CHAPTER 4 — ILLUSTRATIVE CLINICAL RECORD FORM PAGES WITH OASIS-C ITEMS INTEGRATED

Chapter 4 of this manual contains sample illustrative clinical record forms showing the integration of OASIS-C items. These one-page illustrative forms are included for the following timepoints:

Illustration 1 -- Start of Care Assessment

Illustration 2 – Start of Care Assessment

Illustration 3 – Discharge Assessment

Illustration 4 – Transfer to Inpatient Facility

No changes have been made to the documents in Chapter 4 since the original OASIS-C release in December 2009.

ILLUSTRATION 1
Sample Page from Clinical Record Form with Integrated OASIS Items.

START OF CARE ASSESSMENT

(Also used for Resumption of Care Following Inpatient Stay)

(Page 1 of __)

Client's Name: _____

Client Record No. _____

A. DEMOGRAPHIC INFORMATION - Update Patient Tracking Sheet at ROC

1. **(M0080) Discipline of Person Completing Assessment:**

   ☐ 1 - RN ☐ 3 - SLP/ST

   ☐ 2 - PT ☐ 4 - OT

2. **(M0090) Date Assessment Completed:**

   __ __ /__ __ /__ __ __ __
   month / day / year

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

   Start/Resumption of Care

   ☐ **1 - Start of care—further visits planned**

   ☐ **3 - Resumption of care (after inpatient stay)**

   Follow-Up

   4 - Recertification (follow-up) reassessment

   5 - Other follow-up

   Transfer to an Inpatient Facility

   6 - Transferred to an inpatient facility—patient not discharged from agency

   7 - Transferred to an inpatient facility—patient discharged from agency

   Discharge from Agency — Not to an Inpatient Facility

   8 - Death at home

   9 - Discharge from agency

4. **(M0102) Date of Physician-ordered Start of Care (Resumption of Care):** If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.

   __ __ /__ __ /__ __ __ __ *(Go to M0110, if date entered)*
   month / day / year

   ☐ NA –No specific SOC date ordered by physician

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

   __ __ /__ __ /__ __ __ __
   month / day / year

6. **(M0110) Episode Timing:** Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?

   ☐ 1 - Early

   ☐ 2 - Later

   ☐ UK - Unknown

   ☐ NA - Not Applicable: No Medicare case mix group to be defined by this assessment.

7. **Economic/Financial Problems or Needs** (describe):

8. **(M1000)** From which of the following **Inpatient Facilities** was the patient discharged during the past 14 days? **(Mark all that apply.)**

   ☐ 1 - Long-term nursing facility (NF)

   ☐ 2 - Skilled nursing facility (SNF / TCU)

   ☐ 3 - Short-stay acute hospital (IPP S)

   ☐ 4 - Long-term care hospital (LTCH)

   ☐ 5 - Inpatient rehabilitation hospital or unit (IRF)

   ☐ 6 - Psychiatric hospital or unit

   ☐ 7 - Other (specify) _____

   ☐ NA - Patient was not discharged from an inpatient facility **[*Go to M1016*]**

9. **(M1005) Inpatient Discharge Date** (most recent):

   __ __ /__ __ /__ __ __ __
   month / day / year

   ☐ UK - Unknown

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

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

ILLUSTRATION 2
Sample Page from Clinical Record Form with Integrated OASIS Items.

START OF CARE ASSESSMENT
(Also used for Resumption of Care Following Inpatient Stay)
(Page __ of __)

Client's Name: _____
Client Record No._____

L. REVIEW OF SYSTEMS/PHYSICAL ASSESSMENT (cont'd)

14. NEURO / EMOTIONAL / BEHAVIORAL STATUS

____ Hx of previous psych. illness ____ Other (specify) _____

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

- ☐ 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- ☐ 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
- ☐ 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting 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):

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

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

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

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

- ☐ 0 - No
- ☐ 1 - Yes, patient was screened using the PHQ-2©* scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")

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

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

(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed): **(Mark all that apply.)**

- ☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- ☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- ☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- ☐ 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- ☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- ☐ 6 - Delusional, hallucinatory, or paranoid behavior
- ☐ 7 - None of the above behaviors demonstrated

(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed) Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

- ☐ 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?

