CARE Tool

Master Document
(Core and Supplemental Items)

General Information: Please note that this instrument uses the term "2-day assessment period" to refer to the first 2 days of admission and the last 2 days prior-to-discharge for look-back periods.

Post OMB Version
10/29/07

Signatures of Persons who Completed a Portion of the Accompanying Assessment

I certify, to the best of my knowledge, the information in this assessment is

- collected in accordance with the guidelines provided by CMS for participation in this Post Acute Care Payment Reform Demonstration,
- an accurate and truthful reflection of assessment information for this patient,
- based on data collection occurring on the dates specified, and
- data-entered accurately.

I understand the importance of submitting only accurate and truthful data.

- This facility's participation in the Post Acute Care Payment Reform Demonstration is conditioned on the accuracy and truthfulness of the information provided.
- The information provided may be used as a basis for ensuring that the patient receives appropriate and quality care and for conveying information about the patient to a provider in a different setting at the time of transfer.

I am authorized to submit this information by this facility on its behalf.

[I agree] [I do not agree]

	Name/Signature	**Credential**	**License # (if required)**	**Sections Worked On**	**Date(s) of Data collection**
	(Joe Smith)	(RN)	(MA000000)	III A2-6	(MM/DD/YYYY)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

I. Administrative Items

A. Assessment Type

Enter Code

A1. Reason for assessment

1. Acute discharge
2. PAC admission
3. PAC discharge
4. Interim
5. Expired

A2. Admission Date _____/_____/_____ MM DD YYYY

A3. Assessment Reference Date ____/_____/_____ MM DD YYYY

A4. Expired Date (leave blank if not applicable) _____/_____/_____ MM DD YYYY

B. Provider Information

B1. Provider's Name

B2. Medicare Provider's Identification Number

B3. National Provider Identification Code (NPI)

|___|___|___|___|___|___|___|___|___|___|

C. Patient Information

C1. Patient's First Name

C2. Patient's Middle Initial or Name

C3. Patient's Last Name

C4. Patient's Nickname (optional)

C5. Patient's Medicare Health Insurance Number

|___|___|___|___|___|___|___|___|___|___|___|___|

C6. Patient's Medicaid Number

|___|___|___|___|___|___|___|___|___|___|

C7. Patient's Identification/Provider Account Number

|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

C8. Birth Date

_____/_____/_____ MM DD YYYY

C9. Social Security Number (optional)

|___|___|___|-|___|___|-|___|___|___|___|

Enter Code

C10. Gender

1. Male
2. Female

Check all that apply

C11. Race/Ethnicity

- a. American Indian or Alaska Native
- b. Asian
- c. Black or African American
- d. Hispanic or Latino
- e. Native Hawaiian or Pacific Islander
- f. White
- g. Unknown

Enter Code

C12. Is English the patient's primary language?

0. No
1. Yes *(If **Yes**, skip to C13.)*

C12a. If English is not the patient's primary language, what is the patient's primary language?

_____

Enter Code

C13. Does the patient want or need an interpreter (oral or sign language) to communicate with a doctor or health care staff?

0. No
1. Yes

I. Administrative Items (cont.)

D. Payer Information: Current Payment Source(s)

Check all that apply

- ☐ **D1. None** (no charge for current services)
- ☐ **D2. Medicare** (traditional fee-for-service)
- ☐ **D3. Medicare** (HMO/managed care)
- ☐ **D4. Medicaid** (traditional fee-for-service)
- ☐ **D5. Medicaid** (HMO/managed care)
- ☐ **D6. Workers' compensation**
- ☐ **D7. Title programs** (e.g., Title III, V, or XX)
- ☐ **D8. Other government** (e.g., TRICARE, VA, etc.)
- ☐ **D9. Private insurance/Medigap**
- ☐ **D10. Private HMO/managed care**
- ☐ **D11. Self-pay**
- ☐ **D12. Other** (specify) _____
- ☐ **D13. Unknown**

T.I How long did it take you to complete this section? _____ *(minutes)*

II. Admission Information

A. Pre-admission Service Use

A1. Admission Date

_____/_____/_____
MM DD YYYY

A3. If admitted from a medical setting, what was the primary diagnosis being treated in the previous setting?

_____

Enter Code ☐

A2. Admitted From. Immediately preceding this admission, where was the patient?

1. **Directly from community** (e.g., private home, assisted living, group home, adult foster care)
2. **Long-term nursing facility**
3. **Skilled Nursing Facility (SNF/TCU)**
4. **Hospital emergency department**
5. **Short-stay acute hospital**
6. **Long-term care hospital** (LTCH)
7. **Inpatient rehabilitation hospital or unit** (IRF)
8. **Psychiatric hospital or unit**
9. **Other** (specify)_____

Check all that apply

A4. In the last 2 months, what medical services other than those identified in A2 has the patient received?

- ☐ **a. Skilled Nursing Facility (SNF/TCU)**
- ☐ **b. Short-stay acute hospital** (IPPS)
- ☐ **c. Long-term care hospital** (LTCH)
- ☐ **d. Inpatient rehabilitation hospital or unit** (IRF)
- ☐ **e. Psychiatric hospital or unit**
- ☐ **f. Home health**
- ☐ **g. Hospice**
- ☐ **h. Outpatient**
- ☐ **i. None**

B. Patient History Prior To This Current Illness, Exacerbation, or Injury

B1. Prior to this recent illness, where did the patient live?

Enter Code ☐

1. **Private residence**
2. **Community based residence** (e.g., assisted living residence, group home, adult foster care)
3. **Permanently in a long-term care facility** (e.g., nursing home)
4. **Other** (e.g., shelter, jail, no known address)
9. **Unknown**

B2. If the patient lived in the community prior to this illness, please provide the patient's ZIP Code (if patient's residence was in U.S.).

|___|___|___|___|___|

☐ **Lives Outside U.S.** ☐ **Unknown**

Check all that apply

B3. If the patient lived in the community prior to this illness, what help was used?

- ☐ **a. No help received or no help necessary**
- ☐ **b. Unpaid Assistance**
- ☐ **c. Paid Assistance**
- ☐ **d. Unknown**

B3a. If the patient lived in the community prior to this illness, who did the patient live with? (Check all that apply.)

- ☐ **a. Lives alone**
- ☐ **b. Lives with paid helper**
- ☐ **c. Lives with other(s)**
- ☐ **d. Unknown**

II. Admission Information (cont.)

B4. If the patient lived in the community prior to this current illness, exacerbation, or injury, are there any structural barriers in the patient's **prior residence** that could interfere with the patient's discharge?

Check all that apply

- ☐ **a.** Structural barriers are **not an issue**.
- ☐ **b. Stairs inside the living setting** that must be used by patient (e.g., to get to toileting, sleeping, eating areas).
- ☐ **c. Stairs leading from inside to outside** of living setting.
- ☐ **d. Narrow or obstructed doorways** for patients using wheelchairs or walkers.
- ☐ **e. Insufficient space** to accommodate **extra equipment** (e.g., hospital bed, vent equipment).
- ☐ **f. Other** (specify) _____.
- ☐ **g. Unknown**

B5. Prior Functioning. Indicate the patient's usual ability with everyday activities prior to this current illness, exacerbation, or injury.

3. Independent – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.

2. Needed partial assistance – Patient needed partial assistance from another person to complete activities.

1. Dependent – A helper completed the activity for the patient.

8. Not Applicable

9. Unknown

Enter Code	
☐	**B5a. Self Care:** Did the patient need help bathing, dressing, using the toilet, or eating?
☐	**B5b. Mobility (Ambulation):** Did the patient need assistance with walking from room to room (with or without devices such as cane, crutch, or walker)?
☐	**B5c. Stairs (Ambulation):** Did the patient need assistance with stairs (with or without devices such as cane, crutch, or walker)?
☐	**B5d. Mobility (Wheelchair):** Did the patient need assistance with moving from room to room using a wheelchair, scooter, or other wheeled mobility device?
☐	**B5e. Functional Cognition:** Did the patient need help planning regular tasks, such as shopping or remembering to take medication?

B6. Mobility Devices and Aids Used Prior to Current Illness, Exacerbation, or Injury (Check all that apply.)

