CHAPTER 4 — ILLUSTRATIVE CLINICAL RECORD FORM PAGES WITH OASIS-C1/ICD-9 ITEMS INTEGRATED

Chapter 4 of this manual contains sample pages from illustrative clinical record forms showing the integration of OASIS-C1/ICD-9 items. These illustrative forms pages 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

ILLUSTRATION 1
Sample Page from Clinical Record Form with Integrated OASIS-C1/ICD-9 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 – Complete Patient Tracking Sheet at SOC and Update 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)**

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 within the past 14 days? (Mark all that apply.)

   ☐ 1 - Long-term nursing facility (NF)
   ☐ 2 - Skilled nursing facility (SNF / TCU)
   ☐ 3 - Short-stay acute hospital (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):

   __ __ /__ __ /__ __ __ __ ☐ UK - Unknown
   month / day / year

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

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

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

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

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

ILLUSTRATION 2
Sample Page from Clinical Record Form with Integrated OASIS-C1/ICD-9 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 (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):

- ☐ 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, validated 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	NA 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, 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.

(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 (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.

- ☐ 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-C1/ICD-9 Items.

DISCHARGE ASSESSMENT

(Page __ of __)

Client's Name: _____

Client Record No._____

C. IMMUNIZATIONS

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

   ☐ 0 - No **[** ***Go to M1051*** **]**
   ☐ 1 - Yes

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

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

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

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

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

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

D. SENSORY/PAIN ASSESSMENT

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

   ☐ 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
   ☐ 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
   ☐ 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
   ☐ 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
   ☐ 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example: speech is nonsensical or unintelligible).
   ☐ 5 - Patient nonresponsive or unable to speak.

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

   ☐ 0 - Patient has no pain
   ☐ 1 - Patient has pain that does not interfere with activity or movement
   ☐ 2 - Less often than daily
   ☐ 3 - Daily, but not constantly
   ☐ 4 - All of the time

10. Pain notes (location, time of day, activities that exacerbate pain, avoidance of activities, etc.)

_____

_____

_____

E. INTEGUMENTARY STATUS

11. **(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)

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

12. **(M1307)** The **Oldest Stage II Pressure Ulcer** that is present at discharge: (Excludes healed Stage II Pressure Ulcers)

   ☐ 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 II pressure ulcers are present at discharge

ILLUSTRATION 4
Sample Page from Clinical Record Form with Integrated OASIS-C1/ICD-9 Items.

TRANSFER TO INPATIENT FACILITY

(Page 1 of __)

Client's Name: _____

Client Record No._____

B. EMERGENT CARE

(M2300) **Emergent Care:** At the time of or at any time since the previous OASIS assessment has the patient utilized a hospital emergency department (includes holding/observation status)?

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

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

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

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

Plan / Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐0	☐1	☐NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
b. Falls prevention interventions	☐0	☐1	☐NA	Every standardized, validated multi-factor fall risk assessment conducted at or since the last OASIS assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐0	☐1	☐NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the last OASIS assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d. Intervention(s) to monitor and mitigate pain	☐0	☐1	☐NA	Every standardized, validated pain assessment conducted at or since the last OASIS assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	☐0	☐1	☐NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the last OASIS assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	☐0	☐1	☐NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

(M2410) To which **Inpatient Facility** has the patient been admitted?

- ☐ 1 - Hospital **[** ***Go to M2430*** **]**
- ☐ 2 - Rehabilitation facility **[** ***Go to M0903*** **]**
- ☐ 3 - Nursing home **[** ***Go to M0903*** **]**
- ☐ 4 - Hospice **[** ***Go to M0903*** **]**