OASIS-C1 Start of Care (PT)

Clinician:

Patient Name (Last Name, First Name) & MRN:	Mileage:	Gender: ☐ M ☐ F	Agency Name/Branch:

Date: / /	Time In: Time Out:	DOB: / /

Demographics

HCPCS

Select the home health service type that reflects the primary reason for this visit:

(G0151) Services Performed by a qualified physical therapist

(G0157) Services performed by a qualified physical therapist assistant

(G0159) Establishment or delivery of a safe and effective physical therapy maintenance program

Select the location where home health services were provided:

☐ (Q5001) Care provided in patient's home/residence

☐ (Q5002) Care provided in assisted living facility

☐ (Q5009) Care provided in place not otherwise specified (NO)

(M0020) Patient ID Number:

(M0030) Start of Care Date: / /

(M0032) Resumption of Care Date: / / ☐ NA - Not Applicable

Episode Start Date: / /

(M0040) Patient Name:

(Last) (Suffix) (First)

(MI)

(M0064) Social Security Number:

☐ UK - Unknown or Not Available

Patient Street Address City

(M0050) Patient State of Residence:

(M0060) Patient ZIP Code:

Patient Phone Number:

(M0063) Medicare Number: (including suffix, if an) ☐ NA - No Medicare

(M0065) Medicare Number: ☐ NA - No Medicare

Patient Name (Last Name, First Name) & MRN:	Date: / /

(M0066) Birth Date: / /

(M0069) Gender:

O Male O Female

Physician:

Emergency Contact Name

Relationship

Contact Address

Contact Phone ( ) - -

Secondary Physician's Name

Secondary Physician's Phone ( ) - -

(M0080) Discipline of Person Completing Assessment:

O 1 - RN O 2 - PT O 3 - SLP/ST O 4 - OT

(M0090) Date Assessment Completed: / /

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

Start/Resumption of Care

O 1 - Start of care - further visits planned

O 3 - Resumption of care - (after inpatient stay)

Follow-Up

O 4 - Recertification (follow-up) reassessment **[Go to M0110]**

O 5 - Other follow-up **[Go to M0110]**

Transfer to an Inpatient Facility

O 6 - Transferred to inpatient facility - patient not discharged from agency **[Go to M1041]**

O 7 - Transferred to inpatient facility - patient discharged from agency **[Go to M1041]**

Discharge from Agency - Not to an Inpatient Facility

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

O 9 - Discharged from agency **[Go to M1041]**

(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]**

☐ NA - No specific SOC date ordered by physician

Patient Name (Last Name, First Name) & MRN:	Date: / /

Comments:

(M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

/ /

Comments:

(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?

- O 1 - Early
- O 2 - Later
- O UK - Unknown
- O NA - Not Applicable: No Medicare case mix group to be defined by this assessment

(M0140) Race/Ethnicity (as defined by patient): ***(Mark all that apply)***

- ☐ 1 - American Indian or Alaska Native
- ☐ 2 - Asian
- ☐ 3 - Black or African American
- ☐ 4 - Hispanic or Latino
- ☐ 5 - Native Hawaiian or Pacific Islander
- ☐ 6 - White

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

- ☐ 0 - None - Non Charge for current services
- ☐ 1 - Medicare (traditional fee-for-service)
- ☐ 2 - Medicare (HMO/Managed Care/Advantage plan)
- ☐ 3 - Medicaid (traditional fee-for-service)
- ☐ 4 - Medicaid (HMO/Managed Care)
- ☐ 5 - Worker's compensation
- ☐ 6 - Title programs (e.g. Title III, V, or XX)
- ☐ 7 - Other government (e.g. Tri Care, VA etc)
- ☐ 8 - Private Insurance
- ☐ 9 - Private HMO/Managed Care
- ☐ 10- Self-pay
- ☐ 11 - Other *(specify)*
- ☐ UK - Unknown

Patient Name (Last Name, First Name) & MRN:	Date: / /

Patient History and Diagnoses

Vital Sighs

Pulse: Apical:		O (Reg)	O (Irreg)	Height:		**BP**	**Lying**	**Sitting**	**Standing**
Radial:		O (Reg)	O (Irreg)	Weight:		Left			
Temp:		Resp:		O Actual O Stated		Right			

Notify physician of:			
Temperature greater than (>)		or less than (<)	
Pulse greater than (>)		or less than (<)	
Respirations greater than (>)		or less than (<)	
Systolic BP greater than (>)		or less than (<)	
Diastolic BP Greater than (>)		or less than (<)	
$O_{2\ Salt}$ Less than (<)		%	
Fasting blood sugar greater than (>)		or less than (<)	
Random blood sugar greater than (>)		or less than (<)	
Weight greater than (>)		lbs or less than (<)	lbs

(M1000) From which of the following **Inpatient Facilities** was the patient discharged within 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 (IPPS)
- ☐ 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 M1017**]

(M1005) Inpatient Discharge Date: (most recent): / / ☐ UK - Unknown

Indicate events leading to, and reasons for, inpatient stay:

(M1011) List each **Inpatient Diagnosis** and ICD 10-C M code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no V, W, X, Y or Z codes):

	Inpatient Facility Diagnosis	ICD-10-C M Code
a.		
b.		
c.		
d.		
e.		
f.		

	Other Procedures	Procedure Code	Date
a.			/ /
b.			/ /
c.			/ /
d.			/ /

☐ NA - Not applicable

☐ UK - Unknown

(M1017) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-10-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, V, W, X, Y or Z codes):

	Changed Medical Regimen Diagnosis	ICD-10-C M Code
a.		
b.		
c.		
d.		
e.		
f.		

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

(M01018) 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 that 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 above
☐ NA - No inpatient facility discharge and no change in medical or treatment regimen in page 14 days
☐ UK - Unknown

Comments:

Past Medical History (*Mark all that apply*)
☐ CHF ☐ Cardiomyopathy ☐ Arrhythmia ☐ Chest Pain ☐ MI ☐ CAD ☐ HTN ☐ PVD ☐ Murmur
☐ Cancer *(specify type)* In remission? O Y O N
☐ Osteoarthritis/DJD *(specify sites affected)*
☐ Rheumatoid Arthritis ☐ Gait Problems ☐ Fractures ☐ Falls
☐ Joint Replacement *(specify Joint)*
☐ CVA ☐ TIA ☐ MS ☐ Hemiplegia ☐ Seizures ☐ Headaches ☐ Dizziness/Vertigo
☐ IBS ☐ Crohn's Disease ☐ Diverticulitis/Diverticulosis ☐ Constipation ☐ Diarrhea ☐ Fecal Incontinence
☐ Liver/Gallbladder Problems
☐ Substance Abuse *(specify)*
☐ Mental Disorder *(specify)*

☐ Pressure Ulcer ☐ Stasis Ulcer ☐ Diabetic Ulcer ☐ Trauma Wound

☐ Other *(specify)*

☐ Chronic Kidney Disease ☐ Renal Failure ☐ Dialysis

☐ Anemia ☐ Abnormal Coagulation ☐ Blood Clots

☐ Diabetes ☐ Thyroid Problems

☐ COPD ☐ Asthma ☐ Chronic Obstructive Bronchitis ☐ Emphysema ☐ Chronic Obstructive Asthma

☐ Urinary Incontinence ☐ Urinary Retention ☐ BPH ☐ Recent/Frequent UTI

☐ Tuberculosis ☐ Hepatitis *(specify)*

☐ Infectious Disease *(specify)*

☐ Tobacco Dependence Type: Amount Length of Time Used:

☐ Vision Problems ☐ Hearing Loss

☐ Other:

☐ Past Surgical History:

(M1021/1023/1025)

Diagnoses, Severity Index, and Payment Diagnoses

List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-10-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-10-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. Review the OASIS Guidance Manual for additional directions on how to complete M1021, M1023, and M1025.

Column 1: Enter the description of the diagnosis. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Enter the ICD-10-C M code for the condition described in Column 1 - no surgical or procedure codes allowed. Codes must be entered at the level of highest specificity and ICD-10-C M coding rules and sequencing requirements must be followed. Note that external cause codes (ICD-10-C M codes beginning with V, W, X, or Y) may not be reported in M1021 (Primary Diagnosis) but may be reported in M1023 (Secondary Diagnoses). Also note that when a Z-code is reported in Column 2, the code for the underlying condition can often be entered in Column 2, as long as it is an active on-going condition impacting home health care.

Column 2: Rate the degree of symptom control for the condition listed in Column 1. Choose one value that represents the degree of symptom control appropriate for each diagnosis 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 the rating for symptom control in Column 2 should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide.

