

I. Administrative Information

Staff: Please complete this information before providing this questionnaire to the patient or to whoever is helping them.

A.1 Current Date / /
 M M D D Y Y Y Y

Patient Information or ID Sticker
 Patient Name _____
 Date of Birth ____-____-____

A.2 Patient's Medicare Health Insurance Claim Number

A.3 Does the patient need someone to assist them to complete Section II - Patient Information, or answer for them?

There are several items in Section II - Patient Information intended to be reported by the patient. However, some patients may need assistance completing the form.

- A **“recorder”** is someone who writes the answers provided by the patient who can respond reliably; even if the patient requires assistance understanding the content, or giving an answer.
 A recorder should not influence or answer for the patient.
- A **“proxy”** is someone who answers the questions on behalf of the patient. The proxy determines the content of the answer based upon their knowledge of the patient.

A.3a Based on your knowledge of the patient or conversations you have had with him or her, please indicate whether the patient may need assistance completing the form (proxy) or needs to have someone else complete the form for them (recorder). Please check all that apply.

A “recorder” should be used if:

- 1. The patient cannot read English or Spanish.
- 2. The patient has difficulty reading, but can answer reliably verbally.
- 3. The patient cannot write their own responses on the form (e.g., upper limb impairment, vision impairment).
- 4. The patient has difficulty understanding instructions.

8. The patient does not need any assistance and can complete the questionnaire him/herself.

A “proxy” should be used if:

- 5. The patient cannot concentrate for 15 minutes.
- 6. The patient cannot give correct/accurate answers to questions about their health.
- 7. Another reason:

If a patient meets any of the above conditions for a proxy, please choose a proxy from the following list in the order presented below:

1. Clinician who is currently treating patient
2. Family member or companion who came to the appointment with the patient

A.3b Who completed Section II - Patient Information?

Patient

Recorder: Family Member Companion Not Family Staff

Proxy: Clinician Family Member Companion Not Family

FOR OFFICE USE ONLY

II. Patient Information

A.1 Current Date

M	M	D	D	Y	Y	Y	Y		

Patient Information or ID Sticker

Patient Name _____

Date of Birth ____-____-____

Patients: Please complete this form.

B.1 Basic Mobility

Do you have difficulty with getting around (mobility), either walking or in a wheelchair?

- Yes → If “yes,” please answer the rest of the questions on this page.
- No → If “no,” please skip to the next page.

How much DIFFICULTY do you currently have...

(If you have not done an activity recently, how much difficulty do you think you would have if you tried?)

	Unabl e	A Lot of Difficu lty	A Little Difficult y	No Difficu lty	Don't Know
a. Moving from sitting at the side of the bed to lying down on your back?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Moving up in bed (e.g., reposition self)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Standing for at least one minute?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Standing up from an armless straight chair (e.g., dining room chair)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Getting into and out of a car/taxi (sedan)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Walking around on one floor, taking into consideration thresholds, doors, furniture, and a variety of floor coverings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Going up and down a flight of stairs inside, using a handrail?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Bending over from a standing position to pick up a piece of clothing from the floor without holding onto anything?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Reaching overhead while standing, as if to pull a light cord?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How much HELP from another person do you currently need...

(If you have not done an activity recently, how much help do you think you would need if you tried?)

	Unabl e	A Lot of Help Neede d	A Little Help Needed	No Help Neede d	Don't Know
j. Moving to and from a bed to a chair (including a wheelchair)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Moving to and from a toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

II. Patient Information (cont.)

B.2 Do you also use a wheelchair to get around?

- If “yes,” please answer the rest of the questions on this page.
- If “no,” please skip to B.3.
- Yes ➔
- No ➔

Without help from another person, when you are using your wheelchair, how much DIFFICULTY do you currently have...
 (If you have not done an activity recently, how much help do you think you would need if you tried?)

	Unabl e	A Lot of Diffic ulty	A Little Difficult y	No Difficu lty	Don't Know
a. Moving around within one room, including making turns in a wheelchair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Reaching for a high object, using a wheelchair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Opening a door away from a wheelchair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Opening a door toward a wheelchair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Transferring between a wheelchair and other seating surfaces, such as a chair or bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B.3 Everyday Activities

Do you have difficulty with engaging in everyday activities?

- Yes ➔ If “yes,” please answer the rest of the questions on this page.
- No ➔ If “no,” please skip to the next page.

How much HELP do you currently need...
 (If you have not done an activity recently, how much help do you think you would need if you tried?)

	Unabl e	A Lot of Help Need ed	A Little Help Need ed	No Help Need ed	Don't Know
a. Taking care of your personal grooming such as brushing teeth, combing hair, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Bathing yourself (including washing, rinsing, drying the body)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How much DIFFICULTY do you currently have...
 (If you have not done an activity recently, how much difficulty do you think you would have if you tried?)

	Unabl e	A Lot of Difficult y	A Little Difficult y	No Difficult y	Don't Know
c. Picking up thin, flat objects from a table (e.g., coins, post card, envelope)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Putting on and taking off a shirt or blouse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Putting on and taking off socks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Opening small containers like aspirin or vitamins (regular screw tops)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Tying shoes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

II. Patient Information (cont.)

B.4 Life Skills

Do you have difficulty with communicating, remembering, organizing, or planning in your daily life?

- Yes → If "yes," please answer the rest of the questions on this page.
 No → If "no," you are finished with the Patient Information section.

How much DIFFICULTY do you currently have...

(If you have not done an activity recently, how much difficulty do you think you would have if you tried?)

	Unabl e	A Lot of Difficult y	A Little Difficulty	No Difficult y	Don't Know
a. Understanding instructions involving several steps (e.g., how to prepare a meal or following directions)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Answering yes/no questions about basic needs (e.g., "Do you need to use the restroom?" "Are you in pain?")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Making yourself understood to other people during ordinary conversations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Telling someone important information about yourself in case of emergency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Explaining how to do something involving several steps to another person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Reading and following complex instructions (e.g., directions to operate a new appliance or for a new medication)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Telling others your basic needs (e.g., need to use the restroom, have a drink of water or request help)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Reading simple material (e.g., a menu or the TV or radio guide)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Filling out a long form (e.g., insurance form or an application for services)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Writing down a short message or note?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Getting to know new people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Remembering where things were placed or put away (e.g., keys)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Remembering personal information (e.g., medical history, important events)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Keeping track of time (e.g., using a clock)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE!

CARE-F Admission Nursing Facilities

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.

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 0938-1096. The time required to complete this information collection is estimated to average 44 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:

**CARE F Admission – NURSING HOME – Section III: Provider
Information**

CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05,
Baltimore, Maryland 21244-1850.

CARE F Admission – NURSING HOME – Section III: Provider Information

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 Developing Outpatient Therapy Payment Alternatives project,
- 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 Developing Outpatient Therapy Payment Alternatives project 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.