Check all that apply

- ☐ **a. Cane/crutch**
- ☐ **b. Walker**
- ☐ **c. Orthotics/Prosthetics**
- ☐ **d. Wheelchair/scooter full time**
- ☐ **e. Wheelchair/scooter part time**
- ☐ **f. Mechanical lift required**
- ☐ **g. Other** (specify) _____
- ☐ **h. None apply**
- ☐ **i. Unknown**

Enter Code ☐

B7. History of Falls. Has the patient had two or more falls in the past year or any fall with injury in the past year?

0. No

1. Yes

9. Unknown

T.II How long did it take you to complete this section? _____ *(minutes)*

III. Current Medical Information

Clinicians:

For this section, please provide a listing of medical diagnoses, comorbid diseases and complications, and procedures based on a review of the patient's clinical records available at the time of assessment. This information is intended to enhance continuity of care. For discharge only, these lists can be added to throughout the stay and will be specific to each setting.

A. Primary and Other Diagnoses, Comorbidities, and Complications

Indicate the primary diagnosis and up to 14 other diagnoses being treated, managed, or monitored in this setting. Please include all diagnoses (e.g., depression, schizophrenia, dementia, protein calorie malnutrition).

A1. Primary Diagnosis at Assessment _____

B. Other Diagnoses, Comorbidities, and Complications

B1.	
B2.	
B3.	
B4.	
B5.	
B6.	
B7.	
B8.	
B9.	
B10.	
B11.	
B12.	
B13.	
B14.	

Enter ☐ Code

B15. Is this list complete?

0. No

1. Yes

III. Current Medical Information (cont.)

C. Major Procedures (Diagnostic, Surgical, and Therapeutic Interventions)

Enter Code

C1. Did the patient have one or more major procedures (diagnostic, surgical, and therapeutic interventions) during this admission?

0. No *(If **No**, skip to Section D. Treatments.)*

1. Yes

List up to 15 procedures (diagnostic, surgical and therapeutic interventions). Indicate if a procedure was left, right, or not applicable (N/A). If procedure was bilateral (e.g., bilateral knee replacement), check both left and right boxes.

Procedure	Left	Right	N/A
C1a.	C1b. ☐	C1c. ☐	C1d. ☐
C2a.	C2b. ☐	C2c. ☐	C2d. ☐
C3a.	C3b. ☐	C3c. ☐	C3d. ☐
C4a.	C4b. ☐	C4c. ☐	C4d. ☐
C5a.	C5b. ☐	C5c. ☐	C5d. ☐
C6a.	C6b. ☐	C6c. ☐	C6d. ☐
C7a.	C7b. ☐	C7c. ☐	C7d. ☐
C8a.	C8b. ☐	C8c. ☐	C8d. ☐
C9a.	C9b. ☐	C9c. ☐	C9d. ☐
C10a.	C10b. ☐	C10c. ☐	C10d. ☐
C11a.	C11b. ☐	C11c. ☐	C11d. ☐
C12a.	C12b. ☐	C12c. ☐	C12d. ☐
C13a.	C13b. ☐	C13c. ☐	C13d. ☐
C14a.	C14b. ☐	C14c. ☐	C14d. ☐
C15a.	C15b. ☐	C15c. ☐	C15d. ☐

Enter Code

C16. Is this list complete?

0. No

1. Yes

III. Current Medical Information (cont.)

D. Major Treatments

Which of the following treatments did the patient receive? (Please note: "Used at any time during stay" is only necessary at discharge.)

Check all that apply

Admitted/Discharged With:	Used at Any Time During Stay	
D1a. ☐	D1b. ☐	**D1. None**
D2a. ☐	D2b. ☐	**D2. Insulin Drip**
D3a. ☐	D3b. ☐	**D3. Total Parenteral Nutrition**
D4a. ☐	D4b. ☐	**D4. Central Line Management**
D5a. ☐	D5b. ☐	**D5. Blood Transfusion(s)**
D6a. ☐	D6b. ☐	**D6. Controlled Parenteral Analgesia – Peripheral**
D7a. ☐	D7b. ☐	**D7. Controlled Parenteral Analgesia – Epidural**
D8a. ☐	D8b. ☐	**D8. Left Ventricular Assistive Device** (LVAD)
D9a. ☐	D9b. ☐	**D9. Continuous Cardiac Monitoring** ***D9c.*** *Specify reason for continuous monitoring:* _____
D10a. ☐	D10b. ☐	**D10. Chest Tube(s)**
D11a. ☐	D11b. ☐	**D11. Trach Tube with Suctioning** ***D11c.*** *Specify most intensive frequency of suctioning during stay:* *Every____ hours*
D12a. ☐	D12b. ☐	**D12. High O_2 Concentration Delivery System** with FiO_2 > 40%
D13a. ☐	D13b. ☐	**D13. Non-invasive ventilation**
D14a. ☐	D14b. ☐	**D14. Ventilator – Weaning**
D15a. ☐	D15b. ☐	**D15. Ventilator – Non-Weaning**
D16a. ☐	D16b. ☐	**D16. Hemodialysis**
D17a. ☐	D17b. ☐	**D17. Peritoneal Dialysis**
D18a. ☐	D18b. ☐	**D18. Fistula or Other Drain Management**
D19a. ☐	D19b. ☐	**D19. Negative Pressure Wound Therapy**
D20a. ☐	D20b. ☐	**D20. Complex Wound Management** with positioning and skin separation/traction that requires at least two persons
D21a. ☐	D21b. ☐	**D21. Halo**
D22a. ☐	D22b. ☐	**D22. Complex External Fixators** (e.g., Ilizarov)
D23a. ☐	D23b. ☐	**D23. One-on-One 24-Hour Supervision** ***D23c.*** *Specify reason for 24-hour supervision:* _____
D24a. ☐	D24b. ☐	**D24. Specialty Surface or Bed** (i.e., air fluidized, bariatric, low air loss, or rotation bed)
D25a. ☐	D25b. ☐	**D25. Multiple IV Antibiotic Administration**
D26a. ☐	D26b. ☐	**D26. IV Vaso-actors** (e.g., pressors, dilators, medication for pulmonary edema)
D27a. ☐	D27b. ☐	**D27. IV Anti-coagulants**
D28a. ☐	D28b. ☐	**D28. IV Chemotherapy**
D29a. ☐	D29b. ☐	**D29. Indwelling Bowel Catheter Management System**
D30a. ☐	D30b. ☐	**D30. Other Major Treatments** ***D30c.*** *Specify*_____

III. Current Medical Information (cont.)

E. Medications

List all current medications for the patient during the 2-day assessment period. These can be exported to an electronic file for merging with the assessment data.

	Medication Name	Dose	Route	Frequency	Planned Stop Date (if applicable)
1	E1a._____	E1b._____	E1c._____	E1d._____	E1e.___/____/____
2	E2a._____	E2b._____	E2c._____	E2d._____	E2e.___/____/____
3	E3a._____	E3b._____	E3c._____	E3d._____	E3e.___/____/____
4	E4a._____	E4b._____	E4c._____	E4d._____	E4e.___/____/____
5	E5a._____	E5b._____	E5c._____	E5d._____	E5e.___/____/____
6	E6a._____	E6b._____	E6c._____	E6d._____	E6e.___/____/____
7	E7a._____	E7b._____	E7c._____	E7d._____	E7e.___/____/____
8	E8a._____	E8b._____	E8c._____	E8d._____	E8e.___/____/____
9	E9a._____	E9b._____	E9c._____	E9d._____	E9e.___/____/____
10	E10a._____	E10b._____	E10c._____	E10d._____	E10e.___/____/____
11	E11a._____	E11b._____	E11c._____	E11d._____	E11e.___/____/____
12	E12a._____	E12b._____	E12c._____	E12d._____	E12e.___/____/____
13	E13a._____	E13b._____	E13c._____	E13d._____	E13e.___/____/____
14	E14a._____	E14b._____	E14c._____	E14d._____	E14e.___/____/____
15	E15a._____	E15b._____	E15c._____	E15d._____	E15e.___/____/____
16	E16a._____	E16b._____	E16c._____	E16d._____	E16e.___/____/____
17	E17a._____	E17b._____	E17c._____	E17d._____	E17e.___/____/____
18	E18a._____	E18b._____	E18c._____	E18d._____	E18e.___/____/____
19	E19a._____	E19b._____	E19c._____	E19d._____	E19e.___/____/____
20	E20a._____	E20b._____	E20c._____	E20d._____	E20e.___/____/____
21	E21a._____	E21b._____	E21c._____	E21d._____	E21e.___/____/____
22	E22a._____	E22b._____	E22c._____	E22d._____	E22e.___/____/____
23	E23a._____	E23b._____	E23c._____	E23d._____	E23e.___/____/____
24	E24a._____	E24b._____	E24c._____	E24d._____	E24e.___/____/____
25	E25a._____	E25b._____	E25c._____	E25d._____	E25e.___/____/____
26	E26a._____	E26b._____	E26c._____	E26d._____	E26e.___/____/____
27	E27a._____	E27b._____	E27c._____	E27d._____	E27e.___/____/____
28	E28a._____	E28b._____	E28c._____	E28d._____	E28e.___/____/____
29	E29a._____	E29b._____	E29c._____	E29d._____	E29e.___/____/____
30	E30a._____	E30b._____	E30c._____	E30d._____	E30e.___/____/____