(OPTIONAL) There is no requirement that HHAs enter a diagnosis code in M1025 (Columns 3 and 4). Diagnoses reported in M1025 will not impact payment.

Column 3: Agencies may choose to report an underlying condition in M1025 (Columns 3 and 4) when:

- a Z-code is reported in Column 2 AND
- the underlying condition for the Z-code in Column 2 is a resolved condition . An example of a resolved condition is uterine cancer that is no longer being treated following a hysterectomy.

Column 4:	(OPTIONAL) If a Z-code is reported in M1021/M1023 (Column 2) and the agency chooses to report a resolved underlying condition that requires multiple diagnosis codes under ICD-10-C M coding guidelines, enter the diagnosis descriptions and the ICD-10-C M codes in the same row in Columns 3 and 4. For example, if the resolved condition is a manifestation code, record the diagnosis description and ICD-10-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

Patient Name (Last Name, First Name) & MRN:	Date: / /

(M1021) Primary Diagnosis & (M1022) Other Diagnoses - ICD-10		(M1025) Payment Diagnoses (OPTIONAL) - ICD-10	
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-10-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 Z-code is assigned under certain circumstances to Column 2 and underlying diagnosis is resolved.	Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code)
Descriptions	ICD-10-CM / Symptom Control Rating	Description / ICD-10-CM	Description / ICD-10-CM
(M1021) Primary Diagnosis **a.** **O/E** ☐ Exacerbation ☐ Onset **Date** / /	(V, W, X, Y-codes NOT allowed) **Severity:** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	(V, W, X, Y-codes NOT Allowed) **a.**	(V, W, X, Y-codes Not Allowed) **a.**
(M1023) Other Diagnosis **b.** **O/E** ☐ Exacerbation ☐ Onset **Date** / /	(V, W, X, Y-codes NOT allowed) **Severity:** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	(V, W, X, Y-codes NOT allowed) **b.**	(V, W, X, Y-codes NOT allowed) **b.**
(M1023) Other Diagnosis **c.** **O/E** ☐ Exacerbation ☐ Onset **Date** / /	(V - or E-codes allowed) **Severity:** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	(V/E-codes Not Allowed) **c.**	(V/E-codes Not Allowed) **c.**

Patient Name (Last Name, First Name) & MRN:	Date: / /

(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 Assessment

(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as a risk for hospitalization? (***Mark all that apply***)

☐ 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 month)

☐ 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 month

☐ 3 - Multiple hospitalizations (2 or more) in the past 6 months

☐ 4 - Multiple emergency department visits (2 or more) in the past 6 months

☐ 5 - Decline in mental, emotional, or behavioral status in the past 3 months

☐ 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months

☐ 7 - Currently taking 5 or more medications

☐ 8 - Currently reports exhaustion

☐ 9 - Other risk(s) not listed in 1-8

☐ 10 - None of the above

Comments:

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

O 0 - The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age).

O 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).

O 2 - The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.

O 3 - The patient has serious progressive conditions that could lead to death within a year.

O UK - The patient's situation is unknown or unclear.

Comments:

(M1036) Risk Factors, 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

Comments:

Most Recent Immunizations				
Pneumonia	O Yes	O No	O Unknown	Date: / /
Flu	O Yes	O No	O Unknown	Date: / /
Tetanus	O Yes	O No	O Unknown	Date: / /
TB	O Yes	O No	O Unknown	Date: / /
TB Exposure	O Yes	O No	O Unknown	Date: / /
Hepatitis B	O Yes	O No	O Unknown	Date: / /
Additional Immunizations				
	O Yes	O No	O Unknown	Date: / /
	O Yes	O No	O Unknown	Date: / /

Comments:

Patient Name (Last Name, First Name) & MRN:	Date: / /

Health Screening

Last Cholesterol Level:	/ /
Last Mammogram:	/ /
Does patient perform monthly self breast exams?	O Yes O No
Last Pap Smear:	/ /
Last PSA:	/ /
Last Prostate Exam:	/ /
Last Colonoscopy:	/ /

Interventions

Additional Orders:

Goals

Additional Goals:

Prognosis

Advance Directive

O Yes O No

Intent: ☐ DNR ☐ Living Will ☐ Medical Power of Attorney ☐ Other *(specify):*

Copy on file at agency? O Yes O No

Patient was provided written and verbal information on Advance Directive O Yes O No

Prognosis:

O Guarded O Poor O Fair O Good O Excellent

Is the Patient DNR (Do Not Resuscitate)?

O Yes O No

Functional Limitations				
☐ Amputation	☐ Paralysis	☐ Legally Blind	☐ Bowel/Bladder Incontinence	☐ Endurance
☐ Dyspnea	☐ Contracture	☐ Ambulation	☐ Hearing	☐ Speech
☐ Other				

Supportive Assistance

(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 assistant	No assistance available
a. Patient lives alone	O 01	O 02	O 03	O 04	O 05
b. Patient lives with other person(s) in the home	O 06	O 07	O 08	O 09	O 10
c. Patient lives in congregate situation (for example, assisted living, residential care home)	O 11	O 12	O 13	O 14	O 15

Type of Assistance Patient Receives - other than from home health agency staff
(Select all that apply)

Type of Assistance	Family/Friends	Provider Services	Paid Caregiver	Volunteer Organizations
ADL (bathing, dressing, toileting, bowel/bladder, eating/feeding)	☐	☐	☐	☐
IADL (meds, meals, housekeeping, laundry, telephone, shopping, finances)	☐	☐	☐	☐
Psychosocial Support	☐	☐	☐	☐
Assistance with Medical Appointments, Delivery of Medications	☐	☐	☐	☐
Management of Finances	☐	☐	☐	☐

Comments:

Supportive Assistance: Name of organizations providing assistance

Community Agencies/Social Service Screening	Yes	No	Ability of patient to handle finances:
Community resource info needs to manage care	O	O	O Independent O Dependent O Needs Assistance
Altered affect, e.g., expressed sadness or anxiety, grief	O	O	Comments:
Suicidal ideation	O	O	
Suspected Abuse/Neglect: ☐ Unexplained bruises ☐ Inadequate food ☐ Fearful of family member ☐ Exploitation of funds ☐ Sexual abuse ☐ Neglect ☐ Left unattended if constant supervision is needed			
MSW referral indicated for:	O	O	
Coordinator notified	O	O	

Safety/Sanitation Hazards affecting patient: *(Select all that apply)*		
☐ No hazards identified		
☐ Stairs	☐ Narrow or obstructed walkway	☐ No gas/electric appliance
☐ No running ware, plumbing	☐ Insect/rodent infestation	☐ Cluttered/soiled living area
☐ Inadequate lighting, heating and cooling	☐ Lack of fire safety devices	☐ Other: *(specify)*
Comments:		

Fire Assessment for Patients with Oxygen.

☐ Patient not using oxygen

Does patient have No Smoking signs posted? O Yes O No
☐ Patient ☐ Caregiver educated

Does patient or anyone in the home smoke with oxygen in use? O Yes O No
☐ Patient ☐ Caregiver educated

Are smoke detectors present and working properly? O Yes O No
☐ Patient ☐ Caregiver educated

Does patient have a properly functioning fire extinguisher? O Yes O No
☐ Patient ☐ Caregiver educated

Are oxygen cylinders stored properly? O Yes O No
☐ Patient ☐ Caregiver educated

Are all electrical cords near oxygen intact and free from fraying? O Yes O No
☐ Patient ☐ Caregiver educated

Does patient have an evacuation plan in case of fire? O Yes O No
☐ Patient ☐ Caregiver educated

Are all cleaning fluids and aerosols stored away from oxygen, and not used while oxygen is in use? O Yes O No
☐ Patient ☐ Caregiver educated

Does patient refrain from using petroleum products around oxygen? O Yes O No
☐ Patient ☐ Caregiver educated

Does patient only use water-based body and lip moisturizers? O Yes O No
☐ Patient ☐ Caregiver educated

Comments:

Patient Name (Last Name, First Name) & MRN:	Date: / /

Safety Measures		
☐ Anticoagulant Precautions	☐ Emergency Plan Developed	☐ Fall Precautions
☐ Keep Pathway Clear	☐ Keep Side Rails Up	☐ Neutropenic Precautions
☐ O_2 Precautions	☐ Proper Position During Meals	☐ Safety in ADLs
☐ Seizure Precautions	☐ Sharps Safety	☐ Show Position Change
☐ Standard Precautions/Infection Control	☐ Support During Transfer and Ambulation	☐ Use of Assistive Devices

