Follow up - Recertification

(M0010) CMS Certification Number: 367549 (M0014) Branch State: OH (M0016) Branch ID Number: N/A

Patient Identifiers: ☐ **Facial Recognition** ☐ **Patient Address** ☐ **DOB (month/day year)** __ __ /__ __ /__ __ __ __ ☐ **UHHC**

(M0020) Patient ID Number:

(M0030) Start of Care Date: / / (Month / Day / Year)

(M0032) Resumption of Care Date: / / (Month / Day / Year)

(M0040) Patient Name:

(First) (M I) (Last) (Suffix)

Patients Address: _____

(M0060) Patient ZIP Code: –

(M0063) Medicare Number : ☐ NA – No Medicare
(including suffix)

(**M0064) Social Security Number :** ☐ UK – Unknown or Not Available

(M0065) Medicaid Number: ☐ NA – No Medicaid

(M0066) Birth Date: / / (Month / Day / Year)

(M0069) Gender	
Enter Code ☐	1 Male 2 Female

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment:

☐ 1-RN ☐ 2-PT ☐ 3-SLP/ST ☐ 4-OT

Discipline Signature: _____Time In: _____ Time Out: _____

Team Leader: _____

(M0090) Date Assessment Completed: / / (Month / Day / Year)

(M0100) This Assessment is Currently Being Completed for the Following Reason:	
Enter Code ☐	**Follow-Up** 4 - Recertification (follow-up) reassessment [Go to M0110] 5 - Other follow-up [Go to M0110]

Outcome and Assessment Information Set
Items to be Used at Specific Time Points

Time Point	Items Used
Follow-Up ---------- Recertification (follow-up) assessment Other follow-up assessment	M0080-M0100, M0110, M1011, M1021-M1025, M1030, M1200, M1242, M1306, M1311, M1322-M1342, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200

(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?

Enter Code ☐

1	Early
2	Later
UK	Unknown
NA	Not Applicable: No Medicare case mix group to be defined by this assessment.

PATIENT HISTORY AND DIAGNOSES

(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):

	Inpatient Facility Diagnosis	ICD-10-CM Code
a.	_____	☐☐☐ ☐☐☐☐
b.	_____	☐☐☐ ☐☐☐☐
c.	_____	☐☐☐ ☐☐☐☐
d.	_____	☐☐☐ ☐☐☐☐
e.	_____	☐☐☐ ☐☐☐☐
f.	_____	☐☐☐ ☐☐☐☐

☐ NA - Not applicable (patient was not discharged from an inpatient facility) ***[Omit "NA" option on SOC, ROC]***

(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.

Code each row according to the following directions for each column:

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: 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 on-going condition impacting home health care.

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:
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

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.

Column 3: (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.
Agencies may choose to report an underlying condition in M1025 (Columns 3 and 4) when: 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: (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-10CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Form on next page)

(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 a. _____	**V, W, X, Y codes NOT allowed** a. [ ][ ][ ].[ ][ ][ ][ ] □0 □1 □2 □3 □4	**V, W, X, Y, Z codes NOT allowed** a. _____ ([ ][ ][ ].[ ][ ][ ][ ])	**V, W, X, Y, Z codes NOT allowed** a. _____ ([ ][ ][ ].[ ][ ][ ][ ])
(M1023) Other Diagnoses b. _____	**All ICD-10–C M codes allowed** b. [ ][ ][ ].[ ][ ][ ][ ] □0 □1 □2 □3 □4	**V, W, X, Y, Z codes NOT allowed** b. _____ ([ ][ ][ ].[ ][ ][ ][ ])	**V, W, X, Y, Z codes NOT allowed** 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. _____ ([ ][ ][ ].[ ][ ][ ][ ])

(M1030) Therapies the patient receives at home: **(Mark all that apply.)**

- ☐ 1 - Intravenous or infusion therapy (excludes TPN)
- ☐ 2 - Parenteral nutrition (TPN or lipids)
- ☐ 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
- ☐ 4 - None of the above

SENSORY STATUS

(M1200) Vision (with corrective lenses if the patient usually wears them):

Enter Code ☐

0 Normal vision: sees adequately in most situations; can see medication labels, newsprint
1 Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length
2 Severely impaired: cannot locate objects without

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

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain
	Mild				Moderate			Severe				

Enter Code ☐

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

(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 ☐	0 No **[Go to M1322]** 1 Yes