	Name/Signature	Credent ial	Provider NPI	Sections Worked On	Date(s) of Data collection
	(Joe Smith)	(PT)	123456789 0	Sec. III	(MM/DD/YYYY)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

II. Admission Information

A. Pre-admission Service Use (Note: Pre-admission refers to the time before the patient was covered by Medicare Part B)	
<p>A.1 Admitted From: Immediately prior to receiving services covered by Medicare Part B, where was the patient?</p> <p><input type="checkbox"/> a. Private home/apartment</p> <p><input type="checkbox"/> b. Assisted living, group home, adult foster care, board/care, Community-Integrated Living Arrangement (CILA)</p> <p><input type="checkbox"/> c. Long-term nursing facility</p> <p><input type="checkbox"/> d. Skilled nursing facility (SNF/TCU)</p> <p><input type="checkbox"/> e. MR/DD facility (Intermediate Care Facility)</p> <p><input type="checkbox"/> f. Other facility (e.g., hospital)</p> <p><input type="checkbox"/> g. Other (specify) _____</p>	<p>A.2 In the last 2 months, what other medical services besides those identified in A.1 has the patient received?</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">Check all that apply.</p> <p><input type="checkbox"/> a. Skilled nursing facility (SNF/TCU)</p> <p><input type="checkbox"/> b. Long-term nursing facility</p> <p><input type="checkbox"/> c. MR/DD facility (Intermediate Care Facility)</p> <p><input type="checkbox"/> d. Short-stay acute hospital (IPPS)</p> <p><input type="checkbox"/> e. Long-term care hospital (LTCH)</p> <p><input type="checkbox"/> f. Inpatient rehabilitation hospital or unit (IRF)</p> <p><input type="checkbox"/> g. Psychiatric hospital or unit</p> <p><input type="checkbox"/> h. Home health agency (HHA)</p> <p><input type="checkbox"/> i. Hospice</p> <p><input type="checkbox"/> j. Outpatient services</p> <p><input type="checkbox"/> k. None</p>
<p>A.1a Present in Facility (Answer only if your answer to A.1 was c. Long-term nursing facility OR d. Skilled nursing facility)</p> <p>Was the patient present in your facility?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	
B. Patient History Prior To The Current Need for Part B Therapy	
<p>Complete Items B.1 & B.2 ONLY if the patient was admitted from a setting in A.1c-f (long-term nursing facility, SNF/TCU, ICF or other facility)</p>	<p>Complete Items B.3 & B.4 ONLY if the patient was admitted from the community (private home, assisted living, etc.)</p>
<p>B.1 What medical condition(s) led to the admission to that facility?</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">Check all that apply.</p> <p><input type="checkbox"/> a. Stroke/cerebrovascular disease</p> <p><input type="checkbox"/> b. Neurological/neuromuscular</p> <p><input type="checkbox"/> c. Heart failure</p> <p><input type="checkbox"/> d. Dementia/Alzheimer’s disease</p> <p><input type="checkbox"/> e. COPD/emphysema</p> <p><input type="checkbox"/> f. Fractures</p> <p><input type="checkbox"/> g. Bone disorders (incl. osteoporosis)</p> <p><input type="checkbox"/> h. Joint disorders (incl. osteoarthritis)</p> <p><input type="checkbox"/> i. Other muscle disorders</p> <p><input type="checkbox"/> j. Degenerative disorders (incl. wasting, failure to thrive, deconditioning)</p> <p><input type="checkbox"/> k. History of dysphagia/aspiration, pneumonia</p> <p><input type="checkbox"/> l. Other (specify) _____</p>	<p>B.3 If the patient lived in the community prior to this illness, what help was used?</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">Check all that apply.</p> <p><input type="checkbox"/> a. No help received or no help necessary</p> <p><input type="checkbox"/> b. Unpaid assistance</p> <p><input type="checkbox"/> c. Paid assistance</p> <p><input type="checkbox"/> d. Unknown</p>
<p>B.2 Was the patient in a persistent vegetative state/minimally conscious state in that facility immediately prior to receiving Part B therapy?</p>	<p>B.4 If the patient lived in the community prior to this illness, who did the patient live with?</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">Check all that apply.</p> <p><input type="checkbox"/> a. Lived alone</p> <p><input type="checkbox"/> b. Lived with paid helper</p> <p><input type="checkbox"/> c. Lived with other(s)</p> <p><input type="checkbox"/> d. Unknown</p>

CARE F Admission – NURSING HOME – Section III: Provider Information

- a. No**
- b. Yes** (*If Yes, skip to → B.7*)
- c. Unknown**

II. Admission Information (cont.)

B.5 Prior Functioning. Indicate the patient’s usual ability with everyday activities prior to this current illness, exacerbation, or injury.

	Completely Independent: Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.	Needed Some Help: Patient needed partial assistance from another person to complete activities.	Totally Dependent: A helper completed the activity for the patient.	Not Applicable	Unknown
B.5a Self Care: Did the patient need assistance with bathing, dressing, using the toilet, and/or eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.5b Mobility (Ambulation): Did the patient need assistance while walking from room to room (with or without devices such as cane, crutch, or walker)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.5c Stairs (Ambulation): Did the patient need assistance with managing stairs (with or without devices such as cane, crutch, or walker)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.5d Mobility (Wheelchair): Did the patient need assistance with moving from room to room using a wheelchair, scooter, or other wheeled mobility device?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.5e Functional Cognition: Did the patient need assistance with planning regular tasks, such as shopping or remembering to take medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B.6 Mobility Devices and Aids Used Prior to Current Illness, Exacerbation, or Injury

B.7 History of Falls

Check all that apply.	<input type="checkbox"/> a. Cane/crutch <input type="checkbox"/> b. Walker <input type="checkbox"/> c. Orthotics <input type="checkbox"/> d. Prosthetics <input type="checkbox"/> e. Wheelchair/scooter full time		Yes	No	Unknown
		B.7a Has the patient had two or more falls in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CARE F Admission – NURSING HOME – Section III: Provider Information

	<input type="checkbox"/> f. Wheelchair/scooter part time <input type="checkbox"/> g. Mechanical lift <input type="checkbox"/> h. Other (specify) _____ <input type="checkbox"/> i. None apply <input type="checkbox"/> j. Unknown	B.7b Has the patient had any falls with injury in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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III. Current Medical Information

Providers, please complete by the end of your therapy session.

A. Primary and Secondary Medical Diagnoses

Based on available medical information, please indicate the patient's primary (1ary) and secondary (2ary) medical conditions. The primary diagnosis should be related to the reason for therapy. Also, mark ALL secondary diagnoses that the patient has.