Other *(specify):*

☐ Instructed on safe utilities management	☐ Instructed on mobility safety	☐ Instructed on DME & electrical safety
☐ Instructed on sharps container	☐ Instructed on medical gas	☐ Instructed on disaster/emergency plan
☐ Instructed on safety measures	☐ Instructed on proper handling of biohazard waste	
Triage/Risk Code:	**Disaster Code:**	

Comments*:*

Patient Name (Last Name, First Name) & MRN:	Date: / /

Cultural
Primary Language? ☐ English ☐ Spanish ☐ Chinese ☐ Russian ☐ Vietnamese ☐ Other/Unknown
Does patient have cultural practices that influence health care? O Yes O No
If yes, please explain:
Is religion important to the patient ? O Yes O No
Patient's religious preference?
Use of interpreter *(select patient preferences):* ☐ Family ☐ Friend ☐ Professional ☐ Other
Patient's primary source of emotional support:

Sensory Status

Sensory Status	
Eyes:	**Ears:**
☐ WNL (Within Normal Limits)	☐ WNL (Within Normal Limits)
☐ Glasses	☐ Hearing Impaired ☐ Left ☐ Right
☐ Contacts Left	☐ Deaf
☐ Contacts Right	☐ Drainage
☐ Blurred Vision	☐ Pain
☐ Glaucoma	☐ Hearing Aids ☐ Left ☐ Right
☐ Cataracts	
☐ Macular Degeneration	**Nose:**
☐ Redness	☐ WNL (Within Normal Limits)
☐ Drainage	☐ Congestion
☐ Itching	☐ Loss of Smell

☐ Watering

☐ Other

Date of Last Eye Exam: / /

☐ Nose Bleeds *How often?*

☐ Other

(M1200) Vision (with corrective lenses if the patient usually wears them):

O 0 - Normal Vision: sees adequately in most situations; can see medication labels, newsprint.

O 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.

O 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

(M1210) Ability to hear (with hearing aid or hearing appliance if normally used):

O 0 - Adequate: hears normal conversation without difficulty.

O 1 - Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.

O 2 - Severely Impaired: absence of useful hearing.

O UK - Unable to assess hearing

(M1220) Understanding of Verbal Content in patient's own language (with hearing aid or device if used):

O 0 - Understands: clear comprehension without cues or repetitions.

O 1 - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.

O 2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.

O 3 - Rarely/Never Understands.

O UK - Unable to assess Understanding.

(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language):

O 0 - Express complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.

O 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.

O 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.

O 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.

O 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible).

O 5 - Patient nonresponsive or unable to speak.

Interventions

Additional Orders:

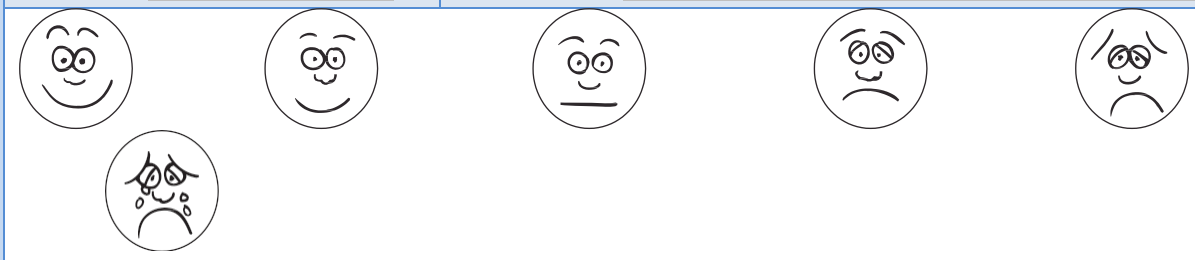
Goals

Additional Goals:

Patient Name (Last Name, First Name) & MRN:	Date: / /

Pain

Pain Scale	
Onset Date: / /	Location of Pain:



NO HURT 0 **HURTS LITTLE BIT** 2 **HURTS LITTLE MORE** 4 **HURTS EVEN MORE** 6 **HURTS WHOLE LOT** 8 **HURTS WORST** 10

Form Hockenberry MJ, Wilson D: Wong's essentials of pediatric nursing, ed. 8, St. Louis, 2009, Mosby. Used with permission. Copyright Mosby

Intensity of Pain:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Duration:	
Quality:	
What makes pain worse:	
What makes pain better:	
Relief rating of pain, i.e., pain level after medications:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Medications patient takes for pain:	
Medication effectiveness:	

Medication adverse side effects:	
Patient's pain goal:	

(M1240) Has this patient had a formal **Pain Assessment** using a standardized, validated pain assessment tool (appropriate to the patient's ability
to communicate the severity of pain)?

- O 0 - No standardized, validated assessment conducted
- O 1 - Yes, and it does not indicate severe pain
- O 2 - Yes, and it indicates severe pain

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

- O 0 - Patient has now pain
- O 1 - Patient has pain that does not interfere with activity or movement
- O 2 - Less often than daily
- O 3 - Daily, but not consistently
- O 4 - All of the time

	Interventions
☐	Therapist to assess pain level and effectiveness of pain medications and current pain management therapy every visit
☐	Therapist to instruct patient to take pain medication before pain becomes severe to achieve better pain control
☐	Therapist to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and/or hot/cold packs
☐	Therapist to assess patient's willingness to take pain medications and/or barriers to compliance, e.g., patient is unable to tolerate side effects such as drowsiness, dizziness, constipation
☐	Therapist to report to physician if patient experiences pain level not acceptable to patient, pain level greater than , pain medications not effective, patient unable to tolerate pain medications, pain affecting ability to perform patient's normal activities

Additional Orders:

Goals				
☐	Patient will verbalize understanding of proper use of pain medication by	/ /		
☐	Patient will achieve pain level less than		within	weeks

Additional Goals:

Integumentary Status

Braden Scale
for Predicating Pressure Sore Risk in Home Care

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body.	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	☐ 4 ☐ 3 ☐ 2 ☐ 1
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Often Moist** Skin is often, but not always moist. Linen must be changed as often as 3 times in 24 hours.	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry; Linen only requires changing at routine intervals.	☐ 4 ☐ 3 ☐ 2 ☐ 1

ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of day in bed or chair.	**4. Walks Frequently** Walks outside bedroom twice a day and inside room at least once every two hours during waking hours.	☐ 4 ☐ 3 ☐ 2 ☐ 1
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.	☐ 4 ☐ 3 ☐ 2 ☐ 1
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** is NPO and/or maintained on clear liquids or IVs for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement **OR** receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	☐ 4 ☐ 3 ☐ 2 ☐ 1
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.		☐ 3 ☐ 2 ☐ 1
				Total:	

Braden Scale Scoring: Risk of developing pressure ulcers: ***15-18:*** *At risk;* ***13-14:*** *Moderate risk;* ***10-12:*** *High risk;* ***9 or below:*** *Very high risk*

Integumentary Status

Skin Turgor:	O Good	O Fair	O Poor	
Skin Color:	☐ Pink/WNL	☐ Pale	☐ Jaundice	☐ Cyanotic
Skin:	☐ Dry	☐ Diaphoretic	☐ Warm	☐ Cool
	☐ Wound	☐ Ulcer	☐ Incision	☐ Rash
	☐ Ostomy	☐ Other		
Instructed on measures to control infections?		O Yes	O No	
Nails:	O Good	O Problem		

Is patient using pressure-relieving device(s)? O **Yes** O **No**

Type:

Comments:

(M1300) Pressure Ulcer Assessment: Was this patient assessed for **Risk of Developing Pressure Ulcers?**

O 0 - No assessment conducted **[Go to M1306]**

O 1 - Yes, based on an evaluation of clinical factors, (for example, mobility, incontinence, nutrition) without use of standardized tool

O 2 - Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)

(M1302) Does this patient have a **Risk of Developing Pressure Ulcers?**

O 0 - No O 1 - Yes

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as Unstageable? (Excludes Stage I Pressure ulcers and healed Stage II pressure ulcers)

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

(M1308) Current Number of Unhealed Pressure Ulcers of Each Stage or Unstageable:
(Enter "0" if none; excludes Stage I pressure ulcers and healed Stage II 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	

(M1320) Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non removal dressing/device**)**

O 0 – Newly epithelialized
O 1 – Fully granulation
O 2 – Early/partial granulation
O 3 – Not healing
O NA – No Stage II pressure ulcers are present at discharge

(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.