Enter Code

E31. Is this list complete?
0. No
1. Yes

III. Current Medical Information (cont.)

F. Allergies & Adverse Drug Reactions

Enter Code

F1. Does patient **have allergies or any known adverse drug reactions**?
0. None known *(If **Unknown**, skip to Section G. Skin Integrity.)*
1. Yes *(If **Yes**, list all allergies/causes of reaction [e.g., food, medications, other] and describe the adverse reactions.)*

Allergies/Causes of Reaction	Patient Reaction
F1a. _____	**F1b.** _____
F2a. _____	**F2b.** _____
F3a. _____	**F3b.** _____
F4a. _____	**F4b** _____
F5a. _____	**F5b.** _____
F6a. _____	**F6b.** _____
F7a. _____	**F7b.** _____
F8a. _____	**F8b.** _____

Enter Code

F9. Is the list complete?
0. No
1. Yes

G. Skin Integrity

G1-2. PRESENCE OF PRESSURE ULCERS

Enter Code

G1. Is this patient at **risk of developing pressure ulcers**?
0. No
1. Yes, indicated by clinical judgment
2. Yes, indicated high risk by formal assessment (e.g., on Braden or Norton tools) **or the patient has a stage 1 or greater ulcer, a scar over a bony prominence, or a non-removable dressing, device, or cast.**

Enter Code

G2. Does this patient have one or more unhealed pressure ulcer(s) at stage 2 or higher?
0. No *(If **No**, skip to Section G5. Major Wounds.)*
1. Yes

IF THE PATIENT HAS ONE OR MORE STAGE 2-4 PRESSURE ULCERS, indicate the number of **unhealed pressure ulcers at each stage**.

CODING:	**Number present at assessment**	**Number with onset during this service**	**Pressure ulcer at stage 2, stage 3, or stage 4 only:**
Please specify the number of ulcers at each stage: **0 = 0 ulcers** **1 = 1 ulcer** **2 = 2 ulcers** **3 = 3 ulcers** **4 = 4 ulcers** **5 = 5 ulcers** **6 = 6 ulcers** **7 = 7 ulcers** **8 = 8 or more ulcers** **9 = Unknown**	Stage 2 Enter Code	Stage 2 Enter Code	**G2a. Stage 2** – Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister (excludes those resulting from skin tears, tape stripping, or incontinence associated dermatitis).
	Stage 3 Enter Code	Stage 3 Enter Code	**G2b. Stage 3** – Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
	Stage 4 Enter Code	Stage 4 Enter Code	**G2c. Stage 4** – Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.
	Unstageable Enter Code	Unstageable Enter Code	**G2d. Unstageable** – Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, gray, green, or brown) or eschar (tan, brown, or black) in the wound bed. Include ulcers that are **known or likely**, but are not stageable due to non-removable dressing, device, cast or suspected deep tissue injury in evolution.

III. Current Medical Information (cont.)

G. Skin Integrity (cont.)

Number of Unhealed Stage 2 Ulcers

☐

G2e. Number of unhealed stage 2 ulcers known to be present for more than 1 month.

If the patient has one or more unhealed stage 2 pressure ulcers, record the number present today that were first observed **more than 1 month ago**, according to the best available records. If the patient has no unhealed stage 2 pressure ulcers, record "0."

G5. MAJOR WOUND (excluding pressure ulcers)

Enter Code ☐

Does the patient have one or more **major wound(s)** that require ongoing care because of draining, infection, or delayed healing?

0. No *(If **No**, skip to Section G6. Turning Surfaces Not Intact.)*

1. Yes

Enter Length |___|___|.|___|cm

Enter Width |___|___|.|___|cm

Date Measured __ _/_ __/ ____ MM DD YYYY

G3. If any pressure ulcer is stage 3 or 4 (or if eschar is present) during the 2-day assessment period, please record the most recent measurements for the LARGEST ulcer (or eschar):

a. Longest length in any direction

b. Width of SAME unhealed ulcer or eschar

c. Date of measurement

G5a–e. NUMBER OF MAJOR WOUNDS

Number of Major Wounds	Type(s) of Major Wound(s)
☐☐	**G5a. Delayed healing of surgical wound**
☐☐	**G5b. Trauma-related wound**
☐☐	**G5c. Diabetic foot ulcer(s)**
☐☐	**G5d. Vascular ulcer (arterial or venous including diabetic ulcers not located on the foot)**
☐☐	**G5e. Other** (e.g., incontinence associated dermatitis, normal surgical wound healing). Please specify. _____

Enter Code ☐

G4. Indicate if any unhealed stage 3 or stage 4 pressure ulcer(s) has undermining and/or tunneling (sinus tract) present.

0. No

1. Yes

8. Unable to assess

G6. TURNING SURFACES NOT INTACT

Indicate which of the following turning surfaces have either a pressure ulcer or major wound.

Check All That Apply

Turning Surface	
☐	**a. Skin for all turning surfaces is intact**
☐	**b. Right hip not intact**
☐	**c. Left hip not intact**
☐	**d. Back/buttocks not intact**
☐	**e. Other turning surface(s) not intact**

III. Current Medical Information *(cont.)*

H. Physiologic Factors

Record the most recent value for each of the following physiologic factors. Indicate the date (MM/DD/YYYY) that the value was collected. If the test was not provided during this admission, check "not tested." If it is not possible to measure height and weight, check box if value is estimated (actual measurement is preferred).

Date	Complete using format below	Value	Check if NOT tested	Check here if value is estimated	Anthropometric Measures
H1a. / /	xxx.x	H1b.	H1c. ☐	H1d. ☐	H1. Height (inches) OR
H2a. / /	xxx.x	H2b.	H2c. ☐	H2d. ☐	H2. Height (cm)
H3a. / /	xxx.x	H3b.	H3c. ☐	H3d. ☐	H3. Weight (pounds) OR
H4a. / /	xxx.x	H4b.	H4c. ☐	H4d. ☐	H4. Weight (Kg)