A.1 Musculoskeletal

1ary 2ary

- a. Pain Syndrome (fibromyalgia, polymyalgia, etc.)
- b. Pain, Not Pain Syndrome
- c. Osteoarthritis
- d. Rheumatoid Arthritis
- e. TMJ Disorder
- f. Fracture
- g. Sprain/Strain
- h. Osteoporosis
- i. Herniated Disc
- j. Spinal Stenosis
- k. Scoliosis
- l. Torticollis
- m. Contusion
- n. Joint Replacement
- o. Amputation
- p. Bursitis
- q. Tendonitis
- r. Internal Derangement of Joint
- s. Tendon Rupture
- t. Nerve Entrapment
- u. Contracture
- v. Other _____

A.2 Circulatory

1ary 2ary

- a. TIA
- b. Stroke
- c. Atrial Fibrillation & Other Dysrhythmia (bradycardia, tachycardia)
- d. Coronary Artery Disease (angina, myocardial infarction)
- e. Deep Vein Thrombosis (DVT)
- f. Heart Failure (including pulmonary edema)
- g. Hypertension
- h. Peripheral Vascular Disease/Peripheral Arterial Disease
- i. Other _____

A.3 Lymphatic System

1ary 2ary

- a. Lymphedema
- b. Other _____

A.4 Pulmonary/Respiratory System

1ary 2ary

- a. Asthma
- b. Bronchitis
- c. Pneumonia
- d. Chronic Obstructive Pulmonary Disease (COPD)
- e. Cystic Fibrosis
- f. Other _____

A.5 Integumentary System

1ary 2ary

- a. Skin Ulcer/Wound
- b. Burn
- c. Other _____

A.6 Genitourinary System

1ary 2ary

- a. End Stage Renal Disease (ESRD)
- b. Incontinence
- c. Pelvic Pain
- d. Other _____

A.7 Mental Health

1ary 2ary

- a. Anxiety Disorder
- b. Depression
- c. Bipolar Disease
- d. Attention Disorder
- e. Schizophrenia
- f. Alzheimer's Disease
- g. Other _____

A.8 Cancer/Other Neoplasms

1ary 2ary

- a. Please Specify _____

III. Current Medical Information

A.9 Metabolic System

1ary 2ary

- a. Diabetes Mellitus
- b. Obesity
- c. Other _____

A.10 Generalized Weakness

1ary 2ary

- a. Generalized Weakness

A.11 Infectious Diseases

1ary 2ary

- a. Please Specify

A.12 HIV

1ary 2ary

- a. HIV

A.13 Gastrointestinal Disorders

1ary 2ary

- a. Please Specify

A.14 Immune Disorders

1ary 2ary

- a. Immune Disorders

A.15 Anemias/Other Hematological Disorders

1ary 2ary

- a. Anemia
- b. Other _____

A.16 Congenital Abnormalities

1ary 2ary

- a. Musculoskeletal Congenital Deformities/ Anomalies
- b. Neurological Congenital/Developmental Anomalies
- c. Other _____

A.17 Neurological Conditions

1ary 2ary

- a. Specific Diseases of Central Nervous System (CNS)
- b. Cranial Neuralgia
- c. Cranial Nerve Injury
- d. Seizure Disorder
- e. Paralysis
- f. Peripheral Nervous System Disorder (including neuropathy)
- g. Complex Regional Syndrome
- h. Vertigo
- i. Multiple Sclerosis
- j. Parkinson's
- k. Huntington's Disease
- l. Head Injury
- m. Traumatic Brain Injury
- n. Non-Traumatic Brain Injury
- o. Encephalopathy
- p. Retinopathy
- q. Guillain-Barré Syndrome
- r. Other _____

A.18 Cognition/Judgment

1ary 2ary

- a. Executive Function Disorder (difficulty with planning, initiating, monitoring, and evaluating goal direct behavior)
- b. Memory Impairment
- c. Pragmatics Disorder (difficulty with the appropriate use of language in social situations)
- d. Dementia
- e. Other _____

A.19 Communication, Voice, or Speech Disorder

1ary 2ary

- a. Aphasia
- b. Apraxia of Speech
- c. Reading or Writing Dysfunction
- d. Voice Disorder (Dysphonia)
- e. Speech Disorder
- f. Cognitive-Communication Disorder
- g. Other _____

A.20 Swallowing Disorder

1ary 2ary

- a. Dysphagia

A.21 Sensory Disorders/Gait or Balance Disorder

1ary 2ary

- a. Hearing Impairment
- b. Vision Impairment
- c. Gait or Balance Disorder
- d. Other _____

A.22 Other Condition

1ary 2ary

- a. Please Specify _____

III. Current Medical Information

B.1 How long has the patient experienced the primary medical condition(s) for which he/she is receiving therapy? If the patient has more than one medical condition, choose the oldest condition that the patient has been diagnosed with.

- Less than 1 week
- More than 3 months
- Between 1 week and 1 month
- Unknown
- Between 1 month and 3 months

B.2a How many surgeries has the patient had in the past associated with the primary medical condition(s) for which he/she is receiving therapy?

- None (Skip to → D.)
- Unknown (Skip to → D.)
- 1
- 2
- 3
- 4 or more

B.2b If the patient had 1 or more surgeries associated with the primary medical condition(s) for which he/she is receiving therapy, when was the most recent surgery?

- Less than 1 week ago
- Between 1 week and 1 month ago
- Between 1 month and 3 months ago
- More than 3 months ago

C. 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? Include treatments such as blood transfusions or dialysis that the patient currently receives as part of their treatment plan. Check all that apply.

a. Admitted With	
<input type="checkbox"/>	C.1 None
<input type="checkbox"/>	C.2 Total Parenteral Nutrition
<input type="checkbox"/>	C.3 Central Line Management
<input type="checkbox"/>	C.4 Left Ventricular Assistive Device (LVAD)
<input type="checkbox"/>	C.5 Trach Tube with Suctioning: Specify most intensive frequency of suctioning during stay: Every ___ hrs
<input type="checkbox"/>	C.6 Non-invasive ventilation (C-PAP)
<input type="checkbox"/>	C.7 Hemodialysis
<input type="checkbox"/>	C.8 Peritoneal Dialysis
<input type="checkbox"/>	C.9 Fistula or Other Drain Management
<input type="checkbox"/>	C.10 Negative Pressure Wound Therapy
<input type="checkbox"/>	C.11 Complex Wound Management with positioning and skin separation/traction that requires at least two persons or extensive and complex wound management by one person
<input type="checkbox"/>	C.12 Halo
<input type="checkbox"/>	C.13 Complex External Fixators (e.g., Ilizarov)
<input type="checkbox"/>	C.14 Specialty Surface or Bed (i.e., air fluidized, bariatric, low air loss, or rotation bed)
<input type="checkbox"/>	C.15 IV Vasoactive Medications (e.g., pressors, dilators, medication for pulmonary edema)
<input type="checkbox"/>	C.16 IV Chemotherapy

CARE F Admission – NURSING HOME – Section III: Provider Information

<input type="checkbox"/>	C.17 Other Major Treatments (e.g., PIC line, isolation, hyperthermia blanket) <i>Specify</i> _____
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III. Current Medical Information

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

D.1-2 PRESENCE OF PRESSURE ULCERS - Do not "reverse" stage

D.1 Is this patient at risk of developing pressure ulcers? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes , indicated by clinical judgment <input type="checkbox"/> 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.	D.2 Does this patient have one or more unhealed pressure ulcer(s) at stage 2 or higher or unstageable? <input type="checkbox"/> 0. No (If No, skip to → D.6) <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. Don't Know
--	--

IF THE PATIENT HAS ONE OR MORE STAGE 2-4 OR UNSTAGEABLE PRESSURE ULCERS, indicate the number of unhealed pressure ulcers at each stage.

