CARE Tool

Master Document
(Core and Supplemental Items)

General Information: Please note that this instrument uses the term “2-day assessment period” to represent the 2-day admission and 2-day prior-to-discharge look-back periods.

OMB Version
7/17/07

Signatures of Persons who Completed a Portion of the Accompanying Assessment

I certify that the accompanying information accurately reflects patient assessment for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information may be used as a basis for ensuring that the patient receives appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Name/Signature	**Credential**	**License # (if required)**	**Sections Worked On**	**Attestation Date**
	(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

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 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

Enter Code

C12a. If not, is an interpreter available?
0. No
1. Yes

C12b. If not, what is the patient's primary language?

____

C13. Advance Care Directives

Enter Code

C13a. Are the patient's choices concerning future treatment documented in the medical record?
0. No
1. Yes

Enter Code

C13b. Does the medical record document who has authority to make decisions if the patient is unable?
0. No
1. Yes

Enter Code

C13c. Does the medical record document whether to resuscitate patient if cardiopulmonary arrest occurs?
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., CHAMPUS, 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 in the previous setting?

A3a. Last Primary Diagnosis	A3b. ICD-9 CM Code
	|__|__|__|.|__|__|

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, long term nursing facility)
2. **Skilled nursing facility** (includes subacute SNF, transitional care unit)
3. **Short-stay acute hospital** (IPPS)
4. **Long-term care hospital** (LTCH)
5. **Inpatient rehabilitation hospital or unit** (IRF)
6. **Psychiatric hospital or unit**
7. **Inpatient Hospice**
8. **Other** (specify)_________________

Check all that apply

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

- ☐ a. **Skilled nursing facility** (includes subacute SNF, transitional care unit)
- ☐ 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?

B3. If the patient lived in the community prior to this illness, who did the patient live with?

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

☐ a. **Lives alone**
☐ b. **Spouse or significant other**
☐ c. **Adult child (> 18 years old)**
☐ d. **Other child (< 18 years old)**
☐ e. **Other unpaid family member or friend**
☐ f. **Paid help living in the home** (other than home care)
☐ g. **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) ________________________________.

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 some help** – Patient needed some help from another person to complete activities.
1. **Dependent** – A helper completed the activity for the patient.
9. **Unknown**

Enter Code	Item
☐	**B5a. Self Care:** Did the patient need help bathing, dressing, 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. **Wheelchair/scooter full time**
- ☐ d. **Wheelchair/scooter part time**
- ☐ e. **Mechanical lift required**
- ☐ f. **Other** (specify) ________________________________

Enter Code ☐

B7. History of Falls. Does the patient have a history of falls?

- **0. No**
- **1. Yes**
- **9. Unknown**

Enter Code ☐

B8. Prior Mental Status. Is there any evidence of an acute change in mental status from the patient's status prior to this current illness, exacerbation, or injury?

- **0. No**
- **1. Yes**

			9. Unknown

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

III. Current Medical Items

A. Primary Diagnosis

Indicate the **primary diagnosis** at the time of assessment. **Indicate the ICD-9 CM code,** if available. For **V-codes**, also indicate the medical diagnosis and associated ICD-9 CM code. Be as specific as possible.

A1. Primary Diagnosis at Assessment	A2a. If Primary Diagnosis was a V-code, what was the primary medical condition or injury being treated?
A2. ICD-9 CM Code |__|__|__|.|__|__|	A2b. ICD-9 CM Code |__|__|__|.|__|__|

B. Other Diagnoses, Comorbidities, and Complications

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

Diagnosis	ICD-9 CM Code
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

III. Current Medical Items (cont.)

C. Procedures (Diagnostic and Therapeutic Interventions)
(If home health agency, skip to Section D. Treatments.)

Enter Code [ ]

C1. Did the patient have one or more therapeutic or major procedures during this admission?
0. No *(If **No**, skip to Section D. Treatments.)*
1. Yes

List up to 15 procedures (diagnostic and therapeutic interventions) performed during this admission and report the appropriate procedure code. Indicate if an orthopedic procedure was bilateral (e.g., bilateral knee replacement, bilateral hip replacement).

Procedure	ICD-9 CM Procedure Code	Bilateral
C1a.	C1b. |__|__|.|__|__|	C1c. [ ]
C2a.	C2b. |__|__|.|__|__|	C2c. [ ]
C3a.	C3b. |__|__|.|__|__|	C3c. [ ]
C4a.	C4b. |__|__|.|__|__|	C4c. [ ]
C5a.	C5b. |__|__|.|__|__|	C5c. [ ]
C6a.	C6b. |__|__|.|__|__|	C6c. [ ]
C7a.	C7b. |__|__|.|__|__|	C7c. [ ]
C8a.	C8b. |__|__|.|__|__|	C8c. [ ]
C9a.	C9b. |__|__|.|__|__|	C9c. [ ]
C10a.	C10b. |__|__|.|__|__|	C10c. [ ]
C11a.	C11b. |__|__|.|__|__|	C11c. [ ]
C12a.	C12b. |__|__|.|__|__|	C12c. [ ]
C13a.	C13b. |__|__|.|__|__|	C13c. [ ]
C14a.	C14b. |__|__|.|__|__|	C14c. [ ]
C15a.	C15b. |__|__|.|__|__|	C15c. [ ]

Enter Code [ ]

C16. Is this list complete?
0. No
1. Yes

III. Current Medical Items (cont.)

D. Treatments

Which of the following treatments are required? (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. ☐		D1. **None**
D2a. ☐	D1b. ☐	D2. **Insulin Drip**
D3a. ☐	D2b. ☐	D3. **Total Parenteral Nutrition**
D4a. ☐	D3b. ☐	D4. **Central Line Management**
D5a. ☐	D4b. ☐	D5. **Blood Transfusion(s)**
D6a. ☐	D5b. ☐	D6. **Controlled Parenteral Analgesia – Peripheral**
D7a. ☐	D6b. ☐	D7. **Controlled Parenteral Analgesia – Epidural**
D8a. ☐	D7b. ☐	D8. **Left Ventricular Assistive Device** (LVAD)
D9a. ☐	D8b. ☐	D9. **Continuous Cardiac Monitoring**
	D9b. ☐	***D9c.*** *Specify reason for continuous monitoring:* ___________________
D10a. ☐		D10. **Chest Tube(s)**
D11a. ☐	D10b. ☐	D11. **ET Tube Care and Management**
D12a. ☐	D11b. ☐	D12. **Trach Tube with Suctioning**
	D12b. ☐	***D12c.*** *Specify frequency of suctioning: Every____ hours*
D13a. ☐		D13. **High O_2 Concentration Delivery System** with FiO_2 > 40%
D14a. ☐	D13b. ☐	D14. **Ventilator – Weaning**
D15a. ☐	D14b. ☐	D15. **Ventilator – Non-Weaning**
D16a. ☐	D15b. ☐	D16. **Hemodialysis**
D17a. ☐	D16b. ☐	D17. **Peritoneal Dialysis**
D18a. ☐	D17b. ☐	D18. **Fistula or Other Drain Management**
D19a. ☐	D18b. ☐	D19. **Negative Pressure Wound Therapy**
D20a. ☐	D19b. ☐	D20. **Complex Dressing Changes** with positioning and skin
	D20b. ☐	separation/traction that requires at least two persons
D21a. ☐		D21. **Halo**
D22a. ☐	D21b. ☐	D22. **Complex External Fixators** (e.g., Ilizarov)
D23a. ☐	D22b. ☐	D23. **One-on-One 24-Hour Supervision**
	D23b. ☐	***D23c.*** *Specify reason for 24-hour supervision:* ______________________
D24a. ☐		D24. **Specialty Bed** (e.g., air fluidized, bariatric, low air loss, or
D25a. ☐	D24b. ☐	rotation bed)
D26a. ☐	D25b. ☐	D25. **Multiple IV Antibiotic Administration**
D27a. ☐	D26b. ☐	D26. **IV Vaso-actors** (e.g., pressors, dilators, Flolan for pulmonary
D28a. ☐	D27b. ☐	edema)
D29a. ☐	D28b. ☐	D27. **IV Anti-coagulants**
D30a. ☐	D29b. ☐	D28. **IV Chemotherapy**
D31a. ☐	D30b. ☐	D29. **Indwelling Urinary Catheter**
D32a. ☐	D31b. ☐	D30. **Intermittent Urinary Catheterization**
	D32b. ☐	D31. **Ostomy**
		D32. **External Fecal Management System**

III. Current Medical Items (cont.)

E. Medications

List all current medications for the patient at 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)
E1a.________	E1b.________	E1c.________	E1d.________	E1e.___/___/___
E2a.________	E2b.________	E2c.________	E2d.________	E2e.___/___/___
E3a.________	E3b.________	E3c.________	E3d.________	E3e.___/___/___
E4a.________	E4b.________	E4c.________	E4d.________	E4e.___/___/___
E5a.________	E5b.________	E5c.________	E5d.________	E5e.___/___/___
E6a.________	E6b.________	E6c.________	E6d.________	E6e.___/___/___
E7a.________	E7b.________	E7c.________	E7d.________	E7e.___/___/___
E8a.________	E8b.________	E8c.________	E8d.________	E8e.___/___/___
E9a.________	E9b.________	E9c.________	E9d.________	E9e.___/___/___
E10a.________	E10b.________	E10c.________	E10d.________	E10e.___/___/___
E11a.________	E11b.________	E11c.________	E11d.________	E11e.___/___/___
E12a.________	E12b.________	E12c.________	E12d.________	E12e.___/___/___
E13a.________	E13b.________	E13c.________	E13d.________	E13e.___/___/___
E14a.________	E14b.________	E14c.________	E14d.________	E14e.___/___/___
E15a.________	E15b.________	E15c.________	E15d.________	E15e.___/___/___
E16a.________	E16b.________	E16c.________	E16d.________	E16e.___/___/___
E17a.________	E17b.________	E17c.________	E17d.________	E17e.___/___/___
E18a.________	E18b.________	E18c.________	E18d.________	E18e.___/___/___
E19a.________	E19b.________	E19c.________	E19d.________	E19e.___/___/___
E20a.________	E20b.________	E20c.________	E20d.________	E20e.___/___/___
E21a.________	E21b.________	E21c.________	E21d.________	E21e.___/___/___
E22a.________	E22b.________	E22c.________	E22d.________	E22e.___/___/___
E23a.________	E23b.________	E23c.________	E23d.________	E23e.___/___/___
E24a.________	E24b.________	E24c.________	E24d.________	E24e.___/___/___
E25a.________	E25b.________	E25c.________	E25d.________	E25e.___/___/___
E26a.________	E26b.________	E26c.________	E26d.________	E26e.___/___/___
E27a.________	E27b.________	E27c.________	E27d.________	E27e.___/___/___
E28a.________	E28b.________	E28c.________	E28d.________	E28e.___/___/___
E29a.________	E29b.________	E29c.________	E29d.________	E29e.___/___/___
E30a.________	E30b.________	E30c.________	E30d.________	E30e.___/___/___

Enter Code	
☐	**E31.** Is this list complete? **0. No** **1. Yes**

III. Current Medical Items (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 [e.g., food, medications, other] and describe the adverse drug reactions.)*

Allergies/Cause of Reaction	Patient Reactions
F1a. ______________	F1b. ______________
F2a. ______________	F2b. ______________
F3a. ______________	F3b. ______________
F4a. ______________	F4b ______________
F5a. ______________	F5b. ______________
F6a. ______________	F6b. ______________
F7a. ______________	F7b. ______________
F8a. ______________	F8b. ______________

Enter Code [ ]

F9. If all eight lines are used, is the list complete?
- 0. No
- 1. Yes

G. Skin Integrity

G1-2. PRESENCE OF PRESSURE ULCERS

Enter Code [ ]

G1. Has this patient had a formal evaluation for **risk of developing pressure ulcers**?
- **0. No**
- **1. Yes, it indicated not high risk**
- **2. Yes, it indicated high risk** (e.g., on Braden or Norton tools) or healed scars or active pressure ulcers are present.

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 G3. 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:

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

Number of unhealed pressure ulcers present	Pressure ulcer at stage 2, stage 3, or stage 4 only:
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.
Stage 3 Enter Code [ ]	**G2b. Stage 3** – Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle 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 [ ]	**G2c. Stage 4** – Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

	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 or cast or possible deep tissue injury in evolution.

III. Current Medical Items (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."

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 most recent measurement date of SAME ulcer or eschar

Enter ☐ Code

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

0. No
1. Yes
8. Unable to assess

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 other complications?

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

G5a–e. NUMBER OF MAJOR WOUNDS

Number of Major Wounds	Type(s) of Major Wound(s)
☐☐	G5a. Non-healing 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 (specify) ______________________

G6. TURNING SURFACES NOT INTACT

Check All That Apply

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

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. None of the above apply.

III. Current Medical Items (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, write **NT** for "not tested" under Value. If it is not possible to measure height and weight, check box if value is estimated (actual measurement is preferred).

Date	Please complete using format below	Value	Please check if NOT tested	Check here if value is estimated	Measures
					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 (^{O}F) OR
H6a. ___/___/___	xx.x	H6b. _______	H6c. ☐		H6. Temperature (^{O}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) %
					Laboratory
H11a. ___/___/___	xx	H11b. _______	H11c. ☐		H11. Hemoglobin (gm/dL)
H12a. ___/___/___	xx	H12b. _______	H12c. ☐		H12. Hematocrit (%)
H13a. ___/___/___	xx.x	H13b. _______	H13c. ☐		H13. WBC (K/mm^3)
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
					Arterial Blood Gases (ABGs)
H22a. ___/___/___	x.xx	H22b. _______	H22c. ☐		H22. pH
H23a. ___/___/___	xxx	H23b. _______	H23c. ☐		H23. PaCO2 (mm/Hg)
H24a. ___/___/___	xxx	H24b. _______	H24c. ☐		H24. HCO3 (mEq/L)
H25a. ___/___/___	xxx	H25b. _______	H25c. ☐		H25. PaO2 (mm/Hg)
H26a. ___/___/___	xx	H26b. _______	H26c. ☐		H26. SaO2 (%)
H27a. ___/___/___	xx	H27b. _______	H27c. ☐		H27. B.E. (base excess) (mEq/L)
					Other
H28a. ___/___/___	xx	H28b. _______	H28c. ☐		H28. Left Ventricular Ejection Fraction (%)

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

IV. Cognitive Status

A. Comatose

A1. Persistent vegetative state/no discernible consciousness at time of admission (discharge)

Enter Code [ ]

0. **No**
1. **Yes** *(If **Yes**, skip to G6.)*

B. Brief Interview for Mental Status (BIMS)

B1. BIMS Interview Attempted?

Enter Code [ ]

0. **No**
1. **Yes** *(If **Yes**, skip to B2. Repetition of three words.)*

Enter Code [ ]

B1a. Indicate reason that BIMS interview was not attempted and then skip to Section C. Observational Assessment:

1. **Unresponsive or minimally conscious**
2. **Communication disorder**
3. **No interpreter available**
4. **Other** (specify) ____________________

B2. Repetition of Three Words

Enter Code [ ]

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.

B. Brief Interview for Mental Status (BIMS) (cont.)

B3. Temporal Orientation (orientation to year and month)

Enter Code [ ]

B3a. 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. 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**

B4. 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 [ ]

B4a. Recalls "sock?"

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

Enter Code [ ]

B4b. Recalls "blue?"

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

Enter Code [ ]

B4c. Recalls "bed?"

2. **Yes**, no cue required
1. **Yes**, after cueing ("a piece of furniture")
0. **No**, could not recall

IV. Cognitive Status (cont.)

C. Observational Assessment of Cognitive Status at 2-Day Assessment Period

Enter Code

C1. Short-term memory: Seems or appears to recall after 5 minutes.
- 0. **Memory OK**
- 1. **Memory problem**
- 8. **Unable to assess**

Check all that apply

C3. Memory/recall ability: Check all that the patient normally recalled during the 2-day assessment period:
- ☐ C3a. **Current season**
- ☐ C3b. **Location of own room**
- ☐ C3c. **Staff names and faces**
- ☐ C3d. **That he or she is in a hospital, nursing home, or home**
- ☐ C3e. **None of the above are recalled** or **unable to assess**

Enter Code

C2. Long-term memory: Seems or appears to recall long past.
- 0. **Memory OK**
- 1. **Memory problem**
- 8. **Unable to assess**

Enter Code

C4. Cognitive skills for daily decision making: Makes decisions regarding tasks of daily life:
- 0. **Independent:** decisions consistently reasonable
- 1. **Impaired:** some difficulty or decisions poor; supervision required
- 8. **Unable to assess**

D. Confusion Assessment Method

Code the following behaviors at 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 (cont.)

E. Behavioral Signs & Symptoms

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

Enter Code

F1. Mood Interview Attempted?
- 0. **No** *(If **No**, skip to Section G6. Observed Pain.)*
- 1. **Yes**

F2. Patient Health Questionnaire (PHQ2)

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

Enter Code

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

Enter Code

G4. Pain Severity
Ask patient: *"Please rate the intensity of your worst pain during the last 2 days."*
1. **Mild**
2. **Moderate**
3. **Severe**
4. **Very severe, horrible**
8. **Unable to answer or no response.** (*Skip to G6. Pain Observational Assessment.*)

Enter Code

G5a. Pain Effect on Function
Ask patient: *"During the past 2 days, has pain made it hard for you to sleep at night?"*
0. **No**
1. **Yes**
8. **Unable to answer or no response**

Enter Code

G5b. 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

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. Impairments

Enter Code

A1. Does the patient have any impairments in bladder or bowel management, hearing, vision, communication, range of motion, weight-bearing, grip strength, respiratory status, or endurance?
- **0. No** *(If **No** impairments, skip to section VI. Functional Status.)*
- **1. Yes**

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

Bladder	Bowel	
B1a. Enter Code	B1b. Enter Code	**B1**. Does this patient use an **external or indwelling device** or require intermittent catheterization? **0. No** **1. Yes**
B2a. Enter Code	B2b. Enter Code	**B2.** 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)
B3a. Enter Code	B3b. Enter Code	**B3.** 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**
B4a. Enter Code	B4b. Enter Code	**B4.** If the patient is incontinent or has an indwelling catheter, does the patient have a history of incontinence (excluding stress incontinence) prior to the current illness, exacerbation, or injury? **0. No** **1. Bladder only** **2. Bowel only** **3. Bladder and bowel** **9. Unknown**

C. Swallowing

Check all that apply

C1. Swallowing Disorder: Signs and symptoms of possible swallowing disorder.
- ☐ **C1a. No signs or symptoms of a possible swallowing disorder**
- ☐ **C1b. Complaints of difficulty or pain with swallowing**
- ☐ **C1c. Coughing or choking during meals or when swallowing medications**
- ☐ **C1d. Holding food in mouth/cheeks or residual food in mouth after meals**
- ☐ **C1e. Loss of liquids/solids from mouth when eating or drinking**
- ☐ **C1f. NPO: intake not by mouth**
- ☐ **C1g. Other** (specify) ______________________

V. Impairments (cont.)

C. Swallowing (cont.)

Check all that apply

C2. Swallowing: Describe the patient's usual ability with swallowing.

- ☐ a. **Regular food:** Solids and liquids swallowed safely without supervision and without modified food or liquid consistency.
- ☐ b. **Modified food consistency/supervision:** Patient requires modified food or liquid consistency and/or needs supervision during eating for safety.
- ☐ c. **Tube/parenteral feeding:** Tube/parenteral feeding used wholly or partially as a means of sustenance.

D. Impairments – Hearing, Vision & Communication Comprehension

D1. Understanding verbal content (with hearing aid or device if used)

Enter Code ☐

3. **Understands:** clear comprehension without cues or repetitions
2. **Usually/Sometimes Understands:** comprehends only basic conversations or simple, direct phrases or requires cues to understand
1. **Rarely/Never Understands**
8. **Unable to assess**
9. **Unknown**

D2. Expression of ideas and wants

Enter Code ☐

3. Expresses complex messages **without difficulty** and with speech that is clear and easy to understand
2. Exhibits **difficulty** with expressing needs and ideas or speech is not clear
1. **Rarely/Never** expresses self or speech is very difficult to understand.
8. **Unable to assess**
9. **Unknown**

D3. 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**

D4. 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**

E. Upper Extremity Range of Motion

CODING:
Indicate the patient's usual ability in functional range of motion in the 2-day assessment period.

1. **Within Normal Limits:** Range of motion is within normal limits.
0. **Limited Range of Motion:** Patient's range of motion is not within normal limits.

Indicate if the patient has functional range of motion within normal limits in the following joints:

E1a. Left Shoulder	E1b. Left Elbow	E1c. Right Shoulder	E1d. Right Elbow
Enter Code ☐	Enter Code ☐	Enter Code ☐	Enter Code ☐

V. Impairments (cont.)

F. Weight-bearing

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

Indicate if the patient has weight-bearing restrictions in the following extremities:

Upper Extremity		Lower Extremity	
F1a. Left	**F1b. Right**	**F1c. Left**	**F1d. Right**
Enter Code	Enter Code	Enter Code	Enter Code

G. Grip Strength

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

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

Indicate the patient's ability to squeeze your hand.

G1a. Left Hand	**G1b. Right Hand**
Enter Code	Enter Code

H. Respiratory Status

Enter Code

H1. 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)

I. Endurance

Enter Code

I1. Mobility Endurance: Did the patient have to stop and rest two or more times when walking or wheeling 50 feet (15 meters) in the 2-day assessment period?

0. **No**
1. **Yes**
8. **Not assessed**

Enter Code

I2. Sitting Endurance: Was the patient able to tolerate sitting at the edge of the bed for 3 minutes in the 2-day assessment period?

0. **No**
1. **Yes**
8. **Not assessed**

J. Mobility Devices and Aides Needed

Check all that apply

Indicate all mobility devices and aides needed (check all that apply):

- ☐ a. Canes/crutch
- ☐ b. Walker
- ☐ c. Wheelchair/scooter full time
- ☐ d. Wheelchair/scooter part time
- ☐ e. Mechanical lift required
- ☐ f. Other (specify) ______________________________

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

VI. Functional Status

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	Item
[ ]	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.
[ ]	A2. **Tube feeding:** The ability to manage all equipment/supplies related to obtaining nutrition once they are presented to the patient.
[ ]	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.
[ ]	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.
[ ]	A5. **Upper body dressing:** The ability to put on and remove shirt or pajama top. Includes buttoning three buttons.
[ ]	A6. **Lower body dressing:** The ability to dress and undress below the waist, including fasteners.

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

Enter Code in Boxes ➔

Enter Code	Item
☐	**B1. Lying to Sitting on Side of Bed:** The ability to move from lying on the back to sitting on side of bed with feet flat on the floor, no back support.
☐	**B2. Sit to Stand:** The ability to come to a standing position from sitting in a chair or on the side of a bed.
☐	**B3. Chair/Bed-to-Chair Transfer:** The ability to transfer to and from a chair (or wheelchair). The chairs are placed at right angles to each other.
☐	**B4. Toilet Transfer:** The ability to get on and off a toilet or commode.

MODE OF MOBILITY

Enter Code	Item
☐	**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.*)
☐	**B5a. Code for the longest distance the patient can walk (observe their performance):** 1. **Walk 150 ft (45 m):** Once standing can walk 150 feet (45 meters) in corridor or similar space. 2. **Walk 100 ft (30 m):** Once standing can walk 100 feet (30 meters) in corridor or similar space 3. **Walk 50 ft (15 m):** Once standing can walk 50 feet (15 meters) in corridor or similar space 4. **Walk in Room Once Standing:** Once standing can walk 10 feet (3 meters) in room, corridor or similar space.

N. Not applicable **P. Patient Refused**		Enter ☐ Code	**B5b. Code for the longest distance the patient can wheel (observe their performance):** 1. **Wheel 150 ft (45 m):** Once sitting can wheel 150 feet (45 meters) in corridor or similar space. 2. **Wheel 100 ft (30 m):** Once standing can wheel 100 feet (30 meters) in corridor or similar space 3. **Wheel 50 ft (15 m):** Once standing can wheel 50 feet (15 meters) in corridor or similar space 4. **Wheel in Room Once Seated:** Once seated can wheel 10 feet (3 meters) in room, corridor or similar space.

VI. Functional Status (cont.)

C. Supplemental Functional Ability: Complete only for patients who had therapy consult or who will need post-acute care or personal assistance following discharge.

Please code patient on all activities they are able to participate in and which you can observe 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.

➔ Enter Code in Boxes ➔

Enter Code	Item
Enter ☐ Code	**C1. Sponge bathe:** The ability to wash, rinse, and dry body from neck down (excluding back) 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 or right:** Ability to roll from lying on back to left or 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:** Ability to bend/stoop to pick up small object such as a spoon from the floor.
MODE OF MOBILITY	
Enter ☐ Code	**C6.** Does this patient primarily use a wheelchair for mobility? **0. No** (*If **No**, code C6a–C6d.)* **1. Yes** (*If **Yes**, code C6e–C6f.)*
Enter ☐ Code	**C6a. 1 step (curb):** The ability to step over a curb or up and down one step.
Enter ☐ Code	**C6b. Walk 50 feet with two turns:** The ability to walk 50 feet and make two turns.
Enter ☐ Code	**C6c. 12 steps-interior:** The ability to go up and down 12 interior steps.
Enter ☐ Code	**C6d. Four steps-exterior:** The ability to go up and down 4 exterior steps with or without a rail.
Enter ☐ Code	**C6e. Wheel short ramp:** Once seated in wheelchair is able to go up and down a ramp of less than 12 feet (4 meters).

If activity was not attempted code:		Enter Code	C6f. Wheel long ramp: The ability to go up or down a ramp of more than 12 feet (4 meters).
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**			

VI. Functional Status (cont.)

C. Supplemental Functional Ability (cont.): Complete only for patients who had therapy consult or who will need post-acute care or personal assistance following discharge.

Please code patient on all activities they are able to participate in and which you can observe using the *4-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.

4. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
3. **Minimal Assistance** – Patient completes the activity with assistance. Helper provides less than half of the effort.
2. **Maximum Assistance** – Patient completes the activity with assistance. Helper provides more than half of the effort.
1. **Dependent (Total Assistance)** – 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 restrictions**
- **S.** Not attempted due to **safety concerns**
- **A.** Task **attempted** but not completed
- **N.** **Not applicable** or cannot be observed in patient's current environment.
- **P.** **Patient Refused**
- **R.** Patient did not perform the task before the current illness, exacerbation, or injury.

➔ Enter Code in Boxes ➔

Enter Code	Item
[ ]	**C7. Telephone-answering:** Ability to pick up call in patient's customary manner and maintain for 3 minutes. Does not include getting to the phone.
[ ]	**C8. Telephone-placing call:** Ability to pick up and place call in patient's customary manner and maintain for 3 minutes. Does not include getting to the phone.
[ ]	**C9. 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.
[ ]	**C10. 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.
[ ]	**C11. 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.
[ ]	**C12. Make light meal:** 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.
[ ]	**C13. Wipe down surface:** 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.
[ ]	**C14. Light shopping:** Once at store, can locate and select up to five needed goods, take to check out, and complete purchasing transaction.
[ ]	**C15. Laundry:** Includes all aspects of completing a load of laundry using a washer and dryer. Includes sorting, loading and unloading, and adding laundry liquid.
[ ]	**C16. Get in/out of car:** The ability to get into and out of a car or van on the passenger side. Does not include open/close door or fasten seat belt.
[ ]	**C17. Drive a car:** Ability to drive a car in local community.

	Enter Code	**C18. Use public transportation:** Ability to use public transportation. Includes boarding, riding, and alighting from transportation.

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

VII. Engagement

A. Engagement

Enter
Code

A1. Indicate the patient's cognitive and emotional resources to comprehend current services, tolerate typical frustrations of care, and participate actively in the treatments.

6. **No Problem:** Participates willingly in treatment; appreciates value of care; places frustrations in perspective.
5. **Minimal Problem:** Participates in treatments; infrequently questions value of activities; infrequent difficulty with frustrations.
4. **Mild Problem:** Requires occasional encouragement; occasionally questions value of activities/occasional difficulty with frustrations.
3. **Moderate Problem:** Requires frequent encouragement; frequently questions value of activities/difficulty dealing with frustrations; much time spent explaining goals/rationale rather than executing treatment plan.
2. **Moderate to Severe problem:** Requires consistent encouragement; does not value treatment; continuous difficulty dealing with frustrations.
1. **Severe Problem:** Refuses to participate, requests discharge.
8. **Not assessed**

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

VIII. Frailty/Life Expectancy

A. Frailty/Life Expectancy

Enter
Code

A1. Would you be surprised if the patient was **readmitted to an acute care hospital in the next 6 months?**

0. **No**
1. **Yes**
8. **Not assessed**
9. **Unknown**

Enter
Code

A2. Would you be surprised if the patient were to **die in the next 12 months?**

0. **No**
1. **Yes**
8. **Not assessed**
9. **Unknown**

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

IX. Discharge Status

A. Discharge Information

A1. Discharge Date

_____/_____/_____
MM DD YYYY

A2. Discharge Location

Where will the patient be discharged to?

Enter Code [ ]

1. **Private residence**
2. **Other community-based residence setting** (e.g., assisted living residents, group home, adult foster care)
3. **Long-term care facility/nursing home**
4. **Skilled nursing facility** (includes subacute) (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. **Inpatient hospice care**
10. **Other** (e.g., shelter, jail, no known address)
11. **Discharged against medical advice**

A3. Frequency of Assistance at Discharge

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

Enter Code [ ]

1. Patient **does not require assistance** (*If selected, skip to C1. Other Discharge Needs.*)
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** 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

B. Caregiver Information: If patient is discharged to a private residence or other community-based setting, please complete this section.

B1. Patient Lives With at Discharge

Upon discharge, who will the patient live with?

Check all that apply

- [ ] **B1a. Will live alone**
- [ ] **B1b. Spouse or significant other**
- [ ] **B1c. Adult child (> 18 years old)**
- [ ] **B1d. Other child (≤ 18 years old)**
- [ ] **B1e. Other unpaid family member or friend**
- [ ] **B1f. Paid help living in the home**
- [ ] **B1g. Unknown**

B2. Caregiver(s) Availability at Discharge

Enter Code [ ]

Does the patient currently have one or more caregiver(s) both ***willing and able*** to provide the necessary care?

0. **No** (*If **No**, skip to C1. Other Discharge Needs.*)
1. **Yes**

B3. Types of Caregiver(s)

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

Check all that apply

- [ ] **B4a. Spouse or Significant other**
- [ ] **B4b. Child**
- [ ] **B4c. Other unpaid family member or friend**
- [ ] **B4d. Paid help**

IX. Discharge Status (cont.)

C. Other Discharge Needs

Enter Code

C1. Will the patient be able to pay for their medications after discharge?

0. **No**
1. **Yes**
8. **Unable to assess** (e.g., patient unresponsive, communication disorder, no interpreter available, other)
9. **Unknown to patient**

Enter Code

C2. Will the patient be able to manage their medications after discharge?

1. **Yes, able to manage medications independently**
2. **Yes, able to manage medications with assistance**
3. **No, unable to manage medications**
4. **Not applicable, no medications**
9. **Unknown**

Enter Code

C3. How will the patient be transported to any follow up physician appointments and/or outpatient therapies or treatments?

1. **No follow up physician appointments and/or outpatient therapies or treatments planned**
2. **Can drive self**
3. **Family member or friend will drive patient**
4. **Public transportation**
5. **Other** (specify) _______________
8. **Unable to assess** (e.g., patient unresponsive, communication disorder, no interpreter available, other)
9. **Unknown to patient**

Enter Code

C4. If the patient lived in the community prior to this current illness, exacerbation, or injury, will the availability (or lack of availability) of a willing and able caregiver affect their discharge care options?

0. **No**
1. **Yes**
9. **Unknown**

D. Discharge Care Options

Please indicate whether the following services were considered appropriate for the patient at discharge (check all that apply).

Type of Service	Deemed 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

IX. Discharge Status (cont.)

D. Discharge Care Options (cont.)

Please indicate whether the following services were considered appropriate for the patient at discharge (check all that apply).

i. LTC Nursing Facility	☐ D1i	☐ D2i	☐ D3i	☐ D4i
j. Other (specify) _______________	☐ D1j	☐ D2j	☐ D3j	☐ D4j

E. Discharge Location Information: Please identify the name, location, and type of service to which the patient is discharged.

E1. Provider's Name

E3. Provider City

Enter Code ☐

E2. 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 Admission
8. Hospice
9. LTC Nursing Facility
10. Other (specify) _______________

E4. Provider State

E5. Medicare Provider's Identification Number

E6. In the situation that the patient or an authorized representative has requested this information not be shared with the next provider, check here ☐

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)_____________________

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

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.