
□ 3 - Short-stay acute hospital (IPP S)
□ 4 - Long-term care hospital (LTCH)
□ 5 - Inpatient rehabilitation hospital or unit (IRF)
□ 6 - Psychiatric hospital or unit
□ 7 - Other (specify)_____
□ NA - Patient was not discharged from an inpatient facility ***[Go to M1016]***

8. **(M1005)**
Inpatient Discharge Date (most recent):
__ __ / __ __ / __ __ __ __
month day year
□ UK - Unknown

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

Inpatient Facility Diagnosis	ICD-9-C M Code
a. _____	__ __ __ . __ __
b. _____	__ __ __ . __ __
c. _____	__ __ __ . __ __
d. _____	__ __ __ . __ __
e. _____	__ __ __ . __ __
f. _____	__ __ __ . __ __

10. **(M1012)**
List each **Inpatient Procedure** and the associated ICD-9-C M procedure code relevant to the plan of care.

Inpatient Procedure	ICD-9-C M Procedure Code
a. _____	__ __ . __ __
b. _____	__ __ . __ __
c. _____	__ __ . __ __
d. _____	__ __ . __ __

□ NA - Not applicable
□ UK - Unknown

(485 #12) **Surgical Procedure(s) impacting Plan of Care**

PROCEDURE	ICD-9-C M Code	Date
a. _____	__ __ . __ __	___/___/___
b. _____	__ __ . __ __	___/___/___

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

Changed Medical Regimen Diagnosis	ICD-9-C M Codes
a. _____	__ __ __ . __ __
b. _____	__ __ __ . __ __
c. _____	__ __ __ . __ __
d. _____	__ __ __ . __ __
e. _____	__ __ __ . __ __
f. _____	__ __ __ . __ __

□ NA - Not Applicable (no medical or treatment regimen changes within the past 14 days)

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

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

PATIENT HISTORY AND DIAGNOSES

13. ****(M01020/1022/1024)**
Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-C M 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-C M 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 P P S 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-C M 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-C M coding guidelines, enter the diagnosis descriptions and the ICD-9-C M 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-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Form on next page)

** (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-C M 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-C M / Symptom Control Rating	Description/ ICD-9-C M	Description/ ICD-9-C M
(M1020) Primary Diagnosis a. _____ Date _____	**(V-codes are allowed)** a. (__ __ __ . __ __) □ 0 □ 1 □ 2 □ 3 □ 4	**(V- or E-codes NOT allowed)** a. _____ (__ __ __ . __ __)	**(V- E-codes NOT allowed)** a. _____ (__ __ __ . __ __)
(M1022) Other Diagnoses b. _____ Date _____	**(V- or E-codes are allowed)** b. (__ __ __ . __ __) □ 0 □ 1 □ 2 □ 3 □ 4	**(V- or E-codes NOT allowed)** b. _____ (__ __ __ . __ __)	**(V- E-codes NOT allowed)** b. _____ (__ __ __ . __ __)
c. _____ Date _____	c. (__ __ __ . __ __) □ 0 □ 1 □ 2 □ 3 □ 4	c. _____ (__ __ __ . __ __)	c. _____ (__ __ __ . __ __)
d. _____ Date _____	d. (__ __ __ . __ __) □ 0 □ 1 □ 2 □ 3 □ 4	d. _____ (__ __ __ . __ __)	d. _____ (__ __ __ . __ __)
e. _____ Date _____	e. (__ __ __ . __ __) □ 0 □ 1 □ 2 □ 3 □ 4	e. _____ (__ __ __ . __ __)	e. _____ (__ __ __ . __ __)
f. _____ Date _____	f. (__ __ __ . __ __) □ 0 □ 1 □ 2 □ 3 □ 4	f. _____ (__ __ __ . __ __)	f. _____ (__ __ __ . __ __)
ADDITIONAL DIAGNOSES IMPACTING PLAN OF CARE:			
g. _____ Date _____	g. (__ __ __ . __ __) □ 0 □ 1 □ 2 □ 3 □ 4	g. _____ (__ __ __ . __ __)	g. _____ (__ __ __ . __ __)
h. _____ Date _____	h. (__ __ __ . __ __) □ 0 □ 1 □ 2 □ 3 □ 4	h. _____ (__ __ __ . __ __)	h. _____ (__ __ __ . __ __)
i. _____ Date _____	i. (__ __ __ . __ __) □ 0 □ 1 □ 2 □ 3 □ 4	i. _____ (__ __ __ . __ __)	i. _____ (__ __ __ . __ __)
j. _____ Date _____	j. (__ __ __ . __ __) □ 0 □ 1 □ 2 □ 3 □ 4	j. _____ (__ __ __ . __ __)	j. _____ (__ __ __ . __ __)

