CARE Tool
Institutional Admission

This instrument uses the phrase "2-day assessment period" to refer to the day of the admission and the next calendar day (ending at 11:59 PM), or, if the patient is admitted after noon, add an additional calendar day.

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.					

I. Administrative Items

A. Assessment Type

Enter [I] Code

A1. Reason for assessment

1. Admit
2. Interim
3. Discharge
4. Expired

A3. Assessment Reference Date

_____/_____/_____
MM DD YYYY

(The last day of the admission assessment period.

- If the patient is admitted before 12 Noon, it is the second calendar day of the admission.
- If the patient is admitted after 12 Noon, it is the third calendar day of the admission.)

B. Provider Information

B1. Provider's Name

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 (if applicable)

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

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

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

C8a. Admission Date

_____/_____/_____
MM DD YYYY

C8b. Birth Date

_____/_____/_____
MM DD YYYY

C9. Social Security Number (Optional)

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

Enter [ ] Code

C10. Gender

1. Male
2. Female

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? _____

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

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

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** (managed care/Part C/Medicare Advantage)
- [ ] **D4. Medicaid** (traditional fee-for-service)
- [ ] **D5. Medicaid** (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 managed care**
- [ ] **D11. Self-pay**
- [ ] **D12. Other** (specify) _____
- [ ] **D13. Unknown**

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

II. Admission Information

A. Pre-admission Service Use

Enter Code ☐

A1. Admitted From. Immediately preceding this admission, where was the patient?

1. **Community residential setting** (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** (IPPS)
6. **Long-term care hospital** (LTCH)
7. **Inpatient rehabilitation hospital or unit** (IRF)
8. **Psychiatric hospital or unit**
9. **Other** (if transferring within units of an acute setting, choose "Other" and indicate if transferring to ICU, stepdown, med/surg, or other unit)_____

Check all that apply.

A3. In the last 2 months, what other medical services besides those identified in A1. 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 agency** (HHA)
- ☐ g. **Hospice**
- ☐ h. **Outpatient services**
- ☐ i. **None**

A2. If admitted from a medical setting, what was the primary diagnosis being treated in the previous setting?

A2a. _____

Check all that apply.

A4. Within this Acute Care Hospital Stay, on what other units has the patient been treated prior to coming to this unit?

- ☐ a. **Critical Care/ Intensive Care Unit** (ICU) **-- 1-2 pts per nurse**
- ☐ b. **Step-Down/Intermediate Care Unit** (includes Progressive Care) **-- 3-6 pts per nurse**
- ☐ c. **General/Medical Unit or Floor -- 6 or more pts per nurse**
- ☐ d. **No previous units or Not applicable**

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

Enter Code ☐

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

In Community

1. **Private residence**
2. **Community based residence** (e.g., assisted living residence, group home, adult foster care)

Other

3. **Long term care facility** (e.g., nursing home) (*skip to B5. Prior Functioning*)
4. **Other** (e.g., shelter, jail, no known address) (*skip to B5. Prior Functioning*)
9. **Unknown** (*skip to B5. Prior Functioning*)

B2. If the patient lived in the community prior to this illness, 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?

- ☐ 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 **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 Some Help – 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. Indoor 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 internal or external stairs (with or without devices such as cane, crutch, or walker)?
☐	**B5d. Indoor 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.

- ☐ **a. Cane/crutch**
- ☐ **b. Walker**
- ☐ **c. Orthotics/Prosthetics**
- ☐ **d. Wheelchair/scooter full time**
- ☐ **e. Wheelchair/scooter part time**
- ☐ **f. Mechanical lift**
- ☐ **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 the **II. Admission Information** 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. 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 at Assessment. 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.)

D. Major Treatments ("Admitted With:" refers to the 2-day admission assessment period.)

Which of the following treatments did the patient receive during the 2-day assessment period? For treatments such as blood transfusions, dialysis, or IV chemotherapy, is the patient currently receiving them as part of their treatment plan?

Check all that apply.

Admitted With:	
D1a. ☐	**D1. None**
D2a. ☐	**D2. Insulin Drip**
D3a. ☐	**D3. Total Parenteral Nutrition**
D4a. ☐	**D4. Central Line Management**
D5a. ☐	**D5. Blood Transfusion(s)**
D6a. ☐	**D6. Controlled Parenteral Analgesia – Peripheral**
D7a. ☐	**D7. Controlled Parenteral Analgesia – Epidural**
D8a. ☐	**D8. Left Ventricular Assistive Device** (LVAD)
D9a. ☐	**D9. Continuous Cardiac Monitoring** ***D9c.*** *Specify reason for continuous monitoring:* _____
D10a. ☐	**D10. Chest Tube(s)**
D11a. ☐	**D11. Trach Tube with Suctioning** ***D11c.*** *Specify most intensive frequency of suctioning during stay:* *Every_____ hours*
D12a. ☐	**D12. High O2 Concentration Delivery System with FiO2 > 40%**
D13a. ☐	**D13. Non-invasive ventilation (CPAP)**
D14a. ☐	**D14. Ventilator – Weaning**
D15a. ☐	**D15. Ventilator – Non-Weaning**
D16a. ☐	**D16. Hemodialysis**
D17a. ☐	**D17. Peritoneal Dialysis**
D18a. ☐	**D18. Fistula or Other Drain Management**
D19a. ☐	**D19. Negative Pressure Wound Therapy**
D20a. ☐	**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. ☐	**D21. Halo**
D22a. ☐	**D22. Complex External Fixators** (e.g., Ilizarov)
D23a. ☐	**D23. One-on-One 24-Hour Staff Supervision** ***D23c.*** *Specify reason for 24-hour supervision:* _____
D24a. ☐	**D24. Specialty Surface or Bed** (e.g., air fluidized, bariatric, low air loss, or rotation bed)
D25a. ☐	**D25. Multiple Types of IV Antibiotic Administration**
D26a. ☐	**D26. IV Vasoactive Medications** (e.g., pressors, dilators, medication for pulmonary edema)
D27a. ☐	**D27. IV Anti-coagulants**
D28a. ☐	**D28. IV Chemotherapy**
D29a. ☐	**D29. Indwelling Bowel Catheter Management System**
D30a. ☐	**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

F1. Does patient **have allergies or any known adverse drug reactions?**
0. None known *(If **None known**, 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 (Complete during the 2-day assessment period.)

G1-2. PRESENCE OF PRESSURE ULCERS - Do not "reverse" stage

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 or unstageable?
0. No *(If **No**, skip to G5. Major Wounds.)*
1. Yes

IF THE PATIENT HAS ONE OR MORE STAGE 2-4 OR UNSTAGEABLE 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 present at assessment	Pressure ulcer at stage 2, stage 3, stage 4, or unstageable:
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	**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	**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	**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 (Complete during the 2-day assessment period.) (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." If the patient has 8 or more unhealed stage 2 pressure ulcers, record "8." If unknown, record "9."

G3. If any unhealed pressure ulcer is stage 3 or 4 (or if eschar is present), record the most recent measurements for the LARGEST ulcer (or eschar):

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

a. **Longest length in any direction (Enter 99.9 if the largest ulcer is unstageable and is not eschar.)**

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

b. **Width of SAME unhealed ulcer or eschar (Enter 99.9 if the largest ulcer is unstageable and is not eschar.)**

Enter Depth |___|___|.|___|cm

c. **Depth of SAME unhealed ulcer or eschar (Enter 99.9 if the largest ulcer is unstageable and is not eschar.)**

Date Measured ____/____/____ MM DD YYYY

d. **Date of measurement**

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**

G5a–e. NUMBER OF MAJOR WOUNDS (excluding pressure ulcers)

Number of Major Wounds	Type(s) of Major Wound(s)
☐	**G5a. Delayed healing of surgical wound**
☐	**G5b. Trauma-related wound (e.g., burns)**
☐	**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: _____

G6. TURNING SURFACES NOT INTACT

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**

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

III. Current Medical Information (cont.)

H. Physiologic Factors (Complete during the 2-day assessment period.)

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

Anthropometric Measures	Date	Value (Complete Using Format Listed)	Check if NOT tested	Check here if value is estimated
H1/H2. Height	H2a. ___/___/___	H2b. _____(xxx.x) ☐ inches ☐ cm	H2c. ☐	H2d. ☐
H3/H4. Weight	H3a. ___/___/___	H3b. _____(xxx.x) ☐ pounds ☐ Kg	H3c. ☐	H3d. ☐

Measures	Date	Value (Complete Using Format Listed)	Check if NOT tested
Vital Signs			
H5/H6. Temperature	H5a. ___/___/___	H5b. _____(xxx.x) ☐ °F ☐ °C	H5c. ☐
H7. Heart Rate (beats/min)	H7a. ___/___/___	H7b. _____(xxx)	H7c. ☐
H8. Respiratory Rate (breaths/min)	H8a. ___/___/___	H8b. _____(xx)	H8c. ☐
H9. Blood Pressure mm/Hg	H9a. ___/___/___	H9b. _____(xxx/xxx)	H9c. ☐
H10. O_2 saturation (Pulse Oximetry) %	H10a. ___/___/___	H10b. _____(xxx)	H10c. ☐
H10d. Please specify source and amount of supplemental O_2 (e.g., room air, nasal cannula, trach collar) _____			
Laboratory			
H11. Hemoglobin (gm/dL)	H11a. ___/___/___	H11b. _____(xx.x)	H11c. ☐
H12. Hematocrit (%)	H12a. ___/___/___	H12b. _____(xx.x)	H12c. ☐
H13. WBC (K/mm3)	H13a. ___/___/___	H13b. _____(xxx.x)	H13c. ☐
H14. HbA1c (%)	H14a. ___/___/___	H14b. _____(xx.x)	H14c. ☐
H15. Sodium (mEq/L)	H15a. ___/___/___	H15b. _____(xxx)	H15c. ☐
H16. Potassium (mEq/L)	H16a. ___/___/___	H16b. _____(x.x)	H16c. ☐
H17. BUN (mg/dL)	H17a. ___/___/___	H17b. _____(xxx)	H17c. ☐
H18. Creatinine (mg/dL)	H18a. ___/___/___	H18b. _____(xx.x)	H18c. ☐
H19. Albumin (gm/dL)	H19a. ___/___/___	H19b. _____(xx.x)	H19c. ☐
H20. Prealbumin (mg/dL)	H20a. ___/___/___	H20b. _____(xx.x)	H20c. ☐
H21. INR	H21a. ___/___/___	H21b. _____(x.x)	H21c. ☐
Other			
H22. Left Ventricular Ejection Fraction (%) (This or prior setting acceptable.)	H22a. ___/___/___	H22b. _____(xx)	H22c. ☐
Arterial Blood Gases (ABGs)			
H23d. Please specify source and amount of supplemental O_2 (e.g., room air, nasal cannula, trach collar) _____	H23a. ___/___/___		H23c. ☐
H24. pH	H24.	H24b. _____(x.xx)	H24c. ☐
H25. PaCO2 (mm/Hg)	H25.	H25b. _____(xxx)	H25c. ☐
H26. HCO3 (mEq/L)	H26.	H26b. _____(xxx)	H26c. ☐
H27. PaO2 (mm/Hg)	H27.	H27b. _____(xxx)	H27c. ☐
H28. SaO2 (%)	H28.	H28b. _____(xx)	H28c. ☐
H29. B.E. (base excess) (mEq/L)	H29.	H29b. _____(xx)	H29c. ☐
Pulmonary Function Tests	H30a. ___/___/___		H30c. ☐
H31. FVC (liters)	H31.	H31b. _____(x.xx)	H31c. ☐
H32. FEV1% or FEV1/FVC (%)	H32.	H32b. _____(xx)	H32c. ☐
H33. FEV1 (liters)	H33.	H33b. _____(x.xx)	H33c. ☐
H34. PEF (liters per minute)	H34.	H34b. _____(x.xx)	H34c. ☐
H35. MVV (liters per minute)	H35.	H35b. _____(xxx)	H35c. ☐
H36. TLC (liters)	H36.	H36b. _____(x.xx)	H36c. ☐
H37. FRC (liters)	H37.	H37b. _____(x.xx)	H37c. ☐
H38. RV (liters)	H38.	H38b. _____(x.xx)	H38c. ☐
H39. ERV (liters)	H39.	H39b. _____(x.xx)	H39c. ☐

*T.III How long did it take you to complete the **III. Current Medical Information** section?* _____ *(minutes)*

Clinician Name(s) _____

IV. Cognitive Status, Mood & Pain

A. Comatose (Complete during the 2-day assessment period.)

Enter Code

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

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

B. Temporal Orientation/Mental Status (Interview during the 2-day assessment period.)

B1. Interview Attempted

Enter Code

B1a. Interview Attempted?

0. **No**
1. **Yes** *(If Yes, skip to B3. BIMS.)*

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**

B3. Brief Interview for Mental Status

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**

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

B3. Brief Interview for Mental Status (cont.)

Enter Code

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.

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

C. Observational Assessment of Cognitive Status: Complete this section only if patient could not be interviewed. **(Complete during the 2-day assessment period.)**

Check all that apply.

C1. Memory/recall ability

- ☐ **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 (CAM©): Code the following behaviors during the 2-day assessment period. Indicate status regardless of cause.

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 (Complete during the 2-day assessment period.)

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 (Interview during the 2-day assessment period.)

Enter Code

F1. Mood Interview Attempted? (Complete the mood interview if you are an IRF, SNF, LTCH, or Home Health agency only. All other providers may enter "0" and skip the Mood Interview.)
- **0. No** *(If **No**, skip to G1. Pain Interview.)*
- **1. Yes**

F2. Patient Health Questionnaire (PHQ-2©)

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)**

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

F3. 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 (Interview during the 2-day assessment period.)

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 Sleep
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. Pain Effect on Activities
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.

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 the **IV. Cognitive Status, Mood & Pain** section? _____ (minutes)*
Clinician Name(s) _____

V. Impairments

A. Bladder and Bowel Management: Use of Device(s) and Incontinence (Complete during the 2-day assessment period.)

Enter Code

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

	Bladder	Bowel
	Enter Code	Enter Code
A2. Does this patient use an **external or indwelling device** or require intermittent catheterization? **0. No** **1. Yes**	A2a. ☐	A2b. ☐
A3. Indicate the **frequency of incontinence**. **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** (e.g., renal failure) **9. Not applicable** (e.g., indwelling catheter)	A3a. ☐	A3b. ☐
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, incontinence pads/undergarments)? **0. No** **1. Yes**	A4a. ☐	A4b. ☐
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**	A5a. ☐	A5b. ☐

B. Swallowing (Complete during the 2-day assessment period.)

B1. Does the patient have any signs or symptoms of a possible swallowing disorder?

Check all that apply.

- ☐ **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) _____
- ☐ **B1g. None**

B2. Describe the patient's usual ability with swallowing. (Check one option ONLY.)

- ☐ **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 (Complete during the 2-day assessment period.)

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 (excluding language barriers)

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**

D. Weight-bearing (Complete during the 2-day assessment period.)

Enter Code

D1. Does the patient have any clinician-ordered weight bearing or limb/spinal loading restrictions (including upper body lift, push, pull, or carry restrictions)?
0. No *(If **No**, skip to Section E. Grip Strength.)*
1. Yes *(If **Yes**, please complete this section.)*

CODING: Indicate all the patient's weight-bearing restrictions.

1. **Fully weight-bearing:** No clinician ordered restrictions
0. **Not fully weight-bearing:** Patient has clinician ordered restrictions

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

V. Impairments (cont.)

E. Grip Strength (Complete during the 2-day assessment period.)

Enter Code

E1. Does the patient have any impairments with grip strength (e.g., reduced/limited or absent)?
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.

2. Normal
1. Reduced/Limited
0. Absent

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

F. Respiratory Status (Complete during the 2-day assessment period.)

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**?
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

G. Endurance (Complete during the 2-day assessment period.)

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)?
0. No, could not do
1. Yes, can do with rest
2. Yes, can do without rest
8. Not assessed due to medical restriction

Enter Code

G1b. Sitting Endurance: Was the patient able to tolerate sitting for 15 minutes?
0. No
1. Yes, with support
2. Yes, without support
8. Not assessed due to medical restriction

V. Impairments (cont.)

H. Mobility Devices and Aids Needed (Complete during the 2-day assessment period.)

Check all that apply.

H1. Indicate all mobility devices and aids needed at time of assessment.

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

*T.V How long did it take you to complete the **V. Impairments** section?* _____ *(minutes) Clinician Name(s)* _____

VI. Functional Status: Usual Performance

A. Core Self Care: The core self care items should be completed on ALL patients. (Complete during the 2-day assessment period.)

Code the patient's most usual performance 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.

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	**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 if applicable.
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 during the 2-day assessment period.)

Complete for ALL patients: Code the patient's most usual performance 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.

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 the side of the 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 the 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	**B5a. Select the longest distance the patient walks and code his/her level of independence (Level 1–6) on that distance. Observe performance. (Select only one.)**
Enter Code	**1. Walk 150 ft (45 m):** Once standing, can walk at least 150 feet (45 meters) in corridor or similar space.
Enter Code	**2. Walk 100 ft (30 m):** Once standing, can walk at least 100 feet (30 meters) in corridor or similar space
Enter Code	**3. Walk 50 ft (15 m):** Once standing, can walk at least 50 feet (15 meters) in corridor or similar space
Enter Code	**4. Walk in Room Once Standing:** Once standing, can walk at least 10 feet (3 meters) in room, corridor or similar space.
Enter Code	**B5b. Select the longest distance the patient wheels and code his/her level of independence (Level 1–6). Observe performance. (Select only one.)**
Enter Code	**1. Wheel 150 ft (45 m):** Once sitting, can wheel at least 150 feet (45 meters) in corridor or similar space.
Enter Code	**2. Wheel 100 ft (30 m):** Once sitting, can wheel at least 100 feet (30 meters) in corridor or similar space
Enter Code	**3. Wheel 50 ft (15 m):** Once sitting, can wheel at least 50 feet (15 meters) in corridor or similar space
Enter Code	**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 during the 2-day assessment period.)

Enter [1] Code

C. Following discharge, is it anticipated that the patient will need post-acute care to improve their functional ability or other types of personal assistance?

0. No
1. Yes

Please code the 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	**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, rinsing, 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:** The ability to go up and down 12 steps with or without a rail.
Enter Code	**C7d. 4 steps:** The ability to go up and down 4 steps with or without 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 or gravel.
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 (Complete during the 2-day assessment period.) (cont.)

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	
Enter ☐ Code	**C8. Telephone-answering:** The ability to pick up call in patient's customary manner and maintain for 1 minute or longer. 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 1 minute or longer. 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 a bowl of cereal or a 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 the **VI. Functional Status** section? _____ (minutes)*
Clinician Name(s) _____

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 condition is unknown or unclear to the respondent.

Check all that apply.

A3. In anticipation of serious clinical complications, has the patient made care decisions which are documented in the medical record?

☐ **1. The patient has designated a decision-maker (if the patient is unable to make decisions) which is documented in the medical record.**

☐ **2. The patient (or surrogate) has made a decision to forgo resuscitation which is documented in the medical record.**

*T.VII How long did it take you to complete the **VII. Overall Plan of Care/Advance Care Directives** section? _____ (minutes)*
Clinician Name(s) _____

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 (Optional)

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?

_____

IX. ICD-9 Coding Information (cont.)

B. Other Diagnoses, Comorbidities, and Complications (Optional on PAC Admission only.)

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

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

*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.