

## Visiting Nurse Association of Northern New Jersey **OASIS**

Sequence #

(Client Name)					
General Information	edicare Provider Num	mber: (M0012) Agency Medicaid Provider Number			
(M0014) Branch State (If applicable): (M0016) Branch	ID (If applicable):	10030) Start of Care Date: / / /			
(M0020) Patient ID Number: State Provided Pat	(IVI)	Resumption of Care Date:    NA (not applicable)			
		NA -(not applicable)  Month Day Year			
(M0040) Patient Name:		Patient Address:			
(First) (M.I.) (Last) (Suffice)		(Street, Route, Apt. Number - Not P.O. Number) (M0050) State			
Patient Phone:		City) (M0060) (M006	9)		
(M0063) Medicare Number: (Including Suffix if any)		Zip Code Gender			
O - NA (No Medicare)		/ / / / / / / / / / / / / / / / / / /			
(M0064) Social Security Number:	<del></del>	Month Day Year 🔾 2 - Fema	ale		
O - UK (Unknown or Not Available)		10072) Primary Referring Physician ID: UPIN #	$\neg$		
(M0065) Medicaid Number:	-	Unknown or Not Available)			
	(M	10080) Discipline of Person Completing Assessment:			
O - NA (No Medicaid) r		) 1 - RN			
Other Insurance:	(M0090) Date Asse	sessment Completed: Agency Document ID (if applica	ble):		
This Assessment is currently being completed for the following reason:  Pharmacy:  Phone:					
3					
○ 1 - Start of Care - Further Visits	s Planned	Allegaries			
9		Allergies: O - Yes (Specify):			
○ 1 - Start of Care - Further Visits	isits Planned		<u> </u>		
<ul><li>○ 1 - Start of Care - Further Visits</li><li>○ 2 - Start of Care - No Further V</li></ul>	isits Planned	(Specify):  O- N.K.A. (No Known Allergies)			
<ul> <li>1 - Start of Care - Further Visits</li> <li>2 - Start of Care - No Further V</li> <li>3 - Resumption of Care (after in</li> </ul>	isits Planned npatient stay)	(Specify):  O- N.K.A. (No Known Allergies)  Religion: O Catholic O Jewish O Hindu			
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(Client Name)				
Homebo	und Status			
Clarify pation	ent homebound status, including t	functional and activity limitations:		
O Weaknes	ss	O Poor Tolerance to Activites	O Physical Barriers to leave home [no ramp, stairs, etc]	
O Fatique		O Shortness of Breath	O Other	
O Needs Ma	ax Assistance for Transfer	O Dyspnea with Minimal Exertion		
Plan fo	r Services	O - SN:		
O - Phy sica	al Therapy O - Occupational Therapy	frequency;	# of weeks.	
O - Speech	Language Pathologist	O - MSW		
O - Special	ty Nurse: ET Psych DM Rehab	O - CHHA: # of hours.	# of weeks.	
Patient info	rmed of care plan: Date informed:	Month Day Year	SOP informed of care plan: O Yes O No	
00410	Patient:	, , , , , , , , , , , , , , , , , , , ,		
GOALS:	Family:			
Telephone	calls/Conferences per evaluation/ass	sessment:		
			-	
Adn	nission Narrative			
Plan for nex	ct Skilled Nurse visit:			
Next SNV:	/ / /			

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