14. **(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

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

- □ 1 - Recent decline in mental, emotional, or behavioral status
- □ 2 - Multiple hospitalizations (2 or more) in the past 12 months
- □ 3 - History of falls (2 or more falls - or any fall with an injury - in the past year)
- □ 4 - Taking five or more medications
- □ 5 - Frailty indicators, e.g., weight loss, self-reported exhaustion
- □ 6 - Other
- □ 7 - None of the above

15. **(M1032)**

16. **(M1034)**
Overall Status: Which description best fits the patient's overall status? **(Check one)**

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

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

- ☐ 1 - Smoking
- ☐ 2 - Obesity
- ☐ 3 - Alcohol dependency
- ☐ 4 - Drug dependency
- ☐ 5 - None of the above
- ☐ UK - Unknown

LIVING ARRANGEMENTS

Emergency contact **outside** the home:
Name: _____
Phone#: _____
Relationship: _____
Caregiver's Name: _____
Address: ❑ Same as patient
Other : _____
If lives in assisted living facility, name of facility:
_____
Contact person/number: _____

CAREGIVER/REFERRAL - NEEDS ASSESSMENT

Caregiver able/willing to provide all care?		☐ Yes	☐ No
Caregiver able to receive and follow instructions?		☐ Yes	☐ No
Able to administer meds?		☐ Yes	☐ No
Able to perform/assist with procedures?		☐ Yes	☐ No
American Cancer Society?	☐ Has ☐ Needs		☐ No
Meals on Wheels?	☐ Has ☐ Needs		☐ No
Transportation service?	☐ Has ☐ Needs		☐ No
Church?	☐ Has ☐ Needs		☐ No
Comm Care Services?	☐ Has ☐ Needs		☐ No

☐ CBA ☐ PHC
Name of agency: _____
Agency phone number: _____
Other: _____
Supporting Documentation: _____
_____
_____

SAFETY HAZARDS IN THE HOME

Unsound structure?	☐ Yes	☐ No
Inadequate heating/electricity?	☐ Yes	☐ No
Unsafe gas/electrical appliances?	☐ Yes	☐ No
Inadequate cooking facilities?	☐ Yes	☐ No
Inadequate sleeping arrangements?	☐ Yes	☐ No
Inadequate ventilation?	☐ Yes	☐ No
Inadequate running water?	☐ Yes	☐ No
Unsafe storage of supplies/equipment?	☐ Yes	☐ No
Presence of infestation of pests?	☐ Yes	☐ No
Neighborhood unsafe?	☐ Yes	☐ No
Inadequate or no emergency plan?	☐ Yes	☐ No
Ramps/railings needed?	☐ Yes	☐ No

Supporting Documentation: _____
_____
_____

(485 #15) **Safety Measures**
Precautions for ☐ Falls ☐ Oxygen ☐ Anticoagulation
☐ Seizures ☐ Aspiration
☐ Infection Control/Standard precautions
☐ Other _____

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

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

Supporting Documentation: _____

SENSORY STATUS

Visual impairment?	□ Yes □ No
Glasses { } Contacts { }	□ Yes □ No
Redness, itching, burning of eyes?	□ Yes □ No
Ear discharge or pain?	□ Yes □ No
Surgery on eyes or ears? (Specify)	□ Yes □ No
Dentures	□ Yes □ No
Limited educational background? Pt { } C/G { }	□ Yes □ No
Reading or writing problems? Pt { } C/G { }	□ Yes □ No
Slow learner? Pt { } C/G { }	□ Yes □ No
Primary language? _____	
Supporting Documentation: _____	

19. ****(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.

20. **(M1210)**
Ability to hear (with hearing aid or hearing appliance if normally used):
- □ 0 - Adequate: hears normal conversation without difficulty.
- □ 1 - Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.
- □ 2 - Severely Impaired: absence of useful hearing.
- □ UK - Unable to assess hearing.

21. **(M1220)**
Understanding of Verbal Content in patient's own language (with hearing aid or device if used):
- □ 0 - Understands: clear comprehension without cues or repetitions.
- □ 1 - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
- □ 2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
- □ 3 - Rarely/Never Understands
- □ UK - Unable to assess understanding

22. **(M1230)**
Speech and Oral (Verbal) Expression of Language (in patient's own language):
- □ 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
- □ 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
- □ 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
- □ 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance 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.

