Unit (Non-Therapist) Staff Activity Form
Medicare Post-Acute Care Study
[Provider Name & Unit]

Staff Name ______ Date __ / __ / __ Form SFU-20071116

Shift Length (Hours) __ . __ ☐ Day ☐ Evening ☐ Night

Position

- ☐ RN
- ☐ LPN/LVN
- ☐ Nursing Assistant/Aide
- ☐ Adv. Practice RN/NP
- ☐ Social Worker
- ☐ Case Mgr./Dis. Planner/Util. Rev.
- ☐ PPS Coordinator
- ☐ Pharmacist
- ☐ Physician Assistant
- ☐ Discharge Planning Mgr.
- ☐ Nurse Manager
- ☐ Physician **(Administrative Activities Only)**
- Other ______

Employment Type

- ☐ Reg. Full/Part Time
- ☐ Per Diem
- ☐ Contract/Agency

PLEASE COMPLETE THIS FORM FOR ALL PATIENTS

Time (in Minutes) Spent in Each Activity

Patient ID # (Completed by Site Coordinator)		Administer Meds/ Blood/ Patient Educ.	Personal Care/ Nursing Care/ Assess-ments/ Patient Educ.	Charting/ Care Planning/ Rounding/ Family Meetings	Transport Patients	Administrative/ Inservice/ Commit-tees/ Breaks/ Other Off Unit Time	**Total Time (min.)**	**Notes**
	Total Time in Shift							
	On-Unit Activities							
	Off-Unit Activities	■	■	■	■			
P R O V A L L	**Not Patient-Specific**				■			
	Patient Name ↴							
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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 collection of information is 0938-XXXX. The time required to complete this information collection is 15 minutes 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, MD 21244-1850.

Therapy Staff Activity Form
Medicare Post-Acute Care Study
[Provider Name & Unit]

Staff Name ______ Date __ / __ / ____ Form SFT-20071116

Therapy Discipline

- Physical Therapy
- Occupational Therapy
- Respiratory Therapy
- Speech Therapy
- Recreation Therapy
- Other ______

Therapy Position

- Licensed Therapist
- Therapy Manager
- Therapy Assistant
- Therapy Aide

Employment Type

- Regular Full/Part Time
- Per Diem
- Contract/Agency

PLEASE COMPLETE THIS FORM FOR ALL PATIENTS

Time (in Minutes) Spent in Each Type of Activity

	Therapy Sessions for **Unit** Patients							Administration/ Charting/ Care Planning/ Breaks	**Total Time (min.)**
	Individual Therapy/ Assessment	Group #1	Group #2	Group #3	Group #4	Group #5	Group #6		
Total Time in All Activities									
Activities With Unit Patients									
Other Activities									

Time (in Minutes) Each *Patient* Spent in Your Therapy Sessions
"Groups" Are Any Therapy Sessions With 2 or More Patients.

Patient ID # (Completed by Site Coordinator)	Patient Name	Individual Therapy/ Assessment	Group #1	Group #2	Group #3	Group #4	Group #5	Group #6	**Notes**
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Home Health Patient Time Log
Medicare Post-Acute Care Study
[Provider Name & Office/Service]

Staff Name ______ Date __ __ / __ __ / __ __ __ __ Form HHL-20071116

Position (Check One)

- ☐ RN
- ☐ LPN/LVN
- ☐ Nursing Asst./Aide
- ☐ Adv. Prac. RN/NP
- ☐ Physical Therapist
- ☐ Physical Therapy Assistant
- ☐ Physical Therapy Aide
- ☐ Occupational Therapist
- ☐ Occupational Therapy Assisant
- ☐ Occupational Therapy Aide
- ☐ Respiratory Therapist
- ☐ Respiratory Therapy Assistant
- ☐ Respiratory Therapy Aide
- ☐ Speech Therapist
- ☐ Speech Therapy Assistant
- ☐ Speech Therapy Aide
- ☐ Social Worker
- ☐ Case Mgr./Dis. Planner/Util. Rev.
- ☐ Nursing Manager
- ☐ Therapy Manager
- ☐ Case/Discharge Plan. Manager
- ☐ Administrative/Secretary/Clerk
- ☐ Other ______

