TRANSFER TO INPATIENT FACILITY

Client's Name:

Client Record No.

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A. DEMOGRAPHIC/GENERAL INFORMATION

1. **(M0010) Agency Medicare Provider Number:** __ __ __ __ __ __

2. **(M0012) Agency Medicaid Provider Number:** __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Branch Identification (Optional, for Agency Use)

3. **(M0014) Branch State:** __ __

4. **(M0016) Branch ID Number:** __ __ __ __ __ __ __ __ __ __ (Agency-assigned)

5. **(M0020) Patient ID Number:** __

6. **(M0030) Start of Care Date:** __ __ – __ __ – __ __ __ __ (m m d d y y y y)

7. **(M0032) Resumption of Care Date:** __ __ – __ __ – __ __ __ __ (m m d d y y y y) ☐ NA - Not Applicable

8. **(M0040) Patient Name:** _____ (First) ____ (MI) _____ (Last) _____ (Suffix)

9. **Patient Address:** _____ Street, Route, Apt. Number - not P.O. Box

_____ City _____ **(M0050)** State _____ **(M0060)** Zip Code

10. **Patient Phone:** ( ) _____ – _____

11. **(M0063) Medicare Number:** __ __ __ __ __ __ __ __ __ __ __ __ (including suffix if any) ☐ NA - No Medicare

12. **(M0064) Social Security Number:** __ __ __ __ __ __ __ __ __ ☐ UK - Unknown or Not Available

13. **(M0065) Medicaid Number:** __ __ __ __ __ __ __ __ __ __ __ __ __ ☐ NA - No Medicaid

14. **(M0066) Birth Date:** __ __ – __ __ – __ __ __ __ (m m d d y y y y)

15. **(M0069) Gender:** ☐ 1 - Male ☐ 2 - Female

16. **(M0072) Primary Referring Physician ID:** __ __ __ __ __ __ __ __ __ __ (UPIN#) ☐ UK - Unknown or Not Available

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

18. **(M0090) Date Assessment Completed:** __ __ – __ __ – __ __ __ __ (m m d d y y y y)

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

Start/Resumption of Care
- 1 - Start of care—further visits planned
- 2 - Start of care—no 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 [Go to *M0150*]**
- ☐ **7 - Transferred to an inpatient facility—patient discharged from agency [Go to *M0150*]**

Discharge from Agency — Not to an Inpatient Facility
- 8 - Death at home
- 9 - Discharge from agency
- 10 - Discharge from agency—no visits completed after start/resumption of care assessment

20. **(M0150) Current Payment Sources for Home Care: (Mark all that apply.)**
- ☐ 0 - None; no charge for current services
- ☐ 1 - Medicare (traditional fee-for-service)
- ☐ 2 - Medicare (HMO/managed care)
- ☐ 3 - Medicaid (traditional fee-for-service)
- ☐ 4 - Medicaid (HMO/managed care)
- ☐ 5 - Workers' compensation
- ☐ 6 - Title programs (e.g., Title III, V or XX)
- ☐ 7 - Other government (e.g., CHAMPUS, VA, etc.)
- ☐ 8 - Private insurance
- ☐ 9 - Private HMO/managed care
- ☐ 10 - Self-pay
- ☐ 11 - Other (specify) _____

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B. EMERGENT CARE

1. **(M0830) Emergent Care:** Since the last time OASIS data were collected, has the patient utilized any of the following services for emergent care (other than home care agency services)? **(Mark all that apply.)**
   - ☐ 0 - No emergent care services **[If no emergent care, go to *Section C #1 - Inpatient Facility*]**
   - ☐ 1 - Hospital emergency room (includes 23-hour holding)
   - ☐ 2 - Doctor's office emergency visit/house call
   - ☐ 3 - Outpatient department/clinic emergency (includes urgicenter sites)
   - ☐ UK - Unknown **[If UK, go to *Section C #1 - Inpatient Facility*]**

