



Home Health Patient Tracking Sheet	
(M0010)	CMS Certification Number: _____
(M0014)	Branch State: ____
(M0016)	Branch ID Number: _____
(M0018)	National Provider Identifier (NPI) for the attending physician who has signed the plan of care: _____ <input type="checkbox"/> UK – Unknown or Not Available
(M0020)	Patient ID Number: _____
(M0030)	Start of Care Date: __/__/____ month/ day/ year
(M0032)	Resumption of Care Date: __/__/____ <input type="checkbox"/> NA – Not Applicable month/ day/ year
(M0040)	Patient Name: _____ (First) (MI) (Last) (Suffix)
(M0050)	Patient State of Residence: ____
(M0060)	Patient ZIP Code: _____
(M0063)	Medicare Number: _____ <input type="checkbox"/> NA – No Medicare (including suffix)
(M0064)	Social Security Number: ____-____-____ <input type="checkbox"/> UK – Unknown or Not Available
(M0065)	Medicaid Number: _____ <input type="checkbox"/> NA – No Medicaid
(M0066)	Birth Date: __/__/____ month/ day/ year
(M0069)	Gender: <input type="checkbox"/> 1 – Male <input type="checkbox"/> 2 – Female
(M0140)	Race/Ethnicity: (Mark all that apply.) <input type="checkbox"/> 1 – American Indian or Alaska Native <input type="checkbox"/> 2 – Asian <input type="checkbox"/> 3 – Black or African-American <input type="checkbox"/> 4 – Hispanic or Latino <input type="checkbox"/> 5 – Native Hawaiian or Pacific Islander <input type="checkbox"/> 6 – White

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(M0050)	Patient State of Residence: □□
(M0060)	Patient ZIP Code: □□□□□-□□□□
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(M0069)	Gender: Enter Code □ 1 Male 2 Female
(M0140)	Race/Ethnicity: (Mark all that apply.) <input type="checkbox"/> 1 – American Indian or Alaska Native <input type="checkbox"/> 2 – Asian <input type="checkbox"/> 3 – Black or African-American <input type="checkbox"/> 4 – Hispanic or Latino <input type="checkbox"/> 5 – Native Hawaiian or Pacific Islander <input type="checkbox"/> 6 – White



(M0150)	Current Payment Sources for Home Care: (Mark all that apply.)
	<input type="checkbox"/> 0 – None, no charge for current services <input type="checkbox"/> 1 – Medicare (traditional fee-for-service) <input type="checkbox"/> 2 – Medicare (HMO)/managed care/Advantage plan) <input type="checkbox"/> 3 – Medicaid (traditional fee-for-service) <input type="checkbox"/> 4 – Medicaid (HMO/managed care) <input type="checkbox"/> 5 – Workers’ compensation <input type="checkbox"/> 6 – Title programs (for example, Title III, V or XX) <input type="checkbox"/> 7 – Other government (for example, TriCare, VA) <input type="checkbox"/> 8 – Private Insurance <input type="checkbox"/> 9 – Private HMO/managed care <input type="checkbox"/> 10 – Self-pay <input type="checkbox"/> 11 – Other (specify) _____ <input type="checkbox"/> UK – Unknown

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Outcome and Assessment Information Set Items to be Used at Specific Time Points	
Time Point	Items Used
Start of Care Start of care ---further visits planned	M0010-M0030, M0040-M0150, M1000-M1036, M1100- M1306, M1308, M1320-M1410, M1600-M2002, M2010, M2020-M2250
Resumption of Care Resumption of care (after inpatient stay)	M0032, M0080-M0110, M1000-M1036, M1100-M1306, M1308, M1320-M1410, M1600-M2002, M2010, M2020- M2250
Follow-Up Recertification (follow-up) assessment Other follow-up assessment	M0080-M0100, M0110, M1011, M1021-M1030, M1200, M1242, M1306, M1308, M1322-M1342, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200
Transfer to an Inpatient Facility Transferred to an inpatient facility —patient not discharged from an agency Transferred to an inpatient facility —patient discharged from agency	M0080-M0100, M1041-M1056, M1500, M1510, M2004, M2015, M2300-M2410, M2430, M0903, M0906
Discharge from Agency — Not to an Inpatient Facility Death at home Discharge from agency	M0080-M0100, M0903, M0906 M0080-M0100, M1041-M1056, M1230, M1242, M1306- M1342, M1400, M1500-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2004, M2015-M2030, M2102, M2300-M2420, M0903, M0906

Outcome and Assessment Information Set Items to be Used at Specific Time Points	
Time Point	Items Used
Start of Care Start of care ---further visits planned	M0010-M0030, M0040-M0150, M1000-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
Resumption of Care Resumption of care (after inpatient stay)	M0032, M0080-M0110, M1000-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
Follow-Up Recertification (follow-up) assessment Other follow-up assessment	M0080-M0100, M0110, M1011, M1021-M1030, M1200, M1242, M1306, M1311, M1322-M1342, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200
Transfer to an Inpatient Facility Transferred to an inpatient facility —patient not discharged from an agency Transferred to an inpatient facility —patient discharged from agency	M0080-M0100, M1041-M1056, M1501, M1511, M2005, M2016, M2301-M2410, M2430, M0903, M0906
Discharge from Agency — Not to an Inpatient Facility Death at home Discharge from agency	M0080-M0100, M2005, M0903, M0906 M0080-M0100, M1041-M1056, M1230, M1242, M1306-M1342, M1400, M1501-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2005, M2016-M2030, M2102, M2301-M2420, M0903, M0906



CLINICAL RECORD ITEMS	
(M0080)	Discipline of Person Completing Assessment: <input type="checkbox"/> 1-RN <input type="checkbox"/> 2-PT <input type="checkbox"/> 3-SLP/ST <input type="checkbox"/> 4-OT
(M0090)	Date Assessment Completed: ___/___/_____ month/ day/ year
(M0100)	This Assessment is Currently Being Completed for the Following Reason: <u>Start/Resumption of Care</u> <input type="checkbox"/> 1 – Start of care – further visits planned <input type="checkbox"/> 3 – Resumption of care (after inpatient stay) <u>Follow-Up</u> <input type="checkbox"/> 4 – Recertification (follow-up) reassessment (<i>Go to M0110</i>) <input type="checkbox"/> 5 – Other follow-up (<i>Go to M0110</i>) <u>Transfer to an Inpatient Facility</u> <input type="checkbox"/> 6 – Transferred to an inpatient facility—patient not discharged from agency (<i>Go to M1041</i>) <input type="checkbox"/> 7 – Transferred to an inpatient facility—patient discharged from agency (<i>Go to M1041</i>) <u>Discharge from Agency – Not to an Inpatient Facility</u> <input type="checkbox"/> 8 – Death at home (<i>Go to M0903</i>) <input type="checkbox"/> 9 – Discharge from agency (<i>Go to M1041</i>)
(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. ___/___/_____ month/ day/ year (<i>Go to M0110, if date entered</i>) <input type="checkbox"/> NA – No specific SOC date ordered by physician
(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
(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? <input type="checkbox"/> 1 – Early <input type="checkbox"/> 2 – Later <input type="checkbox"/> UK – Unknown <input type="checkbox"/> NA – Not Applicable: No Medicare case mix group to be defined by this assessment

CLINICAL RECORD ITEMS	
(M0080)	Discipline of Person Completing Assessment 1 RN 2 PT 3 SLP/ST 4 OT
(M0090)	Date Assessment Completed □□/□□/□□□□ month day year
(M0100)	This Assessment is Currently Being Completed for the Following Reason: <u>Start/Resumption of Care</u> 1 – Start of care – further visits planned 3 – Resumption of care (after inpatient stay) <u>Follow-Up</u> 4 – Recertification (follow-up) reassessment (<i>Go to M0110</i>) 5 – Other follow-up (<i>Go to M0110</i>) <u>Transfer to an Inpatient Facility</u> 6 – Transferred to an inpatient facility—patient not discharged from agency (<i>Go to M1041</i>) 7 – Transferred to an inpatient facility—patient discharged from agency (<i>Go to M1041</i>) <u>Discharge from Agency – Not to an Inpatient Facility</u> 8 – Death at home (<i>Go to M2005</i>) 9 – Discharge from agency (<i>Go to M1041</i>)
(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. □□/□□/□□□□ (<i>Go to M0110, if date entered</i>) month day year <input type="checkbox"/> NA – No specific SOC date ordered by physician
(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
(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