Pressure ulcer at stage 2, stage 3, stage 4, or unstageable:	NUMBER OF PRESSURE ULCERS PRESENT AT ASSESSMENT									
	0	1	2	3	4	5	6	7	8 +	Unknown
D.2a 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).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.2b 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.2c 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.2d 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.2e Number of unhealed stage 2 ulcers known to be present for more than 1 month.	0	1	2	3	4	5	6	7	8 +	Unknown
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D.3 Measurements of LARGEST Unhealed Stage 3 or 4 Pressure Ulcer

IV. Cognitive Status, Mood, &

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

A.1 Persistent vegetative state/no discernible consciousness at time of admission

- 0. No
- 1. Yes (If Yes, skip to → G.7)

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

B.1 Brief Interview for Mental Status Attempted

B.1a Interview conducted?

- 0. No
- 1. Yes (If Yes, skip to → B.2)

B.1b Indicate reason that the interview was not attempted and then skip to → B.4.

- 1. Unresponsive or minimally conscious
- 2. Communication disorder
- 3. No interpreter available
- 4. Patient on ventilator

B.2 Brief Interview for Mental Status

B.2a 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 or no answer

Regardless of patient's performance on B.2a, say: "I will repeat each of the three words with a cue and ask you about them later: sock, something to wear; blue, a color; bed, a piece of furniture." **You may repeat the words up to two more times.**

B.2b Year, Month, Day

B.2b1 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

B.2b2 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

B.2b3 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

B.2 Brief Interview for Mental Status (cont.)

B.2c 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 (e.g., something to wear; a color; a piece of furniture) for that word.

B.2c1 Recalls "sock?"

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

B.2c2 Recalls "blue?"

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

B.2c3 Recalls "bed?"

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

B.3 Does the patient have any problems with memory, attention, problem solving, planning, organizing, or judgment?

- 0. **No**
- 1. **Yes**
- 8. **Don't Know**

DEFINITION:

Difficulty with memory, attention, problem solving, planning, organizing or judgment:

One or more of the following: Memory (e.g., retain relevant functional information, retain multiple steps), attention (e.g., ability to stay focused on task), problem solving/planning, organizing or judgment (e.g., able to understand consequences of actions, safety awareness, follow sequences, plan and execute multiple steps for functional task, keep appointments).

B.3a Please describe the patient's problems with:

- **Memory**
- **Attention**
- **Problem Solving**
- **Planning**
- **Organizing**
- **Judgment**

- Mildly impaired:** Demonstrates some difficulty with one or more of these cognitive abilities.
- Moderately impaired:** Demonstrates marked difficulty with one or more of these cognitive abilities.
- Severely impaired:** Demonstrates extreme difficulty with one or more of these cognitive abilities.

B.4 Observational Assessment of Cognitive Status

Answer **only** if you answered "No" to Interview Conducted (B.1a).

Please indicate all of the following that the patient is able to recall.

- 1. Current season
- 2. Location of own room (nursing home only)
- 3. Staff names and faces
- 4. That s/he is in a hospital, nursing home, clinic, office, or home.
- 5. None of the above

Behavior **not present.**

Behavior **continuously present** does not fluctuate.

Behavior **present fluctuates** (e.g., comes and goes, changes in severity).

B.5 Is there evidence of an acute change in mental status from the patient's baseline?

IV. Cognitive Status, Mood, & Pain

C. Confusion Assessment Method*: Code the following behaviors during the 2-day assessment period. Indicate status regardless of cause.

	Behavior not present.	Behavior continuously present does not fluctuate.	Behavior present fluctuates (e.g., comes and goes, changes in severity).
C.1 Inattention: The patient has difficulty focusing attention (e.g., easily distracted, out of touch, or difficulty keeping track of what is said).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.2 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).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.3 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).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.4 Psychomotor retardation: Patient has an unusually decreased level of activity (e.g., sluggishness, staring into space, staying in one position, moving very slowly).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

D. Difficulty Remembering, Organizing, or Attending in Daily Life (Complete during the 2-day assessment period)

D.1 Is the patient being treated or evaluated for difficulty remembering, organizing, or attending in daily life?

- 0.** No (If **No**, skip to → Section E)
- 1.** Yes (If **Yes**, complete D.2 - D.4)

D.2 Problem Solving

Answer **only** if you answered “Yes” to D.1.

The patient solves:	Simple Problems		Complex Problems	
	D.2a Without Assistance	D.2b With Assistance	D.2c Without Assistance	D.2d With Assistance
Simple Problems: Following basic schedules; requesting assistance; using a call bell; identifying basic wants/needs; preparing a simple cold meal	Never or Rarely			
	Sometimes			
	Usually			
	Always			

Level of Assistance:

Without Assistance: _____ Patient performance **without** cueing, assistive device, or other compensatory augmentative intervention

With Assistance: Patient performance **with** cueing, assistive device, or other compensatory augmentative intervention

Frequency of problem solving:

- Never or Rarely:** _____ Less than 20% of the time
- Sometimes:** Between 20% and 49% of the time
- Usually:** Between 50% and 79% of the time
- Always:** At least 80% of the time

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

D.3 Memory

Answer **only** if you answered “Yes” to D.1 .

The patient recalls: Basic Information: Personal information (e.g., family members, biographical information, physical location); basic schedules; names of familiar staff; location of therapy area Complex Information: Complex and novel information (e.g., carry out multiple-step activities, follow a plan); anticipate future events (e.g., keeping appointments)	Basic Information		Complex Information	
	D.3a Without Assistance	D.3b With Assistance	D.3c Without Assistance	D.3d With Assistance
Never or Rarely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Usually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Always	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Level of Assistance:

Without Assistance: _____ Patient performance **without** cueing, assistive device, or other compensatory augmentative intervention

With Assistance: _____ Patient performance **with** cueing, assistive device, or other compensatory augmentative intervention

Frequency of memory:

Never or Rarely: _____ Less than 20% of the time

Sometimes: _____ Between 20% and 49% of the time

Usually: _____ Between 50% and 79% of the time

Always: _____ At least 80% of the time

D.4 Attention

Answer **only** if you answered “Yes” to D.1.

The patient maintains attention for: Simple Activities: Following simple directions; reading environmental signs or short newspaper/magazine/book passage; eating a meal; completing personal hygiene; dressing Complex Activities: Watching a news program; reading a book; planning and preparing a meal; managing one’s own medical, financial, and personal affairs	Simple Activities		Complex Activities	
	D.4a Without Assistance	D.4b With Assistance	D.4c Without Assistance	D.4d With Assistance
Never or Rarely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Usually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Always	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Level of Assistance:

Without Assistance: _____ Patient performance **without** cueing, assistive device, or other compensatory augmentative intervention

With Assistance: _____ Patient performance **with** cueing, assistive device, or other compensatory augmentative intervention

Frequency of maintaining attention:

Never or Rarely: _____ Less than 20% of the time

Sometimes: _____ Between 20% and 49% of the time

Usually: _____ Between 50% and 79% of the time

Always: _____ At least 80% of the time

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 behavioral symptoms during the 2-day assessment period?

E.1 Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing).

0. No
 1. Yes

E.2 Verbal behavioral symptoms directed towards others (e.g., threatening, screaming at others).