Employment Type (Check One)

- ☐ Regular Full/Part Time
- ☐ Per Visit
- ☐ Contract/Agency

PLEASE COMPLETE THIS FORM FOR ALL PATIENTS

Patient ID # (Completed by Site Coordinator)	Patient Name	-to-Face ıe (minut	ıe Spent ient Outs isit (minu
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Note: Time spent on patient outside of visit includes travel, telephone calls, meetings, charting, OASIS completion, wound care consult calls, and other tasks related to patient care but not in a visit.

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Patient Ancillary Service Log Form
Medicare Post-Acute Care Study
[Provider Name & Unit]

Date ___ ___ / ___ ___ / ___ ___ ___ ___ Form ANC-20071116

PLEASE COMPLETE THIS FORM FOR ALL PATIENTS

Check Imaging/Radiology, Other Diagnostic, or Complex Treatment Received

Patient ID # (Completed by Site Coordinator)	Patient Name
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Patient ID #	Angiogram	Aortogram	Arthrography	Bone Densitometry	Cholangiography	Cisternography	Diskography	Echocardiogram	EKG	GI Series (Upper or Lower)	Lymphangiography	Mammary Ductogram	Modified Barium Swallow	MRI	Myelography	Ultrasound	Ultrasound	Ultrasound	Urethrocystography	Urography	Venography	X-Ray	Other Imaging	Other Imaging	Other Imaging
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Patient ID #	Arterial Blood Gas (ABG)	Bedside Bronchoscopy	Complex Pharyngeal & Speech Evaluation	Other Complex Diagnostics	Other Complex Diagnostics	Other Complex Diagnostics
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Patient ID #	Complex Bowel Management	Complex Bowel Management	Continuous Cardiac Monitoring/Telemetry	Hemodialysis	Intermittent Bladder Catheterization	Multiple IV Antibiotic Administration	Negative Pressure Wound Therapy	Peritoneal Dialysis	Total Parenteral Nutrition	Ventilator Management (Weaning Only)	Other Complex Treatment	Other Complex Treatment	Other Complex Treatment
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Non-Physician Consult Log Form
Medicare Post-Acute Care Study
[Provider Name & Unit]

Date ___ / ___ / ______ Form CON-20071116

PLEASE COMPLETE THIS FORM FOR ALL PATIENTS

Patient ID # (Completed by Site Coordinator)	Patient Name	Consultation Time (minutes)											
		Physical Therapis	Occ. Therapis	Resp. Therapis	Speech athologis	Dietician/ Nutritionis	Wound/ Infection Nurse	Discharge Planner	Social Worker	PPS oordinat	lebotomi Lab Tech	Other Consult	Other Consult Description
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Patient Tracking Form
Medicare Post-Acute Care Study
[Provider Name & Unit]

Data Collection Period Begin Date __ / __ / ____   Data Collection Period End Date __ / __ / ____   Form PTF-20071116

Patient ID #	Patient Name	edica atient Y N	Medicare Health Insurance Claim (HIC) Number	Interim CARE Tool Assessment Date	Admission Date	Discharge Date	Age	Se M
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PROV002				/ /	/ /	/ /		
PROV003				/ /	/ /	/ /		
PROV004				/ /	/ /	/ /		
PROV005				/ /	/ /	/ /		
PROV006				/ /	/ /	/ /		
PROV007				/ /	/ /	/ /		
PROV008				/ /	/ /	/ /		
PROV009				/ /	/ /	/ /		
PROV010				/ /	/ /	/ /		
PROV011				/ /	/ /	/ /		
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PROV020				/ /	/ /	/ /		

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