

# Home Health

## Oasis E CheatSheet Digital or Printable

### Oasis E SOC CheatSheet

Patient Initials: \_\_\_\_\_ SOC Date: \_\_\_\_\_ DOB: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Race: \_\_\_\_\_

Hearing: \_\_\_\_\_ Vision: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

#### Vitals:

BrP: \_\_\_\_\_ Pulse: \_\_\_\_\_ Incontinent: ☐ Y ☐ N Bladder / Bowel Ostomy: \_\_\_\_\_ LTI: \_\_\_\_\_  
 Temp: \_\_\_\_\_ Resp. Rate: \_\_\_\_\_ Assistive Devices: \_\_\_\_\_  
 O2 Sat: \_\_\_\_\_ BrS: \_\_\_\_\_ **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:

Grooming:

Dress upper body:

Dress lower body:

Bathing:

Toilet transferring:

Hygiene:

Transferring:

Ambulation:

Feeding:

Oral Med. Mgt:

Inject. Med. Mgt:

Location:

Size:

Drainage:

Pressure Ulcer: ☐ Y ☐ N

Stage 1:

Stage 2:

Stage 3:

Stage 4:

DTI:

Stasis Ulcer: ☐ Y ☐ N

Surgical Wound ☐ Y ☐ N

Other:

# Oasis Documentation In Home Health Care

**Marilyn D. Harris**



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## **Table of Contents Oasis Documentation In Home Health Care**

1. Understanding the eBook Oasis Documentation In Home Health Care
  - The Rise of Digital Reading Oasis Documentation In Home Health Care
  - Advantages of eBooks Over Traditional Books
2. Identifying Oasis Documentation In Home Health Care
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Oasis Documentation In Home Health Care
  - User-Friendly Interface
4. Exploring eBook Recommendations from Oasis Documentation In Home Health Care
  - Personalized Recommendations
  - Oasis Documentation In Home Health Care User Reviews and Ratings
  - Oasis Documentation In Home Health Care and Bestseller Lists
5. Accessing Oasis Documentation In Home Health Care Free and Paid eBooks

- Oasis Documentation In Home Health Care Public Domain eBooks
- Oasis Documentation In Home Health Care eBook Subscription Services
- Oasis Documentation In Home Health Care Budget-Friendly Options
- 6. Navigating Oasis Documentation In Home Health Care eBook Formats
  - ePub, PDF, MOBI, and More
  - Oasis Documentation In Home Health Care Compatibility with Devices
  - Oasis Documentation In Home Health Care Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Oasis Documentation In Home Health Care
  - Highlighting and Note-Taking Oasis Documentation In Home Health Care
  - Interactive Elements Oasis Documentation In Home Health Care
- 8. Staying Engaged with Oasis Documentation In Home Health Care
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Oasis Documentation In Home Health Care
- 9. Balancing eBooks and Physical Books Oasis Documentation In Home Health Care
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Oasis Documentation In Home Health Care
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Oasis Documentation In Home Health Care
  - Setting Reading Goals Oasis Documentation In Home Health Care
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Oasis Documentation In Home Health Care
  - Fact-Checking eBook Content of Oasis Documentation In Home Health Care
  - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development

- Exploring Educational eBooks

### 14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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