0. No
 1. Yes

E.3 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 (Complete during the 2-day assessment period)

F.1 Mood Interview Attempted?

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

F.2 Patient Health Questionnaire (PHQ-2®)

Ask patient: "During the last 2 weeks, have you been bothered by any of the following problems?"

F.2a Little interest or pleasure in doing things?

0. No (If **No**, skip to → F.2c)
 1. Yes
 8. Unable to respond (If **Unable**, skip to → F.2c)

F.2b 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)

F.2c Feeling down, depressed, or hopeless?

0. No (If **No**, skip to → F.3)
 1. Yes
 8. Unable to respond (If **Unable**, skip to → F.3)

F.2d 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)

F.3 Feeling Sad

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 or Hurting (Complete during the 2-day assessment period)

G.1 Pain Interview Attempted?

- 0. No** Specify Reason: _____
(If **No**, skip to → G.7)
- 1. Yes**

G.2 Pain Presence or Hurting

Ask patient: "Have you had pain or hurting at any time during the last 2 days?"

- 0. No** (If **No**, skip to → Section V)
- 1. Yes**
- 8. Unable to answer or no response**
(If **Unable**, skip to → G.7)

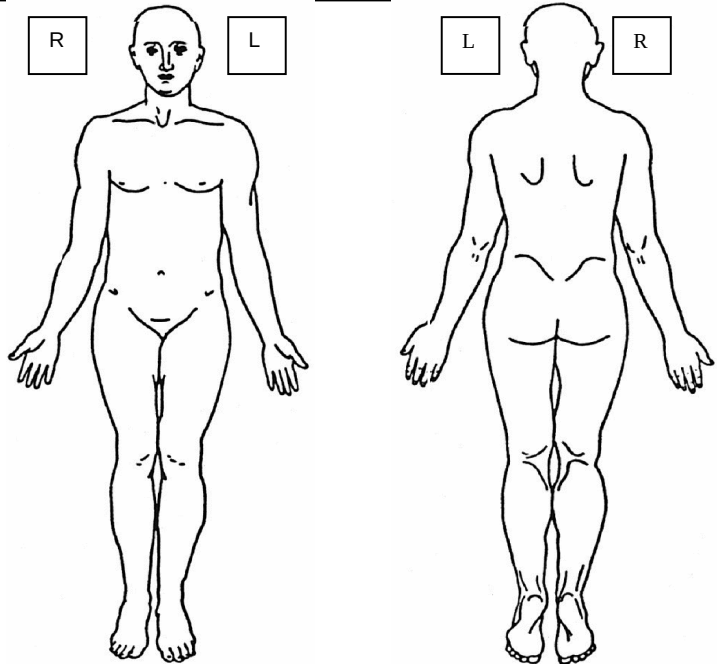
G.3 Pain Severity

Ask patient: "Please rate your worst pain during the last 2 days on a zero to 10 scale, with 0 being no pain and 10 as the worst pain you can imagine."

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
No Pain				Moderate Pain			Worst Pain			

G.4 Pain/Hurting Location

Please mark with an **X** the area(s) of your body where you have pain or hurting.



G.4 Pain/Hurting Effect on Sleep (Check one box.)

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**

G.5 Pain/Hurting Effect on Activities (Check one box.)

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**

G.6 Ask patient: "How would you describe your pain?" (Check all that apply.)

- | | | | |
|--|--------------------------------------|--|--|
| <input type="checkbox"/> a. Constant | <input type="checkbox"/> e. Burning | <input type="checkbox"/> i. Ache/Throb | <input type="checkbox"/> m. Tightness |
| <input type="checkbox"/> b. Intermittent | <input type="checkbox"/> f. Pinching | <input type="checkbox"/> j. Stabbing | <input type="checkbox"/> n. Stiffness |
| <input type="checkbox"/> c. Sharp | <input type="checkbox"/> g. Numbness | <input type="checkbox"/> k. Pulling | <input type="checkbox"/> o. Other: Please write in _____ |
| <input type="checkbox"/> d. Dull | <input type="checkbox"/> h. Tingling | <input type="checkbox"/> l. Cramping | |

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G.7 Pain Observational Assessment. If patient could not be interviewed for pain assessment, check all indicators of pain or possible pain. Only complete if G.1 was coded "No" (0).

Check all that apply..

- G.7a Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)
- G.7b Vocal complaints of pain** (e.g., "that hurts, ouch, stop")
- G.7c Facial expressions** (e.g., grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw)
- G.7d Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
- G.7e None** of these signs observed or documented

V. Impairments

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

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

A.2 Does this patient use an external or indwelling device or require intermittent catheterization?	Check one box. A.2a Bladder	Check one box. A.2b Bowel
		<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
A.3 Indicate the frequency of incontinence. Please check one option under both Bladder and Bowel.	Check one option only. A.3a Bladder	Check one option only. A.3b Bowel
0. Continent (no documented incontinence)	<input type="checkbox"/>	<input type="checkbox"/>
1. Stress incontinence only (bladder only)	<input type="checkbox"/>	
2. Incontinent less than daily (only once during the 2-day assessment period)	<input type="checkbox"/>	<input type="checkbox"/>
3. Incontinent daily (at least once a day)	<input type="checkbox"/>	<input type="checkbox"/>
4. Always incontinent	<input type="checkbox"/>	<input type="checkbox"/>
5. No urine/bowel output (e.g., renal failure)	<input type="checkbox"/>	<input type="checkbox"/>
9. Not applicable (e.g., indwelling catheter)	<input type="checkbox"/>	<input type="checkbox"/>
A.4 Does the incontinence interfere with therapy treatments?	Check one box. A.4a Bladder	Check one box. A.4b Bowel
	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 9. Unknown	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 9. Unknown

V. Impairments (cont.)

DEFINITIONS

Possible swallowing disorder:

One or more of the following: History of dysphagia/aspiration pneumonia, NPO intake not by mouth, complaints of difficulty or pain with swallowing, coughing or choking during meals (i.e. while eating or drinking) or when swallowing medications, wet vocal quality/and throat clearing or coughing after meals, holding food in mouth/cheeks or residual food in mouth/cheeks after meals, loss of liquids/solids from mouth when eating or drinking.

Difficulty communicating:

One or more of the following: Motor speech disorder (e.g., slurred speech; speaking too slow or too fast; or too soft or too loud), deficits in spoken language expression (trouble with naming, grammar, expressing needs or ideas). deficits in comprehension (e.g., needs repetition, gesture, rephrasing, simplification to follow directions or understand), deficits in written expression (e.g., unable to write due to language rather than motor impairment), reading comprehension (e.g., unable to decode words or comprehend sentences or paragraphs), alaryngeal communication, or uses augmentative-alternative communication device.

Language barrier:

The patient does not speak the language in which treatment is conducted.

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

B.1 Does the patient have any signs or symptoms of a possible swallowing disorder?

- Check all that apply.
- B.1a History of dysphagia/aspiration pneumonia
 - B.1b Complaints of difficulty or pain with swallowing
 - B.1c Coughing or choking during meals or when swallowing medications
 - B.1d Wet vocal quality and /or throat clearing
 - B.1e Holding food in mouth/cheeks or residual food in mouth after meals
 - B.1f Loss of liquids/solids from mouth when eating or drinking
 - B.1g NPO: intake not by mouth
 - B.1h Other (specify) _____
 - B.1i None

B.2 Describe the patient’s usual ability with swallowing. (Check all that apply.)