- ☐ 0 - No
- ☐ 1 - Yes

ILLUSTRATION 3
Sample Page from Clinical Record Form with Integrated OASIS Items.

DISCHARGE ASSESSMENT

(Page __ of __)

Client's Name: _____

Client Record No._____

C. IMMUNIZATION/SCREENING TESTS

1. **Immunizations:** Flu Yes ___ No ___ Date _____ Pneumonia Yes ___ No ___ Date _____
   Tetanus Yes ___ No ___ Date _____ Other:_____ Date _____

2. **Screening:** Cholesterol level Yes ___ No ___ Date _____ Colon cancer screen Yes ___ No ___ Date _____
   Mammogram Yes ___ No ___ Date _____ Prostate cancer screen Yes ___ No ___ Date _____

3. **Self-Exam Frequency:** Breast self-exam frequency _____ Testicular self-exam frequency _____

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

   ☐ 0 - No
   ☐ 1 - Yes **[** ***Go to M1050*** **]**
   ☐ NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. **[** ***Go to M1050*** **]**

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

   ☐ 1 - Received from another health care provider (e.g., physician)
   ☐ 2 - Received from your agency previously during this year's flu season
   ☐ 3 - Offered and declined
   ☐ 4 - Assessed and determined to have medical contraindication(s)
   ☐ 5 - Not indicated; patient does not meet age/condition guidelines for influenza vaccine
   ☐ 6 - Inability to obtain vaccine due to declared shortage
   ☐ 7 - None of the above

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

   ☐ 0 - No
   ☐ 1 - Yes **[** ***Go to M1230*** **]**

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

   ☐ 1 - Patient has received PPV in the past
   ☐ 2 - Offered and declined
   ☐ 3 - Assessed and determined to have medical contraindication(s)
   ☐ 4 - Not indicated; patient does not meet age/condition guidelines for PPV
   ☐ 5 - None of the above

D. RISK FACTORS

1. **(M1032) Risk for Rehospitalization:** Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

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

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

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

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

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

ILLUSTRATION 4
Sample Page from Clinical Record Form with Integrated OASIS Items.

TRANSFER TO INPATIENT FACILITY

(Page 1 of __)

Client's Name: _____

Client Record No._____

A. DEMOGRAPHIC/GENERAL INFORMATION - Update Patient Tracking Sheet as needed.

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

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

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

Start/Resumption of Care
- 1 - Start of care—further visits planned
- 3 - Resumption of care (after inpatient stay)

Follow-Up
- 4 - Recertification (follow-up) reassessment
- 5 - Other follow-up

Transfer to an Inpatient Facility
- ☐ **6 - Transferred to an inpatient facility—patient not discharged from agency**
- ☐ **7 - Transferred to an inpatient facility—patient discharged from agency**

Discharge from Agency — Not to an Inpatient Facility
- 8 - Death at home
- 9 - Discharge from agency

B. EMERGENT CARE

(M2300) Emergent Care: Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation)?

- ☐ 0 - No **[** ***Go to M2400*** **]**
- ☐ 1 - Yes, used hospital emergency department WITHOUT hospital admission
- ☐ 2 - Yes, used hospital emergency department WITH hospital admission
- ☐ UK - Unknown **[** ***Go to M2400*** **]**

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

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

(M2400) Intervention Synopsis: (Check only **one** box in each row.) Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

Plan / Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐0	☐1	☐na	Patient is not diabetic or is bilateral amputee
b. Falls prevention interventions	☐0	☐1	☐na	Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐0	☐1	☐na	Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment
d. Intervention(s) to monitor and mitigate pain	☐0	☐1	☐na	Formal assessment did not indicate pain since the last OASIS assessment
e. Intervention(s) to prevent pressure ulcers	☐0	☐1	☐na	Formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment
f. Pressure ulcer treatment based on principles of moist wound healing	☐0	☐1	☐na	Dressings that support the principles of moist wound healing not indicated for this patient's pressure ulcers OR patient has no pressure ulcers with need for moist wound healing