O 0 O 1 O 2 O 3 O 4 or more

(M1324) Stage of most Problematic Unhealed Pressure Ulcer that is Stageable: (Excludes pressure ulcer that cannot be staged due to a non-
removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)

O 1 – Stage I O 2 – Stage II O 3 – Stage III O 4 – Stage IV
O N/A – Patient has no pressure ulcers or no stageable pressure ulcers

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

O 0 – No **[Go to M1340]**
O 1 – Yes, patient has BOTH observable and unobservable stasis ulcers
O 2 – Yes, patient has observable stasis ulcers ONLY
O 3 – Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing) **[Go to M1340]**

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

O 1 – One O 2 – Two O 3 – Three O 4 – Four or more

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

O 1 – Fully granulating O 2 – Early/partial granulation O 3 – Not healing

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

O 0 – No ***[At SOC/ROC, go to M1350; At FU/DC, go to M1400]***
O 1 – Yes, patient has at least one (Observable) surgical wound
O 2 – Surgical wound known but not observable due to not-removable dressing/device ***[At SOC/ROC, go to M1350; At FU/DC, go to M1400]***

Patient Name (Last Name, First Name) & MRN:	Date: / /

(M1342) Status of Most Problematic (Observable) Surgical Wound:

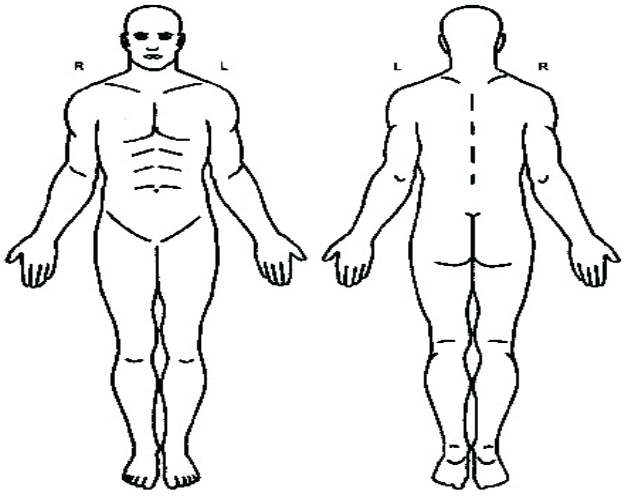
O 0 - Newly epitheliazed O 1 - Fully granulating O 2 - Early/partial granulation O 3 - Not healing

(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?

O 0 - No O 1 - Yes

Wound Graph

1 2 3 4 5



	Wound One	Wound Two	Wound Three	Wound Four	Wound Five
Location:					
Onset Date:	/ /	/ /	/ /	/ /	/ /
Size:					
Drainage:					
Odor:					
Etiology:	☐ Burn ☐ Infection ☐ Pressure ☐ Surgical	☐ Burn ☐ Infection ☐ Pressure ☐ Surgical	☐ Burn ☐ Infection ☐ Pressure ☐ Surgical	☐ Burn ☐ Infection ☐ Pressure ☐ Surgical	☐ Burn ☐ Infection ☐ Pressure ☐ Surgical

	☐ Traumatic ☐ Diabetic ☐ Venous Stasis ☐ Arterial	☐ Traumatic ☐ Diabetic ☐ Venous Stasis ☐ Arterial	☐ Traumatic ☐ Diabetic ☐ Venous Stasis ☐ Arterial	☐ Traumatic ☐ Diabetic ☐ Venous Stasis ☐ Arterial	☐ Traumatic ☐ Diabetic ☐ Venous Stasis ☐ Arterial
Stage:	☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ 1 ☐ 2 ☐ 3 ☐ 4
Undermining:					
Inflammation:					

Comments:

Interventions					
☐	Therapist to instruct the	☐ Patient/Caregiver	☐ Patient	☐ Caregiver	on the turning/repositioning every 2 hours
☐	Therapist to instruct the	☐ Patient/Caregiver	☐ Patient	☐ Caregiver	to float heels
☐	Therapist to instruct the	☐ Patient/Caregiver	☐ Patient	☐ Caregiver	on the methods to reduce friction and shear
☐	Therapist to instruct the	☐ Patient/Caregiver	☐ Patient	☐ Caregiver	on proper use of moisture barrier
☐	Therapist to instruct the	☐ Patient/Caregiver	☐ Patient	☐ Caregiver	to pad all bony prominences

Additional Orders:

Goals	
☐	Patient skin integrity will remain intact during this episode

Additional Goals:

Respiratory Status

Respiratory

☐ **WNL (Within Normal Limits)**

☐ **Lung Sounds:**

- ☐ CTA
- ☐ Rales
- ☐ Rhonchi
- ☐ Wheezes
- ☐ Crackles
- ☐ Diminished
- ☐ Absent
- ☐ Stridor

☐ **Sputum:**
Enter Amount:

Describe color, consistency, and odor:

☐ **O_2 At:**
LMP via:

☐ **O_2 Sat:**

☐ Room Air ☐ **O_2**

☐ **Nebulizer:**

☐ **Cough:** ☐ Productive ☐ Nonproductive

Comments:

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

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

(M1410) Respiratory Treatment 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

Patient Name (Last Name, First Name) & MRN:	Date: / /

Interventions
Additional Orders:

Goals
Additional Goals:

Endocrine

Endocrine			
☐ **WNL (Within Normal Limits)**			
Is patient diabetic?	O Y	O N	
Insulin dependent?	O Y	O N	For how long?
Is patient independently able to draw up correct does of insulin?	O Y	O N	
Is patient able to properly administer own insulin?	O Y	O N	
Is patient taking oral hypoglycemic agent?	O Y	O N	
Is patient independent with glucometer use?	O Y	O N	
Is caregiver able to correctly draw up and administer insulin?	O Y	O N	O N/A, no caregiver
Is caregiver independent with glucometer use?	O Y	O N	O N/A, no caregiver
Does patient or caregiver routinely perform inspection of the patient's lower extremities?	O Y	O N	

Patient Name (Last Name, First Name) & MRN:	Date: / /

Does patient have any of following ?

☐ Polyuria ☐ Polyphagia ☐ Radiculopathy

☐ Polydipsia ☐ Neuropathy ☐ Thyroid problems

Blood Sugar O Random O Fasting O 2 Hours PP

Blood sugar checked by:

Site

Comments:

Interventions

☐ Therapist to instruct ☐ Patient/Caregiver ☐ Patient ☐ Caregiver to inspect patient's feet daily and report any skin or nail problems immediately

☐ SN needed for evaluation for patient due to knowledge deficit related to diabetic foot care

☐ Therapist to instruct ☐ Patient/Caregiver ☐ Patient ☐ Caregiver to wash patient's feet in warm (not hot) water. Wash feet gently and pat dry thoroughly making sure to dry between toes

☐ Therapist to instruct ☐ Patient/Caregiver ☐ Patient ☐ Caregiver to use moisturizer daily but avoid getting between toes

☐ Therapist to instruct patient to wear clean, dry, properly-fitted socks and change them every day

☐ Therapist to instruct ☐ Patient/Caregiver ☐ Patient ☐ Caregiver on appropriate nail care as follows: trim nails straight across and file rough edges with nail file

☐ Therapist to instruct ☐ Patient/Caregiver ☐ Patient ☐ Caregiver that patient should never walk barefoot

☐ Therapist to instruct ☐ Patient/Caregiver ☐ Patient ☐ Caregiver that patient should elevate feet when sitting

☐ Therapist to instruct ☐ Patient/Caregiver ☐ Patient ☐ Caregiver to protect patient's feet from extreme heat or cold

☐ Therapist to instruct ☐ Patient/Caregiver ☐ Patient ☐ Caregiver never to try to cut off corns, calluses, or any other lesions from lower extremities

Additional Orders:

Goals
Additional Goals:

Cardiac Status

Cardiovascular	
☐ WNL (Within Normal Limits)	☐ Dizziness:
☐ Chest Pain	☐ Edema: + + + ☐ Dependent Edema: ☐ Pitting ☐ Nonpitting
☐ Heart Sounds: ☐ Murmur ☐ Gallop ☐ Click ☐ Irregular	☐ Neck Vain Distention:
☐ Peripheral Pulses:	☐ Cap Refill: O <3 sec O >3 sec
Peacemaker: / / (Insertion Date)	AICD: / / (Insertion Date)
Comments:	

Interventions

Additional Orders:

Goals

Additional Goals:

Elimination Status

GU	Digestive
☐ WNL (Within Normal Limits)	☐ WNL
☐ Incontinence	☐ Nausea/Vomiting
☐ Bladder Distention	☐ NPO
☐ Burning	☐ Reflux/Indigestion
☐ Frequency	☐ Diarrhea
☐ Dysuria	☐ Constipation
☐ Retention	☐ Bowel Incontinence
☐ Urgency	☐ Bowel Sounds:
☐ Urostomy	O Hyperactive
☐ **Catheter:** ☐ Foley ☐ Suprapubic	O Hypoactive
Last Changed / /	O Normal
Fr cc	☐ Abd Girth:
☐ Urine:	☐ Last BM: / /
☐ Cloudy	As per: O Clinician Assessment O Pt/CG Report

☐ Odorous
☐ Sediment
☐ Hematuria
☐ Other
☐ External Genitalia:
O Normal
O Abnormal
As per:
O Clinician Assessment
O Pt/CG Report

☐ Abnormal Stool: ☐ Gray ☐ Tarry ☐ Fresh Blood ☐ Black
☐ Constipation: O Chronic O Acute O Occasional
☐ Lax/Enema Use:
☐ Hemorrhoids: O Internal O External
☐ Ostomy:
Ostomy Type(s):
☐ Stoma Appearance:
☐ Stool Appearance:
☐ Surrounding Skin: ☐ Intact

Comments:

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

O 0 - No O 1 - Yes O NA - Patient on prophylactic treatment. O UK - Unknown

(M1610) Urinary Incontinence or Urinary Catheter Presence:

O 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[Go to M1620]**
O 1 - Patient is incontinent
O 2 - Patient requires a urinary catheter (specifically: external, indwelling, intermittent, suprapubic) **[Go to M1620]**

(M1615) When does **Urinary Incontinence** Occur?