PAIN ASSESSMENT

Location:_____ Onset: _____

Pain Scale*

❑ 0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

No pain Mild pain Moderate pain Severe pain Worst pain

Non-verbals demonstrated: □ diaphoresis □ grimacing □ tense □ guarding □ moaning/crying □ irritability □ anger □ change vital signs

Description: □ ache □ throbbing □ sharp □ stabbing □ dull □ burning □ crushing □ radiating □ other: _____

What makes the pain better? _____

Does pain prevent patient from doing things?_____

_____

Current Pain Control Regimen (dose, freq & route of meds; other measures): _____

_____

Time of last pain medication taken: _____

Is current pain control regimen effective? □ Yes □ No

Notified physician: □ Yes □ No

Supporting Documentation:_____

_____

_____

*Adapted from: Hockenberry MJ, Wilson D, Winkelstein ML: Wong's Essentials of Pediatric Nursing, ed. 7, St. Louis, 2005, p. 1259. Copyright, Mosby.

23. **(M1240)**
Has this patient had a formal **Pain Assessment** using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?
- □ 0 - No standardized assessment conducted
- □ 1 - Yes, and it does not indicate severe pain
- □ 2 - Yes, and it indicates severe pain

24. ****(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

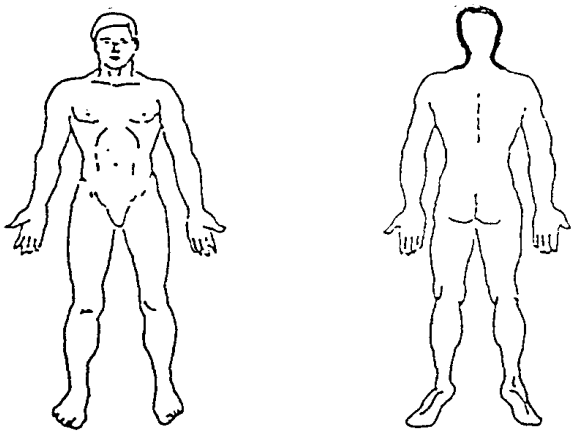
INTEGUMENTARY STATUS

SKIN TURGOR	Good	Fair	Poor
SKIN COLOR	WNL	Pale	Cyanotic
SKIN	Dry	Diaphoretic	
	Warm	Cool	
SKIN	Wounds	Ulcers	Rash
	Incision	Ostomy	Ecchymosis

Supporting Documentation: _____

_____

_____



Ostomy: Type_____

Location _____

Ostomy care provided by:

□ Patient □ Caregiver _____ (Name)

25. **(M1300)**
Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers?
- ☐ 0 - No assessment conducted *[Go to M1306]*
- ☐ 1 - Yes, based on an evaluation of clinical factors, e.g., mobility, incontinence, nutrition, etc., without use of standardized tool
- ☐ 2 - Yes, using a standardized tool, e.g., Braden, Norton, other

26. **(M1302)**
Does this patient have a **Risk of Developing Pressure Ulcers?**
- ☐ 0 - No
- ☐ 1 - Yes

27. **(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

28. ****(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	Number Currently Present
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.	_____

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 the centimeters. If no Stage III or Stage IV pressure ulcers, go to M1320.

29. **(M1310)**
Pressure Ulcer Length: Longest length "head-to-toe"
|__|__|.|__| (cm)

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

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

32. **(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

33. ****(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

34. ****(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

35. ****(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]***

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

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

38. **(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]*

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

40. **(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

Use of accessory muscles?	☐ Yes ☐ No
Orthopnea?	☐ Yes ☐ No
Cough? (Describe)	☐ Yes ☐ No
Sputum? (Describe)	☐ Yes ☐ No
Cyanosis or pain? (Describe)	☐ Yes ☐ No
Use of O_2 at _____ Liters/per min via ☐ nasal cannula ☐ mask ☐ Continuous ☐ HS ☐ PRN	☐ Yes ☐ No
Sleep apnea?	☐ Yes ☐ No
Use of equipment? (Specify)	☐ Yes ☐ No
Tracheostomy? (Size)_____ Managed by: ☐ patient ☐ caregiver name: _____	☐ Yes ☐ No
Nocturnal dyspnea?	☐ Yes ☐ No
Supporting Documentation:_____	

41. ****(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)