PATIENT HISTORY AND DIAGNOSES															
(M1000)	From which of the following Inpatient Facilities was the patient discharged within the past 14 days? (Mark all that apply.)														
	<input type="checkbox"/> 1 - Long-term nursing facility (NF) <input type="checkbox"/> 2 - Skilled nursing facility (SNF/TCU) <input type="checkbox"/> 3 - Short-stay acute hospital (IPPS) <input type="checkbox"/> 4 - Long-term care hospital (LTCH) <input type="checkbox"/> 5 - Inpatient rehabilitation hospital or unit (IRF) <input type="checkbox"/> 6 - Psychiatric hospital or unit <input type="checkbox"/> 7 - Other (specify) _____ <input type="checkbox"/> NA - Patient was not discharged from an inpatient facility [Go to M1017]														
(M1005)	Inpatient Discharge Date (most recent):														
	___/___/_____ month/ day/ year <input type="checkbox"/> UK - Unknown														
(M1011)	List each Inpatient Diagnosis and ICD-10-CM code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes):														
	<table border="0"> <thead> <tr> <th style="text-align: center;"><u>Inpatient Facility Diagnosis</u></th> <th style="text-align: center;"><u>ICD-10-CM Code</u></th> </tr> </thead> <tbody> <tr> <td>a. _____</td> <td>_____ - _____</td> </tr> <tr> <td>b. _____</td> <td>_____ - _____</td> </tr> <tr> <td>c. _____</td> <td>_____ - _____</td> </tr> <tr> <td>d. _____</td> <td>_____ - _____</td> </tr> <tr> <td>e. _____</td> <td>_____ - _____</td> </tr> <tr> <td>f. _____</td> <td>_____ - _____</td> </tr> </tbody> </table> <input type="checkbox"/> NA - Not applicable (patient was not discharged from an inpatient facility) (Omit "NA" option on SOC,ROC)	<u>Inpatient Facility Diagnosis</u>	<u>ICD-10-CM Code</u>	a. _____	_____ - _____	b. _____	_____ - _____	c. _____	_____ - _____	d. _____	_____ - _____	e. _____	_____ - _____	f. _____	_____ - _____
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(M1017)	Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-10-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no V, W, X, Y, or Z codes or surgical codes):														
	<table border="1"> <thead> <tr> <th data-bbox="306 341 667 363">Changed Medical Regimen Diagnosis</th> <th data-bbox="764 341 932 363">ICD-10-CM Code</th> </tr> </thead> <tbody> <tr> <td data-bbox="264 373 667 396">a. _____</td> <td data-bbox="751 373 966 396">----- - -----</td> </tr> <tr> <td data-bbox="264 406 667 428">b. _____</td> <td data-bbox="751 406 966 428">----- - -----</td> </tr> <tr> <td data-bbox="264 438 667 461">c. _____</td> <td data-bbox="751 438 966 461">----- - -----</td> </tr> <tr> <td data-bbox="264 470 667 493">d. _____</td> <td data-bbox="751 470 966 493">----- - -----</td> </tr> <tr> <td data-bbox="264 503 667 526">e. _____</td> <td data-bbox="751 503 966 526">----- - -----</td> </tr> <tr> <td data-bbox="264 535 667 558">f. _____</td> <td data-bbox="751 535 966 558">----- - -----</td> </tr> </tbody> </table> <p data-bbox="243 565 1016 613"><input type="checkbox"/> NA - Not applicable (No medical treatment regimen changes within the past 14 days)</p>	Changed Medical Regimen Diagnosis	ICD-10-CM Code	a. _____	----- - -----	b. _____	----- - -----	c. _____	----- - -----	d. _____	----- - -----	e. _____	----- - -----	f. _____	----- - -----
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(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 that existed <u>prior to</u> the inpatient stay or change in medical or treatment regimen. (Mark all that apply.)														
	<p data-bbox="243 779 1016 1110"> <input type="checkbox"/> 1 - Urinary incontinence <input type="checkbox"/> 2 - Indwelling/suprapubic catheter <input type="checkbox"/> 3 - Intractable pain <input type="checkbox"/> 4 - Impaired decision-making <input type="checkbox"/> 5 - Disruptive or socially inappropriate behavior <input type="checkbox"/> 6 - Memory loss to the extent that supervision required <input type="checkbox"/> 7 - None of the above <input type="checkbox"/> NA - No inpatient facility discharge <u>and</u> no change in medical or treatment regimen in past 14 days <input type="checkbox"/> UK - Unknown </p>														

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(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 that existed <u>prior to</u> the inpatient stay or change in medical or treatment regimen. (Mark all that apply.)															
	<p data-bbox="1209 766 1974 1091"> <input type="checkbox"/> 1 - Urinary incontinence <input type="checkbox"/> 2 - Indwelling/suprapubic catheter <input type="checkbox"/> 3 - Intractable pain <input type="checkbox"/> 4 - Impaired decision-making <input type="checkbox"/> 5 - Disruptive or socially inappropriate behavior <input type="checkbox"/> 6 - Memory loss to the extent that supervision required <input type="checkbox"/> 7 - None of the above <input type="checkbox"/> NA - No inpatient facility discharge <u>and</u> no change in medical or treatment regimen in past 14 days <input type="checkbox"/> UK - Unknown </p>															

<p>(M1021/1023/1025) Diagnoses, Symptom Control, and Optional Diagnoses: List each diagnosis for which the patient is receiving home care in Column 1, and enter its ICD-10-CM code at the level of highest specificity in Column 2 (diagnosis codes only - no surgical or procedure codes allowed). Diagnoses are listed in the order that best reflects the seriousness of each condition and supports the disciplines and services provided. Rate the degree of symptom control for each condition in Column 2. ICD-10-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a Z-code is reported in Column 2 in place of a diagnosis that is no longer active (a resolved condition), then optional item M1025 (Optional Diagnoses - Columns 3 and 4) may be completed. Diagnoses reported in M1025 will not impact payment.</p> <p>Code each row according to the following directions for each column:</p>	
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.
Column 2:	<p>Enter the ICD-10-CM 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-CM coding rules and sequencing requirements must be followed. Note that external cause codes (ICD-10-CM 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 ongoing condition impacting home health care.</p> <p>Rate the degree of symptom control for the condition listed in Column 1. Do not assign a symptom control rating if the diagnosis code is a V, W, X, Y or Z-code. Choose one value that represents the degree of symptom control appropriate for each diagnosis using the following scale:</p> <ul style="list-style-type: none"> 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 <p>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.</p>
Column 3:	<p>(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.</p> <p>Agencies may choose to report an underlying condition in M1025 (Columns 3 and 4) when:</p> <ul style="list-style-type: none"> • 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:	<p>(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-CM coding guidelines, enter the diagnosis descriptions and the ICD-10-CM 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-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.</p>

<p>(M1021/1023/1025) Diagnoses, Symptom Control, and Optional Diagnoses: List each diagnosis for which the patient is receiving home care in Column 1, and enter its ICD-10-CM code at the level of highest specificity in Column 2 (diagnosis codes only - no surgical or procedure codes allowed). Diagnoses are listed in the order that best reflects the seriousness of each condition and supports the disciplines and services provided. Rate the degree of symptom control for each condition in Column 2. ICD-10-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a Z-code is reported in Column 2 in place of a diagnosis that is no longer active (a resolved condition), then optional item M1025 (Optional Diagnoses - Columns 3 and 4) may be completed. Diagnoses reported in M1025 will not impact payment.</p> <p>Code each row according to the following directions for each column:</p>	
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.
Column 2:	<p>Enter the ICD-10-CM 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-CM coding rules and sequencing requirements must be followed. Note that external cause codes (ICD-10-CM 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 ongoing condition impacting home health care.</p> <p>Rate the degree of symptom control for the condition listed in Column 1. Do not assign a symptom control rating if the diagnosis code is a V, W, X, Y or Z-code. Choose one value that represents the degree of symptom control appropriate for each diagnosis using the following scale:</p> <ul style="list-style-type: none"> 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 <p>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.</p>
Column 3:	<p>(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.</p> <p>Agencies may choose to report an underlying condition in M1025 (Columns 3 and 4) when:</p> <ul style="list-style-type: none"> • 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:	<p>(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-CM coding guidelines, enter the diagnosis descriptions and the ICD-10-CM 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-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.</p>



(M1021) Primary Diagnosis & (M1023) Other Diagnoses		(M1025) Optional Diagnoses (OPTIONAL) (not used for payment)	
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-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved.	Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code)
Description	ICD-10-CM / Symptom Control Rating	Description / ICD-10-CM	Description / ICD-10-CM
(M1021) Primary Diagnosis	V, W, X, Y codes NOT allowed	V, W, X, Y codes NOT allowed	V, W, X, Y codes NOT allowed
a. _____	a. _____ □0 □1 □2 □3 □4	a. _____ (____-_____)	a. _____ (____-_____)
(M1023) Primary Diagnosis	All ICD-10-CM Codes allowed	V,W,X,Y codes NOT allowed	V,W,X,Y codes NOT allowed
b. _____	b. _____ □0 □1 □2 □3 □4	b. _____ (____-_____)	b. _____ (____-_____)
c. _____	c. _____ □0 □1 □2 □3 □4	c. _____ (____-_____)	c. _____ (____-_____)
d. _____	d. _____ □0 □1 □2 □3 □4	d. _____ (____-_____)	d. _____ (____-_____)
e. _____	e. _____ □0 □1 □2 □3 □4	e. _____ (____-_____)	e. _____ (____-_____)
f. _____	f. _____ □0 □1 □2 □3 □4	f. _____ (____-_____)	f. _____ (____-_____)

(M1021) Primary Diagnosis & (M1023) Other Diagnoses		(M1025) Optional Diagnoses (OPTIONAL) (not used for payment)	
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-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved.	Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code)
Description	ICD-10-CM / Symptom Control Rating	Description / ICD-10-CM	Description / ICD-10-CM
(M1021) Primary Diagnosis	V, W, X, Y codes NOT allowed	V, W, X, Y codes NOT allowed	V, W, X, Y codes NOT allowed
a. _____	a. _____ □0 □1 □2 □3 □4	a. _____ (____.____)	a. _____ (____.____)
(M1023) Primary Diagnosis	All ICD-10-CM Codes allowed	V, W, X, Y codes NOT allowed	V, W, X, Y codes NOT allowed
b. _____	b. _____ □0 □1 □2 □3 □4	b. _____ (____.____)	b. _____ (____.____)
c. _____	c. _____ □0 □1 □2 □3 □4	c. _____ (____.____)	c. _____ (____.____)
d. _____	d. _____ □0 □1 □2 □3 □4	d. _____ (____.____)	d. _____ (____.____)
e. _____	e. _____ □0 □1 □2 □3 □4	e. _____ (____.____)	e. _____ (____.____)
f. _____	f. _____ □0 □1 □2 □3 □4	f. _____ (____.____)	f. _____ (____.____)

