## **Outcome and Assessment Information Set (OASIS-B1)**

## TRANSFER VERSION (used for Transfer to an Inpatient Facility)

1.0		
<u>CLINI</u>	CAL RECORD ITEMS	
(M0010)	Agency Medicare Provider Number:	
(M0012)	Agency Medicaid Provider Number:	
	Branch Identification (Optional, for Agency Use)	
	(M0014) Branch State:	
	(M0016) Branch ID Number:(Agency-assigned)	_
(M0020)	Patient ID Number:	
(M0030)	Start of Care Date://	
(M0032)	Resumption of Care Date://	□ NA - Not Applicable
	Patient Name:	
(First)	(MI) (Last)	(Suffix)
(M0050)	Patient State of Residence:	
(M0060)	Patient Zip Code:	
(M0063)	Medicare Number:(including suffix)	□ NA - No Medicare
(M0064)	Social Security Number:	☐ UK - Unknown or Not Available
(M0065)	Medicaid Number:	_ □ NA - No Medicaid
(M0066)	Birth Date:/	
(M0069)	Gender:	
	1 - Male 2 - Female	
(M0072)	Primary Referring Physician ID:	
		☐ UK - Unknown or Not Available
(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:
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 [ Go to M0150 ]
☐ 5 — Other follow-up [Go to M0150]
Transfer to an Inpatient Facility
<ul> <li>6 - Transferred to an inpatient facility—patient not discharged from agency [ Go to M0150 ]</li> <li>7 - Transferred to an inpatient facility—patient discharged from agency [ Go to M0150 ]</li> </ul>
Discharge from Agency — Not to an Inpatient Facility
□ 8 − Death at home [Go to M0150]
9 – Discharge from agency [Go to M0150]
☐ 10 — Discharge from agency—no visits completed after start/resumption of care assessment [Go to <i>M0150</i> ]
(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.)
<ul><li>□ 8 - Private insurance</li><li>□ 9 - Private HMO/managed care</li></ul>
☐ 10 - Self-pay
☐ 11 - Other (specify)
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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]
<ul><li>1 - Hospital emergency room (includes 23-hour holding)</li></ul>
☐ 2 - Doctor's office emergency visit/house call
☐ 3 - Outpatient department/clinic emergency (includes urgicenter sites)
☐ UK - Unknown [If UK, go to <i>M0855</i> ]

	ergent Care Reason: For what reason(s) did the patient/family seek emergent care? (Mark all that oly.)
□ 1 □ 2 □ 3	<ul> <li>Improper medication administration, medication side effects, toxicity, anaphylaxis</li> <li>Nausea, dehydration, malnutrition, constipation, impaction</li> <li>Injury caused by fall or accident at home</li> <li>Respiratory problems (e.g., shortness of breath, respiratory infection, tracheobronchial obstruction)</li> </ul>
□ 6 □ 7 □ 8 □ 9	<ul> <li>Wound infection, deteriorating wound status, new lesion/ulcer</li> <li>Cardiac problems (e.g., fluid overload, exacerbation of CHF, chest pain)</li> <li>Hypo/Hyperglycemia, diabetes out of control</li> <li>GI bleeding, obstruction</li> <li>Other than above reasons</li> <li>Reason unknown</li> </ul>
(M0855) To v	which <b>Inpatient Facility</b> has the patient been admitted?
□ 2 □ 3	<ul> <li>Hospital [Go to M0890]</li> <li>Rehabilitation facility [Go to M0903]</li> <li>Nursing home [Go to M0900]</li> <li>Hospice [Go to M0903]</li> </ul>
	NT FACILITY ADMISSION  The patient was admitted to an acute care Hospital, for what Reason was he/she admitted?
□ 1 □ 2 □ 3	<ul> <li>Hospitalization for emergent (unscheduled) care</li> <li>Hospitalization for urgent (scheduled within 24 hours of admission) care</li> <li>Hospitalization for elective (scheduled more than 24 hours before admission) care</li> <li>Unknown</li> </ul>
(M0895) Rea	ason for Hospitalization: (Mark all that apply.)
□ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ 12	<ul> <li>Improper medication administration, medication side effects, toxicity, anaphylaxis</li> <li>Injury caused by fall or accident at home</li> <li>Respiratory problems (SOB, infection, obstruction)</li> <li>Wound or tube site infection, deteriorating wound status, new lesion/ulcer</li> <li>Hypo/Hyperglycemia, diabetes out of control</li> <li>GI bleeding, obstruction</li> <li>Exacerbation of CHF, fluid overload, heart failure</li> <li>Myocardial infarction, stroke</li> <li>Chemotherapy</li> <li>Scheduled surgical procedure</li> <li>Urinary tract infection</li> <li>IV catheter-related infection</li> <li>Deep vein thrombosis, pulmonary embolus</li> </ul>
□ 14 □ 15 □ 16	<ul><li>Uncontrolled pain</li><li>Psychotic episode</li><li>Other than above reasons</li></ul>
ı G	o to M0903

For what Reason(s) was the patient Admitted to a Nursing Home? (Mark all that apply.)
<ul> <li>1 - Therapy services</li> <li>2 - Respite care</li> <li>3 - Hospice care</li> <li>4 - Permanent placement</li> <li>5 - Unsafe for care at home</li> <li>6 - Other</li> <li>UK - Unknown</li> </ul>
Date of Last (Most Recent) Home Visit: //
Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient. //