42. **(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

CARDIAC STATUS

Chest pain? (Describe)	☐ Yes ☐ No
Pacemaker? Date inserted_____ RATE:_____	☐ Yes ☐ No
Faint or absent pulse? (Specify)	☐ Yes ☐ No
Fainting/dizziness?	☐ Yes ☐ No
Palpitations?	☐ Yes ☐ No
Edema? (Describe)	☐ Yes ☐ No
Supporting Documentation:_____	

RESPIRATORY STATUS

ELIMINATION STATUS

GENITOURINARY ASSESSMENT

Urgency/frequency? ☐ Yes ☐ No
Burning or painful urination? ☐ Yes ☐ No
Retention? ☐ Yes ☐ No
Nocturia? xNoc?_____ ☐ Yes ☐ No
Hematuria? (Describe) ☐ Yes ☐ No
External catheter? ☐ Yes ☐ No
Indwelling catheter ☐ Yes ☐ No
Managed by: ☐ Patient ☐ Caregiver
Last changed?_____
Abnormal urine odor or appearance? (Describe) ☐ Yes ☐ No
Supporting Documentation: _____

Dialysis? ☐ Yes ☐ No
If yes: ☐ Hemo with ☐AV shunt ☐ Central Line
Peritoneal - access location:_____
Dialysis Center Location:_____
Telephone: _____ Contact Name:_____
Supporting Documentation_____

REPRODUCTIVE ASSESSMENT

Prostate problems? ☐ Yes ☐ No
Abnormal menses/menopause problems? (Describe) ☐ Yes ☐ No
Discharge from vagina/penis? ☐ Yes ☐ No
Breast lump/discharge? ☐ Yes ☐ No
Supporting Documentation:_____

GASTROINTESTINAL ASSESSMENT

Nausea/vomiting? (Describe) ☐ Yes ☐ No
Abdominal pain? (Describe) ☐ Yes ☐ No
Diarrhea/Constipation? ☐ Yes ☐ No
Other GI issues? ☐ Yes ☐ No
Date of last bowel movement:_____
Supporting Documentation: _____

43. **(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
- ☐ UK - Unknown

44. ****(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]***

45. **(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

46. ****(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
- ☐ UK - Unknown

47. ****(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

NEURO/EMOTIONAL/BEHAVIORAL STATUS

NEURO ASSESSMENT

Tremors? (Describe)	☐ Yes ☐ No
Vertigo or syncope?	☐ Yes ☐ No
Episodes of unconsciousness? (Specify if recent)	☐ Yes ☐ No
Sensory loss? (Specify)	☐ Yes ☐ No
Paralysis? ☐ quadriplegia ☐ paraplegia ☐ dominant side ☐ non dominant	☐ Yes ☐ No
Aphasia?	☐ Yes ☐ No
Headaches? (Describe)	☐ Yes ☐ No
Pupils - Equal? React to light?	☐ Yes ☐ No

Supporting Documentation: _____

EXAM OF ORAL ANATOMY:

Labial:	
Can the patient spread lips to smile?	☐ Yes ☐ No
Round lips for /u/?	☐ Yes ☐ No
Rapidly alternate /I/ and /u/?	☐ Yes ☐ No
Rapidly repeat /pa-pa-pa-pa/?	☐ Yes ☐ No
Tightly close lips?	☐ Yes ☐ No
Maintain lip closure when eating?	☐ Yes ☐ No
Lingual:	
Can the patient extend tongue tip?	☐ Yes ☐ No
Touch each corner of the mouth?	☐ Yes ☐ No
Rapidly alternate elevation and depression of the tongue while maintaining open mouth posture?	☐ Yes ☐ No
Soft Palate Function:	
Can the patient produce a loud, strong /ɔ/?	☐ Yes ☐ No
Sustain for several seconds?	☐ Yes ☐ No
Do you see any movement of the levator muscle & palato-pharyngeus muscle?	☐ Yes ☐ No
Laryngeal Function:	
Vocal Quality: ☐ WNL ☐ Raspy ☐ Breathy ☐ Strained ☐ Hoarse	
Involuntary/voluntary coughs?	☐ Yes ☐ No
Does the patient have the ability to change his/her pitch?	☐ Yes ☐ No

Limitations - Receptive/Expressive/Physiological Behavioral:

_____

_____

_____

_____

_____

PSYCHOSOCIAL/FINANCIAL ASSESSMENT

Grief?	☐ Yes ☐ No
Role change?	☐ Yes ☐ No
Change in body image?	☐ Yes ☐ No
Abuse?	☐ Yes ☐ No
Report to APS/CPS?	☐ Yes ☐ No
Able to afford medications?	☐ Yes ☐ No
Able to access transportation for medical appts?	☐ Yes ☐ No
Able to afford rent/utilities?	☐ Yes ☐ No
Spiritual needs met?	☐ Yes ☐ No
Cultural issues impacting care?	☐ Yes ☐ No