- B.2a **Regular food:** Solids and liquids swallowed safely without supervision and without modified food or liquid consistency.
- B.2b **Modified food consistency/supervision:** Patient requires modified food or liquid consistency and/or needs supervision or feeding by others during eating for safety.
- B.2c **Tube/parenteral feeding:** Tube/parenteral feeding used wholly or partially as a means of sustenance.

B.3 For safety and maximal nutritional intake, the patient requires:

Liquid Diet Modification: Thickened liquids (e.g., consistency of syrup, nectar, honey, or pudding)

Solid Diet Modification: Cooked until soft; chopped, ground, mashed; or pureed

B.3a Diet Modification	B.3b Level of Cueing or Assistance
<input type="checkbox"/> Both Liquids & Solids	<input type="checkbox"/> Maximal
<input type="checkbox"/> Either Liquids or Solids	<input type="checkbox"/> Moderate
<input type="checkbox"/> None	<input type="checkbox"/> Minimal
	<input type="checkbox"/> None

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Level of Cueing or Assistance:

Maximal Cueing: Multiple cues that are obvious to non-clinicians, including any combination of auditory, visual, pictorial, tactile, or written cues

Moderate Cueing: Combination of cueing types, some of which may be obvious to nonclinicians, including any combination of auditory, visual, pictorial, tactile, or written cues.

Minimal Cueing: Subtle and only one type of cueing

None: No cueing provided.

V. Impairments (cont.)

C. Vision, Hearing, and Communication (Complete during the 2-day assessment period)

C.1 Does the patient have any impairments with vision, hearing, or communication?

- 0. No** (If **No** impairments, skip to → Section E)
- 1. Yes** (If **Yes**, please complete this section)

C.1a Ability to See in Adequate Light (with glasses or other visual appliances)

- 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**

C.1b Ability to Hear (with hearing aid or hearing appliance, if normally used)

- 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**

C.1c Understanding Verbal Content (excluding language barriers)

- 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**

C.1d Expression of Ideas and Wants

- 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**

V. Impairments (cont.)

D. Difficulty Communicating in Daily Life (Complete during the 2-day assessment period)

D.1 Is the patient being treated or evaluated for difficulty communicating in daily life?

- 0. No** (If **No**, skip to → Section E)
- 1. Yes** (If **Yes**, please complete D.2 – D.5)

In Questions D.2 through D.5, please use the following definitions for the frequency with which the patient can perform the indicated activity and level of assistance:

D.2 Spoken Language Comprehension

Answer **only** if you answered “Yes” to D.1.

The patient comprehends: Basic Information: Simple 1-step directions; simple yes/no questions; simple words or short phrases Complex Information: Complex sentences, 2-3 step directions, 2-3 part messages; conversations about routine daily activities and a variety of topics	Basic Information		Complex Information	
	D.2a Without Assistance	D.2b With Assistance	D.2c Without Assistance	D.2d With Assistance
Never or Rarely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Usually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Always	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Level of Assistance:

Without Assistance: Patient performance **without** cueing (verbal/written/repetition), assistive device, or other compensatory augmentative intervention

With Assistance: Patient performance **with** cueing (verbal/written/repetition), assistive device, or other compensatory augmentative intervention

Frequency of spoken language comprehension:

Never or Rarely: Less than 20% of the time

Sometimes: Between 20% and 49% of the time

Usually: Between 50% and 79% of the time

Always: At least 80% of the time

D.3 Spoken Language Expression

Answer **only** if you answered “Yes” to D.1.

The patient conveys: Basic Information: Basic information regarding wants/needs or daily routines; using 1-2 words or short phrases Complex Information: Thoughts/ideas using sentences; in conversations about routine daily activities or a variety of topics	Basic Information		Complex Information	
	D.3a Without Assistance	D.3b With Assistance	D.3c Without Assistance	D.3d With Assistance
Never or Rarely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Usually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Always	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Level of Assistance:

Without Assistance: Patient performance **without** cueing (verbal/written/repetition), assistive device, or other compensatory augmentative intervention

With Assistance: Patient performance **with** cueing (verbal/written/repetition), assistive device, or other compensatory augmentative intervention

Frequency of spoken language expression:

Never or Rarely: Less than 20% of the time

Sometimes: Between 20% and 49% of the time

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Usually: Between 50% and 79% of the time

Always: At least 80% of the time

V. Impairments (cont.)

D.4 Motor Speech Production

Answer **only** if you answered “Yes” to D.1.

The patient’s speech is: Intelligible in Short Utterances: Spontaneous production of automatic words, predictable single words, or short phrases in conversation	Intelligible in Short Utterances		Intelligible in Longer Utterances	
	D.4a Without Assistance	D.4b With Assistance	D.4c Without Assistance	D.4d With Assistance
Intelligible in Longer Utterances: Spontaneous production of multisyllabic words in sentences	Never or Rarely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sometimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Usually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Always	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Level of Assistance:

Without Assistance: Patient performance **without** cueing (verbal/written/repetition), assistive device, or other compensatory augmentative intervention

With Assistance: Patient performance **with** cueing (verbal/written/repetition), assistive device, or other compensatory augmentative intervention

Frequency of motor speech production:

Never or Rarely: Less than 20% of the time

Sometimes: Between 20% and 49% of the time

Usually: Between 50% and 79% of the time

Always: At least 80% of the time

D.5 Functional Voice

Answer **only** if you answered “Yes” to D.1.

The patient’s voice is functional in the following types of activities: Low Vocal Demand: Speaking softly; speaking in quiet environments; talking for short periods of time High Vocal Demand: Speaking loudly; speaking in noisy environments; talking for extended periods of time.	Low Vocal Demand		High Vocal Demand	
	D.5a Without Assistance	D.5b With Assistance	D.5c Without Assistance	D.5d With Assistance
	Never or Rarely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sometimes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Usually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Always	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Level of Assistance:

Without Assistance: Patient performance **without** cueing (verbal/written/repetition), assistive device, or other compensatory augmentative intervention

With Assistance: Patient performance **with** cueing (verbal/written/repetition), assistive device, or other compensatory augmentative intervention

Frequency of functional voice:

Never or Rarely: Less than 20% of the time

Sometimes: Between 20% and 49% of the time

Usually: Between 50% and 79% of the time

Always: At least 80% of the time

V. Impairments (cont.)

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

E.1 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** impairments, skip to → Section F)
- 1. Yes** (If **Yes**, please complete this section)

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

Check the appropriate boxes	Upper Extremity		Lower Extremity	
	E.1a Left	E.1b Right	E.1c Left	E.1d Right
1. Fully weight-bearing: No clinician-ordered restrictions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0. Not fully weight-bearing: Patient has clinician-ordered restrictions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

F.1 Does the patient have any impairments with respiratory status?