(M1028)	Active Diagnoses- Comorbidities and Co-existing Conditions – Check all that apply. See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.
<input type="checkbox"/>	1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
<input type="checkbox"/>	2 - Diabetes Mellitus (DM)

(M1030)	Therapies the patient receives <u>at home</u> : (Mark all that apply.)
<input type="checkbox"/>	1 - Intravenous or infusion therapy (excludes TPN)
<input type="checkbox"/>	2 - Parenteral nutrition (TPN or lipids)
<input type="checkbox"/>	3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
<input type="checkbox"/>	4 - None of the above

(M1030)	Therapies the patient receives <u>at home</u> : (Mark all that apply.)
<input type="checkbox"/>	1 - Intravenous or infusion therapy (excludes TPN)
<input type="checkbox"/>	2 - Parenteral nutrition (TPN or lipids)
<input type="checkbox"/>	3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
<input type="checkbox"/>	4 - None of the above



(M1033)	Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)
	<input type="checkbox"/> 1 – History of falls (2 or more falls - or any fall with an injury - in the past 12 months) <input type="checkbox"/> 2 – Unintentional weight loss of a total of 10 pounds or more in the past 12 months <input type="checkbox"/> 3 – Multiple hospitalizations (2 or more) in the past 6 months <input type="checkbox"/> 4 – Multiple emergency department visits (2 or more) in the past 6 months <input type="checkbox"/> 5 – Decline in mental, emotional, or behavioral status in the past 3 months <input type="checkbox"/> 6 – Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months <input type="checkbox"/> 7 – Currently taking 5 or more medications <input type="checkbox"/> 8 – Currently reports exhaustion <input type="checkbox"/> 9 – Other risk(s) not listed in 1 - 8 <input type="checkbox"/> 10 – None of the above
(M1034)	Overall Status: Which description best fits the patient’s overall status? (Check one)
	<input type="checkbox"/> 0 – The patient is stable with no heightened risk(s) for serious complications and death(beyond those typical of the patient’s age). <input type="checkbox"/> 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). <input type="checkbox"/> 2 – The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death. <input type="checkbox"/> 3 – The patient has serious progressive conditions that could lead to death within a year. <input type="checkbox"/> UK – The patient’s situation is unknown or unclear.
(M1036)	Risk Factors, either present or past, likely to affect current health status and/or outcome: (Mark all that apply.)
	<input type="checkbox"/> 1 – Smoking <input type="checkbox"/> 2 – Obesity <input type="checkbox"/> 3 – Alcohol dependency <input type="checkbox"/> 4 – Drug dependency <input type="checkbox"/> 5 – None of the above <input type="checkbox"/> UK – Unknown
(M1041)	Influenza Vaccine Data Collection Period: Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?
	<input type="checkbox"/> 0 – No (Go to M1051) <input type="checkbox"/> 1 – Yes

(M1033)	Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)
	<input type="checkbox"/> 1 – History of falls (2 or more falls - or any fall with an injury - in the past 12 months) <input type="checkbox"/> 2 – Unintentional weight loss of a total of 10 pounds or more in the past 12 months <input type="checkbox"/> 3 – Multiple hospitalizations (2 or more) in the past 6 months <input type="checkbox"/> 4 – Multiple emergency department visits (2 or more) in the past 6 months <input type="checkbox"/> 5 – Decline in mental, emotional, or behavioral status in the past 3 months <input type="checkbox"/> 6 – Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months <input type="checkbox"/> 7 – Currently taking 5 or more medications <input type="checkbox"/> 8 – Currently reports exhaustion <input type="checkbox"/> 9 – Other risk(s) not listed in 1 - 8 <input type="checkbox"/> 10 – None of the above
(M1034)	Overall Status: Which description best fits the patient’s overall status?
Enter Code <input type="checkbox"/>	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.
(M1036)	Risk Factors, either present or past, likely to affect current health status and/or outcome: (Mark all that apply.)
	<input type="checkbox"/> 1 – Smoking <input type="checkbox"/> 2 – Obesity <input type="checkbox"/> 3 – Alcohol dependency <input type="checkbox"/> 4 – Drug dependency <input type="checkbox"/> 5 – None of the above <input type="checkbox"/> UK – Unknown
(M1041)	Influenza Vaccine Data Collection Period: Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?
Enter Code <input type="checkbox"/>	0 – No (Go to M1051) 1 – Yes



(M1046)	<p>Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season?</p> <p><input type="checkbox"/> 1 – Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)</p> <p><input type="checkbox"/> 2 – Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)</p> <p><input type="checkbox"/> 3 – Yes; received from another health care provider (for example, physician, pharmacist)</p> <p><input type="checkbox"/> 4 – No; patient offered and declined</p> <p><input type="checkbox"/> 5 – No; patient assessed and determined to have medicalcontraindication(s)</p> <p><input type="checkbox"/> 6 – No; not indicated - patient does not meet age/condition guidelines for influenza vaccine</p> <p><input type="checkbox"/> 7 – No; inability to obtain vaccine due to declaredshortage</p> <p><input type="checkbox"/> 8 – No; patient did not receive the vaccine due to reasons other than those listed in responses 4 –7.</p>
(M1051)	<p>Pneumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?</p> <p><input type="checkbox"/> 0 – No</p> <p><input type="checkbox"/> 1 – Yes (<i>Go to M1500 at TRN; Go to M1230 at DC</i>)</p>
(M1056)	<p>Reason Pneumococcal Vaccine not received: If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason:</p> <p><input type="checkbox"/> 1 – Offered and declined</p> <p><input type="checkbox"/> 2 – Assessed and determined to have medicalcontraindication(s)</p> <p><input type="checkbox"/> 3 – Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine</p> <p><input type="checkbox"/> 4 – None of the above</p>

(M1046)	<p>Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season?</p> <p>Enter Code <input type="checkbox"/></p> <p>1 Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)</p> <p>2 Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)</p> <p>3 Yes; received from another health care provider (for example, physician, pharmacist)</p> <p>4 No; patient offered and declined</p> <p>5 No; patient assessed and determined to have medical contraindication(s)</p> <p>6 No; not indicated - patient does not meet age/condition guidelines for influenza vaccine</p> <p>7 No; inability to obtain vaccine due to declared shortage</p> <p>8 No; patient did not receive the vaccine due to reasons other than those listed in responses 4 – 7.</p>
(M1051)	<p>Pneumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?</p> <p>Enter Code <input type="checkbox"/></p> <p>0 No</p> <p>1 Yes (<i>Go to M1501 at TRN; Go to M1230 at DC</i>)</p>
(M1056)	<p>Reason Pneumococcal Vaccine not received: If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason:</p> <p>Enter Code <input type="checkbox"/></p> <p>1 Offered and declined</p> <p>2 Assessed and determined to have medical contraindication(s)</p> <p>3 Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine</p> <p>4 None of the above</p>

(M1060)	<p>Height and Weight – While measuring, if the number is X.1 – X.4 round down; X.5 or greater round up</p>
<p><input type="text"/> <input type="text"/> inches</p> <p><input type="text"/> <input type="text"/> <input type="text"/> pounds</p>	<p>a. Height (in inches). Record most recent height measure since the most recent SOC/ROC</p> <p>b. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.)</p>



LIVING ARRANGEMENTS					
(M1100)	Patient Living Situation: Which of the following best describes the patient's residential circumstance and availability of assistance? (Check one box only.)				
Availability of Assistance					
Living Arrangement	Around the clock	Regular Daytime	Regular Nighttime	Occasional/ Short-term assistance	No assistance available
a. Patient lives alone	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	<input type="checkbox"/> 04	<input type="checkbox"/> 05
b. Patient lives with other person(s) in the home	<input type="checkbox"/> 06	<input type="checkbox"/> 07	<input type="checkbox"/> 08	<input type="checkbox"/> 09	<input type="checkbox"/> 10
c. Patient lives in congregate situation (for example, assisted living, residential care home)	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 13	<input type="checkbox"/> 14	<input type="checkbox"/> 15

LIVING ARRANGEMENTS					
(M1100)	Patient Living Situation: Which of the following best describes the patient's residential circumstance and availability of assistance? (Check one box only.)				
Availability of Assistance					
Living Arrangement	Around the clock	Regular Daytime	Regular Nighttime	Occasional/ Short-term assistance	No assistance available
a. Patient lives alone	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	<input type="checkbox"/> 04	<input type="checkbox"/> 05
b. Patient lives with other person(s) in the home	<input type="checkbox"/> 06	<input type="checkbox"/> 07	<input type="checkbox"/> 08	<input type="checkbox"/> 09	<input type="checkbox"/> 10
c. Patient lives in congregate situation (for example, assisted living, residential care home)	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 13	<input type="checkbox"/> 14	<input type="checkbox"/> 15

SENSORY STATUS	
(M1200)	Vision (with corrective lenses if the patient usually wears them): <input type="checkbox"/> 0 – Normal vision: sees adequately in most situations; can see medication labels, newsprint. <input type="checkbox"/> 1 – Partially impaired: cannot see medication labels or newsprint, but <u>can</u> see obstacles in path, and the surrounding layout; can count fingers at arm's length. <input type="checkbox"/> 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): <input type="checkbox"/> 0 – Adequate: hears normal conversation without difficulty. <input type="checkbox"/> 1 – Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly. <input type="checkbox"/> 2 – Severely Impaired: absence of useful hearing. <input type="checkbox"/> UK – Unable to assess hearing.
(M1220)	Understanding of Verbal Content in patient's own language (with hearing aid or device if used): <input type="checkbox"/> 0 – Understands: clear comprehension without cues or repetitions. <input type="checkbox"/> 1 – Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand. <input type="checkbox"/> 2 – Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand. <input type="checkbox"/> 3 – Rarely/Never Understands. <input type="checkbox"/> UK – Unable to assess understanding.

