

Home Health

Oasis E CheatSheet Digital or Printable

Oasis E SOC CheatSheet

Patient Initials: _____ SOC Date: _____ DOB: _____ Ethnicity: _____ Race: _____

Hearing: _____ Vision: _____ Preferred Language: _____

Vitals:

B/P: _____ Pulse: _____ Incontinent: ☐ Y ☐ N Bladder / Bowel Ostomy: _____ LTI: _____
 Temp: _____ Resp. Rate: _____ Assistive Devices: _____
 O2 Sat: _____ B/S: _____ **Inpatient stay in last 14 days?** ☐ Y ☐ N Facility: _____
 HgA1C: _____ Abd. Girth: _____ **NF SNF IPPS LTCH PSYCH**
 Height: _____ Weight: _____ Other: _____
 Pain: _____ Location: _____ D/C Date: _____
 Do you lack transportation for basic needs of daily living? ☐ Y ☐ N

How often do you need someone to help you read medical instructions/information?

Do you need an interpreter to communicate with a doctor or health care staff? ☐ Y ☐ N

BIMS:

(Is the patient able to respond)

Repeat: **Sock, Blue, Bed**

Year: ☐ Y ☐ N

Month: ☐ Y ☐ N

Day: ☐ Y ☐ N

Recall: **Sock, Blue, Bed**

Acute Mental Change? ☐ Y ☐ N

Inattention? ☐ Y ☐ N

Disorganized Thinking? ☐ Y ☐ N

Altered LOC? ☐ Y ☐ N

Alert/Oriented? ☐ Y ☐ N

Confused? ☐ Y ☐ N

Anxious? ☐ Y ☐ N

Supervision Needed? ☐ Y ☐ N

Mood: (Last 14 days)

Little interest/pleasure in doing things? ☐ Y ☐ N

Feeling down, depressed, or hopeless? ☐ Y ☐ N

Trouble sleeping? ☐ Y ☐ N

Feeling tired/low energy? ☐ Y ☐ N

Poor appetite/overeating? ☐ Y ☐ N

Feeling bad about yourself? ☐ Y ☐ N

Trouble concentrating? ☐ Y ☐ N

Moving slow/feeling restless? ☐ Y ☐ N

Thoughts of hurting yourself? ☐ Y ☐ N

Living arrangement? _____

How often do you feel lonely/isolated? _____

Behavior: (Reported or Observed)

Memory deficit? ☐ Y ☐ N

Impaired decision-making? ☐ Y ☐ N

Verbal disruption? ☐ Y ☐ N

Physical aggression? ☐ Y ☐ N

Inappropriate behavior? ☐ Y ☐ N

Delusional/Hallucination/Paranoid? ☐ Y ☐ N

If yes, How often? _____

Mobility:

Roll left and right: ☐ Y ☐ N

Get to lying: ☐ Y ☐ N

Lying to sitting on side of bed: ☐ Y ☐ N

Get to stand: ☐ Y ☐ N

Chair/bed transfer: ☐ Y ☐ N

Toilet transfer: ☐ Y ☐ N

Car transfer: ☐ Y ☐ N

Walk 10 feet: ☐ Y ☐ N

Walk 50 feet w/2 turns: ☐ Y ☐ N

Walk 150 feet: ☐ Y ☐ N

Walk 10 feet on uneven surface: ☐ Y ☐ N

1 step (curb): ☐ Y ☐ N

4 steps: ☐ Y ☐ N

12 steps: ☐ Y ☐ N

Pick up object: ☐ Y ☐ N

Wheel 50 feet w/2 turns: **NA** ☐ Y ☐ N

Wheel 150 feet: **NA** ☐ Y ☐ N

Functional Status:

	NA	Yes, working	Yes, on hold	Working after holiday	Location	Priority
Grooming:						
Dress upper body:						
Dress lower body:						
Bathing:						
Toilet transferring:						
Hygiene:						
Transferring:						
Ambulation:						
Feeding:						
Oral Med. Mgt:						
Inject. Med. Mgt:						

Skin:

Pressure Ulcer: ☐ Y ☐ N Location: _____ Size: _____ Drainage: _____

Stage 1: _____

Stage 2: _____

Stage 3: _____

Stage 4: _____

DTI: _____

Stasis Ulcer: ☐ Y ☐ N

Surgical Wound ☐ Y ☐ N

Other: _____

Oasis Documentation In Home Health Care

JG Myers



Oasis Documentation In Home Health Care:

Complete Guide to Documentation Lippincott Williams & Wilkins, 2008 Thoroughly updated for its Second Edition this comprehensive reference provides clear practical guidelines on documenting patient care in all nursing practice settings the leading clinical specialties and current documentation systems This edition features greatly expanded coverage of computerized charting and electronic medical records EMRs complete guidelines for documenting JCAHO safety goals and new information on charting pain management Hundreds of filled in sample forms show specific content and wording Icons highlight tips and timesavers critical case law and legal safeguards and advice for special situations Appendices include NANDA taxonomy JCAHO documentation standards and documenting outcomes and interventions for key nursing diagnoses

Home Health Guide to Oasis-c2 Melinda A. Gaboury, 2017-01-01 Help your home health agency maintain regulatory compliance by implementing the OASIS data set transitions with convenience and ease using the Home Health Guide to OASIS C2 A Reference for Field Staff This updated book supplies homecare providers with the latest information they need to know about the revised OASIS C2 data set implementation requirements for January 2017 Designed to enable field staff to bring along and complete the OASIS C2 assessments at a patient's bedside the book provides helpful guidance for each assessment type and M item change to ensure documentation standards are upheld and proper reimbursement is obtained for every patient This handy pocket guide provides Convenient access to OASIS guidance use this travel sized pocket guide while filling out the assessment at the bedside Plain English guidance with step by step instructions for filling out each OASIS C2 item to help staff easily improve their OASIS documentation An explanation of how OASIS items fit into various assessments A breakdown of how the data collection affects reimbursement Troubleshooting tips to avert incorrect payment denials and fines Compliance at any time our pocket guide offers information about the revised implementation requirements for October 2016

Home Care Nursing Practice Robyn Rice, 2006-01-01 This text covers conceptual information leadership skills and current issues and trends It provides clear and concise information about the best practices and quality improvement for the most common clinical conditions seen in home care Cover *Home Health Pocket Guide to Oasis-C, Revised Edition* Melinda A. Gaboury, 2009-12-08 Home Health Pocket Guide to OASIS C A Reference for Field Staff Revised Edition Melinda A Gaboury This handy resource puts all the critical need to know information about OASIS C completion and documentation at your fingertips Conveniently sized yet detailed it offers concise advice to comply with the revisions that go into effect in January This pocket guide delivers step by step instruction and details on this major overhaul to the data set Save time with an item by item breakdown of OASIS C Learn how it affects payment and outcomes Gain confidence from detailed instruction Ease the burden of OASIS strengthen your supporting documentation and get proper payment

Handbook of Home Health Care Administration Marilyn D. Harris, 1997 Table of Contents Foreword Introduction Ch 1 Home health administration an overview 3 Ch 2 The home health agency 16 Ch 3 Medicare conditions of participation 27

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Documentation ,2007 This full color handbook is a quick reference guide to all aspects of documentation for every nursing care situation It covers current documentation systems and formats including computerized documentation and features scores of sample filled in forms and in text narrative notes illustrating everything from everyday occurrences to emergency situations Coverage includes timesaving strategies for admission to discharge documentation in acute outpatient rehabilitation long term and home care environments and special documentation practices for selected clinical specialties critical care emergency perioperative maternal neonatal and psychiatric The book includes advice on legal safeguards dangerous abbreviations and compliance with HIPAA guidelines and JCAHO requirements

Handbook of Home Health Care Administration Harris,2015-10 Professional reference for Nurses on Home Health Care

The OTA's Guide to Documentation Marie Morreale,2024-06-01 The bestselling newly updated occupational therapy assistant OTA textbook The OTA s Guide to Documentation Writing SOAP Notes Fifth Edition explains the critical skill of documentation while offering multiple opportunities for OTA students to practice documentation through learning activities worksheets and bonus videos The Fifth Edition contains step by step instruction on occupational therapy documentation and the legal ethical and professional documentation standards required for clinical practice and reimbursement of services Students and professors alike can expect the same easy to read format from previous editions to aid OTAs in learning the purpose and standards of documentation throughout all stages of the occupational therapy process and different areas of clinical practice Essentials of documentation reimbursement and best practice are reflected in the many examples presented throughout the text Worksheets and learning activities provide the reader with multiple opportunities to practice observation skills and clinical reasoning learn documentation methods create occupation based goals and develop a repertoire of professional language Templates are provided to assist beginning OTA students in formatting occupation based SOAP notes and the task of documentation is broken down into smaller units to make learning easier Other formats and methods of recording client care are also explained such as the use of electronic health records and narrative notes This text also presents an overview of the initial evaluation process delineating the roles of the OT and OTA and guidelines for implementing appropriate interventions New in the Fifth Edition Incorporation of the Occupational