Other: _____

Supporting Documentation: _____

_____

_____

(485 #19) Mental Status

1 ❑ Oriented 3 ❑ Forgetful 5 ❑ Disoriented 7 ❑Agitated

2 ❑ Comatose 4 ❑ Depressed 6 ❑ Lethargic

8 ❑ Other: _____

Limitations - Receptive/Expressive/Physiological Behavioral:

_____

_____

_____

_____

48. **(M1700)**

Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory of 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 or 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.

49. **(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

50. **(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

51. **(M1730)**
Depression Screening: Has the patient been screened for depression, using a standardized depression screening tool?
- □ 0 - No
- □ 1 - Yes, patient was screened using the PHQ-2©* scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?")

PHQ-2©*	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 - 11 days	Nearly every day 12 - 14 days	N/A Unable to respond
a) Little interest or pleasure in doing things	□ 0	□ 1	□ 2	□ 3	□ na
b) Feeling down, depressed, or hopeless?	□ 0	□ 1	□ 2	□ 3	□ na

- □ 2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.
- □ 3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression.

52. **(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

53. **(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

54. **(M1750)**
Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?
- □ 0 - No
- □ 1 - Yes

ENDOCRINE/HEMATOPOETIC ASSESSMENT

Bruising?	☐ Yes ☐ No
Petechiae?	☐ Yes ☐ No
Bleeding?	☐ Yes ☐ No
Frequent urination?	☐ Yes ☐ No
Frequent thirst?	☐ Yes ☐ No
Frequent hunger?	☐ Yes ☐ No
Glucometer testing?	☐ Yes ☐ No

Testing performed by ☐ patient ☐ caregiver

Length of time on oral hypoglycemic:_____

Length of time on insulin:_____ Dose:_____

Supporting Documentation:_____

MUSCULOSKELETAL ASSESSMENT

Limited ROM? (Give location)	☐ Yes ☐ No
Bone or joint problems?	☐ Yes ☐ No
Pain or cramps? (Where)	☐ Yes ☐ No
Redness, Warmth, Swelling? (Where)	☐ Yes ☐ No
Decreased mobility/endurance?	☐ Yes ☐ No
Amputation of:	
Prosthesis/Appliance? (Specify)	☐ Yes ☐ No

Supporting Documentation:_____

Assessment

	Functional Status						Functional Status				
	Pre-Illness	Min	Mod	Severe	Non-Func		Pre-Illness	Min	Mod	Severe	Non-Func
Arousal						Augmentative/Alt Comm					
Attention						Pragmatic Skills					
Auditory Processing						Nonverbal Aspects					
Single Words						Suprasegmentals					
Commands						Discourse Rules					
Yes/No Questions						Understand Inferences					
Paragraphs						Verbal Sequencing					
Conversation						Figurative Language					
Verbal Language Express						Motor Speech Production					
Intelligibility						Respiration					
Limitation						Phonation					
Oral Reading						Articulation					
Word-Retrieval						Resonance					
Sentence Formulation						Prosody					
Reading Comprehension						Swallowing					
Matching Level						Oral Preparation					
Single Word						Oral Transfer					
Sentences						Pharyngeal Phase					
Paragraphs						Memory					
Written Formulation						Immediate					
Copying						Recent					
Signature						Remote					
Writing to Dictation						Problem solving					
Words						Routine					
						Complex					

Dysphagia Assessment

Dysphagia Hx. and Background: _____

_____

Subjective Complaint: _____

Current Diet: ☐ Regular ☐ Mechanical Soft ☐ Pureed ☐ NPO

Liquids: ☐ Thin ☐ Nectar thick ☐ Honey thick ☐ Pudding thick

Is the patient on O2? ☐ Yes ☐ No

Nutritional Requirements: ☐ Regular ☐ No Added Salt ☐ Diabetic ☐ Diabetic ☐ Fluid Restrictions

Appetite: ☐ Excellent ☐ Good, but diminished (75% or better) ☐ Fair (505 of meal) ☐ Poor (less than 50% of meal)

Weight loss? ☐ Yes ☐ No Amount: _____ lbs/month

Bedside Swallow Evaluation:

	WNL	Impaired	Coughing	
Solids:				
Pudding thick	☐	☐	☐ Yes	☐ No
Soft	☐	☐	☐ Yes	☐ No
Regular	☐	☐	☐ Yes	☐ No
Liquids:				
Pudding thick	☐	☐	☐ Yes	☐ No
Honey thick	☐	☐	☐ Yes	☐ No
Nectar thick	☐	☐	☐ Yes	☐ No
Thin	☐	☐	☐ Yes	☐ No

(485 #18A) Functional Limitations

1 ☐ Amputation
2 ☐ Bowel/Bladder (Incontinence)
3 ☐ Contracture
4 ☐ Hearing
5 ☐ Paralysis
6 ☐ Endurance
7 ☐ Ambulation
8 ☐ Speech
9 ☐ Legally Blind
A ☐ Dyspnea w/minimal Exertion
B ☐ Other (Specify): _____

(485 #18B) Activities Permitted

1 ☐ Complete Bedrest
2 ☐ Bedrest BRP
3 ☐ Up as Tolerated
4 ☐ Transfer Bed/Chair
5 ☐ Exercises Prescribed
6 ☐ Partial Weight Bearing
7 ☐ Independent at Home
8 ☐ Crutches
9 ☐ Cane
A ☐ Wheelchair
B ☐ Walker
C ☐ No Restriction
D ☐ Other (Specify)_____

EQUIPMENT

Hospital Bed?	☐ Needs ☐ Yes ☐ No
Ambulation aids?	
Wheelchair, Manual?	☐ Needs ☐ Yes ☐ No
Wheelchair, Electric?	☐ Needs ☐ Yes ☐ No
Walker?	☐ Needs ☐ Yes ☐ No
Cane?	☐ Needs ☐ Yes ☐ No
Crutches?	☐ Needs ☐ Yes ☐ No
Transfer equipment?	☐ Needs ☐ Yes ☐ No
Bathroom safety devices?	☐ Needs ☐ Yes ☐ No
Bedside commode?	☐ Needs ☐ Yes ☐ No
Dressing aides?	☐ Needs ☐ Yes ☐ No

Other: _____

_____

_____

_____

ADL/IADLs

55. **(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.

56. **(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.

57. **(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.

58. **(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.

59. **(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.

60. **(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.

61. **(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.

62. ****(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.

63. **(M1870)**

Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- □ 0 - Able to independently feed self.
- □ 1 - Able to feed self independently but requires:
  - (a) meal set-up; OR
  - (b) intermittent assistance or supervision from another person; OR
  - (c) a liquid, pureed or ground meat diet.
- □ 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.
- □ 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
- □ 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
- □ 5 - Unable to take in nutrients orally or by tube feeding.

64. **(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.

65. **(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.

66. **(M1900)**

Prior Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to this current illness, exacerbation, or injury. Check only one box in each row.

Functional Area	Independent	Needed Some Help	Dependent
a. Self-Care (e.g., grooming, dressing, and bathing)	☐ 0	☐ 1	☐ 2
b. Ambulation	☐ 0	☐ 1	☐ 2
c. Transfer	☐ 0	☐ 1	☐ 2
d. Household tasks (e.g., light meal preparation, laundry, shopping)	☐ 0	☐ 1	☐ 2

FALL RISK ASSESSMENT Education provided to:

History of falls	☐ Yes	☐ No	☐ patient	☐ caregiver
Over 65	☐ Yes	☐ No	☐ patient	☐ caregiver
Multiple medications	☐ Yes	☐ No	☐ patient	☐ caregiver
Mental impairment	☐ Yes	☐ No	☐ patient	☐ caregiver
Incontinence/Urgency	☐ Yes	☐ No	☐ patient	☐ caregiver
Impaired mobility	☐ Yes	☐ No	☐ patient	☐ caregiver
Impaired transferring	☐ Yes	☐ No	☐ patient	☐ caregiver
Environmental hazards	☐ Yes	☐ No	☐ patient	☐ caregiver

Supporting Documentation: _____

_____

_____

TIMED UP AND GO FINDINGS: _____ seconds

<10 seconds = normal < 14 seconds = not a falls risk

> 14 seconds = increased risk for falls

For all above identified risks the patient and caregiver will be educated and receive appropriate PT/OT/ST/MSW/aide referrals.