SENSORY STATUS	
(M1200)	Vision (with corrective lenses if the patient usually wears them): Enter Code <input type="checkbox"/> 0 Normal vision: sees adequately in most situations; can see medication labels, newsprint. 1 Partially impaired: cannot see medication labels or newsprint, but <u>can</u> 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.
(M1210)	Ability to Hear (with hearing aid or hearing appliance if normally used): Enter Code <input type="checkbox"/> 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.
(M1220)	Understanding of Verbal Content in patient's own language (with hearing aid or device if used): Enter Code <input type="checkbox"/> 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.



(M1230)	Speech and Oral (Verbal) Expression of Language (in patient's own language):
	<ul style="list-style-type: none"> <input type="checkbox"/> 0 – Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment. <input type="checkbox"/> 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). <input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> 4 – <u>Unable</u> to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible). <input type="checkbox"/> 5 – Patient nonresponsive or unable to speak.
(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)?
	<ul style="list-style-type: none"> <input type="checkbox"/> 0 – No standardized, validated assessment conducted <input type="checkbox"/> 1 – Yes, and it does not indicate severe pain <input type="checkbox"/> 2 – Yes, and it indicates severe pain
(M1242)	Frequency of Pain Interfering with patient's activity or movement:
	<ul style="list-style-type: none"> <input type="checkbox"/> 0 – Patient has no pain <input type="checkbox"/> 1 – Patient has pain that does not interfere with activity or movement <input type="checkbox"/> 2 – Less often than daily <input type="checkbox"/> 3 – Daily, but not constantly <input type="checkbox"/> 4 – All of the above

(M1230)	Speech and Oral (Verbal) Expression of Language (in patient's own language):
Enter Code <input type="checkbox"/>	<ul style="list-style-type: none"> 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 <u>Unable</u> to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible). 5 Patient nonresponsive or unable to speak.
(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)?
Enter Code <input type="checkbox"/>	<ul style="list-style-type: none"> 0 No standardized, validated assessment conducted 1 Yes, and it does not indicate severe pain 2 Yes, and it indicates severe pain
(M1242)	Frequency of Pain Interfering with patient's activity or movement:
Enter Code <input type="checkbox"/>	<ul style="list-style-type: none"> 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	
(M1300)	Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers?
	<input type="checkbox"/> 0 – No assessment conducted [<i>Go to M1306</i>] <input type="checkbox"/> 1 – Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool <input type="checkbox"/> 2 – Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)
(M1302)	Does this patient have a Risk of Developing Pressure Ulcers?
	<input type="checkbox"/> 0 – No <input type="checkbox"/> 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)
	<input type="checkbox"/> 0 – No (<i>Go to M1322</i>) <input type="checkbox"/> 1 – Yes
(M1307)	The Oldest Stage II Pressure Ulcer that is present at discharge: (Excludes healed Stage II Pressure Ulcers)
	<input type="checkbox"/> 1 – Was present at the most recent SOC/ROC assessment <input type="checkbox"/> 2 – Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified: ___/___/____ month/ day/ year <input type="checkbox"/> NA – No Stage II pressure ulcers are present at discharge

INTEGUMENTARY STATUS	
(M1300)	Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers?
Enter Code <input type="checkbox"/>	0 No assessment conducted [<i>Go to M1306</i>] 1 Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool 2 Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)
(M1302)	Does this patient have a Risk of Developing Pressure Ulcers?
Enter Code <input type="checkbox"/>	0 No 1 Yes
(M1306)	Does this patient have at least one Unhealed Pressure Ulcer at Stage 2 or Higher or designated as Unstageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)
Enter Code <input type="checkbox"/>	0 No (<i>Go to M1322</i>) 1 Yes
(M1307)	The Oldest Stage 2 Pressure Ulcer that is present at discharge: (Excludes healed Stage 2 Pressure Ulcers)
Enter Code <input type="checkbox"/>	1 Was present at the most recent SOC/ROC assessment 2 Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified: □□/□□/□□□□ month day year NA No Stage 2 pressure ulcers are present at discharge

(M1308) Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable: (Enter "0" if none; Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)	
Stage Descriptions—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.	_____

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. Stage 2: 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 blister. Number of Stage 2 pressure ulcers [If 0 at FU/DC Go to M1311B1]	<input type="checkbox"/>
A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	<input type="checkbox"/>
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Number of Stage 3 pressure ulcers [If 0 at FU/DC Go to M1311C1]	<input type="checkbox"/>
B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	<input type="checkbox"/>
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Number of Stage 4 pressure ulcers [If 0 at FU/DC Go to M1311D1]	<input type="checkbox"/>
C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	<input type="checkbox"/>
D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device Number of unstageable pressure ulcers due to non-removable dressing/device [If 0 at FU/DC Go to M1311E1]	<input type="checkbox"/>
D2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	<input type="checkbox"/>
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar [If 0 at FU/DC Go to M1311F1]	<input type="checkbox"/>
E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	<input type="checkbox"/>
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution Number of unstageable pressure ulcers with suspected deep tissue injury in evolution [If 0 - Go to M1322 (at Follow up), Go to M1313 (at Discharge)]	<input type="checkbox"/>
F2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	<input type="checkbox"/>
[Omit "A2, B2, C2, D2, E2 and F2" on SOC/ROC]	

(M1309) Worsening in Pressure Ulcer Status since SOC/ROC:	
Instructions for a – c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC	
	Enter Number (Enter “0” if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)
a. Stage II	_____
b. Stage III	_____
c. Stage IV	_____
Instructions for d: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC.	
	Enter Number (Enter “0” if there are no Unstageable pressure ulcers at discharge OR if all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC)
d. Unstageable due to coverage of wound bed by slough or eschar	_____
(M1320)	Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)
	<input type="checkbox"/> 0 – Newly epithelialized <input type="checkbox"/> 1 – Fully granulating <input type="checkbox"/> 2 – Early/partial granulation <input type="checkbox"/> 3 – Not healing <input type="checkbox"/> NA – No observable pressure ulcer
(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.
	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 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.)
	<input type="checkbox"/> 1 – Stage I <input type="checkbox"/> 2 – Stage II <input type="checkbox"/> 3 – Stage III <input type="checkbox"/> 4 – Stage IV <input type="checkbox"/> NA – Patient has no pressure ulcers or no stageable pressure ulcers

(M1313) Worsening in Pressure Ulcer Status since SOC/ROC:	
Instructions for a-c: Indicate the number of current pressure ulcers that were not present or were at a lesser stage at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter 0.	
	Enter Number
a. Stage 2	<input type="checkbox"/>
b. Stage 3	<input type="checkbox"/>
c. Stage 4	<input type="checkbox"/>
Instructions for e: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were at a Stage 1 or 2 at the most recent SOC/ROC.	
d. Unstageable – Known or likely but Unstageable due to non-removable dressing.	<input type="checkbox"/>
e. Unstageable – Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	<input type="checkbox"/>
f. Unstageable – Suspected deep tissue injury in evolution.	<input type="checkbox"/>
(M1320)	Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)
Enter Code <input type="checkbox"/>	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing NA No observable pressure ulcer
(M1322)	Current Number of Stage 1 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. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.
Enter Code <input type="checkbox"/>	0 1 2 3 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.)
Enter Code <input type="checkbox"/>	1 Stage 1 2 Stage 2 3 Stage 3 4 Stage 4 NA Patient has no pressure ulcers or no stageable pressure ulcers



(M1330)	Does this patient have a Stasis Ulcer ?
	<input type="checkbox"/> 0 – No [Go to M1340] <input type="checkbox"/> 1 – Yes, patient has BOTH observable and unobservable stasis ulcers <input type="checkbox"/> 2 – Yes, patient has observable stasis ulcers ONLY <input type="checkbox"/> 3 – Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) [Go to M1340]
(M1332)	Current Number of Stasis Ulcer(s) that are Observable:
	<input type="checkbox"/> 1 – One <input type="checkbox"/> 2 – Two <input type="checkbox"/> 3 – Three <input type="checkbox"/> 4 – Four or more
(M1334)	Status of Most Problematic Stasis Ulcer that is Observable:
	<input type="checkbox"/> 1 – Fully granulating <input type="checkbox"/> 2 – Early/partial granulation <input type="checkbox"/> 3 – Not healing
(M1340)	Does this patient have a Surgical Wound ?
	<input type="checkbox"/> 0 – No [At SOC/ROC, go to M1350 ; At FU//DC, go to M1400] <input type="checkbox"/> 1 – Yes, patient has at least one observable surgical wound <input type="checkbox"/> 2 – Surgical wound known but not observable due to non-removable dressing/device [At SOC/ROC, go to M1350; AtFU/DC, gotoM1400]
(M1342)	Status of Most Problematic Surgical Wound that is Observable
	<input type="checkbox"/> 0 – Newly epithelialized <input type="checkbox"/> 1 – Fully granulating <input type="checkbox"/> 2 – Early/partial granulation <input type="checkbox"/> 3 – Not healing
(M1350)	Does this patient have a Skin Lesion or Open Wound (excluding bowel ostomy), other than those described above, <u>that is receiving intervention</u> by the home health agency?
	<input type="checkbox"/> 0 – No <input type="checkbox"/> 1 – Yes

