CARE-F
Admission

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

Signatures of Clinicians who Completed a Portion of the Accompanying Assessment

I certify, to the best of my knowledge, the information in this assessment is

- collected in accordance with the guidelines provided by CMS for participation in this 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	Credential	NPI (if applicable)	Sections Worked On	Date(s) of Data collection
	(Joe Smith)	(RN)	1234567890	Medical Information	(MM/DD/YYYY)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

I. Administrative Items

A. Assessment Type

A.3 Assessment Reference Date

_____/_____/_____
MM DD YYYY

(The last day of the admission assessment period.)

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

B. Provider Information

B.1 Provider's Name

C.1 Patient's First Name

C.2 Patient's Middle Initial or Name

C.3 Patient's Last Name

C.4 Patient's Gender

- ☐ Male
- ☐ Female

C.5 Race/Ethnicity

Check all that apply.

- ☐ a. American Indian or Alaska Native
- ☐ b. Asian
- ☐ c. Black or African American
- ☐ d. Hispanic or Latino
- ☐ e. Native Hawaiian or Pacific Islander
- ☐ f. White
- ☐ g. Unknown

C.6 Patient's Medicare Health Insurance Claim Number

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

C.7 Admission Date (Note: the admission date is the first day the patient was covered by Medicare Part B)

_____/_____/_____
MM DD YYYY

C.8 Birth Date

_____/_____/_____
MM DD YYYY

C.9 Is English the patient's primary language?

- ☐ No
- ☐ Yes

C.10 Does the patient want or need an interpreter (oral or sign language) to communicate with a doctor or health care staff?

- ☐ No
- ☐ Yes

II. Admission Information

A. Pre-admission Service Use (Note: Pre-admission refers to the time before the patient was covered by Medicare Part B)

A.1 Admitted From. Immediately prior to receiving services covered by Medicare Part B, where was the patient?

- ☐ a. Private home/apartment
- ☐ b. Assisted living, group home, adult foster care, board/care
- ☐ c. Long-term nursing facility
- ☐ d. Skilled nursing facility (SNF/TCU)
- ☐ e. MR/DD facility
- ☐ f. Other facility (e.g., hospital)
- ☐ g. Other (specify)_____

A.1.a Present in Facility (*Answer only if your answer to A.1 was c. Long-term nursing facility OR d. Skilled nursing facility*)

Was the patient present in your facility?

- ☐ a. No
- ☐ b. Yes

A.2 *In the last 2 months*, what other medical services besides those identified in A1. has the patient received?

Check all that apply

- ☐ a. Skilled nursing facility (SNF/TCU)
- ☐ b. Long-term nursing facility
- ☐ c. MR/DD facility
- ☐ d. Short-stay acute hospital (IPPS)
- ☐ e. Long-term care hospital (LTCH)
- ☐ f. Inpatient rehabilitation hospital or unit (IRF)
- ☐ g. Psychiatric hospital or unit
- ☐ h. Home health agency (HHA)
- ☐ i. Hospice
- ☐ j. Outpatient services
- ☐ k. None

B. Patient History Prior To The Current Need for Part B Therapy

Complete Items B1 & B2 **ONLY** if the patient was admitted from a long-term nursing facility, SNF/TCU, or other facility

Check all that apply.

B.1 Because of what medical condition(s) were they in that facility?

- ☐ a. Stroke/cerebrovascular disease
- ☐ b. Heart failure
- ☐ c. Dementia/Alzheimer's disease
- ☐ d. COPD/emphysema
- ☐ e. Joint disorders (incl. osteoarthritis)
- ☐ f. Bone disorders (incl. osteoporosis)
- ☐ g. Neurological/neuromuscular
- ☐ h. Other muscle disorders
- ☐ i. Degenerative disorders (incl. wasting, failure to thrive, deconditioning)
- ☐ j. Fracture
- ☐ k. History of dysphagia/aspiration pneumonia
- ☐ l. Arthritis and arthritities
- ☐ m. Other (specify)_____

B.2 Was the patient in a persistent vegetative state/minimally conscious state in that facility immediately prior to receiving Part B therapy?

- ☐ 0. No
- ☐ 1. Yes *(If **Yes**, skip to B7)*
- ☐ 9. Unknown

Complete Items B3 & B4 **ONLY** if the patient was admitted from the community (private home, assisted living, etc.)

Check all that apply.

B.3 If the patient lived in the community prior to this illness, what help was used?

- ☐ a. No help received or no help necessary
- ☐ b. Unpaid assistance
- ☐ c. Paid assistance
- ☐ d. Unknown

Check all that apply.

B.4 If the patient lived in the community prior to this illness, who did the patient live with?

- ☐ a. Lived alone
- ☐ b. Lived with paid helper
- ☐ c. Lived with other(s)
- ☐ d. 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.

