

# INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT

Identification Information*	Payer Information*
<p>1. Facility Information A. Facility Name _____ _____</p> <p>B. Facility Medicare Provider Number _____</p> <p>2. Patient Medicare Number _____</p> <p>3. Patient Medicaid Number _____</p> <p>4. Patient First Name _____</p> <p>5A. Patient Last Name _____</p> <p>5B. Patient Identification Number _____</p> <p>6. Birth Date _____ MM / DD / YYYY</p> <p>7. Social Security Number _____</p> <p>8. Gender (1 - Male; 2 - Female) _____</p> <p>9. Race/Ethnicity (Check all that apply)                      American Indian or Alaska Native A. _____                      Asian B. _____                      Black or African American C. _____                      Hispanic or Latino D. _____                      Native Hawaiian or Other Pacific Islander E. _____                      White F. _____</p> <p>10. Marital Status _____ (1 - Never Married; 2 - Married; 3 - Widowed; 4 - Separated; 5 - Divorced)</p> <p>11. Zip Code of Patient's Pre-Hospital Residence _____</p>	<p>20. Payment Source A. Primary Source _____</p> <p>B. Secondary Source _____</p> <p><i>(01 - Blue Cross; 02 - Medicare non-MCO; 03 - Medicaid non-MCO; 04 - Commercial Insurance; 05 - MCO HMO; 06 - Workers' Compensation; 07 - Crippled Children's Services; 08 - Developmental Disabilities Services; 09 - State Vocational Rehabilitation; 10 - Private Pay; 11 - Employee Courtesy; 12 - Unreimbursed; 13 - CHAMPUS; 14 - Other; 15 - None; 16 - No-Fault Auto Insurance; 51 - Medicare MCO; 52 - Medicaid MCO)</i></p>
Medical Information*	
<p>12. Admission Date _____ MM / DD / YYYY</p> <p>13. Assessment Reference Date _____ MM / DD / YYYY</p> <p>14. Admission Class _____ (1 - Initial Rehab; 2 - Evaluation; 3 - Readmission; 4 - Unplanned Discharge; 5 - Continuing Rehabilitation)</p> <p>15. Admit From _____ (01 - Home; 02 - Board &amp; Care; 03 - Transitional Living; 04 - Intermediate Care; 05 - Skilled Nursing Facility; 06 - Acute Unit of Own Facility; 07 - Acute Unit of Another Facility; 08 - Chronic Hospital; 09 - Rehabilitation Facility; 10 - Other; 12 - Alternate Level of Care Unit; 13 - Subacute Setting; 14 - Assisted Living Residence)</p> <p>16. Pre-Hospital Living Setting _____ (Use codes from item 15 above)</p> <p>17. Pre-Hospital Living With _____ (Code only if item 16 is 01 - Home; Code using 1 - Alone; 2 - Family/Relatives; 3 - Friends; 4 - Attendant; 5 - Other)</p> <p>18. Pre-Hospital Vocational Category _____ (1 - Employed; 2 - Sheltered; 3 - Student; 4 - Homemaker; 5 - Not Working; 6 - Retired for Age; 7 - Retired for Disability)</p> <p>19. Pre-Hospital Vocational Effort _____ (Code only if item 18 is coded 1 - 4; Code using 1 - Full-time; 2 - Part-time; 3 - Adjusted Workload)</p>	<p>21. Impairment Group _____ Admission _____ Discharge _____ Condition requiring admission to rehabilitation; code according to Appendix A, attached.</p> <p>22. Etiologic Diagnosis _____ (Use an ICD-9-CM code to indicate the etiologic problem that led to the condition for which the patient is receiving rehabilitation)</p> <p>23. Date of Onset of Impairment _____ MM / DD / YYYY</p> <p>24. Comorbid Conditions; Use ICD-9-CM codes to enter up to ten medical conditions</p> <p>A. _____ B. _____</p> <p>C. _____ D. _____</p> <p>E. _____ F. _____</p> <p>G. _____ H. _____</p> <p>I. _____ J. _____</p>
Medical Needs	
<p>25. Is patient comatose at admission? _____ 0 - No, 1 - Yes</p> <p>26. Is patient delirious at admission? _____ 0 - No, 1 - Yes</p> <p>27. Swallowing Status _____ Admission _____ Discharge _____</p> <p>3 - <u>Regular Food</u>: solids and liquids swallowed safely without supervision or modified food consistency</p> <p>2 - <u>Modified Food Consistency/ Supervision</u>: subject requires modified food consistency and/or needs supervision for safety</p> <p>1 - <u>Tube /Parenteral Feeding</u>: tube / parenteral feeding used wholly or partially as a means of sustenance</p> <p>28. Clinical signs of dehydration _____ Admission _____ Discharge _____</p> <p>(Code 0 - No; 1 - Yes) e.g., evidence of oliguria, dry skin, orthostatic hypotension, somnolence, agitation</p>	<p>*The FIM data set, measurement scale and impairment codes incorporated or referenced herein are the property of U B Foundation Activities, Inc. ©1993, 2001 U B Foundation Activities, Inc. The FIM mark is owned by UBFA, Inc.</p>

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Function Modifiers*		39. FIM™ Instrument*		
<p><b>Complete the following specific functional items prior to scoring the FIM™ Instrument:</b></p>		ADMISSION	DISCHARGE	
29. Bladder Level of Assistance (Score using FIM Levels 1 - 7)	<input type="checkbox"/>	<input type="checkbox"/>		