(M1330)	Does this patient have a Stasis Ulcer ?
Enter Code	<input type="checkbox"/> 0 No (Go to M1340) <input type="checkbox"/> 1 Yes, patient has BOTH observable and unobservable <input type="checkbox"/> 2 Yes, patient has observable stasis ulcers ONLY <input type="checkbox"/> 3 Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) (Go to M1340)
(M1332)	Current Number of Stasis Ulcer(s) that are Observable:
Enter Code	<input type="checkbox"/> 1 One <input type="checkbox"/> 2 Two <input type="checkbox"/> 3 Three <input type="checkbox"/> 4 Four or more
(M1334)	Status of Most Problematic Stasis Ulcer that is Observable:
Enter Code	<input type="checkbox"/> 1 Fully granulating <input type="checkbox"/> 2 Early/partial granulation <input type="checkbox"/> 3 Not healing
(M1340)	Does this patient have a Surgical Wound ?
Enter Code	<input type="checkbox"/> 0 No [At SOC/ROC, go to M1350 ; At FU//DC, go to M1400] <input type="checkbox"/> 1 Yes, patient has at least one observable surgical wound <input type="checkbox"/> 2 Surgical wound known but not observable due to non-removable dressing/device [At SOC/ROC, go to M1350 ; At FU/DC, go to M1400]
(M1342)	Status of Most Problematic Surgical Wound that is Observable
Enter Code	<input type="checkbox"/> 0 Newly epithelialized <input type="checkbox"/> 1 Fully granulating <input type="checkbox"/> 2 Early/partial granulation <input type="checkbox"/> 3 Not healing
(M1350)	Does this patient have a Skin Lesion or Open Wound (excluding bowel ostomy), other than those described above, <u>that is receiving intervention</u> by the home health agency?
Enter Code	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes



RESPIRATORY STATUS	
(M1400)	When is the patient dyspneic or noticeably Short of Breath ?
	<input type="checkbox"/> 0 – Patient is not short of breath <input type="checkbox"/> 1 – When walking more than 20 feet, climbing stairs <input type="checkbox"/> 2 – With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet) <input type="checkbox"/> 3 – With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation <input type="checkbox"/> 4 – At rest (during day or night)
(M1410)	Respiratory Treatments utilized at home: (Mark all that apply.)
	<input type="checkbox"/> 1 – Oxygen (intermittent or continuous) <input type="checkbox"/> 2 – Ventilator (continually or at night) <input type="checkbox"/> 3 – Continuous / Bi-level positive airway pressure <input type="checkbox"/> 4 – None of the above

RESPIRATORY STATUS	
(M1400)	When is the patient dyspneic or noticeably Short of Breath ?
Enter Code	<input type="checkbox"/> 0 Patient is not short of breath <input type="checkbox"/> 1 When walking more than 20 feet, climbing stairs <input type="checkbox"/> 2 With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet) <input type="checkbox"/> 3 With minimal exertion (for example, while eating, talking or performing other ADLs) or with agitation <input type="checkbox"/> 4 At rest (during day or night)
(M1410)	Respiratory Treatments utilized at home: (Mark all that apply.)
	<input type="checkbox"/> 1 – Oxygen (intermittent or continuous) <input type="checkbox"/> 2 – Ventilator (continually or at night) <input type="checkbox"/> 3 – Continuous / Bi-level positive airway pressure <input type="checkbox"/> 4 – None of the above

CARDIAC STATUS	
(M1500)	Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at the time of or at any time since the previous OASIS assessment?
	<input type="checkbox"/> 0 – No (<i>Go to M2004 at TRN; Go to M1600 at DC</i>) <input type="checkbox"/> 1 – Yes <input type="checkbox"/> 2 – Not assessed (<i>Go to M2004 at TRN; Go to M1600 at DC</i>) <input type="checkbox"/> NA – Patient does not have diagnosis of heart failure (<i>Go to M2004 at TRN; Go to M1600 at DC</i>)
(M1510)	Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the previous OASIS assessment, what action(s) has (have) been taken to respond? (Mark all that apply.)
	<input type="checkbox"/> 0 – No action taken <input type="checkbox"/> 1 – Patient’s physician (or other primary care practitioner) contacted the sameday <input type="checkbox"/> 2 – Patient advised to get emergency treatment (for example, call 911 or go to emergencyroom) <input type="checkbox"/> 3 – Implemented physician-ordered patient-specific established parameters for treatment <input type="checkbox"/> 4 – Patient education or other clinical interventions <input type="checkbox"/> 5 – Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)

CARDIAC STATUS	
(M1501)	Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at the time of or at any time since the most recent SOC/ROC assessment?
Enter Code	<input type="checkbox"/> 0 No (<i>Go to M2005 at TRN; Go to M1600 at DC</i>) <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 Not assessed (<i>Go to M2005 at TRN; Go to M1600 at DC</i>) <input type="checkbox"/> NA Patient does not have diagnosis of heart failure (<i>Go to M2005 at TRN; Go to M1600 at DC</i>)
(M1511)	Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the most recent SOC/ROC assessment , what action(s) has (have) been taken to respond? (Mark all that apply.)
	<input type="checkbox"/> 0 - No action taken <input type="checkbox"/> 1 - Patient’s physician (or other primary care practitioner) contacted the same day <input type="checkbox"/> 2 - Patient advised to get emergency treatment (for example, call 911 or go to emergency room) <input type="checkbox"/> 3 - Implemented physician-ordered patient-specific established parameters for Treatment <input type="checkbox"/> 4 - Patient education or other clinical interventions <input type="checkbox"/> 5 - Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)



ELIMINATION STATUS	
(M1600)	Has this patient been treated for a Urinary Tract Infection in the past 14 days? <input type="checkbox"/> 0 – No <input type="checkbox"/> 1 – Yes <input type="checkbox"/> NA – Patient on prophylactic treatment <input type="checkbox"/> UK – Unknown (<i>Omit "UK" option on DC</i>)
(M1610)	Urinary Incontinence or Urinary Catheter Presence: <input type="checkbox"/> 0 – No incontinence or catheter (includes anuria or ostomy for urinary drainage) [<i>Go to M1620</i>] <input type="checkbox"/> 1 – Patient is incontinent <input type="checkbox"/> 2 – Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) (<i>Go to M1620</i>)
(M1615)	When does Urinary Incontinence occur? <input type="checkbox"/> 0 – Timed-voiding defers incontinence <input type="checkbox"/> 1 – Occasional stress incontinence <input type="checkbox"/> 2 – During the night only <input type="checkbox"/> 3 – During the day only <input type="checkbox"/> 4 – During day and night
(M1620)	Bowel Incontinence Frequency: <input type="checkbox"/> 0 – Very rarely or never has bowel incontinence <input type="checkbox"/> 1 – Less than once weekly <input type="checkbox"/> 2 – One to three times weekly <input type="checkbox"/> 3 – Four to six times weekly <input type="checkbox"/> 4 – On a daily basis <input type="checkbox"/> 5 – More often than once daily <input type="checkbox"/> NA – Patient has ostomy for bowel elimination <input type="checkbox"/> UK – Unknown [<i>Omit "UK" option on FU, DC</i>]
(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; <u>or</u> b) necessitated a change in medical or treatment regimen? <input type="checkbox"/> 0 – Patient does <u>not</u> have an ostomy for bowel elimination. <input type="checkbox"/> 1 – Patient's ostomy was <u>not</u> related to an inpatient stay and did not necessitate change in medical or treatment regimen. <input type="checkbox"/> 2 – The ostomy <u>was</u> related to an inpatient stay or <u>did</u> necessitate change in medical or treatment regimen.

ELIMINATION STATUS	
(M1600)	Has this patient been treated for a Urinary Tract Infection in the past 14 days? <input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> NA Patient on prophylactic treatment <input type="checkbox"/> UK Unknown (<i>Omit "UK" option on DC</i>)
(M1610)	Urinary Incontinence or Urinary Catheter Presence: <input type="checkbox"/> 0 No incontinence or catheter (includes anuria or ostomy for urinary drainage) [<i>Go to M1620</i>] <input type="checkbox"/> 1 Patient is incontinent <input type="checkbox"/> 2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) [<i>Go to M1620</i>]
(M1615)	When does Urinary Incontinence occur? <input type="checkbox"/> 0 Timed-voiding defers incontinence <input type="checkbox"/> 1 Occasional stress incontinence <input type="checkbox"/> 2 During the night only <input type="checkbox"/> 3 During the day only <input type="checkbox"/> 4 During day and night
(M1620)	Bowel Incontinence Frequency: <input type="checkbox"/> 0 Very rarely or never has bowel incontinence <input type="checkbox"/> 1 Less than once weekly <input type="checkbox"/> 2 One to three times weekly <input type="checkbox"/> 3 Four to six times weekly <input type="checkbox"/> 4 On a daily basis <input type="checkbox"/> 5 More often than once daily <input type="checkbox"/> NA Patient has ostomy for bowel elimination <input type="checkbox"/> UK Unknown (<i>Omit "UK" option on FU, DC</i>)
(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; <u>or</u> b) necessitated a change in medical or treatment regimen? <input type="checkbox"/> 0 Patient does <u>not</u> have an ostomy for bowel elimination <input type="checkbox"/> 1 Patient's ostomy was <u>not</u> related to an inpatient stay and did <u>not</u> necessitate change in medical or treatment regimen. <input type="checkbox"/> 2 The ostomy <u>was</u> related to an inpatient stay or <u>did</u> necessitate change in medical or treatment regimen.