(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]	☐
A2. Number of <u>these</u> 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	☐
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]	☐
B2. Number of <u>these</u> 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	☐
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]	☐
C2. Number of <u>these</u> 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	☐
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	☐
D2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
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]	☐
E2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
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)]	☐
F2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
[Omit "A2, B2, C2, D2, E2 and F2" on SOC/ROC]	

(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 ☐	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 ☐	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**?	
Enter Code ☐	0 No [Go to M1340] 1 Yes, patient has BOTH observable and unobservable stasis ulcers 2 Yes, patient has observable stasis ulcers ONLY 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 ☐	1 One 2 Two 3 Three 4 Four or more
(M1334) Status of Most Problematic Stasis Ulcer that is Observable:	
Enter Code ☐	1 Fully granulating 2 Early/partial granulation 3 Not healing
(M1340) Does this patient have a **Surgical Wound?**	
Enter Code ☐	0 No [At SOC/ROC, go to M1350 ; At FU//DC, go to M1400] 1 Yes, patient has at least one observable surgical wound 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 ☐	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing

RESPIRATORY STATUS

(M1400) When is the patient dyspneic or noticeably **Short of Breath**?	
Enter Code ☐	0 Patient is not short of breath 1 When walking more than 20 feet, climbing stairs 2 With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet) 3 With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation 4 At rest (during day or night)

(M1610) Urinary Incontinence or Urinary Catheter Presence:	
Enter Code ☐	0 No incontinence or catheter (includes anuria or ostomy for urinary drainage) [Go to M1620] 1 Patient is incontinent 2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) **[Go to M1620]**
(M1620) Bowel Incontinence Frequency:	
Enter Code ☐	0 Very rarely or never has bowel incontinence 1 Less than once weekly 2 One to three times weekly 3 Four to six times weekly 4 On a daily basis 5 More often than once daily NA Patient has ostomy for bowel elimination UK UK- Unknown **[Omit "UK" option on FU, DC]**
(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; or b) necessitated a change in medical or treatment regimen?	
Enter Code ☐	0 Patient does not have an ostomy for bowel elimination. 1 Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen. 2 The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

ADL/IADLs

(M1810) Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:	
Enter Code ☐	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 Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:	
Enter Code ☐	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 ☐	0 Able to bathe self in shower or tub 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, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas. 3 Able to participate in bathing self in shower or tub, but 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 and transfer on and off toilet/commode.	
Enter Code ☐	0 Able to get to and from the toilet and transfer independently with or without a device. When 1 reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer. 2 Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance). 3 Unable 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.
(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 ☐	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.
(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 ☐	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, unable to ambulate but is able to wheel self independently. 5 Chairfast, unable to ambulate and is unable to wheel self. 6 Bedfast, unable to ambulate or be up in a chair.

MEDICATIONS

(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**	
Enter Code ☐	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; OR (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 Unable to take injectable medication unless administered by another person. NA No injectable medications prescribed.

THERAPY NEED AND PLAN OF CARE

(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).

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

PHQ-2©*	Not at all 0-1day	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	☐ n/a
b) Feeling down, depressed, or hopeless?	☐ 0	☐ 1	☐ 2	☐ 3	☐ n/a

Tug Test
Timed Up and Go

Wearing regular footwear, patient starts with back against the chair, arms resting on the armrests and walking aid ready. When you say go, they rise from the armed chair and stand on both feet. On the command GO have patient walk forward ten feet turn around, return to starting point, and sit down.

_____Seconds to complete

0 – unable to Test
0 – High Mobility (<10 seconds)
2 – typical Mobility (10 to 19 seconds)
4 – Slower Mobility (20 to 29 seconds)
5 – Diminished Mobility (> = 30 seconds)

_____ Score

"Unable to test" applies to persons who are non-ambulatory, unable to walk the full 20 feet and/or refuse to take the test. If unable to complete the Tug Test, continue to the MACH 10 Fall Risk Assessment Tool.