30. Bladder Frequency of Accidents (Score as below)	<input type="checkbox"/>	<input type="checkbox"/>		
7 - No accidents 6 - No accidents; uses device such as a catheter 5 - One accident in the past 7 days 4 - Two accidents in the past 7 days 3 - Three accidents in the past 7 days 2 - Four accidents in the past 7 days 1 - Five or more accidents in the past 7 days				
<i>Enter in Item 39G (Bladder) the lower (more dependent) score from Items 29 and 30 above.</i>		ADMISSION	DISCHARGE	
31. Bowel Level of Assistance (Score using FIM Levels 1 - 7)	<input type="checkbox"/>	<input type="checkbox"/>		
32. Bowel Frequency of Accidents (Score as below)	<input type="checkbox"/>	<input type="checkbox"/>		
7 - No accidents 6 - No accidents; uses device such as an ostomy 5 - One accident in the past 7 days 4 - Two accidents in the past 7 days 3 - Three accidents in the past 7 days 2 - Four accidents in the past 7 days 1 - Five or more accidents in the past 7 days				
<i>Enter in Item 39H (Bowel) the lower (more dependent) score of Items 31 and 32 above.</i>		ADMISSION	DISCHARGE	
33. Tub Transfer	<input type="checkbox"/>	<input type="checkbox"/>		
34. Shower Transfer	<input type="checkbox"/>	<input type="checkbox"/>		
(Score Items 33 and 34 using FIM Levels 1 - 7; use 0 if activity does not occur) See training manual for scoring of Item 39K (Tub/Shower Transfer)		ADMISSION	DISCHARGE	
35. Distance Walked	<input type="checkbox"/>	<input type="checkbox"/>		
36. Distance Traveled in Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>		
(Code items 35 and 36 using: 3 - 150 feet; 2 - 50 to 149 feet; 1 - Less than 50 feet; 0 - activity does not occur)		ADMISSION	DISCHARGE	
37. Walk	<input type="checkbox"/>	<input type="checkbox"/>		
38. Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>		
(Score Items 37 and 38 using FIM Levels 1 - 7; 0 if activity does not occur) See training manual for scoring of Item 39L (Walk/Wheelchair)				
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	ADMISSION	DISCHARGE	GOAL
<b>SELF-CARE</b>			
A. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Dressing - Upper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Dressing - Lower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SPHINCTER CONTROL</b>			
G. Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>TRANSFERS</b>			
I. Bed, Chair, Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Tub, Shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>LOCOMOTION</b>			
L. Walk/Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>COMMUNICATION</b>			
N. Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O. Expression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SOCIAL COGNITION</b>			
P. Social Interaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q. Problem Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R. Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>FIM LEVELS</b>			
No Helper			
7 Complete Independence (Timely, Safely)			
6 Modified Independence (Device)			
Helper - Modified Dependence			
5 Supervision (Subject = 100%)			
4 Minimal Assistance (Subject = 75% or more)			
3 Moderate Assistance (Subject = 50% or more)			
Helper - Complete Dependence			
2 Maximal Assistance (Subject = 25% or more)			
1 Total Assistance (Subject less than 25%)			
0 Activity does not occur; Use this code only at admission			

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Discharge Information*	Quality Indicators																																																																
<p>40. Discharge Date <span style="float: right;">_____ / _____ / _____ MM / DD / YYYY</span></p> <p>41. Patient discharged against medical advice? _____ (0 - No, 1 - Yes)</p> <p>42. Program Interruption(s) _____ (0 - No; 1 - Yes)</p> <p>43. Program Interruption Dates (Code only if Item 42 is 1 - Yes)</p> <p>A. 1<sup>st</sup> Interruption Date <span style="float: right;">B. 1<sup>st</sup> Return Date</span>  <input style="width: 100px; height: 20px;" type="text"/> <span style="float: right;"><input style="width: 100px; height: 20px;" type="text"/></span>  MM / DD / YYYY <span style="float: right;">MM / DD / YYYY</span></p> <p>C. 2<sup>nd</sup> Interruption Date <span style="float: right;">D. 2<sup>nd</sup> Return Date</span>  <input style="width: 100px; height: 20px;" type="text"/> <span style="float: right;"><input style="width: 100px; height: 20px;" type="text"/></span>  MM / DD / YYYY <span style="float: right;">MM / DD / YYYY</span></p> <p>E. 3<sup>rd</sup> Interruption Date <span style="float: right;">F. 3<sup>rd</sup> Return Date</span>  <input style="width: 100px; height: 20px;" type="text"/> <span style="float: right;"><input style="width: 100px; height: 20px;" type="text"/></span>  MM / DD / YYYY <span style="float: right;">MM / DD / YYYY</span></p> <p>44A. Discharge to Living Setting _____ (01 - Home; 02 - Board and Care; 03 - Transitional Living; 04 - Intermediate Care; 05 - Skilled Nursing Facility; 06 - Acute Unit of Own Facility; 07 - Acute Unit of Another Facility; 08 - Chronic Hospital; 09 - Rehabilitation Facility; 10 - Other; 11 - Died; 12 - Alternate Level of Care Unit; 13 - Subacute Setting; 14 - Assisted Living Residence)</p> <p>44B. Was patient discharged with Home Health Services? _____ (0 - No; 1 - Yes) (Code only if Item 44A is 01 - Home, 02 - Board and Care, 03 - Transitional Living, or 14 - Assisted Living Residence)</p> <p>45. Discharge to Living With _____ (Code only if Item 44A is 01 - Home; Code using 1 - Alone; 2 - Family / Relatives; 3 - Friends; 4 - Attendant; 5 - Other)</p> <p>46. Diagnosis for Interruption or Death _____ (Code using ICD-9-CM code)</p> <p>47. Complications during rehabilitation stay (Use ICD-9-CM codes to specify up to six conditions that began with this rehabilitation stay)</p> <p>A. _____ B. _____ C. _____ D. _____ E. _____ F. _____</p>	<p><b>PAIN</b></p> <p>51. Rate the highest level of pain reported by the patient within the assessment period: Admission: _____ Discharge: _____ (Score using the scale below; report whole numbers only)</p> <table style="width: 100%; text-align: center;"> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> </tr> <tr> <td> </td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td> </td> </tr> <tr> <td>No</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Worst</td> </tr> <tr> <td>Pain</td><td></td><td></td><td></td><td></td><td>Moderate</td><td></td><td></td><td></td><td></td><td>Possible Pain</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td>Pain</td><td></td><td></td><td></td><td></td><td></td> </tr> </table> <p><b>Pressure Ulcers</b></p> <p>52A. Highest current pressure ulcer stage Admission _____ Discharge _____ (0 - No pressure ulcer; 1 - Any area of persistent skin redness (Stage 1); 2 - Partial loss of skin layers (Stage 2); 3 - Deep craters in the skin (Stage 3); 4 - Breaks in skin exposing muscle or bone (Stage 4); 5 - Not stageable (necrotic eschar predominant; no prior staging available)</p> <p>52B. Number of current pressure ulcers Admission _____ Discharge _____</p> <p><b>PUSH Tool v. 3.0 ©</b></p> <p>SELECT THE CURRENT LARGEST PRESSURE ULCER TO CODE THE FOLLOWING. Calculate three components (C through E) and code total score in F.</p> <p>52C. Length multiplied by width (open wound surface area) Admission _____ Discharge _____ (Score as 0 - 0 cm<sup>2</sup>; 1 - &lt; 0.3 cm<sup>2</sup>; 2 - 0.3 to 0.6 cm<sup>2</sup>; 3 - 0.7 to 1.0 cm<sup>2</sup>; 4 - 1.1 to 2.0 cm<sup>2</sup>; 5 - 2.1 to 3.0 cm<sup>2</sup>; 6 - 3.1 to 4.0 cm<sup>2</sup>; 7 - 4.1 to 8.0 cm<sup>2</sup>; 8 - 8.1 to 12.0 cm<sup>2</sup>; 9 - 12.1 to 24.0 cm<sup>2</sup>; 10 - &gt; 24 cm<sup>2</sup>)</p> <p>52D. Exudate amount Admission _____ Discharge _____ 0 - None; 1 - Light; 2 - Moderate; 3 - Heavy</p> <p>52E. Tissue type Admission _____ Discharge _____ 0 - Closed/resurfaced: The wound is completely covered with epithelium (new skin); 1 - Epithelial tissue: For superficial ulcers, new pink or shiny tissue (skin) that grows in from the edges or as islands on the ulcer surface. 2 - Granulation tissue: Pink or beefy red tissue with a shiny, moist, granular appearance. 3 - Slough: Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps or is mucinous. 4 - Necrotic tissue (eschar): Black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges.</p> <p>52F. TOTAL PUSH SCORE (Sum of above three items – C, D and E) Admission _____ Discharge _____</p> <p><b>SAFETY</b></p> <table style="width: 100%;"> <tr> <td></td> <td style="text-align: center;">Admission</td> <td style="text-align: center;">Discharge</td> </tr> <tr> <td>53. 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<p><b>RESPIRATORY STATUS</b> (Score items 48 to 50 as 0 - No; 1 - Yes)</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;">Admission</th> <th style="width: 20%; text-align: center;">Discharge</th> </tr> </thead> <tbody> <tr> <td>48. Shortness of breath with exertion</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>49. Shortness of breath at rest</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>50. Weak cough and difficulty clearing airway secretions</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>			Admission	Discharge	48. Shortness of breath with exertion	_____	_____	49. Shortness of breath at rest	_____	_____	50. Weak cough and difficulty clearing airway secretions	_____	_____																																																				
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