



OASIS Action Plan

Client Name: _____
 Birthdate (dd/mm/yy): _____
 Family Dr.: _____
 Appt Date: _____

Physician requested to coordinate Client Action Plan

Scores Physician Tool: _____ Physician Vas: _____ Surgical: _____ MMSE: _____ Beck: _____ Cage: _____ Berg Bal: _____

Information provided for:

Weight Management Nutrition Mobility/Exercise Assistive devices/ADL OA
 Pain Management Social Services Home Support Other (specify) _____

RECOMMENDATIONS No recommendations

Initiated By: OASIS Physician Client	Medical History	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Consider referral to specialist (specify): _____
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> History of Anaemia - repeat Hemoglobin _____
Pain	New Issues Found:	Action Recommended: _____
		1) _____
Live/Wrk	ADL	2) _____
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Re-assess pain medication regime (comments): _____
Nutrition	Mobility	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Refer to pain specialist or relevant clinic (specify): _____
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pharmacist (specify): _____
Surgery	Surgery	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Refer to PT/OT for functional pain management _____
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Refer to Social Work (specify): _____
Ed	Ed	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Recommend Case Manager (specify): _____
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Refer to other community resources (specify): _____
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Home Support assessment (reason): _____
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Home OT/safety assessment/equipment recommendation (reason): _____
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Refer to Dietician (specify reason): _____
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Community weight control program: _____
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Refer to PT for functional mobility/exercise/equipment: _____
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Recommend community exercise program: _____
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Recommend Falls Prevention program: _____
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Recommend other community services: _____
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Smoking Cessation Program: _____
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Surgical Consult for (circle) right / left hip / knee : _____
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Client to arrange equipment and home setup in advance of surgery _____
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Client to arrange a person to help post surgery and does not anticipate difficulty _____
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Recommended education sessions: _____

Re-Assessment is recommended at request of physician or client, or within: _____

Completed by: 1) _____ 2) _____ 3) _____ Date: _____	Copies distributed to: Distributed by: _____ (Initial) <input type="checkbox"/> Client <input type="checkbox"/> Surgeon <input type="checkbox"/> Family Doctor <input type="checkbox"/> Other: _____
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