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OASIS-E1 Cheat Sheet

RN | PT | SLP/ST | OT   SOC | ROC ____________

Name ______________ **DOB** ________ **Gender** ________ **SOC Date** ________

Ethnicity ______________ **Race** ________ **Hearing** ________ **Vision** ________

Preferred Language ______________ **Allergies** ______________

Lives with ______________ **Assistance** ______________

Patient goal ______________

Do you have 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 ______________

Inpatient stay last 14 days? Y N **Facility** ______________ **DC Date** ________

Vitals

Time ____ Temp____ HR ____ BP____ SPO2 ____

Time ____ Temp____ HR ____ BP____ SPO2 ____

Time ____ Temp____ HR ____ BP____ SPO2 ____

Medical History

____

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BIMS

Is the patient able to respond?

Repeat	SOC	BLUE	BED
Year	Y	N	________
Month	Y	N	________
Day	Y	N	________
Recall	SOC	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

How often do you feel lonely or isolated from those around you?

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Mood

Over the last 2 weeks, have you been bothered by any of the following problems?

Little interest or pleasure in doing things	Y	N
Feeling down, depressed, or hopeless	Y	N
Trouble sleeping	Y	N
Feeling tired or having little energy	Y	N
Poor appetite or overeating	Y	N
Feeling bad about yourself	Y	N
Trouble Concentrating	Y	N
Moving slow or feeling restless	Y	N
Thoughts of hurting yourself	Y	N

Behavior

Memory deficit?	Y	N
Impaired decision-making?	Y	N
Verbal disruption?	Y	N
Physical aggression?	Y	N
Inappropriate behavior?	Y	N
Delusional/hallucinatory/ paranoid?	Y	N

If yes, how often? ______________

Bladder and Bowel

Incontinence?	Y	N
Urinary catheter?	Y	N
Bowel incontinence?	Y	N

Frequency ____________________

In the past 14 days, was this patient treated for a urinary tract infection?	Y	N

Mobility

Roll left and right	Y	N
Sit to lying	Y	N
Lying to sitting on side of bed	Y	N
Sit to stand	Y	N
Chair/bed-to chair transfer	Y	N
Toilet transfer	Y	N
Car transfer	Y	N
Walk 10 feet	Y	N
Walk 50 feet with two turns	Y	N
Walk 150 feet	Y	N
Walking 10 feet on uneven surfaces	Y	N

1 step Y N 4 steps Y N 12 steps Y N

Picking up object	Y	N
Wheel 50 feet with two turns	Y	N
Wheel 150 feet	Y	N

Functional Status

Functional Status	Able	Able with prep	Able with help	Unable: possible other options	Unable	Totally Dependent
Grooming						
Dress upper body						
Dress lower body						
Bathing						
Toilet transferring						
Toileting hygiene						
Transferring						
Ambulation/locomotion						
Feeding						
Oral medication management						
Injection medication management						

Fall History

History of falls? Y N Any since SOC/ROC? Y N

Minor injury? Y N Major injury (bone fracture, head injury, joint dislocation)? Y N

Reason for referral ______________________________

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Comorbidities and Co-existing Conditions

Condition	Y	N
Peripheral vascular disease (PVD)	Y	N
Peripheral arterial disease (PAD)	Y	N
Diabetes mellitus (DM)	Y	N
Shortness of breath (SOB)	Y	N

Pain

	Y	N
Affects sleep	Y	N
Interferes with therapy activities	Y	N
Interferes with day-to-day activities	Y	N

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Medications

Medication	Y	N
Antibiotic	Y	N
Anticoagulant	Y	N
Antiplatelet	Y	N
Antipsychotic	Y	N
Hypoglycemic	Y	N
Opioid	Y	N
COVID-19 vaccine up to date?	Y	N

Date ______________________________

	Y	N
Flu vaccine	Y	N

Date ______________________________

Nutritional Approaches

	Y	N	
Parenteral/IV feeding	Y	N	____________
Feeding tube	Y	N	____________
Mechanically altered diet	Y	N	____________
Therapeutic diet	Y	N	____________

Height ______________________________

Weight ______________________________

Other Pertinent Info

Primary Care Provider

____

Most recent face-to-face encounter date

____

Emergency Contact/POA

____

Advanced Directives

____

Pharmacy

____

Recent Surgeries

____

Risk for Hospitalization

(Check all that apply)

- ☐ History of falls
- ☐ Multiple ER visits
- ☐ Difficulty following medical instructions
- ☐ Weight loss
- ☐ Mental decline
- ☐ Reports exhaustion
- ☐ Multiple hospitalizations
- ☐ Taking 5 or more meds
- ☐ Other risk(s) ______________________________