				Vital Signs
H5a. / /	xxx.x	H5b.	H5c. ☐	H5. Temperature (°F) OR
H6a. / /	xx.x	H6b.	H6c. ☐	H6. Temperature (°C)
H7a. / /	xxx	H7b.	H7c. ☐	H7. Heart Rate (beats/min)
H8a. / /	xx	H8b.	H8c. ☐	H8. Respiratory Rate (breaths/min)
H9a. / /	xxx/xxx	H9b.	H9c. ☐	H9. Blood Pressure mm/Hg
H10a. / /	xxx	H10b.	H10c. ☐	H10. O_2 saturation (Pulse Oximetry) %
				H10d. *Please specify source and amount of supplemental O_2* _____
				Laboratory
H11a. / /	xx.x	H11b.	H11c. ☐	H11. Hemoglobin (gm/dL)
H12a. / /	xx.x	H12b.	H12c. ☐	H12. Hematocrit (%)
H13a. / /	xxx.x	H13b.	H13c. ☐	H13. WBC (K/mm³)
H14a. / /	xx.x	H14b.	H14c. ☐	H14. HbA1c (%)
H15a. / /	xxx	H15b.	H15c. ☐	H15. Sodium (mEq/L)
H16a. / /	x.x	H16b.	H16c. ☐	H16. Potassium (mEq/L)
H17a. / /	xx	H17b.	H17c. ☐	H17. BUN (mg/dL)
H18a. / /	x.x	H18b.	H18c. ☐	H18. Creatinine (mg/dL)
H19a. / /	x.x	H19b.	H19c. ☐	H19. Albumin (gm/dL)
H20a. / /	xx.x	H20b.	H20c. ☐	H20. Prealbumin (mg/dL)
H21a. / /	x.x	H21b.	H21c. ☐	H21. INR
				Other
H22a. / /	xx	H22b.	H22c. ☐	H22. Left Ventricular Ejection Fraction (%)
				Arterial Blood Gases (ABGs)
H23a. / /			H23c. ☐	***H23d.*** *Please specify source and amount of supplemental O2* _____
H24.	x.xx	H24b.	H24c. ☐	H24. pH
H25.	xxx	H25b.	H25c. ☐	H25. PaCO2 (mm/Hg)
H26.	xxx	H26b.	H26c. ☐	H26. HCO3 (mEq/L)
H27.	xxx	H27b.	H27c. ☐	H27. PaO2 (mm/Hg)
H28.	xx	H28b.	H28c. ☐	H28. SaO2 (%)
H29.	xx	H29b.	H29c. ☐	H29. B.E. (base excess) (mEq/L)
H30a. / /			H30c. ☐	**Pulmonary Function Tests**
H31.	xxxx	H31b.	H31c. ☐	H31. FVC (cc's)
H32.	xxx	H32b.	H32c. ☐	H32. FEV (% of FVC)
H33.	xxx	H33b.	H33c. ☐	H33. FEV1 (% of FVC in 1 second)
H34.	xxx	H34b.	H34c. ☐	H34. FEV2 (% of FVC in 2 seconds)
H35.	xxx	H35b.	H35c. ☐	H35. FEV3 (% of FVC in 3 seconds)
H36.	xxx	H36b.	H36c. ☐	H36. PEF (liters per minute)
H37.	xx,x	H37b.	H37c. ☐	H37. MVV (liters per minute)
H38.	xxxx	H38b.	H38c. ☐	H38. SVC (cc's)
H39.	xxxx	H39b.	H39c. ☐	H39. TLC (cc's)
H40.	xxxx	H40b.	H40c. ☐	H40. FRC (cc's)
H41.	xxxx	H41b.	H41c. ☐	H41. RV (cc's)
H42.	xxxx	H42b.	H42c. ☐	H42. ERV (cc's)

T.III How long did it take you to complete this section? _____ *(minutes)*

IV. Cognitive Status, Mood and Pain

A. Comatose

Enter Code

A1. Persistent vegetative state/no discernible consciousness at time of admission (discharge)
- **0. No**
- **1. Yes** *(If **Yes**, skip to G6. Pain Observational Assessment.)*

B. Temporal Orientation/Mental Status

B1. Interview Completed

Enter Code

B1a. Interview Attempted?
- **0. No**
- **1. Yes** *(If **Yes**, skip to B2a. [for acute care discharges] or B3. BIMS (for PAC admissions.)*

Enter Code

B1b. Indicate reason that the interview was not attempted and *then skip to Section C. Observational Assessment of Cognitive Status*:
- **1. Unresponsive or minimally conscious**
- **2. Communication disorder**
- **3. No interpreter available**

B2. Temporal Orientation Complete only for acute care discharges.

Enter Code

B2a. Ask patient: *"Please tell me what year it is right now."*

Patient's answer is:
- **3. Correct**
- **2. Missed by 1 year**
- **1. Missed by 2 to 5 years**
- **0. Missed by more than 5 years or no answer**

Enter Code

B2b. Ask patient: *"What month are we in right now?*

Patient's answer is:
- **2. Accurate within 5 days**
- **1. Missed by 6 days to 1 month**
- **0. Missed by more than 1 month or no answer**

B3. BIMS Complete only for PAC admission.

Enter Code

B3a. Repetition of Three Words

Ask patient: "*I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue and bed. Now tell me the three words.*"

Number of words repeated by patient after first attempt:
- **3. Three**
- **2. Two**
- **1. One**
- **0. None**

After the patient's first attempt say: "*I will repeat each of the three words with a cue and ask you about them later: sock, something to wear; blue, a color; bed, a piece of furniture.*" **You may repeat the words up to two more times.**

Enter Code

B3b. Year, Month, Day

B3b.1. Ask patient: *"Please tell me what year it is right now."*

Patient's answer is:
- **3. Correct**
- **2. Missed by 1 year**
- **1. Missed by 2 to 5 years**
- **0. Missed by more than 5 years or no answer**

Enter Code

B3b.2. Ask patient: *"What month are we in right now?*

Patient's answer is:
- **2. Accurate within 5 days**
- **1. Missed by 6 days to 1 month**
- **0. Missed by more than 1 month or no answer**

Enter Code

B3b.3. Ask patient: *"What day of the week is today?"*

Patient's answer is:
- **2. Accurate**
- **1. Incorrect or no answer**

B3c. Recall

Ask patient: *"Let's go back to the first question. What were those three words that I asked you to repeat?"* If unable to remember a word, give cue (i.e., something to wear; a color; a piece of furniture) for that word.

Enter Code

B3c.1. Recalls "sock?"
- **2. Yes**, no cue required
- **1. Yes**, after cueing ("something to wear")
- **0. No**, could not recall

Enter Code

B3c.2. Recalls "blue?"
- **2. Yes**, no cue required
- **1. Yes**, after cueing ("a color")
- **0. No**, could not recall

Enter Code

B3c.3. Recalls "bed?"
- **2. Yes**, no cue required
- **1. Yes**, after cueing ("a piece of furniture")
- **0. No**, could not recall

IV. Cognitive Status, Mood & Pain (cont.)

C. Observational Assessment of Cognitive Status at 2-Day Assessment Period: Complete this section only if patient could not be interviewed.

Check all that apply

C1. Memory/recall ability: Check all that the patient normally recalled during the 2-day assessment period:

- ☐ **C1a. Current season**
- ☐ **C1b. Location of own room**
- ☐ **C1c. Staff names and faces**
- ☐ **C1d. That he or she is in a hospital, nursing home, or home**
- ☐ **C1e. None of the above are recalled**
- ☐ **C1f. Unable to assess**

Specify reason _____

D. Confusion Assessment Method: Complete this section only if patient scored 0 or 1 on B2a. or B2b. (for acute care discharges) or B3b.1., B3b.2., or B3b.3 (for PAC admissions).

Code the following behaviors during the 2-day assessment period.

CODING:

0. Behavior **is not present.**

1. Behavior **continuously present** does not fluctuate.

2. Behavior **present, fluctuates** (e.g., comes and goes, changes in severity).

→ **Enter Code in Boxes** →

Enter ☐ Code	**D1. Inattention:** The patient has difficulty focusing attention (e.g., easily distracted, out of touch, or difficulty keeping track of what is said).
Enter ☐ Code	**D2. Disorganized thinking:** The patient's thinking is disorganized or incoherent (e.g., rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching of topics or ideas).
Enter ☐ Code	**D3. Altered level of consciousness/alertness:** The patient has an altered level of consciousness: vigilant (e.g., startles easily to any sound or touch), lethargic (e.g., repeatedly dozes off when asked questions, but responds to voice or touch), stuporous (e.g., very difficult to arouse and keep aroused for the interview), or comatose (e.g., cannot be aroused).
Enter ☐ Code	**D4. Psychomotor retardation:** Patient has an unusually decreased level of activity (e.g., sluggishness, staring into space, staying in one position, moving very slowly).

IV. Cognitive Status, Mood & Pain (cont.)

E. Behavioral Signs & Symptoms: PAC Admission and Discharge

Has the patient exhibited any of the following behaviors during the 2-day assessment period?