NEURO/EMOTIONAL/BEHAVIORAL STATUS						
(M1700)	Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.					
	<input type="checkbox"/> 0 – Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently. <input type="checkbox"/> 1 – Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions. <input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> 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):					
	<input type="checkbox"/> 0 – Never <input type="checkbox"/> 1 – In new or complex situations only <input type="checkbox"/> 2 – On awakening or at night only <input type="checkbox"/> 3 – During the day and evening, but not constantly <input type="checkbox"/> 4 – Constantly <input type="checkbox"/> NA – Patient nonresponsive					
(M1720)	When Anxious (Reported or Observed Within the Last 14 Days):					
	<input type="checkbox"/> 0 – None of the time <input type="checkbox"/> 1 – Less than daily <input type="checkbox"/> 2 – Daily, but not constantly <input type="checkbox"/> 3 – All of the time <input type="checkbox"/> NA – Patient nonresponsive					
(M1730)	Depression Screening: Has the patient been screened for depression, using a standardized, validated depression screening tool?					
	<input type="checkbox"/> 0 – No <input type="checkbox"/> 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	NA Unable to Respond
	a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA
	b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA
	<input type="checkbox"/> 2 - Yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression. <input type="checkbox"/> 3 - Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression.					
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NEURO/EMOTIONAL/BEHAVIORAL STATUS																			
(M1700)	Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.																		
Enter Code <input type="checkbox"/>	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 (for example, on all tasks involving shifting of 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.																		
(M1710)	When Confused (Reported or Observed Within the Last 14 Days):																		
Enter Code <input type="checkbox"/>	0 Never 1 In new or complex situations only 2 On awakening or at night only 3 During the day evening, but not constantly 4 Constantly NA Patient nonresponsive																		
(M1720)	When Anxious (Reported or Observed Within the Last 14 Days):																		
Enter Code <input type="checkbox"/>	0 None of the time 1 Less often than daily 2 Daily, but not constantly 3 All of the time NA Patient nonresponsive																		
(M1730)	Depression Screening: Has the patient been screened for depression, using a standardized, validated depression screening tool?																		
Enter Code <input type="checkbox"/>	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?" <table border="1" data-bbox="1207 1096 1963 1323"> <thead> <tr> <th>PHQ-2@*</th> <th>Not at all 0 – 1 day</th> <th>Several Days 2-6 days</th> <th>More than Half of the Days 7 – 11 days</th> <th>Nearly every day 12 – 14 days</th> <th>NA Unable to Respond</th> </tr> </thead> <tbody> <tr> <td>a) Little interest or pleasure in doing things</td> <td><input type="checkbox"/> 0</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> NA</td> </tr> <tr> <td>b) Feeling down, depressed, or hopeless?</td> <td><input type="checkbox"/> 0</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> NA</td> </tr> </tbody> </table> 2 - Yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression. 3 - Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression. *Copyright© Pfizer Inc. All rights reserved. Reproduced with permission.	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	NA Unable to Respond	a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA	b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA
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	NA Unable to Respond														
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA														
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA														



(M1740)	Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed): (Mark all that apply.)
	<input type="checkbox"/> 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 <input type="checkbox"/> 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions <input type="checkbox"/> 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc. <input type="checkbox"/> 4 - Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects) <input type="checkbox"/> 5 - Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions) <input type="checkbox"/> 6 - Delusional, hallucinatory, or paranoid behavior <input type="checkbox"/> 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.
	<input type="checkbox"/> 0 - Never <input type="checkbox"/> 1 - Less than once a month <input type="checkbox"/> 2 - Once a month <input type="checkbox"/> 3 - Several times each month <input type="checkbox"/> 4 - Several times a week <input type="checkbox"/> 5 - At least daily
(M1750)	Is this patient receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse?
	<input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes

(M1740)	Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed): (Mark all that apply.)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	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 (for example, 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.
Enter Code <input type="checkbox"/>	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
(M1750)	Is this patient receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse?
Enter Code <input type="checkbox"/>	0 No 1 Yes

ADL/IADLs	
(M1800)	Grooming: Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).
	<input type="checkbox"/> 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods. <input type="checkbox"/> 1 - Grooming utensils must be placed within reach before able to complete grooming activities. <input type="checkbox"/> 2 - Someone must assist the patient to groom self. <input type="checkbox"/> 3 - Patient depends entirely upon someone else for grooming needs.
(M1810)	Current Ability to Dress <u>Upper</u> Body safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:
	<input type="checkbox"/> 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. <input type="checkbox"/> 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient. <input type="checkbox"/> 2 - Someone must help the patient put on upper body clothing. <input type="checkbox"/> 3 - Patient depends entirely upon another person to dress the upper body.
(M1820)	Current Ability to Dress <u>Lower</u> Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:
	<input type="checkbox"/> 0 - Able to obtain, put on, and remove clothing and shoes without assistance. <input type="checkbox"/> 1 - Able to obtain, put on, and remove clothing and shoes without assistance. <input type="checkbox"/> 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. <input type="checkbox"/> 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).
	<input type="checkbox"/> 0 - Able to bathe self in <u>shower or tub</u> independently, including getting in and out of tub/shower. <input type="checkbox"/> 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. <input type="checkbox"/> 2 - Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, <u>OR</u> (b) to get in and out of the shower or tub, <u>OR</u> (c) for washing difficult to reach areas. <input type="checkbox"/> 3 - Able to participate in bathing self in shower or tub, <u>but</u> requires presence of another person throughout the bath for assistance or supervision. <input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> 6 - Unable to participate effectively in bathing and is bathed totally by another person.

ADL/IADLs	
(M1800)	Grooming: Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).
Enter Code <input type="checkbox"/>	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.
(M1810)	Current Ability to Dress <u>Upper</u> Body safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:
Enter Code <input type="checkbox"/>	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.
(M1820)	Current Ability to Dress <u>Lower</u> Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:
Enter Code <input type="checkbox"/>	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.
(M1830)	Bathing: Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair).
Enter Code <input type="checkbox"/>	0 Able to bathe self in <u>shower or tub</u> 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, <u>OR</u> (b) to get in and out of the shower or tub, <u>OR</u> (c) for washing difficult to reach areas. 3 Able to participate in bathing self in shower or tub, <u>but</u> 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. 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 <u>and</u> transfer on and off toilet/commode.
	<ul style="list-style-type: none"> <input type="checkbox"/> 0 - Able to get to and from the toilet and transfer independently with or without a device. <input type="checkbox"/> 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer. <input type="checkbox"/> 2 - <u>Unable</u> to get to and from the toilet but is able to use a bedside commode (with or without assistance). <input type="checkbox"/> 3 - <u>Unable</u> to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently. <input type="checkbox"/> 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.
	<ul style="list-style-type: none"> <input type="checkbox"/> 0 - Able to manage toileting hygiene and clothing management without assistance. <input type="checkbox"/> 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient. <input type="checkbox"/> 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing. <input type="checkbox"/> 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.
	<ul style="list-style-type: none"> <input type="checkbox"/> 0 - Able to independently transfer. <input type="checkbox"/> 1 - Able to transfer with minimal human assistance or with use of an assistive device. <input type="checkbox"/> 2 - Able to bear weight and pivot during the transfer process but unable to transfer self. <input type="checkbox"/> 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person. <input type="checkbox"/> 4 - Bedfast, unable to transfer but is able to turn and position self in bed. <input type="checkbox"/> 5 - Bedfast, unable to transfer and is unable to turn and position self.

(M1840)	Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely <u>and</u> transfer on and off toilet/commode.
Enter Code <input type="checkbox"/>	<ul style="list-style-type: none"> 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 <u>Unable</u> to get to and from the toilet but is able to use a bedside commode (with or without assistance). 3 <u>Unable</u> 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.
(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.
Enter Code <input type="checkbox"/>	<ul style="list-style-type: none"> 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.
(M1850)	Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.
Enter Code <input type="checkbox"/>	<ul style="list-style-type: none"> 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.



Section GG: FUNCTIONAL ABILITIES and GOALS – SOC/ROC			
(GG0170C) Mobility			
Code the patient’s usual performance at the SOC/ROC using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient’s discharge goal using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal.			
Coding: Safety and Quality of Performance - If helper assistance is required because patient’s performance is unsafe or of poor quality, score according to amount of assistance provided. Activity may be completed with or without assistive devices. 06 Independent – Patient completes the activity by him/herself with no assistance from a helper. 05 Setup or clean-up assistance – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity. 04 Supervision or touching assistance – Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 03 Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort. 02 Substantial/maximal assistance – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01 Dependent – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity. If activity was not attempted, code reason: 07 Patient refused 09 Not applicable 88 Not attempted due to medical condition or safety concerns	1. SOC/ROC Performance	2. Discharge Goal	Lying to Sitting on Side of Bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
	↓Enter Codes in Boxes↓		
	□ □	□ □	



(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.
	<ul style="list-style-type: none"> <input type="checkbox"/> 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). <input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> 3 - Able to walk only with the supervision or assistance of another person at all times. <input type="checkbox"/> 4 - Chairfast, <u>unable</u> to ambulate but is able to wheel self independently. <input type="checkbox"/> 5 - Chairfast, unable to ambulate and is <u>unable</u> to wheel self. <input type="checkbox"/> 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 <u>eating</u> , <u>chewing</u> , and <u>swallowing</u> , <u>not preparing</u> the food to be eaten.
	<ul style="list-style-type: none"> <input type="checkbox"/> 0 - Able to independently feed self. <input type="checkbox"/> 1 - Able to feed self independently but requires: <ul style="list-style-type: none"> (a) meal set-up; <u>OR</u> (b) intermittent assistance or supervision from another person; <u>OR</u> (c) a liquid, pureed or ground meat diet. <input type="checkbox"/> 2 - <u>Unable</u> to feed self and must be assisted or supervised throughout the meal/snack. <input type="checkbox"/> 3 - Able to take in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy. <input type="checkbox"/> 4 - <u>Unable</u> to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy. <input type="checkbox"/> 5 - Unable to take in nutrients orally or by tube feeding.
(M1880)	Current Ability to Plan and Prepare Light Meals (for example, cereal, sandwich) or reheat delivered meals safely:
	<ul style="list-style-type: none"> <input type="checkbox"/> 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; <u>OR</u> (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 (specifically: prior to this home care admission). <input type="checkbox"/> 1 - <u>Unable</u> to prepare light meals on a regular basis due to physical, cognitive, or mental limitations. <input type="checkbox"/> 2 - Unable to prepare any light meals or reheat any delivered meals.