- 0. No** (If **No**, skip to → Section G)
- 1. Yes** (If **Yes**, please complete this section)

F.1a Check one option only. With Supplemental O ₂	F.1b Check one option only. Without Supplemental O ₂	Respiratory Status: Was the patient dyspneic or noticeably short of breath?
<input type="checkbox"/>	<input type="checkbox"/>	5. Severe, with evidence the patient is struggling to breathe at rest
<input type="checkbox"/>	<input type="checkbox"/>	4. Mild at rest (during day or night)
<input type="checkbox"/>	<input type="checkbox"/>	3. With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
<input type="checkbox"/>	<input type="checkbox"/>	2. With moderate exertion (e.g., while dressing, using commode or bedpan, walking between rooms)
<input type="checkbox"/>	<input type="checkbox"/>	1. When climbing stairs
<input type="checkbox"/>	<input type="checkbox"/>	0. Never, patient was not short of breath
<input type="checkbox"/>	<input type="checkbox"/>	8. Not assessed (e.g., on ventilator, unsafe to remove oxygen from patient)
<input type="checkbox"/>	<input type="checkbox"/>	9. Not applicable

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

G.1 Does the patient have any impairments with endurance?

- 0. No** (If **No**, skip to → VI. Section A.)
- 1. Yes** (If **Yes**, please complete this section)

G.1a 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**

G.1b Sitting Endurance: Was the patient able to tolerate sitting for 15 minutes?

- 0. No**
- 1. Yes, with support** (e.g., regular chair or W/C)
- 2. Yes, without support** (e.g., at edge of bed)
- 8. Not assessed due to medical restriction**

VI. Functional Status / Performance

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

Code the patient's 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.

If patient has an assistive device, score patient using this device.

- 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.
- N. Activity Not Assessed** - The item was not assessed because not clinically relevant for this patient or due to medical conditions, safety concerns, or environmental constraints.

	Patient's Performance						Activity Not Assessed Code
	6 = Independent 1 = Dependent						
	6	5	4	3	2	1	N
A.1 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A.2 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A.3 Toileting 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A.4 Wash upper body: The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A.5 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A.6 Upper body dressing: The ability to put on and remove shirt or pajama top. Includes buttoning if applicable. Does not include hosp. gown in SNF/NH setting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A.7 Lower body dressing: The ability to dress and undress below the waist, including fasteners. Does not include footwear. In SNF/NH setting does not include hospital gown.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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A.8 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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VI. Functional Status / Performance (cont.)

B. Mobility Devices and Aids Needed

B.1 Indicate all mobility devices and aids being used at the time of assessment.

Check all that	<input type="checkbox"/> a. Canes/crutch	<input type="checkbox"/> e. Wheelchair/scooter part time
	<input type="checkbox"/> b. Walker	<input type="checkbox"/> f. Mechanical lift
<input type="checkbox"/> c. Orthotics/prosthetic	<input type="checkbox"/> g. Other (specify) _____	
<input type="checkbox"/> d. Wheelchair/scooter full time	<input type="checkbox"/> h. None apply	

C. Functional Mobility (Complete during the 2-day assessment period)

Code the patient's 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.
If patient has an assistive device, score patient using this device.

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.

N. Activity Not Assessed - The item was not assessed because not clinically relevant for this patient or due to medical conditions, safety concerns, or environmental constraints.

	Patient's Performance						Activity Not Assessed Code
	6 = Independent 1 = Dependent						
	6	5	4	3	2	1	N
C.1 Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.2 Roll left and right: The ability to roll from lying on back to left and right side, and roll back to back.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.3 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.4 Sit to stand: The ability to safely come to a standing position from sitting in a chair or on the side of the bed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.5 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.6 Picking up object while standing: The ability to bend/stoop from a standing position to pick up small object such as a spoon from the floor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.7 Walk 50 feet with two turns: The ability to walk 50 feet and make two turns without a rest break.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.8 Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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surfaces, such as grass or gravel without a rest break.							
C.9 1 step (curb): The ability to step over a curb or up and down one step without a rest break.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.10 Four steps: The ability to go up and down 4 steps with or without a rail without a rest break.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.11 Twelve steps: The ability to go up and down 12 steps with or without a rail without a rest break.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.12 Wheel up and down ramp: Once seated in wheelchair, goes up and down a ramp of less than 12 feet (4 meters) without a rest break.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VI. Functional Status / Performance

C. Functional Mobility (Complete during the 2-day assessment period)

Code the patient's 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.

If patient has an assistive device, score patient using this device.

- 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.

N. Activity Not Assessed - The item was not assessed because not clinically relevant for this patient or due to medical conditions, safety concerns, or environmental constraints.

C.13 Select the longest distance the patient walks without a rest break, and code his/her level of independence (Level 1-6) on that distance. Observe performance. If patient does not walk, select C.13d and check "N". (SELECT ONLY ONE.)

	Patient's Performance 6 = Independent 1 = Dependent						Activity Not Assessed Code
	6	5	4	3	2	1	N
C.13a Walk 150 ft (45 m): Once standing, can walk at least 150 feet (45 meters) in corridor or similar space.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.13b Walk 100 ft (30 m): Once standing, can walk at least 100 feet (30 meters) in corridor or similar space.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.13c Walk 50 ft (15 m): Once standing, can walk at least 50 feet (15 meters) in corridor or similar space.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.13d Walk in room once standing: once standing, can walk at least 10 feet (3 meters) in room, corridor or similar space.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C.14 Select the longest distance the patient wheels without a rest break, and code his/her level of independence (Level 1-6). Observe performance. If patient does not use wheelchair, select C.14d and check "N". (SELECT ONLY ONE.)

	Patient's Performance 6 = Independent 1 = Dependent						Activity Not Assessed Code
	6	5	4	3	2	1	N
C.14a Wheel 150 ft (45 m): Once seated, can wheel at least 150 feet (45 meters) in corridor or similar space.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.14b Wheel 100 ft (30 m): Once seated, can wheel at least 100 feet (30 meters) in corridor or similar space.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.14c Wheel 50 ft (15 m): Once seated, can wheel at least 50 feet (15 meters) in corridor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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or similar space.							
C.14d Wheel in room once seated: Once seated, can wheel at least 10 feet (3 meters) in room, corridor, or similar space.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VI. Functional Status / Performance

D. Instrumental Activities of Daily Living (IADL) (Complete during the 2-day assessment period)

Code the patient's 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.

If patient has an assistive device, score patient using this device.

- 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.

N. Activity Not Assessed - The item was not assessed because not clinically relevant for this patient or due to medical conditions, safety concerns, or environmental constraints.

	Patient's Performance						Activity Not Assessed Code
	6 = Independent			1 = Dependent			
	6	5	4	3	2	1	N
D.1 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.2 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.3 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.4 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.5 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.6 Make light meal: The ability to plan and prepare all aspects of a light meal such as a sandwich and cold drink.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.7 Wipe down surface & clean the cloth: 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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manner.							
D.8 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VI. Functional Status / Performance

E. Participation

E.1 Social Participation

Ask patient: *“Think about how you currently get together or do things with others, like going out or visiting with family and friends. Which of the following best describes you?”*

- I do not have any difficulty doing things with others socially.
- Even though it's hard, I keep doing things with people as usual.
- I no longer can do as much or the same kinds of things with others.
- I hardly ever do the types of things I use to do, or I hardly ever get together with others.
- I do not see family or friends, and I only see those who take care of me.

VII. Primary Reason for Therapy

A. Primary Reason for Therapy

Please indicate the primary body function(s), body structure(s), and activity & participation reason(s) for which you are treating this patient using the categories below. **Mark all primary reasons for therapy that apply.**

A.1 Body Functions (Check at least one)	A.2 Body Structures (Check at least one)	A.3 Activities and Participation (Check at least one)																										
<ul style="list-style-type: none"> <input type="radio"/> a. Global Mental Functions (consciousness, orientation, intellectual function, energy & drive, sleep, temperament, personality) <input type="radio"/> b. Specific Mental Functions (attention, memory, psychomotor, emotional, perceptual, higher level cognition, sequencing of complex tasks, calculation, mental functions of language) <input type="radio"/> c. Seeing & Related Functions <input type="radio"/> d. Hearing <input type="radio"/> e. Vestibular Functions <input type="radio"/> f. Proprioceptive & Touch Functions <input type="radio"/> g. Other Sensory Functions (taste, smell) <input type="radio"/> h. Pain <input type="radio"/> i. Voice & Speech Functions (articulation, speech, fluency & rhythm, alternative vocalization) <input type="radio"/> j. Functions of the Cardiovascular System <input type="radio"/> k. Functions of the Immunological & Hematological Systems <input type="radio"/> l. Functions of the Respiratory System <input type="radio"/> m. Functions of the Digestive System <input type="radio"/> n. Functions Related to Metabolism & Endocrine System <input type="radio"/> o. Urinary Functions <input type="radio"/> p. Genital & Reproductive Functions <input type="radio"/> q. Functions of the Joints & Bones <input type="radio"/> r. Muscle Functions (muscle power, tone, endurance) <input type="radio"/> s. Movement Functions (motor reflexes, involuntary movements, control of movements, gait patterns, neuromuscular functions) <input type="radio"/> t. Functions of the Skin <input type="radio"/> u. Functions of the Hair & Nails 	<p>Structures Related to Movement</p> <ul style="list-style-type: none"> <input type="radio"/> a. General/No Specific Body Location <input type="radio"/> b. Head <input type="radio"/> c. Cervical Spine <input type="radio"/> d. Thoracic Spine <input type="radio"/> e. Lumbar Spine <input type="radio"/> f. Pelvic Girdle <p>L: Left Side; R: Right Side</p> <table border="0"> <tr> <td style="padding-right: 10px;">L</td> <td>R</td> </tr> <tr> <td><input type="radio"/> g. Hip</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> h. Thigh</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> i. Knee</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> j. Calf</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> k. Foot/Ankle</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> l. Toes</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> m. Shoulder</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> n. Arm</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> o. Elbow</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> p. Wrist</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> q. Hand</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> r. Fingers</td> <td><input type="radio"/></td> </tr> </table> <p>Structures Involved in Voice, Speech, & Swallowing</p> <ul style="list-style-type: none"> <input type="radio"/> s. Nose <input type="radio"/> t. Mouth <input type="radio"/> u. Tongue <input type="radio"/> v. Pharynx <input type="radio"/> w. Larynx <p>Other Structures</p> <ul style="list-style-type: none"> <input type="radio"/> x. Eye & Related Structures <input type="radio"/> y. Ear & Related Structures <input type="radio"/> z. Structures of the Central Nervous System <input type="radio"/> aa. Structures of the Peripheral Nervous System <input type="radio"/> bb. Structures of the Cardiovascular, Immunological, & Respiratory Systems <input type="radio"/> cc. Structures Related to the Digestive, Metabolic, & Endocrine Systems <input type="radio"/> dd. Structures Related to the Genitourinary & Reproductive Systems <input type="radio"/> ee. Skin & Related Structures 	L	R	<input type="radio"/> g. Hip	<input type="radio"/>	<input type="radio"/> h. Thigh	<input type="radio"/>	<input type="radio"/> i. Knee	<input type="radio"/>	<input type="radio"/> j. Calf	<input type="radio"/>	<input type="radio"/> k. Foot/Ankle	<input type="radio"/>	<input type="radio"/> l. Toes	<input type="radio"/>	<input type="radio"/> m. Shoulder	<input type="radio"/>	<input type="radio"/> n. Arm	<input type="radio"/>	<input type="radio"/> o. Elbow	<input type="radio"/>	<input type="radio"/> p. Wrist	<input type="radio"/>	<input type="radio"/> q. Hand	<input type="radio"/>	<input type="radio"/> r. Fingers	<input type="radio"/>	<ul style="list-style-type: none"> <input type="radio"/> a. Purposeful Sensory Experiences (watching, listening) <input type="radio"/> b. Basic Learning (copying, rehearsing, learning to read, write, acquiring skills) <input type="radio"/> c. Applying Knowledge (focusing attention, thinking, reading, writing, calculating, solving problems, making decisions) <input type="radio"/> d. General Tasks & Demands (simple and multiple tasks, carrying out daily routine, handling stress) <input type="radio"/> e. Communication: Reception (spoken, nonverbal, sign language, written) <input type="radio"/> f. Communication: Expression (speaking, nonverbal, sign language, writing) <input type="radio"/> g. Conversation & Use of Communication Devices (conversation, discussion, using devices and techniques) <input type="radio"/> h. Changing & Maintaining Body Position <input type="radio"/> i. Carrying, Moving, & Handling Objects <input type="radio"/> j. Walking & Moving <input type="radio"/> k. Moving Around Using Transportation <input type="radio"/> l. Self Care (washing oneself, toileting, dressing, eating, drinking) <input type="radio"/> m. Acquisition of Necessities (a place to live, goods and services) <input type="radio"/> n. Household Tasks (preparing meals, doing housework) <input type="radio"/> o. Caring for Household Objects & Assisting Others <input type="radio"/> p. General Interpersonal Interactions <input type="radio"/> q. Particular Interpersonal Interactions (relating with strangers, formal and informal relationships, family and intimate relationships) <input type="radio"/> r. Education <input type="radio"/> s. Work & Employment <input type="radio"/> t. Economic Life <input type="radio"/> u. Community, Social, & Civic Life
L	R																											
<input type="radio"/> g. Hip	<input type="radio"/>																											
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<input type="radio"/> q. Hand	<input type="radio"/>																											
<input type="radio"/> r. Fingers	<input type="radio"/>																											
<p>A.4 Why is the patient receiving therapy services covered by Medicare Part B?</p>																												

CARE F Admission – NURSING HOME – Section III: Provider Information

Check all that apply.

- a. Continuation of therapy services provided under Medicare Part A
- b. Change in physical functional status
- c. Change in cognitive status (incl. emergence from coma, persistent vegetative state, etc.)
- d. Change in medical status
- e. Change in availability or loss of caregiver
- f. Other (specify) _____

VIII. Other Useful Information

A. Is there other useful information about this patient that you want to add?

Empty box for additional information.

IX. Feedback

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.

CARE F Admission – NURSING HOME – Section III: Provider Information

[Empty rectangular box for provider information]