O 0 - Timed-voiding defers incontinence
O 1 - Occasional stress incontinence
O 2 - During the night only
O 3 - During the day only
O 4 - During the day and night only

(M1620) Bowel Incontinence Frequency:

O 0 - Very rarely or never has bowel incontinence
O 1 - Less than once weekly

O 2 - One to three times weekly

O 3 - Four to six times weekly

O 4 - On a daily basis

O 5 - More often than once daily

O NA - Patient has ostomy for bowel elimination

O UK - Unknown

(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?

O 0 - Patient does not have an ostomy for bowel elimination

O 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen

O 2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen

Is patient on dialysis? O Y O N

☐ Hemodialysis

☐ AV Graft / Fistula Site:

☐ Central Venous Catheter Access Site:

☐ Peritoneal Dialysis

☐ CCPD (Continuous Cyclic Peritoneal Dialysis)

☐ IPD (Intermittent Peritoneal Dialysis)

☐ CAPD (Continuous Ambulatory peritoneal Dialysis)

☐ Catheter site free from signs and symptoms of infection

☐ Other:

Dialysis Center:

Phone Number:

Contact Person:

Interventions

☐ No blood pressure in _____ arm

Additional Orders:

Goals

Additional Goals:

Patient Name (Last Name, First Name) & MRN:	Date: / /

Nutrition

Nutrition
☐ WNL (Within Normal Limits)
☐ Dysphagia
☐ Decreased Appetite
☐ Weight Loss/Gain O Loss O Gain Amount: in: *(how long)*
☐ Meals Prepared Appropriately
☐ Diet O Adequate O Inadequate ☐ NG ☐ PEG ☐ Dobhoff ☐ Tube Placement Checked
☐ Residual Checked, Amount: cc ☐ Throat problems? ☐ Sore throat? ☐ Dentures? ☐ Other: ☐ Hoarseness? ☐ Dental problems? ☐ Problems chewing?
Comments:

Nutritional Health Screen	Yes	Score
☐ Without reason, has lost more than 10 lbs, in the last 3 months	15	☐ **Good Nutritional Status (Score 0 - 25)**
☐ Has an illness or condition that made pt change the type and/or amount of food eaten	10	☐ **Moderate Nutritional Risk (Score 25 - 55)**
☐ Has open decubitus, ulcer, burn or wound	10	☐ **High Nutritional Risk (Score 55 - 100)**
☐ Eats fewer than 2 meals a day	10	Nutritional Status Comments:
☐ Has a tooth/mouth problem that makes it hard to eat	10	
☐ Has 3 or more drinks of beer, liquor or wine almost every day	10	

☐ Does not always have enough money to buy foods needed	10	
☐ Eats few fruits or vegetables, or milk products	5	☐ **Non-compliant with prescribed diet**
☐ Eats alone most of the time	5	☐ **Over/under weight by 10%**
☐ Takes 3 or more prescribed or OTC medications a day	5	Meals prepared by:
☐ Is not always physically able to cook and/or feed self and has no caregiver to assist	5	
☐ Frequently has diarrhea or constipation	5	

Enter Physician's Orders or Diet Requirements

☐ _____ Sodium
☐ No Added Salt
☐ _____ Calorie ADA Diet
☐ Regular
☐ High Protein _____
☐ Low Protein _____
☐ Carbohydrate O Low O High
☐ Mechanical Soft
☐ High Fiber
☐ Supplement _____
☐ Renal Diet
☐ Coumadin Diet
☐ Fluid Restriction _____ cc/24 hours
☐ Other _____

☐ No Concentrated Sweet
☐ Heart Health
☐ Low Cholesterol
☐ Low Fat
☐ Enter Nutrition _____ (Formula)
Amount _____ cc/day via
☐ _____ Pump ☐ Gravity
☐ PEG ☐ NG ☐ Dobhoff
☐ Continuous ☐ Bolus
☐ TPN _____ @cc/hr
☐ via _____

Interventions

Additional Orders:

Goals
Additional Goals:

Neurological/Emotional/Behavioral Status

Neurological/Emotional/Behavioral Status	
Neurological	**Psychosocial**
Oriented to:	☐ WNL (Within Normal Limits)
☐ Person	☐ Poor Home Environment
☐ Place	☐ Poor Coping Skills
☐ Time	☐ Agitated
☐ Disoriented	☐ Depressed Mood
☐ Forgetful	☐ Impaired Decision Making
☐ PERRL	☐ Demonstrated/Expressed Anxiety
☐ Seizures	☐ Inappropriate Behavior
☐ Tremors Location(s)	☐ Irritability
Comments:	

(M1700) Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

O 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.

O 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions

O 2 - Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility

O 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

O 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium

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

O 0 - Never
O 1 - In new or complex situations only
O 2 - On awakening or at night only
O 3 - During the day and evening, but not constantly
O 4 - Constantly
O NA - Patient nonresponsive

(M1720) When Anxious (Reported or Observed Within the Last 14 Days):

O 0 - None of the time
O 1 - Less often than daily
O 2 - Daily, but not constantly
O 3 - All of the time
O NA - Patient nonresponsive

(M1730) Depression Screening: Has the patient been screened for depression, using a standardized, validated depression screening tool?

O 0 - No
O 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?	O 0	O 1	O 2	O 3	O na
b) Feeling down, depressed, or hopeless?	O 0	O 1	O 2	O 3	O na

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

(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

(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.

O 0 - Never

O 1 - Less than once a month

O 2 - Once a month

O 3 - Several times each month

O 4 - Several times a week

O 5 - At least daily

(M1750) Is this patient receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse?

O 0 - No O 1 - Yes

Interventions	
☐	***Notify SN or Physician that this patient was screened for depression using the PHQ-2 scale and meets criteria for further evaluation for depression**
☐	SN to evaluate patient for signs and symptoms of depression
☐	MSW: O 1-2 OR O _____ visit, every 60 days for provider services
☐	MSW: O 1-2 OR O _____ visit, every 60 days for long term planning
☐	MSW: O 1-2 OR O _____ visit, every 60 days for community resource assistance

Additional Orders:

Goals	
☐	Patient's community resource needs will be met with the assistance of social worker

Additional Goals:

Mental Status			
☐ Oriented	☐ Comatose	☐ Forgetful	☐ Agitated
☐ Depressed	☐ Disoriented	☐ Lethargic	☐ Other *(specify)*

Additional Orders *(specify)*:

ADL/IADLs

Activities Permitted			
☐ Completed 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 *(specify)*

Musculoskeletal	
☐ WNL (Within Normal Limits)	☐ Bedbound
☐ Weakness	☐ Chairbound
☐ Ambulation Difficulty	☐ Contracture: *(location)*
☐ Limited Mobility/ROM *(location)*	☐ Paralysis: *(location)*
☐ Joint Pain/Stiffness *(location)*	O Dominant
☐ Poor Balance	O Nondominant

☐ Grip Strength
- O Equal
- O Unequal

☐ Assistive Device: *(type)*

Comments:

(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).

- O 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods
- O 1 - Grooming utensils must be placed within reach before able to complete grooming activities
- O 2 - Someone must assist the patient to groom self
- O 3 - Patient depends entirely upon someone else for grooming needs

(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:

- O 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods
- O 1 - Grooming utensils must be placed within reach before able to complete grooming activities
- O 2 - Someone must assist the patient to groom self
- O 3 - Patient depends entirely upon someone else for grooming needs

Patient Name (Last Name, First Name) & MRN: | Date: / /

(M1820) Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

- O 0 - Able to obtain, put on, and remove clothing and shoes without assistance
- O 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient
- O 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes
- O 3 - Patient depends entirely upon another person to dress lower body

(M1830) Bathing: Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**

- O 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower
- O 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
- O 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

O 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision

O 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

O 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

O 6 - Unable to participate effectively in bathing and is bathed totally by another person

(M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

O 0 - Able to get to and from the toilet and transfer independently with or without a device

O 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer

O 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance)

O 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently

O 4 - Is totally dependent in toileting

(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.