(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.
Enter Code <input type="checkbox"/>	<ul style="list-style-type: none"> 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). 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. 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. 3 Able to walk only with the supervision or assistance of another person at all times. 4 Chairfast, <u>unable</u> to ambulate but is able to wheel self independently. 5 Chairfast, unable to ambulate and is <u>unable</u> to wheel self. 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 <u>eating</u> , <u>chewing</u> , and <u>swallowing</u> , <u>not preparing</u> the food to be eaten.
Enter Code <input type="checkbox"/>	<ul style="list-style-type: none"> 0 Able to independently feed self. 1 Able to feed self independently but requires: <ul style="list-style-type: none"> (a) meal set-up; <u>OR</u> (b) intermittent assistance or supervision from another person; <u>OR</u> (c) a liquid, pureed or ground meat diet. 2 <u>Unable</u> to feed self and must be assisted or supervised throughout the meal/snack. 3 Able to take in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy. 4 <u>Unable</u> 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.
(M1880)	Current Ability to Plan and Prepare Light Meals (for example, cereal, sandwich) or reheat delivered meals safely:
Enter Code <input type="checkbox"/>	<ul style="list-style-type: none"> 0 (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; <u>OR</u> (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 (specifically: prior to this home care admission). 1 <u>Unable</u> 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.



(M1890)	Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and <u>effectively</u> using the telephone to communicate.		
	<input type="checkbox"/> 0 - Able to dial numbers and answer calls appropriately and as desired. <input type="checkbox"/> 1 - Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers. <input type="checkbox"/> 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls. <input type="checkbox"/> 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation. <input type="checkbox"/> 4 - <u>Unable</u> to answer the telephone at all but can listen if assisted with equipment. <input type="checkbox"/> 5 - Totally unable to use the telephone. <input type="checkbox"/> NA - Patient does not have a telephone.		
(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
	a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene)	<input type="checkbox"/> 0	<input type="checkbox"/> 1
	b. Ambulation	<input type="checkbox"/> 0	<input type="checkbox"/> 1
	c. Transfer	<input type="checkbox"/> 0	<input type="checkbox"/> 1
	d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use)	<input type="checkbox"/> 0	<input type="checkbox"/> 1
(M1910)	Has this patient had a multi-factor Falls Risk Assessment using a standardized, validated assessment tool?		
	<input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes, and it does not indicate a risk for falls. <input type="checkbox"/> 2 - Yes, and it does indicate a risk for falls.		

(M1890)	Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and <u>effectively</u> using the telephone to communicate.	
Enter Code <input type="checkbox"/>	0 Able to dial numbers and answer calls appropriately and as desired. 1 Able to use a specially adapted telephone (for example, 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 <u>Unable</u> 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.	
(M1900)	Prior Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to his/her most recent illness, exacerbation, or injury.	
Enter Code <input type="checkbox"/>	a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene) 0 Independent 1 Needed Some Help 2 Dependent	
Enter Code <input type="checkbox"/>	b. Ambulation 0 Independent 1 Needed Some Help 2 Dependent	
Enter Code <input type="checkbox"/>	c. Transfer 0 Independent 1 Needed Some Help 2 Dependent	
Enter Code <input type="checkbox"/>	d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use) 0 Independent 1 Needed Some Help 2 Dependent	
(M1910)	Has this patient had a multi-factor Falls Risk Assessment using a standardized, validated assessment tool?	
Enter Code <input type="checkbox"/>	0 No 1 Yes, and it does not indicate a risk for falls. 2 Yes, and it does indicate a risk for falls.	





MEDICATIONS	
(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])? <input type="checkbox"/> 0 - Not assessed/reviewed [Go to M2010] <input type="checkbox"/> 1 - No problems found during review [Go to M2010] <input type="checkbox"/> 2 - Problems found during review <input type="checkbox"/> NA - Patient is not taking any medications [Go to M2040]
(M2002)	Medication Follow-up: Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation? <input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes
(M2004)	Medication Intervention: If there were any clinically significant medication issues at the time of, or at any time since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day to resolve any identified clinically significant medication issues, including reconciliation? <input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes <input type="checkbox"/> NA - No clinically significant medication issues identified at the time of or at any time since the previous OASIS assessment
(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? <input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes <input type="checkbox"/> NA - Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications
(M2015)	Patient/Caregiver Drug Education Intervention: At the time of, or at any time since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur? <input type="checkbox"/> 0 - No <input type="checkbox"/> 1 - Yes <input type="checkbox"/> NA – Patient not taking any drugs

MEDICATIONS	
(M2001)	Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues? Enter Code <input type="checkbox"/> 0 No No issues found during review [Go to M2010] 1 Yes Issues found during review 9 NA Patient is not taking any medications [Go to M2040]
(M2003)	Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues? Enter Code <input type="checkbox"/> 0 No 1 Yes
(M2005)	Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC? Enter Code <input type="checkbox"/> 0 No 1 Yes 9 NA There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications
(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? Enter Code <input type="checkbox"/> 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
(M2016)	Patient/Caregiver Drug Education Intervention: At the time of, or at any time since the most recent SOC/ROC assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur? Enter Code <input type="checkbox"/> 0 No 1 Yes NA Patient not taking any drugs



(M2020)	Management of Oral Medications: Patient's <u>current ability</u> to prepare and take <u>all</u> 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.)			
	<input type="checkbox"/> 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times. <input type="checkbox"/> 1 - Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; <u>OR</u> (b) another person develops a drug diary or chart. <input type="checkbox"/> 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times <input type="checkbox"/> 3 - <u>Unable</u> to take medication unless administered by another person. <input type="checkbox"/> NA - No oral medications prescribed.			
(M2030)	Management of Injectable Medications: Patient's <u>current ability</u> to prepare and take <u>all</u> prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. Excludes IV medications.			
	<input type="checkbox"/> 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times. <input type="checkbox"/> 1 - Able to take injectable medication(s) at the correct times if: (a) individual syringes are prepared in advance by another person; <u>OR</u> (b) another person develops a drug diary or chart. <input type="checkbox"/> 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection <input type="checkbox"/> 3 - <u>Unable</u> to take injectable medication unless administered by another person. <input type="checkbox"/> 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 medication	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> NA
b. Injectable Medications	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> NA

(M2020)	Management of Oral Medications: Patient's <u>current ability</u> to prepare and take <u>all</u> 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.)			
Enter Code <input type="checkbox"/>	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; <u>OR</u> (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 <u>Unable</u> to take medication unless administered by another person. NA No oral medications prescribed.			
(M2030)	Management of Injectable Medications: Patient's <u>current ability</u> to prepare and take <u>all</u> prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. Excludes IV medications.			
Enter Code <input type="checkbox"/>	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; <u>OR</u> (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 <u>Unable</u> to take injectable medication unless administered by another person. 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.			
Enter Code <input type="checkbox"/>	a. Oral medications 0 Independent 1 Needed Some Help 2 Dependent NA Not Applicable			
Enter Code <input type="checkbox"/>	b. Injectable medications 0 Independent 1 Needed Some Help 2 Dependent NA Not Applicable			



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 <u>not likely</u> to provide assistance OR it is <u>unclear</u> 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)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
b. IADL assistance (for example, meals, housekeeping, laundry, telephone, shopping, finances)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
c. Medication administration (for example, oral, inhaled or injectable)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
d. Medical procedures/ treatments (for example, changing wound dressing, home exercise program)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
e. Management of Equipment (for example, oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
f. Supervision and safety (for example, due to cognitive impairment)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
g. Advocacy or facilitation of patient's participation in appropriate medical care (for example, transportation to or from appointments)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

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



(M2110)	How Often does the patient receive ADL or IADL assistance from any caregiver(s) (other than home health agency staff)?
	<input type="checkbox"/> 1 - At least daily <input type="checkbox"/> 2 - Three or more times per week <input type="checkbox"/> 3 - One to two times per week <input type="checkbox"/> 4 - Received, but less often than weekly <input type="checkbox"/> 5 - No assistance received <input type="checkbox"/> UK - Unknown

(M2110)	How Often does the patient receive ADL or IADL assistance from any caregiver(s) (other than home health agency staff)?
Enter Code <input type="checkbox"/>	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

THERAPY NEED	
(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). <input type="checkbox"/> NA - Not Applicable: No case mix group defined by this assessment.

THERAPY NEED	
(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.)
	(<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined). <input type="checkbox"/> NA - Not Applicable: No case mix group defined by this assessment



PLAN OF CARE			
(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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
c. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Pain assessment indicates patient has no pain.
f. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

PLAN OF CARE			
(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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
c. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Pain assessment indicates patient has no pain.
f. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.





EMERGENT CARE	
(M2300)	Emergent Care: At the time of or at any time since the previous OASIS assessment has the patient utilized a hospital emergency department (includes holding/observation status)?
	<input type="checkbox"/> 0 - No [Go to M2400] <input type="checkbox"/> 1 - Yes, used hospital emergency department WITHOUT hospital admission <input type="checkbox"/> 2 - Yes, used hospital emergency department WITH hospital admission <input type="checkbox"/> UK - Unknown [Go to M2400]
(M2310)	Reason for Emergent Care: For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? (Mark all that apply.)
	<input type="checkbox"/> 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis <input type="checkbox"/> 2 - Injury caused by fall <input type="checkbox"/> 3 - Respiratory infection (for example, pneumonia, bronchitis) <input type="checkbox"/> 4 - Other respiratory problem <input type="checkbox"/> 5 - Heart failure (for example, fluid overload) <input type="checkbox"/> 6 - Cardiac dysrhythmia (irregular heartbeat) <input type="checkbox"/> 7 - Myocardial infraction or chest pain <input type="checkbox"/> 8 - Other heart disease <input type="checkbox"/> 9 - Stroke (CVA) or TIA <input type="checkbox"/> 10 - Hypo/Hyperglycemia, diabetes out of control <input type="checkbox"/> 11 - GI bleeding, obstruction, constipation, impaction <input type="checkbox"/> 12- Dehydration, malnutrition <input type="checkbox"/> 13 - Urinary tract infection <input type="checkbox"/> 14 - IV catheter-related infection or complication <input type="checkbox"/> 15 - Wound infection or deterioration <input type="checkbox"/> 16 - Uncontrolled pain <input type="checkbox"/> 17 - Acute mental/behavioral health problem <input type="checkbox"/> 18 - Deep vein thrombosis, pulmonary embolus <input type="checkbox"/> 19 - Other than above reasons <input type="checkbox"/> UK - Reason unknown

EMERGENT CARE	
(M2301)	Emergent Care: At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)?
Enter Code <input type="checkbox"/>	0 No (Go to M2401) 1 Yes, used hospital emergency department WITHOUT hospital admission 2 Yes, used hospital emergency department WITH hospital admission UK Unknown (Go to M2401)
(M2310)	Reason for Emergent Care: For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? (Mark all that apply.)
	<input type="checkbox"/> 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis <input type="checkbox"/> 2 - Injury caused by fall <input type="checkbox"/> 3 - Respiratory infection (for example, pneumonia, bronchitis) <input type="checkbox"/> 4 - Other respiratory problem <input type="checkbox"/> 5 - Heart failure (for example, fluid overload) <input type="checkbox"/> 6 - Cardiac dysrhythmia (irregular heartbeat) <input type="checkbox"/> 7 - Myocardial infraction or chest pain <input type="checkbox"/> 8 - Other heart disease <input type="checkbox"/> 9 - Stroke (CVA) or TIA <input type="checkbox"/> 10 - Hypo/Hyperglycemia, diabetes out of control <input type="checkbox"/> 11 - GI bleeding, obstruction, constipation, impaction <input type="checkbox"/> 12- Dehydration, malnutrition <input type="checkbox"/> 13 - Urinary tract infection <input type="checkbox"/> 14 - IV catheter-related infection or complication <input type="checkbox"/> 15 - Wound infection or deterioration <input type="checkbox"/> 16 - Uncontrolled pain <input type="checkbox"/> 17 - Acute mental/behavioral health problem <input type="checkbox"/> 18 - Deep vein thrombosis, pulmonary embolus <input type="checkbox"/> 19 - Other than above reasons <input type="checkbox"/> UK - Reason unknown



DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY				
(M2400)	Intervention Synopsis: (Check only one box in each row.) At the time of or at any time since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?			
Plan / Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
b. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Every standardized, validated multi- factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY				
(M2401)	Intervention Synopsis: (Check only one box in each row.) At the time of or at any time since the most recent SOC/ROC assessment , were the following interventions BOTH included in the physician-ordered plan of care AND implemented?			
Plan / Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
b. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

(M2410)	To which Inpatient Facility has the patient been admitted? <input type="checkbox"/> 1 - Hospital [Go to M2430] <input type="checkbox"/> 2 - Rehabilitation facility [Go to M0903] <input type="checkbox"/> 3 - Nursing home [Go to M0903] <input type="checkbox"/> 4 - Hospice [Go to M0903] <input type="checkbox"/> NA - No inpatient facility admission [Omit "NA" option on TRN]
(M2420)	Discharge Disposition: Where is the patient after discharge from your agency? (Choose only one answer.)
	<input type="checkbox"/> 1 - Patient remained in the community (without formal assistive services) <input type="checkbox"/> 2 - Patient remained in the community (with formal assistive services) <input type="checkbox"/> 3 - Patient transferred to a non-institutional hospice <input type="checkbox"/> 4 - Unknown because patient moved to a geographic location not served by this agency <input type="checkbox"/> NA - Other unknown [Go to M0903]
(M2430)	Reason for Hospitalization: For what reason(s) did the patient require hospitalization? (Mark all that apply.)
	<input type="checkbox"/> 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis <input type="checkbox"/> 2 - Injury caused by fall <input type="checkbox"/> 3 - Respiratory infection (for example, pneumonia, bronchitis) <input type="checkbox"/> 4 - Other respiratory problem <input type="checkbox"/> 5 - Heart failure (for example, fluid overload) <input type="checkbox"/> 6 - Cardiac dysrhythmia (irregular heartbeat) <input type="checkbox"/> 7 - Myocardial infraction or chest pain <input type="checkbox"/> 8 - Other heart disease <input type="checkbox"/> 9 - Stroke (CVA) or TIA <input type="checkbox"/> 10 - Hypo/Hyperglycemia, diabetes out of control <input type="checkbox"/> 11 - GI bleeding, obstruction, constipation, impaction <input type="checkbox"/> 12- Dehydration, malnutrition <input type="checkbox"/> 13 - Urinary tract infection <input type="checkbox"/> 14 - IV catheter-related infection or complication <input type="checkbox"/> 15 - Wound infection or deterioration <input type="checkbox"/> 16 - Uncontrolled pain <input type="checkbox"/> 17 - Acute mental/behavioral health problem <input type="checkbox"/> 18 - Deep vein thrombosis, pulmonary embolus <input type="checkbox"/> 19 - Scheduled treatment or procedure <input type="checkbox"/> 20 - Other than above reasons <input type="checkbox"/> UK - Reason unknown

(M2410)	To which Inpatient Facility has the patient been admitted? <input type="checkbox"/> 1 Hospital [Go to M2430] <input type="checkbox"/> 2 Rehabilitation facility [Go to M0903] <input type="checkbox"/> 3 Nursing home [Go to M0903] <input type="checkbox"/> 4 Hospice [Go to M0903] <input type="checkbox"/> NA No inpatient facility admission [Omit "NA" option on TRN]
(M2420)	Discharge Disposition: Where is the patient after discharge from your agency? (Choose only one answer.)
	<input type="checkbox"/> 1 Patient remained in the community (without formal assistive services) <input type="checkbox"/> 2 Patient remained in the community (with formal assistive services) <input type="checkbox"/> 3 Patient transferred to a non-institutional hospice <input type="checkbox"/> 4 Unknown because patient moved to a geographic location not served by this agency <input type="checkbox"/> UK Other unknown [Go to M0903]
(M2430)	Reason for Hospitalization: For what reason(s) did the patient require hospitalization? (Mark all that apply.)
	<input type="checkbox"/> 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis <input type="checkbox"/> 2 - Injury caused by fall <input type="checkbox"/> 3 - Respiratory infection (for example, pneumonia, bronchitis) <input type="checkbox"/> 4 - Other respiratory problem <input type="checkbox"/> 5 - Heart failure (for example, fluid overload) <input type="checkbox"/> 6 - Cardiac dysrhythmia (irregular heartbeat) <input type="checkbox"/> 7 - Myocardial infraction or chest pain <input type="checkbox"/> 8 - Other heart disease <input type="checkbox"/> 9 - Stroke (CVA) or TIA <input type="checkbox"/> 10 - Hypo/Hyperglycemia, diabetes out of control <input type="checkbox"/> 11 - GI bleeding, obstruction, constipation, impaction <input type="checkbox"/> 12- Dehydration, malnutrition <input type="checkbox"/> 13 - Urinary tract infection <input type="checkbox"/> 14 - IV catheter-related infection or complication <input type="checkbox"/> 15 - Wound infection or deterioration <input type="checkbox"/> 16 - Uncontrolled pain <input type="checkbox"/> 17 - Acute mental/behavioral health problem <input type="checkbox"/> 18 - Deep vein thrombosis, pulmonary embolus <input type="checkbox"/> 19 - Scheduled treatment or procedure <input type="checkbox"/> 20 - Other than above reasons <input type="checkbox"/> UK - Reason unknown



(M0903)	Date of Last (Most Recent) Home Visit:
	<p>__/__/____</p> <p>month/ day/ year</p>
(M0906)	Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.
	<p>__/__/____</p> <p>month/ day/ year</p>

(M0903)	Date of Last (Most Recent) Home Visit:
	<p><input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>month day year</p>
(M0906)	Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.
	<p><input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>month day year</p>