Therapy Practice Framework Domain and Process Fourth Edition and other updated American Occupational Therapy Association documents Updated information to meet Medicare Part B and other third party payer requirements Revised clinical terminology on par with current trends Added examples from emerging practice areas Expanded tables along with new worksheets and learning activities Included with the text are online supplemental materials for faculty use in the classroom this includes access to supplemental website worksheets learning activities and scenario based videos to practice the documentation process *Handbook of Home Health Standards, Revised Reprint* Tina M. Marrelli, 2011-08-11

Handbook of Home Health Standards Revised Reprint Nursing Documentation Made Incredibly Easy Kate Stout, 2018-06-05 Publisher's Note Products purchased from 3rd Party sellers are not guaranteed by the Publisher for quality authenticity or access to any online entitlements included with the product Feeling unsure about the ins and outs of charting Grasp the essential basics with the irreplaceable *Nursing Documentation Made Incredibly Easy* 5th Edition Packed with colorful images and clear as day guidance this friendly reference guides you through meeting documentation requirements working with electronic medical records systems complying with legal requirements following care planning guidelines and more Whether you are a nursing student or a new or experienced nurse this on the spot study and clinical guide is your ticket to ensuring your charting is timely accurate and watertight Let the experts walk you through up to date best practices for nursing documentation with NEW and updated fully illustrated content in quick read bulleted format NEW discussion of the necessary documentation process outside of charting informed consent advanced directives medication reconciliation Easy to retain guidance on using the electronic medical records electronic health records EMR EHR documentation systems and required charting and documentation practices Easy to read easy to remember content that provides helpful charting examples demonstrating what to document in different patient situations while addressing the different styles of charting Outlines the Do's and Don'ts of charting a common sense approach that addresses a wide range of topics including Documentation and the nursing process assessment nursing diagnosis planning care outcomes implementation evaluation Documenting the patient's health history and physical examination The Joint Commission standards for assessment Patient rights and safety Care plan guidelines Enhancing documentation Avoiding legal problems Documenting procedures Documentation practices in a variety of settings acute care home healthcare and long term care Documenting special situations release of patient information after death nonreleasable information searching for contraband documenting inappropriate behavior Special features include Just the facts a quick summary of each chapter's content Advice from the experts seasoned input on vital charting skills such as interviewing the patient writing outcome standards creating top notch care plans Nurse Joy and Jake expert insights on the nursing process and problem solving That's a wrap a review of the topics covered in that chapter About the Clinical Editor Kate Stout RN MSN is a Post Anesthesia Care Staff Nurse at Doshier Memorial Hospital in Southport North Carolina **Legal, Ethical, and Practical Aspects of Patient Care**

Documentation Ron W. Scott, 2013 Fourth Edition is the only text to integrate coverage of the legal responsibilities of rehabilitation professionals with basic essential advice on how to effectively document patient care activities from intake through discharge. This resource thoroughly covers the basics of documentation and includes many exemplar cases and forms as well as a sample abbreviations used in rehabilitation settings. This book covers all the bases from ethics to practical aspects of patient care documentation to relevant and salient legal implications and illustrative case examples that will help students excel in practice.

Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations for 2002 United States. Congress. House. Committee on Appropriations. Subcommittee on the Departments of Labor, Health and Human Services, Education, and Related Agencies, 2001

The How-to Guide to Home Health Therapy Documentation Cindy Krafft, 2011-06 Legal Aspects of Documenting Patient Care for Rehabilitation

Professionals Ronald W. Scott, 2006 Because communication among health care professionals can mean the difference between patient life and death, clear and effective patient care documentation is as important as the delivery of care itself. The rehabilitation professional faces formidable documentation responsibilities. Patient care documentation created by the rehabilitation professional must be accurate, comprehensive, concise, objective, and timely. In an interdisciplinary health care environment, documentation must also be expeditiously communicated to other professionals on the health care team.

Documentation Basics Mia Erickson, Mia L. Erickson, 2012 Complete and accurate documentation is one of the most important skills for a physical therapist assistant to develop and use effectively. The new Second Edition of *Documentation Basics: A Guide for the Physical Therapist Assistant* continues the path of teaching the student and clinician documentation from A to Z. Mia Erickson and Rebecca McKnight have updated this Second Edition to reflect changes of the American Physical Therapy Association and the ever-evolving profession. Updated inside *Documentation Basics: A Guide for the Physical Therapist Assistant* Second Edition: The discussion on integrating disablement into documentation; The discussion on how a PTA can show medical necessity and need for skilled care; The discussion on using documentation to communicate with other providers; Writing the assessment and plan to coincide with the initial documentation; Sample notes completed on forms; More examples and practice including physical agents, school-based services, paediatrics, traumatic brain injury, spinal cord injury, and interventions consistent with the *Guide to Physical Therapist Practice*; Medicare reimbursement in different settings; The importance of consistent, reliable, and valid measurements; How to improve communication and consistency between documentation by the PT and the PTA. The discussion on disablement has also been updated, shifting away from the Nagi Model toward the International Classification of Functioning, Disability, and Health (ICF). In addition, the PTA Normative Model has been integrated throughout to include more information on clinical decision making. New inside *Documentation Basics: A Guide for the Physical Therapist Assistant* Second Edition: Navigating the PT plan of care: A step-by-step model for PTAs to use as they navigate the initial PT documentation and plan of care; How the PTA uses the PT goals from the initial