O 0 - Able to manage toileting hygiene and clothing management without assistance

O 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient

O 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing

O 3 - Patient depends entirely upon another person to maintain toileting hygiene

(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

O 0 - Able to independently transfer

O 1 - Able to transfer with minimal human assistance or with use of an assistive device

O 2 - Able to bear weight and pivot during the transfer process but unable to transfer self

O 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person

O 4 - Bedfast, unable to transfer but is able to turn and position self in bed

O 5 - Bedfast, unable to transfer and is unable to turn and position self

(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.

O 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device)

O 1 - With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings

O 2 - Requires use of a two-handed device (for example, 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

O 3 - Able to walk only with the supervision or assistance of another person at all times

O 4 - Chairfast, unable to ambulate but is able to wheel self independently

O 5 - Chairfast, unable to ambulate and is unable to wheel self

O 6 - Bedfast, unable to ambulate or be up in a chair

(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.

O 0 - Able to independently feed self

O 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

O 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack

O 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy

O 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy

O 5 - Unable to take in nutrients orally or by tube feeding

(M1880) Current **Ability to Plan and Prepare Light Meals** (e.g., cereal, sandwich) or reheat delivered meals safely.

O 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)

O 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations

O 2 - Unable to prepare any light meals or reheat any delivered meals

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

O 0 - Able to dial numbers and answer calls appropriately and as desired

O 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers

O 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls

O 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation

O 4 - Unable to answer the telephone at all but can listen if assisted with equipment

O 5 - Totally unable to use the telephone

O NA - Patient does not have a telephone

Patient Name (Last Name, First Name) & MRN:	Date: / /

Interventions		
☐	HHA (Freq)	assistance with ADLs/IADLs

Additional Orders:

Goals	
☐	Patient's ADL/IADL needs will be met with assistance of HHA

Additional Goals:

(M1900) Prior Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to his/her most recent illness, exacerbation, or injury. Check only **one** box in each row.

Functional Area	Independent	Needed Some Help	Dependent
a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene)	O 0	O 1	O 2
b. Ambulation	O 0	O 1	O 2
c. Transfer	O 0	O 1	O 2
d. Household tasks (specially: light meal, preparation, laundry, shopping, and phone use)	O 0	O 1	O 2

MAHC 10 - Fall Risk Assessment Tool		
Required Core Elements **Assess one point for each core element "yes".** *Information may be gathered from medical record, assessment and if applicable, the patient/caregiver.* *Beyond protocols listed below, scoring should be based on your clinical judgment.*	**Yes**	**No**
Age 65+	O	O

Diagnosis (3 or more co-existing) *Includes only documented medical diagnosis.*	O	O
Prior history of falls within 3 months *Fall definition: "An unintentional change in position resulting in coming to rest on the ground or at a lower level."*	O	O

Incontinence *Inability to make it to the bathroom or commode in timely manner. Includes frequency, urgency, and/or nocturia.*	O	O
Visual impairment *Includes but not limited to, macular degeneration, diabetic retinopathies, visual field loss, age related changes, decline in visual acuity, accommodation, glare tolerance, depth perception, and night vision or not wearing prescribed glasses or having the correct prescription.*	O	O
Impaired functional mobility *May include patients who need help with IADLs or ADLs or have gait or transfer problems, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination or improper use of assistive devices.*	O	O
Environmental hazards *May include but not limited to, poor illumination, equipment tubing, inappropriate footwear, pets, hard to reach items, floor surfaces that are uneven or cluttered, or outdoor entry and exits.*	O	O
Poly Pharmacy (4 or more prescriptions - any type) *All PRESCRIPTIONS including prescriptions for OTC meds. Drugs highly associated with fall risk include but are not limited to, sedatives, anti-depressants, tranquilizers, narcotics, antihypertensives, cardiac meds, corticosteroids, anti-anxiety drugs, anticholinergic drugs, and hypoglycemic drugs*	O	O
Pain affecting level of function *Pain often affects an individual's desire or ability to move or pain can be a factor in depression or compliance with safety recommendations.*	O	O
Cognitive impairment *Could include patients with dementia, Alzheimer's or stroke patients or patients who are confused, use poor judgment, have decreased comprehension, impulsivity, memory deficits. Consider patient's ability to adhere to the plan of care.*	O	O
A score of 4 or more is considered at risk for falling **Total:**		
Ref: The Missouri Alliance for Home Care		

Patient Name (Last Name, First Name) & MRN:	Date: / /

Fall Risk Assessment: Timed Get Up and Go

Assessment to be performed with patient wearing regular footwear, using usual walking aid if needed and sitting back in a chair with arm rests.

Observe patient for postural stability, steppage, stride length, and sway.

Instructions for Timed Get Up and Go:

On the word "GO", ask patient to do the following from a seated position:

1. Stand up from the chair
2. Walk three meters (approximately nine feet) in a straight line
3. Turn
4. Walk back to the chair
5. Sit down

Have patient perform the above once for practice. Then have patient repeat the exercise while you time them.

Score _____ seconds

Understanding Scoring:

- Lower scores generally correlate with good functional independence
- Higher scores generally correlate with poor functional independence and higher risk of falls

(M1910) Has this patient had a multi-factor **Fall Risk Assessment** using a standardized, validated assessment tool?

O 0 - No

O 1 - Yes, and it does not indicate a risk for falls

O 2 - Yes, and it indicates a risk for falls

Patient Name (Last Name, First Name) & MRN:	Date: / /

Interventions	
☐	Therapist to instruct the patient to wear proper footwear when ambulating
☐	Therapist to instruct the patient to used prescribed assistive device when ambulating
☐	Therapist to instruct the patient to change positions slowly
☐	Therapist to instruct the ☐ Patient/Caregiver ☐ Patient ☐ Caregiver to remove throw rugs or use double-sided tape to secure rug in place
☐	Therapist to instruct the ☐ Patient/Caregiver ☐ Patient ☐ Caregiver to remove clutter from patient's path such as clothes, books, shoes, electrical cords, or other items that may cause
☐	Therapist to instruct the ☐ Patient/Caregiver ☐ Patient ☐ Caregiver to contact agency for increased dizziness or problems with balance
☐	Therapist to instruct the patient to use non-skid mats in tub/shower
☐	Therapist to instruct the ☐ Patient/Caregiver ☐ Patient ☐ Caregiver on importance of adequate lighting in patient area
☐	Therapist to instruct the ☐ Patient/Caregiver ☐ Patient ☐ Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility
☐	Therapist to request Physical Therapy Evaluation order from physician

Additional Orders:

Patient Name (Last Name, First Name) & MRN:	Date: / /

Goals	
☐	The patient will be free from falls during the certification period
☐	The patient will be free from injury during the certification period
☐	The ☐ Patient/Caregiver ☐ Patient ☐ Caregiver will remove all clutter from patient's path, such as clothes, books, shoes, electrical cords, and other items, that may cause patient to trip by: / /
☐	The ☐ Patient/Caregiver ☐ Patient ☐ Caregiver will remove throw rugs or secure them with double-sided tape by: / /

Additional Goals:

DME				
☐ Beside Commode	☐ Cane	☐ Elevated Toilet Seat	☐ Grab Bars	☐ Hospital Bed
☐ Nebulizer	☐ Oxygen	☐ Tub/Shower Bench	☐ Walker	☐ Wheelchair

Other:

Supplies				
☐ ABDs	☐ Ace Wrap	☐ Alcohol Pads	☐ Chux/Underpads	☐ Diabetic Supplies
☐ Dressing Supplies	☐ Drainage Bag	☐ Duoderm	☐ Exam Gloves	☐ Foley Catheter
☐ Gauze Pads	☐ Insertion Kit	☐ Irrigation Set	☐ Irrigation Solution	☐ Kerlix Rolls

☐ Leg Bag	☐ Needles	☐ NG Tube	☐ Probe Covers	☐ Sharps Container
☐ Sterile Gloves	☐ Syringe	☐ Tape		

Other:

DME Provider

Information or company (other than home health agency) that provides supplies/DME:

Name:

Address:

Phone Number:

Supplies/DME Provided:

Patient Name (Last Name, First Name) & MRN:	Date: / /

Supplies

Supplies	
Name	**HCPCS**

Patient Name (Last Name, First Name) & MRN:	Date: / /

Medications

Medication Record

Medication Profile
Wilson, Les (1233333)

07/18/2015 - 09-15-2015

Pharmacy (name, address and phone)

Allergy Profile

O NKA (Food / Drug / Latex / Environmental)

O Allergies and Sensitivities

Substance	Reaction

O +/- Allergy Substance not in Medispan list?