	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.	**Dependent:** A helper completed the activity for the patient.	**Not Applicable**	**Unknown**
B.5.a Self Care: Did the patient need help bathing, dressing, using the toilet, or eating?	☐	☐	☐	☐	☐
B.5.b Mobility (Ambulation): Did the patient need assistance with walking from room to room (with or without devices such as cane, crutch, or walker)?	☐	☐	☐	☐	☐
B.5.c Stairs (Ambulation): Did the patient need assistance with stairs (with or without devices such as cane, crutch, or walker)?	☐	☐	☐	☐	☐
B.5.d Mobility (Wheelchair): Did the patient need assistance with moving from room to room using a wheelchair, scooter, or other wheeled mobility device?	☐	☐	☐	☐	☐
B.5.e Functional Cognition: Did the patient need help planning regular tasks, such as shopping or remembering to take medication?	☐	☐	☐	☐	☐

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

Check all that apply.

- ☐ a. Cane/crutch
- ☐ b. Walker
- ☐ c. Orthotics
- ☐ d. Prosthetics
- ☐ e. Wheelchair/scooter full time
- ☐ f. Wheelchair/scooter part time
- ☐ g. Mechanical lift
- ☐ h. Other (specify) _____
- ☐ i. None apply
- ☐ j. Unknown

B.7 History of Falls

	Yes	**No**	**Unknown**
B.7.a Has the patient had two or more falls in the past year?	☐	☐	☐
B.7.b Has the patient had any falls with injury in the past year?	☐	☐	☐

III. Current Medical Information

A. Primary Reason for Therapy

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

A.1 Body Functions (Check at least one)

- ☐ a. Global Mental Functions (consciousness, orientation, intellectual function, energy & drive, sleep, temperament, personality)
- ☐ b. Specific Mental Functions (attention, memory, psychomotor, emotional, perceptual, higher level cognition, sequencing of complex tasks, calculation, mental functions of language)
- ☐ c. Seeing & Related Functions
- ☐ d. Hearing
- ☐ e. Vestibular Functions
- ☐ f. Proprioceptive & Touch Functons
- ☐ g. Other Sensory Functions (taste, smell)
- ☐ h. Pain
- ☐ i. Voice & Speech Functions (articulation, speech, fluency & rhythm, alternative vocalization)
- ☐ j. Functions of the Cardiovascular System
- ☐ k. Functions of the Immunological & Hematological Systems
- ☐ l. Functions of the Respiratory System
- ☐ m. Functions of the Digestive System
- ☐ n. Functions Related to Metabolism & Endocrine System
- ☐ o. Urinary Functions
- ☐ p. Genital & Reproductive Functions
- ☐ q. Functions of the Joints & Bones
- ☐ r. Muscle Functions (muscle power, tone, endurance)
- ☐ s. Movement Functions (motor reflexes, involuntary movements, control of movements, gait patterns, neuromuscular functions)
- ☐ t. Functions of the Skin
- ☐ u. Functions of the Hair & Nails

A.2 Body Structures (Check at least one)

Structures Related to Movement

- ☐ a. General/No Specific Body Location
- ☐ b. Head
- ☐ c. Cervical Spine
- ☐ d. Thoracic Spine
- ☐ e. Lumbar Spine
- ☐ f. Pelvic Girdle

L: Left Side; R: Right Side

L	R		
☐	☐	g.	Hip
☐	☐	h.	Thigh
☐	☐	i.	Knee
☐	☐	j.	Calf
☐	☐	k.	Foot/Ankle
☐	☐	l.	Toes
☐	☐	m.	Shoulder
☐	☐	n.	Arm
☐	☐	o.	Elbow
☐	☐	p.	Wrist
☐	☐	q.	Hand
☐	☐	r.	Fingers

Structures Involved in Voice & Speech

- ☐ s. Nose
- ☐ t. Mouth
- ☐ u. Tongue
- ☐ v. Pharynx
- ☐ w. Larynx

Other Structures

- ☐ x. Eye & Related Structures
- ☐ y. Ear & Related Structures
- ☐ z. Structures of the Central Nervous System
- ☐ aa. Structures of the Peripheral Nervous System
- ☐ bb. Structures of the Cardiovascular, Immunological, & Respiratory Systems
- ☐ cc. Structures Related to the Digestive, Metabolic, & Endocrine Systems
- ☐ dd. Structures Related to the Genitourinary & Reproductive Systems
- ☐ ee. Skin & Related Structures

A.3 Activities and Participation (Check at least one)