2. **(M0840) Emergent Care Reason:** For what reason(s) did the patient/family seek emergent care? **(Mark all that apply.)**
   - ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
   - ☐ 2 - Nausea, dehydration, malnutrition, constipation, impaction
   - ☐ 3 - Injury caused by fall or accident at home
   - ☐ 4 - Respiratory problems (e.g., shortness of breath, respiratory infection, tracheobronchial obstruction)
   - ☐ 5 - Wound infection, deteriorating wound status, new lesion/ulcer
   - ☐ 6 - Cardiac problems (e.g., fluid overload, exacerbation of CHF, chest pain
   - ☐ 7 - Hypo/Hyperglycemia, diabetes out of control
   - ☐ 8 - GI bleeding, obstruction
   - ☐ 9 - Other than above reasons
   - ☐ UK - Reason unknown

C. INPATIENT FACILITY ADMISSION OR DISCHARGE FROM HOME CARE

1. **(M0855)** To which **Inpatient Facility** has the patient been admitted?
   - ☐ 1 - Hospital **[Go to *#2 - Hospital Reason*]**
   - ☐ 2 - Rehabilitation facility **[Go to *#5 - Most Recent Home Visit Date*]**
   - ☐ 3 - Nursing home **[Go to *#4 - Reason Admitted Nursing Home*]**
   - ☐ 4 - Hospice **[Go to *#5 - Most Recent Home Visit Date*]**

2. **(M0890)** If the patient was admitted to an acute care **Hospital**, for what **Reason** was he/she admitted?
   - ☐ 1 - Hospitalization for emergent (unscheduled) care
   - ☐ 2 - Hospitalization for urgent (scheduled within 24 hours of admission) care
   - ☐ 3 - Hospitalization for elective (scheduled more than 24 hours before admission) care
   - ☐ UK - Unknown

3. **(M0895) Reason for Hospitalization: (Mark all that apply.)**
   - ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
   - ☐ 2 - Injury caused by fall or accident at home
   - ☐ 3 - Respiratory problems (SOB, infection, obstruction)
   - ☐ 4 - Wound or tube site infection, deteriorating wound status, new lesion/ulcer
   - ☐ 5 - Hypo/Hyperglycemia, diabetes out of control
   - ☐ 6 - GI bleeding, obstruction
   - ☐ 7 - Exacerbation of CHF, fluid overload, heart failure
   - ☐ 8 - Myocardial infarction, stroke
   - ☐ 9 - Chemotherapy
   - ☐ 10 - Scheduled surgical procedure
   - ☐ 11 - Urinary tract infection
   - ☐ 12 - IV catheter-related infection
   - ☐ 13 - Deep vein thrombosis, pulmonary embolus
   - ☐ 14 - Uncontrolled pain
   - ☐ 15 - Psychotic episode
   - ☐ 16 - Other than above reasons

   Go to *#5 - Most Recent Home Visit Date*

4. **(M0900)** For what **Reason(s)** was the patient **Admitted** to a **Nursing Home**? **(Mark all that apply.)**
   - ☐ 1 - Therapy services
   - ☐ 2 - Respite care
   - ☐ 3 - Hospice care
   - ☐ 4 - Permanent placement
   - ☐ 5 - Unsafe for care at home
   - ☐ 6 - Other
   - ☐ UK - Unknown

5. **(M0903) Date of Last (Most Recent) Home Visit:**

   __ __ – __ __ – __ __ __ __
   m m d d y y y y

6. **(M0906) Discharge/Transfer/Death Date:** Enter the date of the discharge, transfer, or death (at home) of the patient.

   __ __ – __ __ – __ __ __ __
   m m d d y y y y

7. Was the patient **Discharged** from the **Agency?**
   - ☐ No **[If No, STOP here]**
   - ☐ Yes **[If Yes, go to *Section D*]**

D. SUMMARY OF CARE PROVIDED DURING HOME CARE EPISODE

1.

Identified Problem	Interventions	Current Status

2. Overall Status at Discharge:

Copy of Summary to ☐ Referral Source ☐ Attending Physician

Date of Assessment: _____ Signature of Assessor: _____