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Special Treatment, Procedures and Programs (Check all that apply)

Chemotherapy	Y	N	☐	IV	☐	Oral	☐	Other
Radiation	Y	N						
Oxygen therapy	Y	N	☐	Continuous	☐	Intermittent	☐	High-concentration
Suctioning	Y	N	☐	Scheduled	☐	As needed		
Tracheostomy care	Y	N						
Invasive mechanical ventilator	Y	N						
Non-invasive mechanical ventilator	Y	N	☐	BiPAP	☐	CPAP		
IV medications	Y	N	☐	Vasoactive meds	☐	Antibiotics	☐	Anticoagulation
Transfusions	Y	N						
Dialysis	Y	N	☐	Hemodialysis	☐	Peritoneal dialysis		
IV access	Y	N	☐	Peripheral	☐	Mid-line	☐	Central

Skin Conditions

≥ One stage 2 pressure ulcer or unstageable? Y N

(Identify ulcer/wound type on line then place on figure by number)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

More than 4 wounds of any type? Y N

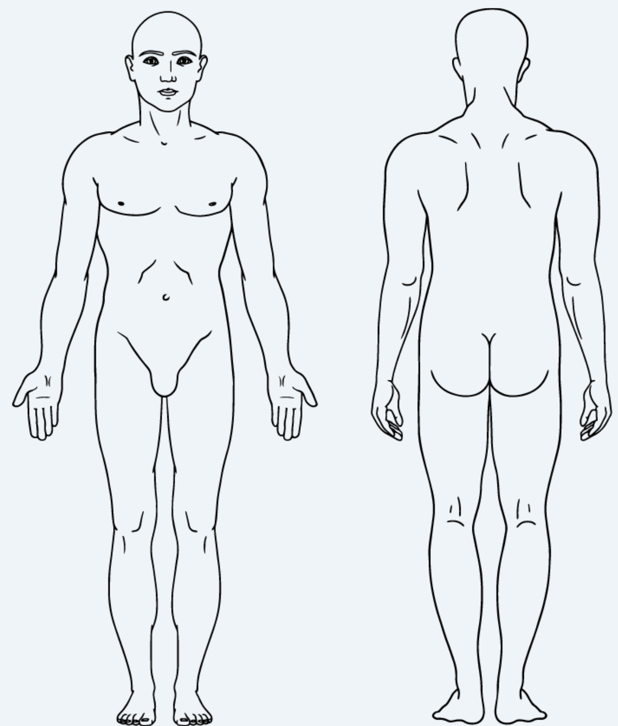
Total number of each wound type:

Stage 2 ________ Surgical ________

Stage 3 ________ Surgical ________

Stage 4 ________ Surgical ________

(Unstageable includes deep tissue injuries, slough/eschar, covered, and non-removeable dressing



Most problemeatic ulcer (that is observable)

Type ______________ Location ______________ Size ________ Drainage ____________

Stage 1 2 3 4 n/a

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Community Resources Needed

- [ ] Safety measures in place
- [ ] Anticoagulant precautions
- [ ] Fall precautions
- [ ] Neutropenic precautions
- [ ] O2 precautions
- [ ] Seizure precautions

Notes ______________________________

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Home health procedures and training videos in the field

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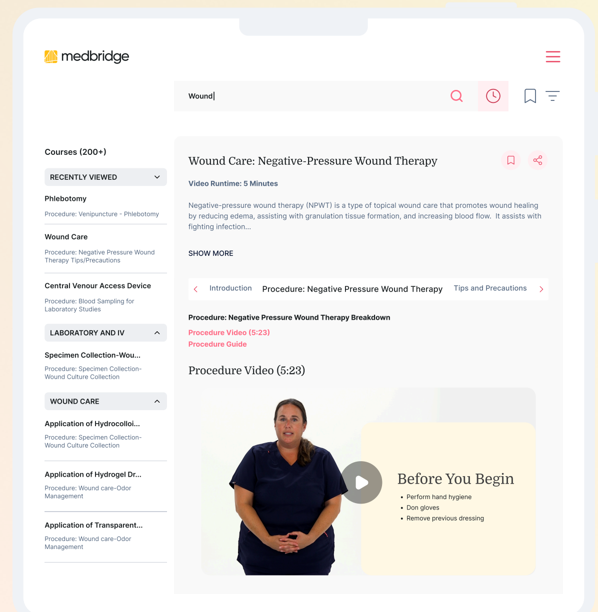

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