Enter Code

E1. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing).
- **0. No**
- **1. Yes**

Enter Code

E2. Verbal behavioral symptoms directed towards others (e.g., threatening, screaming at others).
- **0. No**
- **1. Yes**

Enter Code

E3. Other disruptive or dangerous behavioral symptoms not directed towards others, including self-injurious behaviors (e.g., hitting or scratching self, attempts to pull out IVs, pacing).
- **0. No**
- **1. Yes**

F. Mood: PAC Admission and Discharge

Enter Code

F1. Mood Interview Attempted?
- **0. No** *(If **No**, skip to Section G1. Pain Interview.)*
- **1. Yes**

F2. Patient Health Questionnaire (PHQ2): PAC Admission and Discharge

Ask patient: *"During the last 2 weeks, have you been bothered by any of the following problems?"*

Enter Code

F2a. Little interest or pleasure in doing things?
- **0. No** *(If **No**, skip to question F2c.)*
- **1. Yes**
- **8. Unable to respond** *(If **Unable**, skip to question F2c.)*

Enter Code

F2b. If ***Yes***, how many days in the last 2 weeks?
- **0. Not at all (0 to 1 days)**
- **1. Several days (2 to 6 days)**
- **2. More than half of the days (7 to 11 days)**
- **3. Nearly every day (12 to 14 days)**

F2. Patient Health Questionnaire (PHQ2) (cont.)

Enter Code

F2c. Feeling down, depressed, or hopeless?
- **0. No** *(If **No**, skip to question F3.)*
- **1. Yes**
- **8. Unable to respond** *(If **Unable**, skip to question F3.)*

Enter Code

F2d. If ***Yes***, how many days in the last 2 weeks?
- **0. Not at all (0 to 1 days)**
- **1. Several days (2 to 6 days)**
- **2. More than half of the days (7 to 11 days)**
- **3. Nearly every day (12 to 14 days)**

F3. Feeling Sad: PAC Admission and Discharge

Enter Code

F3a. Ask patient: *"During the past 2 weeks, how often would you say, 'I feel sad'?"*
- **0. Never**
- **1. Rarely**
- **2. Sometimes**
- **3. Often**
- **4. Always**
- **8. Unable to respond**

IV. Cognitive Status, Mood & Pain (cont.)

G. Pain

Enter Code

G1. Pain Interview Attempted?
- **0. No** *(If **No**, skip to G6. Pain Observational Assessment.)*
- **1. Yes**

Enter Code

G2. Pain Presence
Ask patient: *"Have you had pain or hurting at any time during the last 2 days?"*
- **0. No** *(If **No**, skip to Section V. Impairments.)*
- **1. Yes**
- **8. Unable to answer or no response** (*Skip to G6. Pain Observational Assessment.*)

Enter Code

G3. Pain Severity
Ask patient: *"Please rate your worst pain during the last 2 days on a zero to 10 scale, with zero being no pain and 10 as the worst pain you can imagine."*

Enter 88 if patient does not answer or is unable to respond and skip to *G6. Pain Observational Assessment.*

Enter Code

G4. Pain Effect on Function
Ask patient: *"During the past 2 days, has pain made it hard for you to sleep?"*
- **0. No**
- **1. Yes**
- **8. Unable to answer or no response**

Enter Code

G5. Ask patient: *"During the past 2 days, have you limited your activities because of pain?"*
- **0. No**
- **1. Yes**
- **8. Unable to answer or no response**

G6. Pain Observational Assessment. If patient could not be interviewed for pain assessment, check all indicators of pain or possible pain at the 2-day assessment period.

Check all that apply

- ☐ **G6a. Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)
- ☐ **G6b. Vocal complaints of pain** (e.g., "that hurts, ouch, stop")
- ☐ **G6c. Facial Expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
- ☐ **G6d. Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
- ☐ **G6e. None** of these signs observed or documented

T.IV How long did it take you to complete this section? _____ (minutes)

V. Impairments

A. Bladder and Bowel Management: Use of Device(s) and Incontinence

Enter Code

A1. Does the patient have any impairments with bladder or bowel management?
0. No *(If **No** impairments, skip to Section B. Swallowing.)*
1. Yes (*If **Yes**, please complete this section.*)

Bladder	Bowel	
A2a. Enter Code	A2b. Enter Code	**A2**. Does this patient use an **external or indwelling device** or require intermittent catheterization? **0. No** **1. Yes**
A3a. Enter Code	A3b. Enter Code	**A3.** Indicate the **frequency of incontinence** during the 2-day assessment period. **0. Continent** (no documented incontinence) **1. Stress incontinence only** (bladder only) **2. Incontinent less than daily** (only once during the 2-day assessment period) **3. Incontinent daily** (at least once a day) **4. Always incontinent** **5. No urine/bowel output during the 2-day assessment period** (e.g., renal failure)
A4a. Enter Code	A4b. Enter Code	**A4.** Does the patient **need assistance** to manage equipment or devices related to bladder or bowel care (e.g., urinal, bedpan, indwelling catheter, intermittent catheterization, ostomy)? **0. No** **1. Yes**
A5a. Enter Code	A5b. Enter Code	**A5.** If the patient is incontinent or has an indwelling device, was the patient incontinent (excluding stress incontinence) immediately prior to the current illness, exacerbation, or injury? **0. No** **1. Yes** **9. Unknown**

B. Swallowing

Enter Code

B1. Does the patient have any impairments with swallowing?
0. No *(If **No** impairments, skip to Section C. Hearing, Vision, and Communication.)*
1. Yes (*If **Yes**, please complete this section.*)

Check all that apply

B1. Swallowing Disorder: Signs and symptoms of possible swallowing disorder.
- ☐ **B1a. Complaints of difficulty or pain with swallowing**
- ☐ **B1b. Coughing or choking during meals or when swallowing medications**
- ☐ **B1c. Holding food in mouth/cheeks or residual food in mouth after meals**
- ☐ **B1d. Loss of liquids/solids from mouth when eating or drinking**
- ☐ **B1e. NPO: intake not by mouth**
- ☐ **B1f. Other** (specify) _____

B2. Swallowing: Describe the patient's usual ability with swallowing.
- ☐ **B2a. Regular food:** Solids and liquids swallowed safely without supervision and without modified food or liquid consistency.
- ☐ **B2b. Modified food consistency/supervision:** Patient requires modified food or liquid consistency and/or needs supervision during eating for safety.
- ☐ **B2c. Tube/parenteral feeding:** Tube/parenteral feeding used wholly or partially as a means of sustenance.

V. Impairments (cont.)

C. Hearing, Vision, and Communication

Enter Code

C1. Does the patient have any impairments with hearing, vision, or communication?
0. No *(If **No** impairments, skip to Section D. Weight-bearing.)*
1. Yes (*If **Yes**, please complete this section.*)

C1a. Understanding Verbal Content

Enter Code

4. **Understands:** Clear comprehension without cues or repetitions
3. **Usually Understands:** Understands most conversations, but misses some part/intent of message. Requires cues at times to understand
2. **Sometimes Understands:** Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand
1. **Rarely/Never Understands**
8. **Unable to assess**
9. **Unknown**

C1b. Expression of Ideas and Wants

Enter Code

4. Expresses complex messages **without difficulty** and with speech that is clear and easy to understand
3. Exhibits some **difficulty** with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear
2. **Frequently** exhibits difficulty with expressing needs and ideas
1. **Rarely/Never** expresses self or speech is very difficult to understand.
8. **Unable to assess**
9. **Unknown**

C1c. Ability to See in Adequate Light (with glasses or other visual appliances)

Enter Code

3. **Adequate:** Sees fine detail, including regular print in newspapers/books
2. **Mildly to Moderately Impaired:** Can identify objects; may see large print
1. **Severely Impaired:** No vision or object identification questionable
8. **Unable to assess**
9. **Unknown**

C1d. Ability to Hear (with hearing aid or hearing appliance if normally used)

Enter Code

3. **Adequate:** Hears normal conversation and TV without difficulty
2. **Mildly to Moderately Impaired:** Difficulty hearing in some environments or speaker may need to increase volume or speak distinctly
1. **Severely Impaired:** Absence of useful hearing
8. **Unable to assess**
9. **Unknown**

V. Impairments (cont.)

D. Weight-bearing

Enter Code

D1. Does the patient have any impairments with weight-bearing?
0. No *(If **No** impairments, skip to Section E.. Grip Strength.)*
1. Yes (*If **Yes**, please complete this section.*)

CODING: Indicate all the patient's weight-bearing restrictions in the 2-day assessment period.

1. **Fully weight-bearing:** No medical restrictions
0. **Not fully weight-bearing:** Patient has medical restrictions or unable to bear weight (e.g. amputation)

Upper Extremity		Lower Extremity	
D1a. Left	**D1b. Right**	**D1c. Left**	**D1d. Right**
Enter Code	Enter Code	Enter Code	Enter Code

E. Grip Strength

Enter Code

E1. Does the patient have any impairments with grip strength?
0. No *(If **No** impairments, skip to Section F. Respiratory Status.)*
1. Yes (*If **Yes**, please complete this section.*)

CODING: Indicate the patient's ability to squeeze your hand in the 2-day assessment period.

2. **Normal**
1. **Reduced/Limited**
0. **Absent**

E1a. Left Hand	E1b. Right Hand
Enter Code	Enter Code

F. Respiratory Status

Enter Code

F1. Does the patient have any impairments with respiratory status?
0. No *(If **No** impairments, skip to Section G. Endurance.)*
1. Yes (*If **Yes**, please complete this section.*)

With Supplemental O_2	Without Supplemental O_2
Enter Code	Enter Code
F1a.	**F1b.**

Respiratory Status: Was the patient dyspneic or noticeably **Short of Breath** in the 2-day assessment period?

5. **Severe, with evidence the patient is struggling to breathe at rest**
4. **Mild at rest** (during day or night)
3. **With minimal exertion** (e.g., while eating, talking, or performing other ADLs) **or with agitation**
2. **With moderate exertion** (e.g., while dressing, using commode or bedpan, walking between rooms)
1. **When climbing stairs**
0. **Never, patient was not short of breath**
8. **Not assessed** (e.g., on ventilator)
9. **Not applicable**

V. Impairments (cont.)

G. Endurance

Enter Code

G1. Does the patient have any impairments with endurance?
0. No *(If **No** impairments, skip to Section H. Mobility Devices and Aids Needed.)*
1. Yes (*If **Yes**, please complete this section.*)

Enter Code

G1a. Mobility Endurance: Was the patient able to walk or wheel 50 feet (15 meters) in the 2-day assessment period?
0. No, could not do
1. Yes, can do with rest
2. Yes, can do without rest
8. Not assessed due to medical counter indication

Enter Code

G1b. Sitting Endurance: Was the patient able to tolerate sitting for 15 minutes during the 2-day assessment period?
0. No
1. Yes, with support
2. Yes, without support
8. Not assessed due to medical counter indication

H. Mobility Devices and Aids Needed

Check all that apply

H1. Indicate all mobility devices and aids needed at time of assessment. (Check all that apply.)

- **a. Canes/crutch**
- **b. Walker**
- **c. Orthotics/Prosthetics**
- **d. Wheelchair/scooter full time**
- **e. Wheelchair/scooter part time**
- **f. Mechanical lift required**
- **g. Other** (specify) _____
- **h. None apply**

T.V How long did it take you to complete this section? _____ (minutes)

VI. Functional Status: Usual Performance

A. Core Self Care: The core self care items should be completed on ALL patients.

Code the patient's most usual performance for the 2-day assessment period using the 6-point scale below.

CODING:
Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Code for the most usual performance in the 2-day assessment period.

Activities may be completed with or without assistive devices.

6. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
5. **Setup or clean-up assistance** – Helper SETS UP OR CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
4. **Supervision or touching assistance** –Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
3. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
2. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
1. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the task.

If activity was not attempted code:
M. Not attempted due to **medical condition**
S. Not attempted due to **safety concerns**
A. Task **attempted** but not completed
N. **Not applicable**
P. **Patient Refused**

Enter Code in Boxes

Enter Code	
Enter ☐ Code	**A1. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
Enter ☐ Code	**A2. Tube feeding:** The ability to manage all equipment/supplies related to obtaining nutrition.
Enter ☐ Code	**A3. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures: The ability to remove and replace dentures from and to mouth, and manage equipment for soaking and rinsing.
Enter ☐ Code	**A4. Toilet hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using toilet, commode, bedpan, urinal. If managing ostomy, include wiping opening but not managing equipment.
Enter ☐ Code	**A5. Upper body dressing:** The ability to put on and remove shirt or pajama top. Includes buttoning three buttons.
Enter ☐ Code	**A6. Lower body dressing:** The ability to dress and undress below the waist, including fasteners. Does not include footwear.

VI. Functional Status (cont.)

B. Core Functional Mobility: The core functional mobility items should be completed on ALL patients.

Complete for ALL patients: Code the patient's most usual performance for the 2-day assessment period using the 6-point scale below.

CODING:

Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Code for the most usual performance in the 2-day assessment period.

Activities may be completed with or without assistive devices.

6. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
5. **Setup or clean-up assistance** – Helper SETS UP OR CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
4. **Supervision or touching assistance** –Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
3. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
2. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
1. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the task.

If activity was not attempted code:

M. Not attempted due to **medical condition**
S. Not attempted due to **safety concerns**
A. Task **attempted** but not completed
N. **Not applicable**
P. **Patient Refused**

Enter Code in Boxes

Enter ☐ Code	**B1. Lying to Sitting on Side of Bed:** The ability to safely move from lying on the back to sitting on side of bed with feet flat on the floor, no back support.
Enter ☐ Code	**B2. Sit to Stand:** The ability to safely come to a standing position from sitting in a chair or on the side of a bed.
Enter ☐ Code	**B3. Chair/Bed-to-Chair Transfer:** The ability to safely transfer to and from a chair (or wheelchair). The chairs are placed at right angles to each other.
Enter ☐ Code	**B4. Toilet Transfer:** The ability to safely get on and off a toilet or commode.
MODE OF MOBILITY	
Enter ☐ Code →	**B5.** Does this patient primarily use a wheelchair for mobility? **0. No** (*If **No**, code B5a for the longest distance completed.)* **1. Yes** (*If **Yes**, code B5b for the longest distance completed.)*
Enter ☐ Code Enter ☐ Code Enter ☐ Code Enter ☐ Code →	**B5a. Select the longest distance the patient walks and code his/her level of independence (Level 1–6) on that distance (observe their performance):** **1. Walk 150 ft (45 m):** Once standing, can walk at least150 feet (45 meters) in corridor or similar space. **2. Walk 100 ft (30 m):** Once standing, can walk at least 100 feet (30 meters) in corridor or similar space **3. Walk 50 ft (15 m):** Once standing, can walk at least 50 feet (15 meters) in corridor or similar space **4. Walk in Room Once Standing:** Once standing, can walk at least 10 feet (3 meters) in room, corridor or similar space.
Enter ☐ Code Enter ☐ Code Enter ☐ Code Enter ☐ Code	**B5b. Select the longest distance the patient wheels and code his/her level of independence (Level 1–6) (observe their performance):** **1. Wheel 150 ft (45 m):** Once sitting, can wheel at least 150 feet (45 meters) in corridor or similar space. **2. Wheel 100 ft (30 m):** Once sitting, can wheel at least 100 feet (30 meters) in corridor or similar space **3. Wheel 50 ft (15 m):** Once sitting, can wheel at least 50 feet (15 meters) in corridor or similar space **4. Wheel in Room Once Seated:** Once seated, can wheel at least 10 feet (3 meters) in room, corridor, or similar space.

VI. Functional Status (cont.)

C. Supplemental Functional Ability: Complete only for patients who will need post-acute care to improve their functional ability or personal assistance following discharge.

Please code patient on all activities they are able to participate in and which you can observe, or have assessed by other means, using the 6-point scale below.

CODING:

Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Code for the most usual performance in the 2-day assessment period.

Activities may be completed with or without assistive devices.

6. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
5. **Setup or clean-up assistance** – Helper SETS UP OR CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
4. **Supervision or touching assistance** – Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
3. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
2. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
1. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the task.

If activity was not attempted code:

M. Not attempted due to **medical condition**
S. Not attempted due to **safety concerns**
E. Not attempted due to **environmental constraints**
A. Task **attempted** but not completed
N. **Not applicable**
P. **Patient Refused**

→ **Enter Code in Boxes** ←

Enter Code	
Enter ☐ Code	**C1. Wash Upper Body:** The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.
Enter ☐ Code	**C2. Shower/bathe self:** The ability to bathe self in shower or tub, including washing and drying self. Does not include transferring in/out of tub/shower.
Enter ☐ Code	**C3. Roll left and right:** The ability to roll from lying on back to left and right side, and roll back to back.
Enter ☐ Code	**C4. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
Enter ☐ Code	**C5. Picking up object:** The ability to bend/stoop from a standing position to pick up small object such as a spoon from the floor.
Enter ☐ Code	**C6. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that are appropriate for safe mobility.
MODE OF MOBILITY	
Enter ☐ Code	**C7.** Does this patient primarily use a wheelchair for mobility? **0. No** (*If **No**, code C7a–C7f.*) **1. Yes** (*If **Yes**, code C7f–C7h.*)
Enter ☐ Code	**C7a. 1 step (curb):** The ability to step over a curb or up and down one step.
Enter ☐ Code	**C7b. Walk 50 feet with two turns:** The ability to walk 50 feet and make two turns.
Enter ☐ Code	**C7c. 12 steps-interior:** The ability to go up and down 12 interior steps with a rail.
Enter ☐ Code	**C7d. Four steps-exterior:** The ability to go up and down 4 exterior steps with a rail.
Enter ☐ Code	**C7e. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces, such as grass, gravel, ice or snow.
Enter ☐ Code	**C7f. Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
Enter ☐ Code	**C7g. Wheel short ramp:** Once seated in wheelchair, goes up and down a ramp of less than 12 feet (4 meters).
Enter ☐ Code	**C7h. Wheel long ramp:** Once seated in wheelchair, goes up and down a ramp of more than 12 feet (4 meters).

VI. Functional Status (cont.)

C. Supplemental Functional Ability (cont.): Complete only for patients who will need post-acute care to improve their functional ability or personal assistance following discharge.

Please code patient on all activities they are able to participate in and which you can observe, or have assessed by other means, using the 6-point scale below.

CODING:

Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Code for the most usual performance in the first 2-day assessment period.

Activities may be completed with or without assistive devices.

6. Independent – Patient completes the activity by him/herself with no assistance from a helper.

5. Setup or clean-up assistance – Helper SETS UP OR CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.

4. Supervision or touching assistance – Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.

3. Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.

2. Substantial/maximal assistance – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

1. Dependent – Helper does ALL of the effort. Patient does none of the effort to complete the task.

If activity was not attempted code:

M. Not attempted due to **medical condition**
S. Not attempted due to **safety concerns**
E. Not attempted due to **environmental constraints**
A. Task **attempted** but not completed
N. Not applicable
P. Patient Refused

Enter Code in Boxes →

Enter Code	**C8. Telephone-answering:** The ability to pick up call in patient's customary manner and maintain for 3 minutes. Does not include getting to the phone.
Enter Code	**C9. Telephone-placing call:** The ability to pick up and place call in patient's customary manner and maintain for 3 minutes. Does not include getting to the phone.
Enter Code	**C10. Medication management-oral medications:** The ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.
Enter Code	**C11. Medication management-inhalant/mist medications:** The ability to prepare and take all prescribed inhalant/mist medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.
Enter Code	**C12. Medication management-injectable medications:** The ability to prepare and take all prescribed injectable medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.
Enter Code	**C13. Make light meal:** The ability to plan and prepare all aspects of a light meal such as bowl of cereal or sandwich and cold drink, or reheat a prepared meal.
Enter Code	**C14. Wipe down surface:** The ability to use a damp cloth to wipe down surface such as table top or bench to remove small amounts of liquid or crumbs. Includes ability to clean cloth of debris in patient's customary manner.
Enter Code	**C15. Light shopping:** Once at store, can locate and select up to five needed goods, take to check out, and complete purchasing transaction.
Enter Code	**C16. Laundry:** Includes all aspects of completing a load of laundry using a washer and dryer. Includes sorting, loading and unloading, and adding laundry detergent.
Enter Code	**C17. Use public transportation:** The ability to plan and use public transportation. Includes boarding, riding, and alighting from transportation.

T.VI How long did it take you to complete this section? _____ (minutes)

VII. Overall Plan of Care/Advance Care Directives

A. Overall Plan of Care/Advance Care Directives

Enter Code

A1. Have the patient (or representative) and the care team (or physician) documented agreed-upon care goals and expected dates of completion or re-evaluation?

- **0. No, but this work is in process**
- **1. Yes**
- **9. Unclear or unknown**

Enter Code

A2. Which description best fits the patient's overall status?

- **1. The patient is stable with no risk for serious complications and death (beyond those typical of the patient's age).**
- **2. The patient is temporarily facing high health risks but likely to return to being stable without risk for serious complications and death (beyond those typical of the patient's age).**
- **3. The patient is likely to remain in fragile health and have ongoing high risks of serious complications and death.**
- **4. The patient has serious progressive conditions that could lead to death within a year.**
- **9. The patient's situation is unknown or unclear to the respondent.**

Check all that apply

A3. In anticipation of serious clinical complications, has the patient made and documented care decisions?

- **1. The patient has designated and documented a decision-maker (if the patient is unable to make decisions).**
- **2. The patient (or surrogate) has made and documented a decision to forgo resuscitation.**

T.VIII How long did it take you to complete this section? _____ (minutes)

VIII. Discharge Status

A. Discharge Information: Items with an asterisk (*) relating to assistance/support needs and caregiver availability are also included in home health admission assessments.

A1. Discharge Date

_____/_____/_____
MM DD YYYY

A2. Attending Physician

A3. Discharge Location

Where will the patient be discharged to?

Enter Code

1. **Private residence**
2. **Other community-based residential setting** (e.g., assisted living residents, group home, adult foster care)
3. **Long-term care facility/nursing home**
4. **Skilled nursing facility** (SNF/TCU)
5. **Short-stay acute hospital** (IPPS)
6. **Long-term care hospital** (LTCH)
7. **Inpatient rehabilitation hospital or unit** (IRF)
8. **Psychiatric hospital or unit**
9. **Facility-based hospice**
10. **Other** (e.g., shelter, jail, no known address)
11. **Discharged against medical advice**

A4. * Frequency of Assistance at Discharge (or admission for HH)

How often will the patient require assistance (physical care or supervision) from a caregiver(s) or provider(s)?

Enter Code

1. Patient **does not require assistance**
2. **Weekly** or less (e.g., requires help with grocery shopping or errands, etc.)
3. **Less than daily** but more often than weekly
4. **Intermittently** and predictably during the day or night
5. **All night** but not during the day
6. **All day** but not at night
7. **24** hours per day, or standby services

A5. Caregiver(s) Availability

Was the discharge destination decision influenced by the availability of a family member or friend to provide assistance?

Enter Code

0. **No** *(If **No**, skip to Section B. Residential Information.)*
1. **Yes**

A6. Willing Caregiver(s)*

Does the patient have one or more willing caregiver(s)?

Enter Code

0. **No** *(If* **No,** skip to *Section B. Residential Information.)*
1. **Yes, confirmed by caregiver**
2. **Yes, confirmed only by patient**
9. **Unclear from patient; no confirmation from caregiver**

A7. Types of Caregiver(s)*

What is the relationship of the caregiver(s) to the patient?

Check all that apply

- a. **Spouse or significant other**
- b. **Child**
- c. **Other unpaid family member or friend**
- d. **Paid help**

B. Residential Information: Complete only if patient is discharged to a private residence or other community-based setting.

B1. * Patient Lives With at Discharge (or admission for HH)

Upon discharge (admission), who will the patient live with?

Check all that apply

- a. **Lives alone**
- b. **Lives with paid helper**
- c. **Lives with other(s)**
- d. **Unknown**

VIII. Discharge Status (cont.)

C. Support Needs/Caregiver Assistance*

Type of Assistance Needed Patient needs assistance with (check all that apply)		Support Needs/Caregiver Assistance (If patient needs assistance, check one on each row)			
		CG able	CG will need training and/or other supportive services	CG not likely to be able	CG ability unclear
☐ C1a	**a. ADL assistance (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)**	☐ C2a	☐ C3a	☐ C4a	☐ C5a
☐ C1b	**b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)**	☐ C2b	☐ C3b	☐ C4b	☐ C5b
☐ C1c	**c. Medication administration (e.g., oral, inhaled, or injectable)**	☐ C2c	☐ C3c	☐ C4c	☐ C5c
☐ C1d	**d. Medical procedures/treatments (e.g., changing wound dressing)**	☐ C2d	☐ C3d	☐ C4d	☐ C5d
☐ C1e	**e. Management of equipment (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment, or supplies)**	☐ C2e	☐ C3e	☐ C4e	☐ C5e
☐ C1f	**f. Supervision and safety**	☐ C2f	☐ C3f	☐ C4f	☐ C5f
☐ C1g	**g. Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from appointments)**	☐ C2g	☐ C3g	☐ C4g	☐ C5g
☐ C1h	**h. None of the above**				

VIII. Discharge Status (cont.)

D. Discharge Care Options

Please indicate whether the following services were considered appropriate for the patient at discharge; for those identified as potentially appropriate, were they: available, refused by family, or not covered by insurance. (Check all that apply.)

Type of Service	Considered Appropriate by the Provider	Bed/Services Available	Refused by Patient/Family	Not Covered by Insurance
a. **Home Health Care (HHA)**	☐ D1a	☐ D2a	☐ D3a	☐ D4a
b. **Skilled Nursing Facility (SNF)**	☐ D1b	☐ D2b	☐ D3b	☐ D4b
c. **Inpatient Rehabilitation Hospital (IRF)**	☐ D1c	☐ D2c	☐ D3c	☐ D4c
d. **Long-Term Care Hospital (LTCH)**	☐ D1d	☐ D2d	☐ D3d	☐ D4d
e. **Psychiatric Hospital**	☐ D1e	☐ D2e	☐ D3e	☐ D4e
f. **Outpatient Services**	☐ D1f	☐ D2f	☐ D3f	☐ D4f
g. **Acute Hospital Admission**	☐ D1g	☐ D2g	☐ D3g	☐ D4g
h. **Hospice**	☐ D1h	☐ D2h	☐ D3h	☐ D4h
i. **Long-term personal care services**	☐ D1i	☐ D2i	☐ D3i	☐ D4i
j. **LTC Nursing Facility**	☐ D1j	☐ D2j	☐ D3j	☐ D4j
k. **Other** (specify) _____	☐ D1k	☐ D2k	☐ D3k	☐ D4k

VIII. Discharge Status (cont.)

E. Discharge Location Information

Enter Code

E1. Is the patient being discharged with referral for additional services?
- **0. No** (*If* **No,** skip to *E7. Discharge Delay.*)
- **1. Yes** (*If* **yes,** *please identify the name, location, and type of service to which the patient is discharged.)*

E2. Provider's Name

E4. Provider City

Enter Code

E3. Provider Type
1. **Home Health Care (HHA)**
2. **Skilled Nursing Facility (SNF)**
3. **Inpatient Rehabilitation Hospital (IRF)**
4. **Long-Term Care Hospital (LTCH)**
5. **Psychiatric Hospital**
6. **Outpatient Services**
7. **Acute Hospital**
8. **Hospice**
9. **LTC Nursing Facility**
10. **Other** (specify) _____

E5. Provider State

E6. Medicare Provider's Identification Number

E7. Discharge Delay

Enter Code

Was the patient's discharge delayed for at least 24 hours?
- **0. No**
- **1. Yes**

E8. Reason for Discharge Delay

Enter Code

1. **No bed available**
2. **Services, equipment or medications not available** (e.g., home health care, durable medical equipment, IV medications)
3. **Family/support** (e.g., family could not pick patient up)
4. **Medical** (patient condition changed)
5. **Other** (specify)_____

E9. In the situation that the patient or an authorized representative has requested this information not be shared with the next provider, check here: ☐

T.IX How long did it take you to complete this section? _____ *(minutes)*

IX. Medical Coding Information

Coders:

For this section, please provide a listing of principal diagnosis, comorbid diseases and complications, and procedures based on a review of the patient's clinical records at the time of discharge or at the time of a significant change in the patient's status affecting Medicare payment.

A. Principal Diagnosis

Indicate the **principal diagnosis for billing purposes**. **Indicate the ICD-9 CM code**. For **V-codes**, also indicate the medical diagnosis and associated ICD-9 CM code. Be as specific as possible.

A1. ICD-9 CM code for Principal Diagnosis at Assessment |___|___|___|.|___|___|	**A2. If Principal Diagnosis was a V-code, what was the ICD-9 CM code for the primary medical condition or injury being treated?** |___|___|___|.|___|___|
A1a. Principal Diagnosis at Assessment _____	**A2a. If Principal Diagnosis was a V-code, what was the primary medical condition or injury being treated?** _____

B. Other Diagnoses, Comorbidities, and Complications

List up to 15 **ICD-9 CM codes** and associated diagnoses being treated, managed, or monitored in this setting. Include all diagnoses (e.g., depression, schizophrenia, dementia, protein calorie malnutrition). If a V-code is listed, also provide the **ICD-9 CM code** for the medical diagnosis being treated.

ICD-9 CM code		Diagnosis	
B1a.	|___|___|___|.|___|___|	**B1b.**	
B2a.	|___|___|___|.|___|___|	**B2b.**	
B3a.	|___|___|___|.|___|___|	**B3b.**	
B4a.	|___|___|___|.|___|___|	**B4b.**	
B5a.	|___|___|___|.|___|___|	**B5b.**	
B6a.	|___|___|___|.|___|___|	**B6b.**	
B7a.	|___|___|___|.|___|___|	**B7b.**	
B8a.	|___|___|___|.|___|___|	**B8b.**	
B9a.	|___|___|___|.|___|___|	**B9b.**	
B10a.	|___|___|___|.|___|___|	**B10b.**	
B11a.	|___|___|___|.|___|___|	**B11b.**	
B12a.	|___|___|___|.|___|___|	**B12b.**	
B13a.	|___|___|___|.|___|___|	**B13b.**	
B14a.	|___|___|___|.|___|___|	**B14b.**	
B15a.	|___|___|___|.|___|___|	**B15b.**	

Enter Code

B16. Is this list complete?

0. No

1. Yes

IX. Medical Coding Information (cont.)

C. Major Procedures (Diagnostic, Surgical, and Therapeutic Interventions)

Enter Code

C1. Did the patient have one or more major procedures (diagnostic, surgical, and therapeutic interventions) during this admission?

0. No *(If **No**, skip section)*

1. Yes

List up to 15 **ICD-9 CM codes** and associated procedures (diagnostic, surgical, and therapeutic interventions) performed during this admission.

ICD-9 CM code		Procedure	
C1a.	|___|___|.|___|___|	**C1b.**	
C2a.	|___|___|.|___|___|	**C2b.**	
C3a.	|___|___|.|___|___|	**C3b.**	
C4a.	|___|___|.|___|___|	**C4b.**	
C5a.	|___|___|.|___|___|	**C5b.**	
C6a.	|___|___|.|___|___|	**C6b.**	
C7a.	|___|___|.|___|___|	**C7b.**	
C8a.	|___|___|.|___|___|	**C8b.**	
C9a.	|___|___|.|___|___|	**C9b.**	
C10a.	|___|___|.|___|___|	**C10b.**	
C11a.	|___|___|.|___|___|	**C11b.**	
C12a.	|___|___|.|___|___|	**C12b.**	
C13a.	|___|___|.|___|___|	**C13b.**	
C14a.	|___|___|.|___|___|	**C14b.**	
C15a.	|___|___|.|___|___|	**C15b.**	

Enter Code

C16. Is this list complete?

0. No

1. Yes

X. Other Useful Information

A1. Is there other useful information about this patient that you want to add?

XI. Feedback

A. Notes

Thank you for your participation in this important project. So that we may improve the form for future use, please comment on any areas of concern or things you would change about the form.