Visiting Nurse Association of Northern New Jersey
OASIS

13459

Sequence #

(Client Name)

A. Demograph General Information

(M0010) Agency Medicare Provider Number:

(M0012) Agency Medicaid Provider Number

(M0014) Branch State (If applicable): N J

(M0016) Branch ID (If applicable):

(M0020) Patient ID Number:

State Provided Patient ID Number:

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

(M0032) Resumption of Care Date: ○ NA -(not applicable) Month / Day / Year

(M0040) Patient Name:

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

Patient Phone:

Patient Address:

(Street, Route, Apt. Number - Not P.O. Number)

(City) **(M0050)** State

(M0060) Zip Code

(M0069) Gender

(M0063) Medicare Number: (Including Suffix if any)

○ - NA (No Medicare)

(M0066) Birth Date: Month / Day / Year

○ 1 - Male ○ 2 - Female

(M0064) Social Security Number:

○ - UK (Unknown or Not Available)

(M0072) Primary Referring Physician ID: UPIN #

○ - UK (Unknown or Not Available)

(M0065) Medicaid Number:

○ - NA (No Medicaid)

(M0080) Discipline of Person Completing Assessment:

○ 1 - RN ○ 2 - PT ○ 3 - SLP/ST ○ 4 - OT

Other Insurance:

(M0090) Date Assessment Completed: / /

Agency Document ID (if applicable):

(M0100) This Assessment is currently being completed for the following reason:

- ○ **1 - Start of Care - Further Visits Planned**
- ○ **2 - Start of Care - No Further Visits Planned**
- ○ **3 - Resumption of Care (after inpatient stay)**

Pharmacy: Phone:

Allergies: ○ - Yes (Specify):

○ - **N.K.A.** (No Known Allergies)

Primary RN Name:

Nurses' ID:

Religion: ○ Catholic ○ Jewish ○ Hindu ○ Protestant ○ Muslim ○ Other

Advanced Directive: ○ Yes ○ No ○ Copy Kept

Do Not Resuscitate: ○ Yes (only yes if MD and Patient consent on record)

(M0140) Race / Ethnicity (as identified by patient): (FILL ALL THAT APPLY)

○ 1-American Indian or Alaskan Native ○ 2-Asian ○ 3-Black or African American ○ 4-Hispanic or Latino ○ 5-Native Hawaiian Pacific Islander ○ 6-White ○ UK-Unknown

Marital Status:

○ Married ○ Widowed ○ Separated ○ Not Married ○ Divorced ○ Unknown

Emergency Contact (Relationship)

Phone Number:

Primary Care Person (Relationship)

Phone Number:

Household Members (Relationship)

Community Resources / Contact Name: (CCPED - CHAP...)

Directions to Home:

Special Consideration for visit:

Primary Physician:

Address:

Phone #

Fax #

Other Physician:

Address:

Phone #

Fax #

13459

Reset

(Client Name)

Homebound Status

Clarify patient homebound status, including functional and activity limitations:

- ○ Weakness
- ○ Poor Tolerance to Activites
- ○ Physical Barriers to leave home [no ramp, stairs, etc]
- ○ Fatique
- ○ Shortness of Breath
- ○ Other
- ○ Needs Max Assistance for Transfer
- ○ Dyspnea with Minimal Exertion

Plan for Services

- ○ - Physical Therapy
- ○ - Occupational Therapy
- ○ - Speech Language Pathologist
- ○ - Specialty Nurse: ET Psych DM Rehab
- ○ - SN: _____ frequency; # of weeks.
- ○ - MSW _____ frequency; duration.
- ○ - CHHA: _____ frequency; # of hours. # of weeks.

Patient informed of care plan: ○ Yes ○ No **Date informed:** ___ / ___ / ____ (Month / Day / Year)

SOP informed of care plan: ○ Yes ○ No

GOALS:

Patient:

Family:

Telephone calls/Conferences per evaluation/assessment: _____

Admission Narrative

Plan for next Skilled Nurse visit: _____

Next SNV: ___ / ___ / ____

Signature: X _____