Use only for allergies / sensitivities not found in the Medispan database.
These substances will not be included in the drug-allergy interaction checks.

Order Date: / /

Add New Medication

☐ Longstanding
☐ Change
☐ New

Start Date / /

Drug / Route / Form / Strength

Amount

Frequency / Instructions

(Maximum characters: 1024)

Discontinue Date / /

Medication Type ☐ **Nonstandard Dosage** Order Date: / / ☐ Generate Order ☐ Medication Reconciliation / Snapshot

Add Nonstandard Dosage Medication

☐ Longstanding

Start Date

Drug / Route / Form / Strength

☐ Change
☐ New

Dose

Frequency / Instructions

(Maximum characters: 1024)

Discontinue Date

Order Date: / /

Add Off Market / Unlisted Medication

Use only for medications not found in the Medispan database.
These medications will not be included in the clinical interaction checks.

☐ Longstanding ☐ Change ☐ New

Start Date / /

Drug / Route / Strength / Amount / Form / Frequency / Comments

(Maximum characters: 1024)

Classification:

☐ ALTERNATIVE MEDICINES
☐ AMEBICIDES
☐ AMINOGLYCOSIDES
☐ ANALGESICS - ANTI-INFLAMMATORY
☐ ANALGESICS - NonNarcotic
☐ ANALGESICS - OPIOID
☐ ANDROGENS - ANABOLIC
☐ ANORECTAL AGENTS
☐ ANTACIDS
☐ ANTHELMINTICS
☐ ANTI-INFECTIVE AGENTS - MISC
☐ ANTIANGINAL AGENTS
☐ ANTIANXIETY AGENTS
☐ ANTICOAGULANTS
☐ ANTICONVULSANTS
☐ ANTIDEPRESSANTS
☐ ANTIPARKINSON AGENTS
☐ ANTIPSYCHOTICS/ANTIMANIC AGENTS
☐ ANTISEPTICS & DISINFECTANTS
☐ ANTIVIRALS
☐ ASSORTED CLASSES
☐ BETA BLOCKERS
☐ BIOLOGICAL MISC
☐ CALCIUM CHANNEL BLOCKERS
☐ CARDIOTONICS
☐ CARDIOVASCULAR AGENTS - MISC.
☐ CEPHALOSPORINS
☐ CHEMICALS
☐ CONTRACEPTIVES
☐ COUGH/COLD/ALLERGY
☐ DERMATOLOGICALS
☐ DIAGNOSTIC PRODUCTS
☐ LAXATIVES
☐ LOCAL ANESTHETICS-Parenteral
☐ MACROLIDES
☐ MEDICAL DEVICES
☐ MIGRAINE PRODUCTS
☐ MULTIVITAMINS
☐ NEUROMUSCULAR AGENTS
☐ NUTRIENTS
☐ OPHTHALMIC AGENTS
☐ OTIC AGENTS
☐ OXYTOCICS
☐ PASSIVE IMMUNIZING AGENTS
☐ PENICILLINS
☐ PROGESTINS
☐ RESPIRATORY AGENTS - MISC.
☐ SULFONAMIDES

Patient Name (Last Name, First Name) & MRN:	Date: / /

- ☐ ANTIDIABETICS
- ☐ ANTIDIARRHEALS
- ☐ ANTIDOTES
- ☐ ANTIEMETICS
- ☐ ANTIFUNGALS
- ☐ ANTIHISTAMINES
- ☐ ANTIHYPERLIPIDEMICS
- ☐ ANTIHYPERTENSIVES
- ☐ ANTIMALARIALS
- ☐ ANTIMYCOBACTERIAL AGENTS
- ☐ DIGESTIVE AIDS
- ☐ DIURETICS
- ☐ ESTROGENS
- ☐ FLUOROQUINOLONES
- ☐ GASTROINTESTINAL AGENTS - MISC.
- ☐ GENERAL ANESTHETICS
- ☐ GOUT AGENTS
- ☐ HEMATOLOGICAL AGENTS - MISC.
- ☐ HEMATOPOIETIC AGENTS
- ☐ HEMOSTATICS
- ☐ TETRACYCLINES
- ☐ THYROID AGENTS
- ☐ TOXOIDS
- ☐ ULCER DRUGS
- ☐ URINARY ANTI-INFECTIVES
- ☐ URINARY ANTISPASMODICS
- ☐ VACCINES
- ☐ VAGINAL PRODUCTS
- ☐ VASOPRESSORS
- ☐ VITAMINS
- ☐ ANTIASTHMATIC AND BRONCHODILATOR AGENTS
- ☐ ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
- ☐ ANTIMYASTHENIC/CHOLINERGIC AGENTS
- ☐ ENDOCRINE AND METABOLIC AGENTS - MISC.
- ☐ MUSCULOSKELETAL THERAPY AGENTS
- ☐ NASAL AGENTS - SYSTEMIC AND TOPICAL
- ☐ ADHD/ANTI-NARCOLEPSY/ANTI-OBESITEY/ANOREXIANTS
- ☐ DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
- ☐ GENITOURINARY AGENTS - MISCELLANEOUS GOUT AGENTS
- ☐ HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
- ☐ MINERALS & ELECTROLYTES MOUTH/DENTAL AGENTS
- ☐ PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

Discontinue Date

Medication Administration Record

Time in: Time Out: Date:

Time:

Medication **Does** **Route**

Frequency **PRN Reason**

Location **Patient Response**

Comment

Legend

IM Location		*SQ Location*		*Patient Responses*	
LD/RD	Left / Right Deltoid	**LA**	Left Arm	**NB**	No Bleeding/Brushing
LVG/RVG	Left / Right Ventrogluteal	**RA**	Right Arm	**NC**	No Complaint
LDG/RDG	Left / Right Dorsogluteal	**ABD**	Abdomen	**NN**	See Narrative

LV/RV	Left / Right Vastus Lateralis	**LT**	Left Thigh
		RT	Right Thigh

(M2000) Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues (for example,
adverse drug reactions, ineffective drug therapy, significant side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance [non-adherence])??

- O 0 - Not assessed/reviewed **[Go to M2010]**
- O 1 - No problems found during review **[Go to M2010]**
- O 2 - Problems found during review
- O NA - Patient is not taking any medications **[Go to M2040]**

Does patient have IV access? O Y O N

Type:

Date of Insertion: / /

Date of Last Dressing Change: / /

(M2002) Medication Follow-up: Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant
medication issues, including reconciliation?

O 0 - No O 1 - Yes

(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?

- O 0 - No O 1 - Yes
- O NA - Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

(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.)**

- O 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times
- O 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
- O 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
- O 3 - Unable to take medication unless administered by another person
- O NA - No oral medications prescribed

(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.**

- O 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times
- O 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
- O 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection
- O 3 - Unable to take injectable medication unless administered by another person
- O NA - No injectable medications prescribed

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

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

Interventions	
☐	SN to evaluate due to exhibited ☐ Patient/Caregiver ☐ Patient ☐ Caregiver medication regiment knowledge deficits

Additional Orders:

Goals
Additional Goals:

Care Management

(M2102) Types and Sources of Assistance: Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff. (Check only **one** box in each row.)

Type of Assistance	No assistance needed - patient is independent or does not have needs in this area	Non-agency caregiver(s) currently provide assistance	Non-agency caregiver(s) need training/supportive services to provide assistance	Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance	Assistance needed, but no non-agency caregiver(s) available
a. **ADL assistance** (for example, transfer/ambulation, bathing, dressing, toileting, eating/feeding)	O 0	O 1	O 2	O 3	O 4
b. **IADL assistance** (for example, meals, housekeeping, laundry, telephone, shopping, finances)	O 0	O 1	O 2	O 3	O 4
c. **Medication administration** (for example, oral, inhaled or injectable)	O 0	O 1	O 2	O 3	O 4
d. **Medical procedures/treatments** (for example, changing wound dressing, home exercise program)	O 0	O 1	O 2	O 3	O 4
e. **Management of equipment** (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)	O 0	O 1	O 2	O 3	O 4
f. **Supervision and safety** (for example, due to cognitive impairment)	O 0	O 1	O 2	O 3	O 4
g. **Advocacy or facilitation** of patient's participation in appropriate medical care (includes transportation to or from appointments)	O 0	O 1	O 2	O 3	O 4

(M2110) How often does the patient receive **ADL or IADL assistance** from any caregiver(s) (other than home health agency staff)?