MACH 10 FALL RISK ASSESSMENT

REQUIRED CORE ELEMENTS **Assess one point for each core element "yes"** *Information may be gathered from medical record assessment and if applicable, the patient/caregiver. Beyond protocols listed below, scoring should be based on your clinical judgment*	**POINTS**
Age 65+	
Diagnosis (3 or more co-existing)	
Prior history of falls within 3 months	
Incontinence	
Visual Impairment	
Impaired functional mobility	
Environmental hazards	
Poly Pharmacy (4 or more prescriptions of any type)	
Pain affecting level of function	
Cognitive impairment	
• A score of 4 or more is considered at risk for falling TOTAL	

*****See SOC packet for full definition of MACH 10 assessment items*****

Braden Scale

Points	Sensory Perception Ability to respond meaningfully to pressure-related discomfort
1	**Completely limited –** Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation, OR limited ability to feel pain over most of body surface.
2	**Very limited -** Responds only to painful stimuli, cannot communicate discomfort except by moaning or restlessness, OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ body.
3	**Slightly limited –** Responds to verbal commands but cannot always communicate discomfort or need to be turned, OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.
4	**No Impairment -** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.

Points	Moisture – Degree to which skin is exposed to moisture
1	**Constantly moist -** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.
2	**Often moist -** Skin is often but not always moist. Linen must be changed at least once per shift.
3	**Occasionally moist -** Skin is occasionally moist: requiring an extra linen change approximately once a day.
4	**Rarely moist -** Skin is usually dry: linen only requires changing at routine intervals.

Points	Activity – Degree of physical activity
1	**Bedfast -** Confined to bed.
2	**Chair fast -** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.
3	**Walks occasionally -** Walks occasionally during day but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.
4	**Walks frequently -** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.

Points	Mobility – Ability to change and control body position
1	**Completely immobile –** Does not make even slight changes in body or extremity position without assistance.
2	**Very limited –** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.
3	**Slightly limited –** Makes frequent thought slight changes in body or extremity position independently.
4	**No limitation –** Makes major and frequent changes in position without assistance.

Points	Nutrition – Usual food intake pattern
1	**Very poor –** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings of protein (meat or daily products) per day.
2	**Probably inadequate –** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or daily products per day. Occasionally will take a dietary supplement, OR receives less than optimum amount of liquid diet or tube feeding.
3	**Adequate -** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal but will usually take a supplement if offered, OR is on a tube feeding or TPN regimen, which probable meets most of nutritional needs.
4	**Excellent –** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.

Points	Friction and shear
1	**Problem -** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction
2	**Potential problem -** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.
3	**No apparent problem –** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or in chair at all times.
_____	**Total Score**

Mark applicable risk status:

- ☐ >16 if under 75 yo. >18 if over 75 yo.
- ☐ **Low risk:** Total score 15 – 16 if under 75 yo, OR 15 – 18 if over 75 yo.
- ☐ **Moderate risk:** Total score 13 – 14
- ☐ **High risk:** Total score < 12

Summary of care provided including general assessments, vital sign ranges, stats of wound and measurement changes, labs, medication compliance, progress towards goals, status of all disease processes, hospitalizations.

Patient Name:_____ **DOB:**_____ **Freq of Visits:** _____

Scheduled recertification of visit ( ) Next visit: _____

Allergies:_____ **(R)**

Temp: _____ **Ap Pulse:** _____ **Radical Pulse:** _____ **Resp:**_____ **Wt:** _____ **Ht:** _____ **B/P**

