Outcome and Assessment Information Set (OASIS-B1)

TRANSFER VERSION
(used for Transfer to an Inpatient Facility)

Items to be Used at this Time Point------------------------- **M0080-M0100, M0830-M0855, M0890-M0906**

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:

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

EMERGENT CARE

(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 *M0855*]**
☐   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 *M0855*]**

(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

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION ONLY

(M0855) To which **Inpatient Facility** has the patient been admitted?

☐   1 - Hospital **[Go to *M0890*]**
☐   2 - Rehabilitation facility **[Go to *M0903*]**
☐   3 - Nursing home **[Go to *M0900*]**
☐   4 - Hospice **[Go to *M0903*]**
☐ NA - No inpatient facility admission

(M0890) If the patient was admitted to an acute care **Hospital**, for what **Reason** was he/she admitted?

    ☐   1   -   Hospitalization for <u>emergent</u> (unscheduled) care
    ☐   2   -   Hospitalization for <u>urgent</u> (scheduled within 24 hours of admission) care
    ☐   3   -   Hospitalization for <u>elective</u> (scheduled more than 24 hours before admission) care
    ☐   UK   -   Unknown

(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 *M0903*** |

(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

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

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

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

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