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

Therapy Need and Plan of Care

(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.

(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	O 0	O 1	O 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	O 0	O 1	O NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
c. Falls prevention interventions	O 0	O 1	O NA	Falls risk assessment indicates patient has no risk for falls.
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment and/or physician notified that patient screened positive for depression	O 0	O 1	O NA	Patient has no diagnosis of depression AND depression screening indicates 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.
e. Intervention(s) to monitor and mitigate pain	O 0	O 1	O NA	Pain assessment indicates patient has no pain.
f. Intervention(s) to prevent pressure ulcers	O 0	O 1	O NA	Pressure ulcer risk assessment (clinical or formal) indicates patient is not at risk of developing 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	O 0	O 1	O NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

Orders for Discipline and Treatments

Orders for Discipline and Treatments	
SN Frequency	
PT Frequency	
OT Frequency	
ST Frequency	

MSW Frequency	
HHA Frequency	

☐ Dietitian

Additional Orders:

Rehab Potential

☐ Good to achieve stated goals with skilled intervention and patient's compliance with the plan of care

☐ Fair to achieve stated goals with skilled intervention and patient's compliance with the plan of care

☐ Poor to achieve stated goals with skilled intervention and patient's compliance with the plan of care

Other rehab potential:

Discharge Plan

☐ Discharge when medical condition is stable and patient is no longer in need of skilled services

☐ Discharge to care of physician

☐ Discharge when patient independent with help

☐ Discharge to caregiver

☐ Discharge patient to self care

☐ Discharge when caregiver willing and able to manage all aspects of patient's care

☐ Discharge when goals met/maximum potential is reached

Additional discharge plans:

Patient Strengths		
☐ Motivated Learner	☐ Strong Support System	☐ Absence of Multiple Diagnosis
☐ Enhanced Socioeconomic Status	Other:	

Skilled Intervention

Assessment/Instruction/Performance:

☐ **Tolerated Well**

☐ **Response to Skilled Intervention**

Verbalized Understanding	☐ Pt		%	☐ CG		%
Return Demonstration	☐ Pt		%	☐ CG		%
Require Further Teaching	☐ Pt	☐ CG				

Comments:

Title of Teaching Tool Used/Given:	
Progress To Goals:	

Conferenced With: ☐ MD ☐ SN ☐ PT ☐ OT ☐ ST ☐ MSW ☐ HHA

Name:	

Regarding:

Physician Contacted Re:	
Order Changes:	
Plans for Next Visit:	
Next Physician Visit:	/ /
Discharge Planning:	

☐ Written notice of discharge provided to patient. Discharge scheduled for: / /

PT Evaluation

Patient Name (Last Name, First Name) & MRN:	Date: / /

Diagnosis/History

Medical Diagnosis:		☐ Exacerbation ☐ Onset	/ /
PT Diagnosis:		☐ Exacerbation ☐ Onset	/ /

Relevant Medical History:

Prior Level of Functioning:

Patient's Goals:

Precautions :

Homebound? O Yes O No

☐ Residual Weakness
☐ Needs assistance for all activities
☐ Requires max assistance / taxing effort to leave home
☐ Unable to safely leave home unattended
☐ Severe SOB or SOB upon exertion
☐ Confusion, unsafe to go out of home alone

Other:

Social Support/Safety Hazards

Evaluation of Living Situation, Supports, and Hazards

Physical Assessment

Speech:		**Musical Tone:**	
Vision:		**Coordination:**	
Hearing:		**Sensation:**	
Skin:		**Endurance:**	
Edema:		**Posture:**	

Evaluation of Cognitive and/or Emotional Functioning

ROM / Strength

		ROM		Strength				ROM		Strength	
Part	***Action***	***Right***	***Left***	***Right***	***Left***	***Part***	***Action***	***Right***	***Left***	***Right***	***Left***
Shoulder	Flexion					Hip	Flexion				
	Extension						Extension				
	Abduction						Abduction				
	Adduction						Adduction				
	Int Rot						Int Rot				
	Ext Rot						Ext Rot				
Elbow	Flexion					Knee	Flexion				
	Extension						Extension				
Forearm	Pronation					Ankle	Planter Flexion				
	Supination						Dorsiflexion				
Finger	Flexion						Inversion				
	Extension						Eversion				
Wrist	Flexion					Neck	Flexion				
	Extension						Extension				
Trunk	Extension						Lat Flexion				
	Rotation						Rotation				
	Flexion										

Comments:

/ /

Functional Assessment

Independence Scale

Dep Indep	Max Assist	Mod Assist	Min Assist	CGA	SBA	Supervision	Mod Indep
Therapist helps 100% to complete task or activity	Therapist helps 75-99% to complete task or activity	Therapist helps 26-75% to complete task or activity	Therapist helps 1-26% to complete task or activity	Person requires another person standing close			

enough to take hold of the client

Bed Mobility

	Assist Level		
Rolling		☐ L	☐ R

	Assistive Device
Supine - Sit	
Sit - Supine	

Deficits Due To / Comments:

Gait

	Assist Level		Distance / Amount	Assistive Device
Level		X		
Unlevel		X		
Steps/Stairs		X		

Deficits Due To / Deviations / Comments:

Transfer

	Assist Level	Assistive Device
Sit - Stand		
Stand - Sit		
Bed - Wheelchair		
Wheelchair - Bed		
Toilet or BSC		
Tub or Shower		
Car/Van		

Deficits Due To / Comments:

Wheelchair Mobility

Assist Level	Assist Level	Assist Level
Level	Unlevel	Maneuver

Deficits Due To / Comments:

Weight Bearing Status

Balance

☐ Able to assume/maintain midline orientation

Sitting

Standing

Evaluation and Testing Description:

Fall Risk and Other Testing

Test 1 **Result**

☐ Tinetti ☐ Functional Reach ☐ Timed Up & Go

☐ One Leg Standing - Left	☐ 3 meter walk test	☐ 4 Square Step	
☐ One Leg Standing - Right	☐ Berg Balance	☐ Gait Velocity	

Test 2 **Result**

☐ Tinetti	☐ Functional Reach	☐ Timed Up & Go	
☐ One Leg Standing - Left	☐ 3 meter walk test	☐ 4 Square Step	
☐ One Leg Standing - Right	☐ Berg Balance	☐ Gait Velocity	

Test 3 **Result**

☐ Tinetti	☐ Functional Reach	☐ Timed Up & Go	
☐ One Leg Standing - Left	☐ 3 meter walk test	☐ 4 Square Step	
☐ One Leg Standing - Right	☐ Berg Balance	☐ Gait Velocity	

Evaluation Assessment

Evaluation Assessment Summary

Functional Limitations

☐ Decreased ROM / Strength ☐ One Impaired Balance / Gait ☐ Increased Pain ☐ Decreased Wheelchair Mobility

☐ Poor Safety Awareness ☐ Decreased Transfer Ability ☐ Decreased Bed Mobility

Comments:

Treatment Goals

		Time Frame
1:		
2:		
3:		
4:		

5:		
6:		
7:		
8:		
9:		
10:		

Treatment Plan

☐ Thera Ex ☐ Balance Training ☐ Home Safety Training

☐ Hip Precaution Training ☐ Muscle Re-education ☐ Assistive Device Training *(specify):*

☐ Establish or Upgrade HEP ☐ Bed Mobility Training

☐ Knee Precaution Training ☐ Ultrasound ☐ Modalities for Pain Control *(specify):*

☐ Transfer Training ☐ Prosthetic Training

☐ Pulmonary Physical Therapy ☐ Electrotherapy ☐ CPM *(specify):*

☐ Gait Training ☐ Stairs / Steps Training

☐ Range of Motion ☐ O_2 Sat Monitoring PRN

☐ Other *(specify):*

Comments:

Care Coordination

Conference With

☐ PT ☐ PTA ☐ OT ☐ COTA ☐ ST ☐ SN ☐ Aide ☐ Supervisor ☐ Other:

Name(s):

Regarding:

☐ Physician Notified Re: Plan of Care, Goals, Frequency, Duration and Direction

Other Discipline Recommendations: ☐ OT ☐ ST ☐ MSW ☐ Aide ☐ Other:

Reason:

Treatment / Skilled Intervention This Visit

Patient Name (Last Name, First Name) & MRN:	Date: / /

Frequency And Duration

	Start Date	End Date	Effective Date	Frequency
Current Episode:	/ /	/ /	/ /	
Next Episode:	/ /		/ /	