Lying	Sitting	Standing

CIRCLE APPROPRIATE RESPONSE IN EACH AREA

MENTAL STATUS/PSYCHO-SOCIAL	NEURO/MUSCOLO-SKELETAL	CV	GI/GU/NUTRITION	WOUND ASSESSMENT
Alert / Oriented X _____	Vision / Hearing / Tactile	Chest Pain / Murmur	Nausea / Vomiting / Anorexia	Location: _____
Anxious / Depressed / Agitated	Speech: Slur / Garb	Peripheral Pulses: ____/ 4 site _____	Epigastria Distress	L _____cm W_____cm D _____ cm
Confused / Forgetful Delusional / Disoriented / MRDD	Aphasia: Rec. / Exp.	Neck Vein Distention	Appetite: Good / Fair / Poor	Pressure Stage _____ Stasis / Arterial _____
Halluc / Paranoia / Suic. Ideation	Hand Grasp / Pedal Push	CAP refill: => 3 sec / < 3 sec	Dietary Compliance	Drainage Amt:
Knowledge Deficit / Coping Sleep Disturbance	Pupillary Reaction: Rt: Lt:	Edema: +1 +2 +3 +4	Fluid Intake _____ 24 hrs Meals QD _____	Diabetic / Burn Surgical-Dehis
Evidence of Abuse, Neglect, Drug or ETOH use	HA / Syncope / Vertigo Numbness / Tingling	RUE RLE, LUE LLE Other: _____	BS x _____ Quads Normal / Hypo / Hyperactive	Tunnel _____cm o'clock Odor: YES NO
No Problem Assessed	Tremors / Spasms / Seizures	No Problem Assessed	Diarrhea / Incont / Colostomy Flatulence / LBM _____	Wound Bed:
ENVIRONMENT / SAFETY	Balance Poor / Unsteady Gait	**CP**	Constipation / Impaction	Purulent : Yellow / Tan / Green
Hazards: Fire / Mobility	Cane / Walker / WC	SOB / Dyspnea / DOE	G-Tube / NG-tube / J-tube	Type: Serous / Ser.Sang / Frank
Lifeline Use / Impaired Phone Access	Weakness / Endurance	Orthopnea	Abdomen: Tenderness / Distention	Surrounding Tissue:
No Problem Assessed	Bed / Chair bound	O2 lpm/ %SpO2	Abdomen: Girth	Wound Care: Cleanse / Irrigate
Pain	No Problem Assessed	Cough / Prod / Non – Prod	Urinary Output _____24 hrs	Apply:_____ Pack: _____
Non / Chronic / Acute	**SKIN**	Cyanosis / Pallor	Pain / Burning / Hematuria	Cover _____ Wrap _____
Scale 0 - 10 Goal <10	Pale / Jaundice / Flush / Mottled	Breath Sounds: CTA	Distention / Retention	Secure: _____ Other _____
Location:	Clammy / Diaphoretic / Dry	Crackles / Wheeze / Rhonchi	Frequency / Urgency / Incont	Other:
Character:	Hot / Warm / Cool / Cold	Absent / Diminished / Clear	Catheter: Foley Suprapubic	
Pain Management Tx:	Tugor / Poor / Fair / Elastic Rash / Itch	Location:	Blood Glucose _____ Random / FBS / Trends	Wound #2 (see summary)
Pain Triggers: Activity / Stress Weather / Lack of Rest	WNL / Other:	No Problem Assessed	No Problem Assessed	No Wounds

	Care Plan	Insurance	Medications
Pain diminished by: Meds/Temp/Rest/Movement/Massage/Music/TENS			
S/S Accompany Pain: Sleep/SOB/NV/Spasms/Weakness/Vital change Relationships/Diaphoreses/Numbness/Appetite/Concentration/Emotions	View SOC folder	Verification done Authorization obtained	View all meds Compliant? YES NO
Tx Effective / Ineffective	Update & Sign Care Plan	Visual of Insurance Card	Update Med Profile

Pain Intervention: 1 - Teach patient action, side effects & appropriate use of meds: 2 - Teach patient non-pharm methods: 3 - Teach patient monitoring & reporting symptoms: 4 - Evaluate patient for therapy referral: 5 - Notify Med if change in Vitals (↑ or ↓) 6 – Evaluate for pain mgmt referral: 7 - Evaluate patient for ER assess - notify MD

Falls Risk: **HIGH** (Hx of falls (60 days/ unresolved) dizziness, gait, environ, incontinence. ROM Hx substance abuse, med cond). **LOW** (Hx of falls (90 days), Asst dev,medication, alone, pets)

Falls Protocol: **LOW** = Teach patient & family safety, check appropriate equip, ? Need for therapy referral. **HIGH** = low protocol + ? Need for ↑ Aide hrs. ? Need for APS/ CSB referral

Teaching _____

Response to teaching _____

SERVICES PROVIDED		INSTRUCT		GOALS	
Skilled Assessment		Medication Effects / Side Effects		Verbalizes Tow S/S of Illness	
Foley care / Urine Testing		Pain Management Techniques		Verbalizes Two Disease Management Skills	
Wound Care / Dressing		Diet / Fluid Intake		Verbalizes Two Pain Management Techniques	
Vein puncture / Central Line / Port Access		Safety		Verbalizes knowledge of Medication Regimen	
Bowel / Bladder / training		Universal precautions / Infection Control		Demonstrates Safe Ambulation	
Digital Exam / Manual / Enema		Emergency Protocols		Participates in POC Development / Modification	
Administration med:		Discharge Planning		Exhibits Goal Directed Behavior	
Medication Box fill		Other:		Other:	

Supplies used during this visit