examination and evaluation Positive and negative aspects of using electronic documentation and a discussion on integrating SOAP notes and the problem oriented medical record into electronic documentation Sample notes and discussion of documentation in school based settings early intervention skilled nursing settings in patient rehabilitation and direct access Medicare Parts C and D Cash based services and pro bono services Instructors in educational settings can visit www.efacultylounge.com for additional material to be used for teaching in the classroom Documentation Basics A Guide for the Physical Therapist Assistant Second Edition is the perfect guide for all physical therapist assistant students and clinicians who want to update and refine their knowledge and skills in documentation

Documentation for Physical Therapist Practice Jacqueline A. Osborne, 2015-07-31 Documentation for Physical Therapist Practice A Clinical Decision Making Approach provides the framework for successful documentation It is synchronous with Medicare standards as well as the American Physical Therapy Association's recommendations for defensible documentation It identifies documentation basics which can be readily applied to a broad spectrum of documentation formats including paper based and electronic systems This key resource utilizes a practical clinical decision making approach and applies this framework to all aspects of documentation This text emphasizes how the common and standard language of the Guide to Physical Therapist Practice and the International Classification of Functioning Disability and Health ICF model can be integrated with a physical therapist's clinical reasoning process and a physical therapist assistant's skill set to produce successful documentation Includes content on documentation formations Initial Evaluations Re examination Notes Daily Notes Conclusion of the Episode of Care Summaries Home Exercise Program Reviews all the important issues related to style types of documentation and utilization of documentation Covers documentation relevant in different settings inpatient home health skilled nursing facility outpatient Helps students learn how to report findings and demonstrate an appropriate interpretation of results Includes up to date information in line with APTA Guidelines for Defensible Documentation World Health Organization International Classification of Functioning Disability and Health Mode and Medicare Reviews electronic documentation ICD 9 ICD 10 and CPT codes Includes important chapters on Interprofessional Communication Legal Aspects Principles of Measurement

Second in Series on Medicare Reform United States. Congress. House. Committee on Ways and Means. Subcommittee on Health, 2001 A Practical Introduction to Health Information Management Lisa T. Johns, 1998 Introducing the best one step source of practical health information management guidance In this text your students will find information they need to know for every key area of health information management information management standards and requirements clinical data systems computerized patient records confidentiality and security issues quality improvement telemedicine people management issues and much more Aging issues related GAO products in calendar years 2001 and 2002. , *Documentation and Reimbursement for Speech-Language Pathologists* Nancy Swigert, 2024-06-01 Although it is the least noticed by patients effective documentation is one of the most critical skills that speech language pathologists must

learn With that in mind Documentation and Reimbursement for Speech Language Pathologists Principles and Practice provides a comprehensive guide to documentation coding and reimbursement across all work settings The text begins with section 1 covering the importance of documentation and the basic rules both ethical and legal followed by an exploration of the various documentation forms and formats Also included are tips on how to use electronic health records as well as different coding systems for diagnosis and for procedures with an emphasis on the link between coding reimbursement and the documentation to support reimbursement Section 2 explains the importance of focusing on function in patient centered care with the ICF as the conceptual model then goes on to cover each of the types of services speech language pathologists provide evaluation treatment planning therapy and discharge planning Multiple examples of forms and formats are given for each In section 3 Nancy Swigert and her expert team of contributors dedicate each chapter to a work setting in which speech language pathologists might work whether adult or pediatric because each setting has its own set of documentation and reimbursement challenges And since client documentation is not the only kind of writing done by speech language pathologists a separate chapter on other professional writing includes information on how to write correspondence avoid common mistakes and even prepare effective PowerPoint presentations Each chapter in Documentation and Reimbursement for Speech Language Pathologists contains activities to apply information learned in that chapter as well as review questions for students to test their knowledge Customizable samples of many types of forms and reports are also available Included with the text are online supplemental materials for faculty use in the classroom Documentation and Reimbursement for Speech Language Pathologists Principles and Practice is the perfect text for speech language pathology students to learn these vital skills but it will also provide clinical supervisors new clinicians and speech language pathologists starting a private practice or managing a department with essential information about documentation coding and reimbursement

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