CARE Tool
Expired

This instrument uses the phrase "2-day assessment period" to refer to the day of death or the day before the day of death.

Signatures of Clinicians 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)	Medical Information	(MM/DD/YYYY)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1037. The time required to complete this information collection is estimated to average one hour or less per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Expiration Date: 03/31/2011.

I. Administrative Items

A. Assessment Type

Enter Code: 4

A1. Reason for assessment
1. Admit
2. Interim
3. Discharge
4. Expired

A3. Assessment Reference Date

_____/_____/_____
MM DD YYYY

(The first date of the expired assessment period. It is the day before the patient expired.)

B. Provider Information

B1. Provider's Name

C. Patient Information

C1. Patient's First Name

C4. Patient's Nickname (Optional)

C2. Patient's Middle Initial or Name

C5. Patient's Medicare Health Insurance Number

|__|__|__|__|__|__|__|__|__|__|__|__|

C3. Patient's Last Name

C6. Patient's Medicaid Number (if applicable)

|__|__|__|__|__|__|__|__|__|__|

C7. Patient's Facility/Agency Identification Number (for internal tracking)

|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

C8a. Admission Date

_____/_____/_____
MM DD YYYY

C8b. Birth Date

_____/_____/_____
MM DD YYYY

C8c. Expired Date

_____/_____/_____
MM DD YYYY

Enter Code: __

C10. Gender
1. Male
2. Female

*T.1 How long did it take you to complete the **I. Administrative Items** section? ________ (minutes)*
Clinician Name(s) ____

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.

A. Primary and Other Diagnoses, Comorbidities, and Complications

Indicate the primary diagnosis. Be as specific as possible.

A1. Primary Diagnosis at Assessment

____

B. Other Diagnoses, Comorbidities, and Complications

List other diagnoses being treated, managed, or monitored in this setting. Please include all diagnoses (e.g., depression, schizophrenia, dementia, protein calorie malnutrition).

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 (e.g., G-tube placement, EEG, abdominal cat scans; do not include x-rays, EKGs, ultrasounds) during this admission?

0. No *(If **No**, skip to Section D. Major 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

D. Major Treatments

Which of the following treatments did the patient receive a) on the day of death or the day before the day of death or b) at any time during their admission?

Check all that apply.

Used on the Day of Death or the Day Before the Day of Death:	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 O2 Concentration Delivery System with FiO2 > 40%**
D13a. ☐	D13b. ☐	**D13. Non-invasive ventilation (CPAP)**
D14a. ☐	D14b. ☐	**D14. Ventilator – Weaning** ***D14c.*** *If patient is completely independent of the ventilator, specify the number of days it took to wean patient:* ____________
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 or extensive and complex wound management by one person
D21a. ☐	D21b. ☐	**D21. Halo**
D22a. ☐	D22b. ☐	**D22. Complex External Fixators** (e.g., Ilizarov)
D23a. ☐	D23b. ☐	**D23. One-on-One 24-Hour Staff Supervision** ***D23c.*** *Specify reason for 24-hour supervision:* ________________________
D24a. ☐	D24b. ☐	**D24. Specialty Surface or Bed** (e.g., air fluidized, bariatric, low air loss, or rotation bed)
D25a. ☐	D25b. ☐	**D25. Multiple Types of IV Antibiotic Administration**
D26a. ☐	D26b. ☐	**D26. IV Vasoactive Medications** (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** (e.g., isolation, hyperthermia blanket) ***D30c.*** *Specify*____

III. Current Medical Information (cont.)

E. Medications (Optional)

Please list the **ten** most clinically relevant medications for the patient during the 2-day assessment period.

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

Enter "1" if this section skipped due to OPTIONAL status.

III. Current Medical Information (cont.)

F. Allergies & Adverse Drug Reactions

Enter Code: **0**

F1. Does patient **have allergies or any known adverse drug reactions**?
- **0. None known**
- **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: **1**

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

IX. ICD-9 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 assessment 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. ICD-9 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 to Section X, Other Useful Information)*
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	
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.**	
C16a.	|__|__|.|__|__|	**C16b.**	

Enter [ ] Code

C17. Is this list complete?

0. No
1. Yes

D. Coding Complete

Enter [ ] Code

D1. Is this coding section complete?

0. No
1. Yes

*T.IX How long did it take you to complete the **IX. ICD-9 Coding Information** section? _______ (minutes)*
Clinician Name(s) ____

X. Other Useful Information

A. 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.