Form Approved
OMB No. 0938-0842

INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT

Identification Information*

1. Facility Information
   A. Facility Name
   _____
   _____
   _____
   B. Facility Medicare Provider Number _____

2. Patient Medicare Number _____

3. Patient Medicaid Number _____

4. Patient First Name _____

5A. Patient Last Name _____

5B. Patient Identification Number _____

6. Birth Date _____/_____/_____ (MM / DD / YYYY)

7. Social Security Number _____

8. Gender (*1 - Male; 2 - Female*) _____

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. _____

10. Marital Status _____
(*1 - Never Married; 2 - Married; 3 - Widowed; 4 - Separated; 5 - Divorced*)

11. Zip Code of Patient's Pre-Hospital Residence _____

Admission Information*

12. Admission Date _____/_____/_____ (MM / DD / YYYY)

13. Assessment Reference Date _____/_____/_____ (MM / DD / YYYY)

14. Admission Class _____
(*1 - Initial Rehab; 2 - Evaluation; 3 - Readmission; 4 - Unplanned Discharge; 5 - Continuing Rehabilitation)*

15. Admit From _____
(*01 - Home; 02 - Board & 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*)

16. Pre-Hospital Living Setting _____
(*Use codes from item 15 above*)

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*)

18. Pre-Hospital Vocational Category _____
(*1 - Employed; 2 - Sheltered; 3 - Student; 4 - Homemaker; 5 - Not Working; 6 - Retired for Age; 7 - Retired for Disability*)

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*)

Payer Information*

20. Payment Source
   A. Primary Source _____
   B. Secondary Source _____

(*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)*

Medical Information*

21. Impairment Group _____ (Admission) _____ (Discharge)
Condition requiring admission to rehabilitation; code according to Appendix A, attached.

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*)

23. Date of Onset of Impairment _____/_____/_____ (MM / DD / YYYY)

24. Comorbid Conditions; Use ICD-9-CM codes to enter up to ten medical conditions

A. _____	B. _____
C. _____	D. _____
E. _____	F. _____
G. _____	H. _____
I. _____	J. _____

Medical Needs

25. Is patient comatose at admission? _____ (0 - No, 1 - Yes)

26. Is patient delirious at admission? _____ (0 - No, 1 - Yes)

27. Swallowing Status _____ (Admission) _____ (Discharge)

3 - Regular Food: solids and liquids swallowed safely without supervision or modified food consistency
2 - Modified Food Consistency/ Supervision: subject requires modified food consistency and/or needs supervision for safety
1 - Tube /Parenteral Feeding: tube / parenteral feeding used wholly or partially as a means of sustenance

28. Clinical signs of dehydration _____ (Admission) _____ (Discharge)

(Code 0 – No; 1 – Yes) e.g., *evidence of oliguria, dry skin, orthostatic hypotension, somnolence, agitation*

INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT

Function Modifiers*

Complete the following specific functional items prior to scoring the FIM™ Instrument:

	ADMISSION	DISCHARGE
29. Bladder Level of Assistance (Score using FIM Levels 1 - 7)	☐	☐
30. Bladder Frequency of Accidents (Score as below)	☐	☐

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

Enter in Item 39G (Bladder) the lower (more dependent) score from Items 29 and 30 above.

	ADMISSION	DISCHARGE
31. Bowel Level of Assistance (Score using FIM Levels 1 - 7)	☐	☐
32. Bowel Frequency of Accidents (Score as below)	☐	☐

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

Enter in Item 39H (Bowel) the lower (more dependent) score of Items 31 and 32 above.

	ADMISSION	DISCHARGE
33. Tub Transfer	☐	☐
34. Shower Transfer	☐	☐

(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	☐	☐
36. Distance Traveled in Wheelchair	☐	☐

(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	☐	☐
38. Wheelchair	☐	☐

(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)

*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.

39. FIM™ Instrument*

	ADMISSION	DISCHARGE	GOAL
SELF-CARE			
A. Eating	☐	☐	☐
B. Grooming	☐	☐	☐
C. Bathing	☐	☐	☐
D. Dressing - Upper	☐	☐	☐
E. Dressing - Lower	☐	☐	☐
F. Toileting	☐	☐	☐
SPHINCTER CONTROL			
G. Bladder	☐	☐	☐
H. Bowel	☐	☐	☐
TRANSFERS			
I. Bed, Chair, Whlchair	☐	☐	☐
J. Toilet	☐	☐	☐
K. Tub, Shower	☐	☐	☐
LOCOMOTION (W - Walk; C - wheelChair; B - Both)			
L. Walk/Wheelchair	☐ ☐	☐ ☐	☐
M. Stairs	☐	☐	☐
COMMUNICATION (A - Auditory; V - Visual; B - Both)			
N. Comprehension	☐ ☐	☐ ☐	☐
O. Expression (V - Vocal; N - Nonvocal; B - Both)	☐ ☐	☐ ☐	☐
SOCIAL COGNITION			
P. Social Interaction	☐	☐	☐
Q. Problem Solving	☐	☐	☐
R. Memory	☐	☐	☐

FIM LEVELS

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

INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT

Discharge Information*

40. Discharge Date _____/_____/_____
MM / DD / YYYY

41. Patient discharged against medical advice? _____
(0 - No, 1 -Yes)

42. Program Interruption(s) _____
(0 - No; 1 - Yes)

43. Program Interruption Dates
(Code only if Item 42 is 1 - Yes)

A. 1st Interruption Date _____ MM / DD / YYYY

B. 1st Return Date _____ MM / DD / YYYY

C. 2nd Interruption Date _____ MM / DD / YYYY

D. 2nd Return Date _____ MM / DD / YYYY

E. 3rd Interruption Date _____ MM / DD / YYYY

F. 3rd Return Date _____ MM / DD / YYYY

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)

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)

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

46. Diagnosis for Interruption or Death _____
(Code using ICD-9-CM code)

47. Complications during rehabilitation stay
(Use ICD-9-CM codes to specify up to six conditions that began with this rehabilitation stay)

A. _____ B. _____

C. _____ D. _____

E. _____ F. _____

Quality Indicators

RESPIRATORY STATUS
(Score items 48 to 50 as 0 - No; 1 - Yes)

	Admission	Discharge
48. Shortness of breath with exertion	_____	_____
49. Shortness of breath at rest	_____	_____
50. Weak cough and difficulty clearing airway secretions	_____	_____

* 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.

Quality Indicators

PAIN
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)

0 1 2 3 4 5 6 7 8 9 10
No Pain — Moderate Pain — Worst Possible Pain

Pressure Ulcers

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)

52B. Number of current pressure ulcers
Admission _____ Discharge _____

PUSH Tool v. 3.0 ©

SELECT THE CURRENT LARGEST PRESSURE ULCER TO CODE THE FOLLOWING. Calculate three components (C through E) and code total score in F.

52C. Length multiplied by width (open wound surface area)
Admission _____ Discharge _____

(Score as 0 - 0 cm^2; 1 - < 0.3 cm^2; 2 - 0.3 to 0.6 cm^2; 3 - 0.7 to 1.0 cm^2 ; 4 - 1.1 to 2.0 cm^2; 5 - 2.1 to 3.0 cm^2; 6 - 3.1 to 4.0 cm^2; 7 - 4.1 to 8.0 cm^2; 8 - 8.1 to 12.0 cm^2; 9 - 12.1 to 24.0 cm^2; 10 - > 24 cm^2)

52D. Exudate amount
Admission _____ Discharge _____
0 - None; 1 - Light; 2 - Moderate; 3 - Heavy

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.

52F. TOTAL PUSH SCORE (Sum of above three items -- C, D and E)
Admission _____ Discharge _____

SAFETY	Admission	Discharge
53. Balance problem *(0 - No; 1 - Yes)* *e.g., dizziness, vertigo, or light-headedness*	_____	_____
		Discharge
54. Total number of falls during the rehabilitation stay		_____