Education provided: _____

_____

_____

67. **(M1910)**

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

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

(485 #16) **NUTRITIONAL ASSESSMENT**

Diet: _____

Type: _____

Enteral ☐ J-tube ☐ G-tube ☐continuous ☐intermittent

Complex wounds?	☐ Yes	☐ No	(3)
TPN therapy?	☐ Yes	☐ No	(3)
Impaired/inadequate food intake?	☐ Yes	☐ No	(2)
Eats less than 2 meals a day?	☐ Yes	☐ No	(3)
Eats few fruits, vegetables or milk products?	☐ Yes	☐ No	(2)
Tooth, mouth or swallowing problems?	☐ Yes	☐ No	(2)
Insufficient money to buy food?	☐ Yes	☐ No	(4)
Eats alone?	☐ Yes	☐ No	(1)
Takes 3 or more meds?	☐ Yes	☐ No	(1)
Invol. Weight loss/gain of 10 lbs. in past 6 months?	☐ Yes	☐ No	(2)
Total:	(_____)		

Nutritional Screen

0-5 = Low Nutritional Risk
(Continue to observe for nutritional needs and intervene as necessary)

6-9 = Moderate Risk
(Educate the patient/family/caregiver to improve eating habits and life style including consideration for patient's food preference and frequency of meals. Involve the R.D. as needed for educational materials or suggestions in improvement measures)

10+ = High Nutritional risk
(R.N. to consult with R.D. consult with the physician, consider labs, weight changes, diet. Send written communication to the R.D. Obtain order for R.D. as needed)

MEDICATIONS

68. **(M2000)**
Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?
- □ 0 - Not assessed/reviewed ***[Go to M2010]***
- □ 1 - No problems found during review ***[Go to M2010]***
- □ 2 - Problems found during review
- □ NA - Patient is not taking any medications ***[Go to M2040]***

List problems identified: _____

_____

69. **(M2002)**
Medication Follow-up: Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?
- □ 0 - No
- □ 1 - Yes

Name of physician called: _____
Date/Time physician acknowledged receipt of information and/or orders: _____

70. **(M2010)**
Patient/Caregiver High Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?
- □ 0 - No
- □ 1 - Yes
- □ NA - Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

List high risk medications identified: _____
Education provided: _____

_____
_____
_____
_____
_____

71. **(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 medication prescribed.

72. ****(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.

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

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	□ 0	□ 1	□ 2	□ na
b. Injectable medications	□ 0	□ 1	□ 2	□ na

Supporting Documentation: _____

CARE MANAGEMENT

74. **(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

75. **(M2110)**

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

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

Other Service Providers	Notified of admission	Supporting Documentation	Other Service Providers	Notified of admission	Supporting Documentation
☐ Dialysis		Dialysis Days: S M T W T F S	☐ Adult Day Care		
☐ PHC			☐ CBA		
☐ Cancer Center		☐ Chemotherapy ☐ Radiation	☐ Wound Care Center		
☐ Other physicians involved in care		List:			
☐ Others involved in care		List:			

FIRE RISK ASSESSMENT, if patient has oxygen in the home

"No Smoking" Signs Posted? ☐ Needs ☐ Yes ☐ No
Functioning Smoke Detector? ☐ Needs ☐ Yes ☐ No
Intact electrical cords near oxygen? ☐ Yes ☐ No
Electrical medical equipment away from oxygen? ☐ Yes ☐ No
Medical gas cylinders stored on their sides in a well ventilated area? ☐ NA ☐ Yes ☐ No
Smoking materials in the home (cigarettes, etc.)? ☐ Yes ☐ No
Open flames (candles, gas heaters, fire place, etc)? ☐ Yes ☐ No
Are petroleum based products used near flow of O_2? ☐ Yes ☐ No
Supporting Documentation: _____

If any responses, other than yes, education was provided to
☐ Patient ☐ Caregiver

PREVENTATIVE / PERIODIC HEALTH SCREENING

Immunizations:

	Date Received	Who or Where Received
Influenza		
Pneumonia		
Td		
Other		

Screenings:

Cholesterol ☐ Yes ☐ No Date:_____
Mammogram ☐ Yes ☐ No Date:_____
Colon Cancer ☐ Yes ☐ No Date:_____
Prostate Cancer ☐ Yes ☐ No Date:_____
Cervical Cancer ☐ Yes ☐ No Date:_____

Self-Exam Frequency:

Breast: _____ Testicular: _____
Other: _____

EDUCATIONAL NEEDS ASSESSMENT:

Educational Readiness/motivation:	Patient	Caregiver
Ready to learn	☐ Yes ☐ No	☐ Yes ☐ No
Motivated to learn	☐ Yes ☐ No	☐ Yes ☐ No
Ability to read	☐ Yes ☐ No	☐ Yes ☐ No

Education needed Related to:

Technical procedures? (Specify) ☐ Yes ☐ No
ADL Training? (Specify) ☐ Yes ☐ No
Safety in the Home? ☐ Yes ☐ No
Swallowing Precautions? ☐ Yes ☐ No
Caregiver Training? ☐ Yes ☐ No
Fall Precautions? ☐ Yes ☐ No
Proper equipment use? ☐ Yes ☐ No
Exercise Program? ☐ Yes ☐ No
Other: _____
Supporting Documentation: _____

The following disciplines may be indicated based on assessment:

Discipline	Reason
☐ SN	
☐ OT	
☐ PT	
☐ MSW	
☐ HA	

If Patient refused any of above specify discipline and reason

THERAPY NEED AND PLAN OF CARE

76. **(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 care mix group defined by this assessment

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

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

Is the patient receiving supplies from any other provider? ❑ Yes ❑ No
If yes, type of supplies (ostomy, catheter, dressings, etc.) Supplies: _____

Name of Provider: _____ Phone: _____
Address: _____
DME Company preferred: _____

(485 #14) DME and Supplies (Only Billable by Home Health): _____
_____

(485 #17) Allergies
Food allergies □ Yes □ No If yes, list: _____
Environmental allergies □ Yes □ No If yes, list: _____
Drug/Medication allergies □ Yes □ No If yes, see list on Medication Profile

(485 #20) Prognosis: 1❑ Poor 2❑ Guarded 3❑ Fair 4❑ Good 5❑ Excellent

VITAL SIGNS:

Temp:_____ Pulse: Apical _____ (Reg) (Irreg) Radial:_____ (Reg) (Irreg) Resp: _____ O_2 saturation: _____

B/P:	Lying	Sitting	Standing
(L)	____	____	____
(R)	____	____	____

Height: _____

Weight: _____ □Actual □Stated

Girth measurement: □ Abdominal _____

□ Other _____

Initial Summary of History: _____

Skilled Need (provide detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences, the complexity of the service to be performed, and any other pertinent characteristics of the beneficiary or home): _____

Skilled Interventions/Procedures: (provided/performed/administered this visit) _____

Patient/Caregiver Response to above care/teaching:_____

Care planned for next visit: _____

Patient Strengths: ❒ Able to read ❒ Willing to Learn ❒ Able to Learn ❒ Family Supportive ❒ Other

Patient/Caregiver participated in the plan of care and is aware of treatment options? □ Yes □ No

Content of Advance Directive(s), if applicable: _____

Instruction given on Safety measures in the home include:_____

Emergency Preparedness/Natural Disaster Code:_____

Homebound Status (describe the patient's functional status that renders him/her homebound; must meet criteria one and criteria two)

Criteria One: A. Requires the aid of supportive device, use of special transportation, or the assistance of another person to leave home (describe/explain)_____

OR B. Leaving the home is medically contraindicated (describe/explain) _____

_____

_____

AND

Criteria Two: A. There exists a normal inability to leave home (describe/explain)_____

_____

AND B. Leaving home requires a considerable taxing effort (describe/explain)_____

_____

AND

Absences from the home are infrequent, of relatively short duration, or to receive medical care (describe)_____

_____

Discharge Plans: ☐ When goals are met ☐ When caregiver is available and willing to assist with care

☐ DC to self/physician when SN no longer needed ☐ Other_____

Supervision (NA for SOC)

Aide Supervision Employee Name:_____ ☐ Employee present

☐ Patient/Caregiver satisfied with care ☐ Employee courteous, respectful ☐ Change in ADL needs assessment

☐ Care provided according to assignment ☐ Continue frequency at: _____

Instructions given to employee: _____

_____

Coordination of Care: ☐ RN ☐ Therapist ☐ Other_____ Discussion: _____

_____

_____

Last physician visit:_____ Next physician visit: _____

Physician contacted to approve additional orders not on referral: _____

Date: _____ Time: _____ Spoke with: _____

Patient Name (or Signature) _____

SLP's signature:_____Date of visit: _____ Time In:_____ Time Out:_____

Patient Name: _____ SLP's Name: _____

(485#21) Orders for Discipline and Treatment (Specify Amount/Frequency Duration):
SLP (Frequency)
SLP to Assess: (include parameters)
SLP to Teach:
ST to Perform:

Health Aide (Frequency)
Health Aide to:
❑ Skilled Nursing to assess and develop Nursing Plan of Care
❑ Physical Therapy to Evaluate and Treat
❑ Occupational Therapy to Evaluate and Treat
❑ Social Worker (Frequency) For
(485 #22) Goals/Rehabilitation Potential/Discharge Plans: