

CARE Tool

PAC Discharge

**This instrument uses the phrase
“2-day assessment period” referring to either:**

**1) The day of discharge and the calendar day
before the day of discharge (beginning at
12:00 AM);**

or

**2) For Home Health, the day of the last visit
or the day before the last visit.**

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. | | | | | |
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| 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.

III. Current Medical Information

Clinicians:

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

A. Primary and Other Diagnoses, Comorbidities, and Complications

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

A1. Primary Diagnosis at Assessment _____

B. Other Diagnoses, Comorbidities, and Complications

B1a. _____

B2a. _____

B3a. _____

B4a. _____

B5a. _____

B6a. _____

B7a. _____

B8a. _____

B9a. _____

B10a. _____

B11a. _____

B12a. _____

B13a. _____

B14a. _____

Enter

Code

B15. Is this list complete?

0. No

1. Yes

III. Current Medical Information (cont.)

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

Enter

Code

C1. Did the patient have one or more major procedures (diagnostic, surgical, and therapeutic interventions) during this admission?
0. No (If No, skip to Section D. 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. <input type="text"/> | C1b. <input type="checkbox"/> | C1c. <input type="checkbox"/> | C1d. <input type="checkbox"/> |
| C2a. <input type="text"/> | C2b. <input type="checkbox"/> | C2c. <input type="checkbox"/> | C2d. <input type="checkbox"/> |
| C3a. <input type="text"/> | C3b. <input type="checkbox"/> | C3c. <input type="checkbox"/> | C3d. <input type="checkbox"/> |
| C4a. <input type="text"/> | C4b. <input type="checkbox"/> | C4c. <input type="checkbox"/> | C4d. <input type="checkbox"/> |
| C5a. <input type="text"/> | C5b. <input type="checkbox"/> | C5c. <input type="checkbox"/> | C5d. <input type="checkbox"/> |
| C6a. <input type="text"/> | C6b. <input type="checkbox"/> | C6c. <input type="checkbox"/> | C6d. <input type="checkbox"/> |
| C7a. <input type="text"/> | C7b. <input type="checkbox"/> | C7c. <input type="checkbox"/> | C7d. <input type="checkbox"/> |
| C8a. <input type="text"/> | C8b. <input type="checkbox"/> | C8c. <input type="checkbox"/> | C8d. <input type="checkbox"/> |
| C9a. <input type="text"/> | C9b. <input type="checkbox"/> | C9c. <input type="checkbox"/> | C9d. <input type="checkbox"/> |
| C10a. <input type="text"/> | C10b. <input type="checkbox"/> | C10c. <input type="checkbox"/> | C10d. <input type="checkbox"/> |
| C11a. <input type="text"/> | C11b. <input type="checkbox"/> | C11c. <input type="checkbox"/> | C11d. <input type="checkbox"/> |
| C12a. <input type="text"/> | C12b. <input type="checkbox"/> | C12c. <input type="checkbox"/> | C12d. <input type="checkbox"/> |
| C13a. <input type="text"/> | C13b. <input type="checkbox"/> | C13c. <input type="checkbox"/> | C13d. <input type="checkbox"/> |
| C14a. <input type="text"/> | C14b. <input type="checkbox"/> | C14c. <input type="checkbox"/> | C14d. <input type="checkbox"/> |
| C15a. <input type="text"/> | C15b. <input type="checkbox"/> | C15c. <input type="checkbox"/> | C15d. <input type="checkbox"/> |

Enter

Code

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

III. Current Medical Information (cont.)

D. Major Treatments (“Discharged With:” refers to the 2-day discharge assessment period.)

Which of the following treatments did the patient receive at the time of the assessment?

| Discharged With: | Used at Any Time During Stay: | |
|--------------------------------|--------------------------------|---|
| D1a. <input type="checkbox"/> | D1b. <input type="checkbox"/> | D1. None |
| D2a. <input type="checkbox"/> | D2b. <input type="checkbox"/> | D2. Insulin Drip |
| D3a. <input type="checkbox"/> | D3b. <input type="checkbox"/> | D3. Total Parenteral Nutrition |
| D4a. <input type="checkbox"/> | D4b. <input type="checkbox"/> | D4. Central Line Management |
| D5a. <input type="checkbox"/> | D5b. <input type="checkbox"/> | D5. Blood Transfusion(s) |
| D6a. <input type="checkbox"/> | D6b. <input type="checkbox"/> | D6. Controlled Parenteral Analgesia – Peripheral |
| D7a. <input type="checkbox"/> | D7b. <input type="checkbox"/> | D7. Controlled Parenteral Analgesia – Epidural |
| D8a. <input type="checkbox"/> | D8b. <input type="checkbox"/> | D8. Left Ventricular Assistive Device (LVAD) |
| D9a. <input type="checkbox"/> | D9b. <input type="checkbox"/> | D9. Continuous Cardiac Monitoring <i>D9c. Specify reason for continuous monitoring: _____</i> |
| D10a. <input type="checkbox"/> | D10b. <input type="checkbox"/> | D10. Chest Tube(s) |
| D11a. <input type="checkbox"/> | D11b. <input type="checkbox"/> | D11. Trach Tube with Suctioning <i>D11c. Specify most intensive frequency of suctioning during stay: Every _____ hours</i> |
| D12a. <input type="checkbox"/> | D12b. <input type="checkbox"/> | D12. High O2 Concentration Delivery System with FiO2 > 40% |
| D13a. <input type="checkbox"/> | D13b. <input type="checkbox"/> | D13. Non-invasive ventilation |
| D14a. <input type="checkbox"/> | D14b. <input type="checkbox"/> | D14. Ventilator – Weaning |
| D15a. <input type="checkbox"/> | D15b. <input type="checkbox"/> | D15. Ventilator – Non-Weaning |
| D16a. <input type="checkbox"/> | D16b. <input type="checkbox"/> | D16. Hemodialysis |
| D17a. <input type="checkbox"/> | D17b. <input type="checkbox"/> | D17. Peritoneal Dialysis |
| D18a. <input type="checkbox"/> | D18b. <input type="checkbox"/> | D18. Fistula or Other Drain Management |
| D19a. <input type="checkbox"/> | D19b. <input type="checkbox"/> | D19. Negative Pressure Wound Therapy |
| D20a. <input type="checkbox"/> | D20b. <input type="checkbox"/> | D20. Complex Wound Management with positioning and skin separation/traction that requires at least two persons |
| D21a. <input type="checkbox"/> | D21b. <input type="checkbox"/> | D21. Halo |
| D22a. <input type="checkbox"/> | D22b. <input type="checkbox"/> | D22. Complex External Fixators (e.g., Ilizarov) |
| D23a. <input type="checkbox"/> | D23b. <input type="checkbox"/> | D23. One-on-One 24-Hour Supervision <i>D23c. Specify reason for 24-hour supervision: _____</i> |
| D24a. <input type="checkbox"/> | D24b. <input type="checkbox"/> | D24. Specialty Surface or Bed (i.e., air fluidized, bariatric, low air loss, or rotation bed) |
| D25a. <input type="checkbox"/> | D25b. <input type="checkbox"/> | D25. Multiple IV Antibiotic Administration |
| D26a. <input type="checkbox"/> | D26b. <input type="checkbox"/> | D26. IV Vaso-actors (e.g., pressors, dilators, medication for pulmonary edema) |
| D27a. <input type="checkbox"/> | D27b. <input type="checkbox"/> | D27. IV Anti-coagulants |
| D28a. <input type="checkbox"/> | D28b. <input type="checkbox"/> | D28. IV Chemotherapy |
| D29a. <input type="checkbox"/> | D29b. <input type="checkbox"/> | D29. Indwelling Bowel Catheter Management System |
| D30a. <input type="checkbox"/> | D30b. <input type="checkbox"/> | D30. Other Major Treatments <i>D30c. Specify _____</i> |

Check all that apply.

III. Current Medical Information (cont.)

E. Medications (Optional)

List all current medications for the patient.

| <u>Medication Name</u> | | <u>Dose</u> | <u>Route</u> | <u>Frequency</u> | <u>Planned Stop Date (if applicable)</u> | | | | |
|------------------------|-------|-------------|--------------|------------------|--|-------|-------|-------|----------------|
| 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 Information (cont.)

F. Allergies & Adverse Drug Reactions

| | |
|---------------------------------------|---|
| Enter <input type="text"/> 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 <input type="text"/> Code | F9. Is the list complete? 0. No 1. Yes |
|---------------------------------------|---|

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

GI-2. PRESENCE OF PRESSURE ULCERS

| | | | |
|---------------------------------------|--|---------------------------------------|---|
| Enter <input type="text"/> Code | G1. Is this patient at risk of developing pressure ulcers? 0. Respond at a later date. 1. No 2. Yes, indicated by clinical judgment 3. Yes, indicated high risk by formal assessment (e.g., on Braden or Norton tools) or the patient has a stage I or greater ulcer, a scar over a bony prominence, or a non-removable dressing, device, or cast. | Enter <input type="text"/> 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 PRESSURE ULCERS, indicate the number of **unhealed pressure ulcers** at each stage.

| CODING: | Number present at assessment | Number with onset during this service | Pressure ulcer at stage 2, stage 3, or stage 4 only: |
|--|--|--|--|
| Please specify the number of ulcers at each stage: 0 = 0 ulcers 1 = 1 ulcer 2 = 2 ulcers 3 = 3 ulcers 4 = 4 ulcers 5 = 5 ulcers 6 = 6 ulcers 7 = 7 ulcers 8 = 8 or more ulcers 9 = Unknown | Stage 2 Enter <input type="text"/> Code | Stage 2 Enter <input type="text"/> 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 <input type="text"/> Code | Stage 3 Enter <input type="text"/> 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 <input type="text"/> Code | Stage 4 Enter <input type="text"/> 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 <input type="text"/> Code | Unstageable Enter <input type="text"/> 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.)

| | | | |
|---|---|---|--|
| <p>Number of Unhealed Stage 2 Ulcers</p> <p><input type="text"/></p> | <p>G2e. Number of unhealed stage 2 ulcers known to be present for more than 1 month.</p> <p>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."</p> | <p>G5. MAJOR WOUND (excluding pressure ulcers)</p> | |
| <p>G3. If any pressure ulcer is stage 3 or 4 (or if eschar is present), record the most recent measurements for the LARGEST ulcer (or eschar):</p> <p>a. Longest length in any direction</p> <p>Enter Length <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> cm</p> <p>b. Width of SAME unhealed ulcer or eschar</p> <p>Enter Width <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> cm</p> <p>c. Date of measurement</p> <p>Date Measured <input type="text"/> / <input type="text"/> / <input type="text"/> MM DD YYYY</p> | | <p>G5a-e. NUMBER OF MAJOR WOUNDS</p> | |
| | | <p>Number of Major Wounds</p> | <p>Type(s) of Major Wound(s)</p> |
| | | <p><input type="text"/> <input type="text"/></p> | <p>G5a. Delayed healing of surgical wound</p> |
| | | <p><input type="text"/> <input type="text"/></p> | <p>G5b. Trauma-related wound</p> |
| | | <p><input type="text"/> <input type="text"/></p> | <p>G5c. Diabetic foot ulcer(s)</p> |
| | | <p><input type="text"/> <input type="text"/></p> | <p>G5d. Vascular ulcer (arterial or venous including diabetic ulcers not located on the foot)</p> |
| | | <p><input type="text"/> <input type="text"/></p> | <p>G5e. Other (e.g., incontinence associated dermatitis, normal surgical wound healing). Please specify: _____</p> |
| <p>Enter Code <input type="text"/></p> | <p>G4. Indicate if any unhealed stage 3 or stage 4 pressure ulcer(s) has undermining and/or tunneling (sinus tract) present.</p> <p>0. No 1. Yes 8. Unable to assess</p> | <p>G6. TURNING SURFACES NOT INTACT</p> | |
| | | <p>Turning Surface</p> <p>Check all that apply.</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> | <p>Indicate which of the following turning surfaces have either a pressure ulcer or major wound.</p> <p>a. Skin for all turning surfaces is intact</p> <p>b. Right hip not intact</p> <p>c. Left hip not intact</p> <p>d. Back/buttocks not intact</p> <p>e. Other turning surface(s) not intact</p> |

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

| Date | Complete using format below | Value | Check if NOT tested | Check here if value is estimated | Anthropometric Measures |
|-----------|-----------------------------|-------------|--------------------------------|--|--|
| H1a. / / | xxx.x | H1b. _____ | H1c. <input type="checkbox"/> | H1d. <input type="checkbox"/> | Anthropometric Measures H1. Height (inches) OR H2. Height (cm) H3. Weight (pounds) OR H4. Weight (Kg) |
| H2a. / / | xxx.x | H2b. _____ | H2c. <input type="checkbox"/> | H2d. <input type="checkbox"/> | |
| H3a. / / | xxx.x | H3b. _____ | H3c. <input type="checkbox"/> | H3d. <input type="checkbox"/> | |
| H4a. / / | xxx.x | H4b. _____ | H4c. <input type="checkbox"/> | H4d. <input type="checkbox"/> | |
| H5a. / / | xxx.x | H5b. _____ | H5c. <input type="checkbox"/> | Vital Signs H5. Temperature (°F) OR H6. Temperature (°C) H7. Heart Rate (beats/min) H8. Respiratory Rate (breaths/min) H9. Blood Pressure mm/Hg H10. O ₂ saturation (Pulse Oximetry) % H10d. Please specify source and amount of supplemental O ₂ _____ | |
| H6a. / / | xx.x | H6b. _____ | H6c. <input type="checkbox"/> | Laboratory H11. Hemoglobin (gm/dL) H12. Hematocrit (%) H13. WBC (K/mm ³) H14. HbA1c (%) H15. Sodium (mEq/L) H16. Potassium (mEq/L) H17. BUN (mg/dL) H18. Creatinine (mg/dL) H19. Albumin (gm/dL) H20. Prealbumin (mg/dL) H21. INR Other H22. Left Ventricular Ejection Fraction (%) (This or prior setting acceptable.) Arterial Blood Gases (ABGs) H23d. Please specify source and amount of supplemental O ₂ _____ H24. pH H25. PaCO ₂ (mm/Hg) H26. HCO ₃ (mEq/L) H27. PaO ₂ (mm/Hg) H28. SaO ₂ (%) H29. B.E. (base excess) (mEq/L) Pulmonary Function Tests H31. FVC (liters) H32. FEV1% or FEV1/FVC (%) H33. FEV1 (liters) H34. PEF (liters per minute) H35. MVV (liters per minute) H36. TLC (liters) H37. FRC (liters) H38. RV (liters) H39. ERV (liters) | |
| H7a. / / | xxx | H7b. _____ | H7c. <input type="checkbox"/> | | |
| H8a. / / | xx | H8b. _____ | H8c. <input type="checkbox"/> | | |
| H9a. / / | xxx/xxx | H9b. _____ | H9c. <input type="checkbox"/> | | |
| H10a. / / | xxx | H10b. _____ | H10c. <input type="checkbox"/> | | |
| H11a. / / | xx.x | H11b. _____ | H11c. <input type="checkbox"/> | | |
| H12a. / / | xx.x | H12b. _____ | H12c. <input type="checkbox"/> | | |
| H13a. / / | xxx.x | H13b. _____ | H13c. <input type="checkbox"/> | | |
| H14a. / / | xx.x | H14b. _____ | H14c. <input type="checkbox"/> | | |
| H15a. / / | xxx | H15b. _____ | H15c. <input type="checkbox"/> | | |
| H16a. / / | x.x | H16b. _____ | H16c. <input type="checkbox"/> | | |
| H17a. / / | xx | H17b. _____ | H17c. <input type="checkbox"/> | | |
| H18a. / / | x.x | H18b. _____ | H18c. <input type="checkbox"/> | | |
| H19a. / / | x.x | H19b. _____ | H19c. <input type="checkbox"/> | | |
| H20a. / / | xx.x | H20b. _____ | H20c. <input type="checkbox"/> | | |
| H21a. / / | x.x | H21b. _____ | H21c. <input type="checkbox"/> | | |
| H22a. / / | xx | H22b. _____ | H22c. <input type="checkbox"/> | | |
| H23a. / / | | | H23c. <input type="checkbox"/> | | |
| H24. / / | x.xxx | H24b. _____ | H24c. <input type="checkbox"/> | | |
| H25. / / | xxx | H25b. _____ | H25c. <input type="checkbox"/> | | |
| H26. / / | xxx | H26b. _____ | H26c. <input type="checkbox"/> | | |
| H27. / / | xxx | H27b. _____ | H27c. <input type="checkbox"/> | | |
| H28. / / | xx | H28b. _____ | H28c. <input type="checkbox"/> | | |
| H29. / / | xx | H29b. _____ | H29c. <input type="checkbox"/> | | |
| H30a. / / | | | H30c. <input type="checkbox"/> | | |
| H31. / / | x.xxx | H31b. _____ | H31c. <input type="checkbox"/> | | |
| H32. / / | xx | H32b. _____ | H32c. <input type="checkbox"/> | | |
| H33. / / | x.xx | H33b. _____ | H33c. <input type="checkbox"/> | | |
| H34. / / | x.xx | H34b. _____ | H34c. <input type="checkbox"/> | | |
| H35. / / | xxx | H35b. _____ | H35c. <input type="checkbox"/> | | |
| H36. / / | x.xxx | H36b. _____ | H36c. <input type="checkbox"/> | | |
| H37. / / | x.xxx | H37b. _____ | H37c. <input type="checkbox"/> | | |
| H38. / / | x.xxx | H38b. _____ | H38c. <input type="checkbox"/> | | |
| H39. / / | x.xx | H39b. _____ | H39c. <input type="checkbox"/> | | |

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

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

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

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

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

Enter

Code

F1. Mood Interview Attempted?
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

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

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



| | | | |
|---|---|---------------------------------------|---|
| Enter <input type="text"/> Code | G1. Pain Interview Attempted? 0. No (If No, skip to G6. Pain Observational Assessment.) 1. Yes | Enter <input type="text"/> 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 <input type="text"/> 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 <i>skip to G6. Pain Observational Assessment.</i> | | |
| Enter <input type="text"/> 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 <input type="text"/> 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. | <input type="checkbox"/> G6a. Non-verbal sounds (e.g., crying, whining, gasping, moaning, or groaning) <input type="checkbox"/> G6b. Vocal complaints of pain (e.g., "that hurts, ouch, stop") <input type="checkbox"/> G6c. Facial expressions (e.g., grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw) <input type="checkbox"/> 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) <input type="checkbox"/> 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

A2a. Enter Code

A2b. Enter Code

A2. Does this patient use an **external or indwelling device** or require intermittent catheterization?
0. No
1. Yes

A3a. Enter Code

A3b. Enter Code

A3. Indicate the **frequency of incontinence**.
0. Continent (no documented incontinence)
1. Stress incontinence only (bladder only)
2. Incontinent less than daily
3. Incontinent daily (at least once a day)
4. Always incontinent
5. No urine/bowel output (e.g., renal failure)

A4a. Enter Code

A4b. Enter Code

A4. Does the patient **need assistance** to manage equipment or devices related to bladder or bowel care (e.g., urinal, bedpan, indwelling catheter, intermittent catheterization, ostomy, incontinence pads/undergarments)?
0. No
1. Yes

A5a. Enter Code

A5b. Enter Code

A5. If the patient is incontinent or has an indwelling device, was the patient incontinent (excluding stress incontinence) immediately prior to the current illness, exacerbation, or injury?
0. No
1. Yes
9. Unknown

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

Check all that apply.

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

B1a. Complaints of difficulty or pain with swallowing

B1b. Coughing or choking during meals or when swallowing medications

B1c. Holding food in mouth/cheeks or residual food in mouth after meals

B1d. Loss of liquids/solids from mouth when eating or drinking

B1e. NPO: intake not by mouth

B1f. Other (specify) _____

B1g. None

Enter

Code

B2. Describe the patient's usual ability with swallowing.

3. Regular food: Solids and liquids swallowed safely without supervision and without modified food or liquid consistency.

2. Modified food consistency/supervision: Patient requires modified food or liquid consistency and/or needs supervision during eating for safety.

1. 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

CI. 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.)

CIa. 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**

CIc. 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**

CIb. 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**

CI d. 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

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

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

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

| Upper Extremity | | Lower Extremity | |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| D1a. Left | D1b. Right | D1c. Left | D1d. Right |
| Enter <input type="text"/> Code | Enter <input type="text"/> Code | Enter <input type="text"/> Code | Enter <input type="text"/> Code |

V. Impairments (cont.)

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

Enter

 Code

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

CODING: Indicate the patient's ability to squeeze your hand.

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

EIa. Left Hand

Enter

 Code

EIb. Right Hand

Enter

 Code

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

Enter

 Code

FI. 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 O₂
 Enter

 Code

FIa.

Without Supplemental O₂
 Enter

 Code

FIb.

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

GI. 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

GIa. 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

GIb. 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.

HI. 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 three buttons.

Enter

Code

A6. Lower body dressing: The ability to dress and undress below the waist, including fasteners. Does not include footwear.

VI. Functional Status (cont.)

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

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 (If No, skip to Section VII. Overall Plan of Care/Advance Care Directives.)
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 <input type="text"/> 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 <input type="text"/> 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 <input type="text"/> 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 <input type="text"/> Code | C4. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed. |
| Enter <input type="text"/> 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 <input type="text"/> 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 <input type="text"/> 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 <input type="text"/> Code | C7a. 1 step (curb): The ability to step over a curb or up and down one step. |
| Enter <input type="text"/> Code | C7b. Walk 50 feet with two turns: The ability to walk 50 feet and make two turns. |
| Enter <input type="text"/> Code | C7c. 12 steps-interior: The ability to go up and down 12 interior steps with a rail. |
| Enter <input type="text"/> Code | C7d. Four steps-exterior: The ability to go up and down 4 exterior steps with a rail. |
| Enter <input type="text"/> 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 <input type="text"/> 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 <input type="text"/> Code | C7g. Wheel short ramp: Once seated in wheelchair, goes up and down a ramp of less than 12 feet (4 meters). |
| Enter <input type="text"/> Code | C7h. Wheel long ramp: Once seated in wheelchair, goes up and down a ramp of more than 12 feet (4 meters). |

Enter Code in Boxes

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 <input type="text"/> Code | C8. Telephone-answering: The ability to pick up call in patient's customary manner and maintain for 3 minutes. Does not include getting to the phone. |
| | Enter <input type="text"/> Code | C9. Telephone-placing call: The ability to pick up and place call in patient's customary manner and maintain for 3 minutes. Does not include getting to the phone. |
| | Enter <input type="text"/> 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 <input type="text"/> 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 <input type="text"/> 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 <input type="text"/> 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 <input type="text"/> 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 <input type="text"/> 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 <input type="text"/> 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 <input type="text"/> 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 <input type="text"/> Code | <p>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?</p> <p>0. No, but this work is in process 1. Yes 9. Unclear or unknown</p> |
| Enter <input type="text"/> Code | <p>A2. Which description best fits the patient's overall status?</p> <p>1. The patient is stable with no risk for serious complications and death (beyond those typical of the patient's age). 2. The patient is temporarily facing high health risks but likely to return to being stable without risk for serious complications and death (beyond those typical of the patient's age). 3. The patient is likely to remain in fragile health and have ongoing high risks of serious complications and death. 4. The patient has serious progressive conditions that could lead to death within a year. 9. The patient's situation is unknown or unclear to the respondent.</p> |
| Check all that apply. | <p>A3. In anticipation of serious clinical complications, has the patient made and documented care decisions?</p> <p>1. The patient has designated and documented a decision-maker (if the patient is unable to make decisions). 2. The patient (or surrogate) has made and documented a decision to forgo resuscitation.</p> |

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

VIII. Discharge Status

A. Discharge Information

A1. Discharge Date / /
MM DD YYYY

A2. Attending Physician (at this location)

A3. Discharge Location

Where will the patient be discharged to?

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

A4. Frequency of Assistance at Discharge

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

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

A5. Caregiver(s) Availability

- Enter Code
- Was the discharge destination decision influenced by the availability of a family member or friend to provide assistance?
0. **No** (*If No, skip to Section B. Residential Information.*)
 1. **Yes**

A6. Willing Caregiver(s)

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

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

A7. Types of Caregiver(s)

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

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

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

B1. Patient Lives With at Discharge

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

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

VIII. Discharge Status (cont.)

C. Support Needs/Caregiver (CG) Assistance

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

VIII. Discharge Status (cont.)

D. Discharge Care Options

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

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

VIII. Discharge Status (cont.)

E. Discharge Location Information

| | | |
|---|---|---|
| Enter <input type="checkbox"/> Code | E1. Is the patient being discharged with referral for additional services? 0. No (If No, skip to E7. Discharge Delay.) 1. Yes (If yes, please identify the name, location, and type of service to which the patient is discharged.) | |
| E2. Provider's Name <input style="width: 100%;" type="text"/> | | E6. Medicare Provider's Identification Number (optional) <input style="width: 100%;" type="text"/> |
| Enter <input type="checkbox"/> Code | E3. Provider Type 1. Home health care (HHA) 2. Skilled nursing facility (SNF/TCU) 3. Inpatient rehabilitation hospital or unit (IRF) 4. Long-term care hospital (LTCH) 5. Psychiatric hospital or unit 6. Outpatient services 7. Short-stay acute hospital (IPPS) 8. Hospice 9. Long-term nursing facility 10. Other (specify) _____ | |
| | | E7. Discharge Delay Enter <input type="checkbox"/> Code Was the patient's discharge delayed for at least 24 hours? 0. No 1. Yes |
| | | E8. Reason for Discharge Delay Enter <input type="checkbox"/> 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) _____ |
| E4. Provider City <input style="width: 100%;" type="text"/> | | E9. In the situation that the patient or an authorized representative has requested this information not be shared with the next provider, check here: <input type="checkbox"/> |
| E5. Provider State <input style="width: 100%;" type="text"/> | | |

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

IX. Medical Coding Information

Coders:

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

A. Principal Diagnosis

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

A1. ICD-9 CM code for Principal Diagnosis at Assessment

A2. If Principal Diagnosis was a V-code, what was the ICD-9 CM code for the primary medical condition or injury being treated?

A1a. Principal Diagnosis at Assessment

A2a. If Principal Diagnosis was a V-code, what was the primary medical condition or injury being treated?

B. Other Diagnoses, Comorbidities, and Complications

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

| ICD-9 CM code | Diagnosis |
|----------------------------|----------------------------|
| B1a. <input type="text"/> | B1b. <input type="text"/> |
| B2a. <input type="text"/> | B2b. <input type="text"/> |
| B3a. <input type="text"/> | B3b. <input type="text"/> |
| B4a. <input type="text"/> | B4b. <input type="text"/> |
| B5a. <input type="text"/> | B5b. <input type="text"/> |
| B6a. <input type="text"/> | B6b. <input type="text"/> |
| B7a. <input type="text"/> | B7b. <input type="text"/> |
| B8a. <input type="text"/> | B8b. <input type="text"/> |
| B9a. <input type="text"/> | B9b. <input type="text"/> |
| B10a. <input type="text"/> | B10b. <input type="text"/> |
| B11a. <input type="text"/> | B11b. <input type="text"/> |
| B12a. <input type="text"/> | B12b. <input type="text"/> |
| B13a. <input type="text"/> | B13b. <input type="text"/> |
| B14a. <input type="text"/> | B14b. <input type="text"/> |
| B15a. <input type="text"/> | B15b. <input type="text"/> |

Enter

Code

B16. Is this list complete?
0. No
1. Yes

IX. Medical Coding Information (cont.)

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

Enter

 Code

C1. Did the patient have one or more major procedures (diagnostic, surgical, and therapeutic interventions) during this admission?
0. No (If No, skip to Section X.)
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

T.IX How long did it take you to complete the **IX. Medical 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.