- ☐ a. Purposeful Sensory Experiences (watching, listening)
- ☐ b. Basic Learning (copying, rehearsing, learning to read, write, acquiring skills)
- ☐ c. Applying Knowledge (focusing attention, thinking, reading, writing, calculating, solving problems, making decisions)
- ☐ d. General Tasks & Demands (simple and multiple tasks, carrying out daily routine, handling stress)
- ☐ e. Communication: Receiving (spoken, non verbal, sign language, written)
- ☐ f. Communication: Producing (speaking, nonverbal, sign language, writing)
- ☐ g. Conversation & Use of Communication Devices (conversation, discussion, using devices and techniques)
- ☐ h. Changing & Maintaining Body Position
- ☐ i. Carrying, Moving & Handling Objects
- ☐ j. Walking & Moving
- ☐ k. Moving Around Using Transportation
- ☐ l. Self Care (washing oneself, toileting, dressing, eating, drinking)
- ☐ m. Acquisition of Necessities (a place to live, goods and services)
- ☐ n. Household Tasks (preparing meals, doing housework)
- ☐ o. Caring for Household Objects & Assisting Others
- ☐ p. General Interpersonal Interactions
- ☐ q. Particular Interpersonal Interactions (relating with strangers, formal and informal relationships, family and intimate relationships)
- ☐ r. Education
- ☐ s. Work & Employment
- ☐ t. Economic Life
- ☐ u. Community, Social & Civic Life

A.4 Why is the patient receiving therapy services covered by Medicare Part B?

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 or loss of caregiver
- ☐ f. Other (specify) _____

III. Current Medical Information (cont.)

B. 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. **Please check all that apply.**

B.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. Torticolis
- ☐ ☐ 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 _____

B.2 Circulatory

1ary 2ary

- ☐ ☐ a. TIA
- ☐ ☐ b. Stroke
- ☐ ☐ c. Atrial Fibrillation & Other Dysrhythmia (bradycardia, tachydardia)
- ☐ ☐ 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 _____

B.3 Lymphatic System

1ary 2ary

- ☐ ☐ a. Lymphedema
- ☐ ☐ b. Other _____

B.4 Pulmonary/Respiratory System

1ary 2ary

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

B.5 Integumentary System

1ary 2ary

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

B.6 Genitourinary System

1ary 2ary

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

B.7 Mental Health

1ary 2ary

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

B.8 Cancer/Other Neoplasms

1ary2ary

- ☐ ☐ a. Please Specify

B.9 Metabolic System

1ary 2ary

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

B.10 Generalized Weakness

1ary 2ary

- ☐ ☐ a. Generalized Weakness

B.11 Infectious Diseases

1ary 2ary

- ☐ ☐ a. Please Specify

B.12 HIV

1ary 2ary

- ☐ ☐ a. HIV

B.13 Gastrointestinal Disorders

1ary 2ary

- ☐ ☐ a. Please Specify

B.14 Immune Disorders

1ary 2ary

- ☐ ☐ a. Immune Disorders

B.15 Anemias/Other Hematological Disorders

1ary 2ary

- ☐ ☐ a. Anemia
- ☐ ☐ b. Other _____

B.16 Congenital Abnormalities

1ary 2ary

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

B.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 _____

B.18 Cognition/Judgement

1ary 2ary

- ☐ ☐ a. Executive Function Disorder
- ☐ ☐ b. Memory Impairment
- ☐ ☐ c. Pragmatics Disorder
- ☐ ☐ d. Dementia
- ☐ ☐ e. Other _____

B.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 _____

B.20 Swallowing Disorder

1ary 2ary

- ☐ ☐ a. Dysphagia

B.21 Sensory Disorders/Gait or Balance Disorder

1ary 2ary

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

B.22 Other Condition

1ary 2ary

- ☐ ☐ a. Please Specify _____

III. Current Medical Information (cont.)

C.1 For how long has the patient experienced the primary medical condition related to the reason they are receiving therapy?

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

C.2.a How many surgeries has the patient had in the past associated with the primary medical condition related to the reason they are receiving therapy?

- ☐ None ☐ Unknown
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4 or more

C.2.b If the patient has had 1 or more surgeries associated with the primary medical condition related to the reason they are 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

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

Which of the following treatments did the patient receive during the 2-day assessment period? 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		
☐	D.1	None
☐	D.2	Insulin Drip
☐	D.3	Total Parenteral Nutrition
☐	D.4	Central Line Management
☐	D.5	Blood Transfusion(s)
☐	D.6	Controlled Parenteral Analgesia – Peripheral
☐	D.7	Controlled Parenteral Analgesia – Epidural
☐	D.8	Left Ventricular Assistive Device (LVAD)
☐	D.9	Continuous Cardiac Monitoring: *Specify reason for continuous monitoring:*
☐	D.10	Chest Tube(s)
☐	D.11	Trach Tube with Suctioning: *Specify most intensive frequency of suctioning during stay: Every____ hrs*
☐	D.12	High O2 Concentration Delivery System with FiO2 > 40%
☐	D.13	Non-invasive ventilation
☐	D.14	Ventilator – Weaning
☐	D.15	Ventilator – Non-Weaning
☐	D.16	Hemodialysis
☐	D.17	Peritoneal Dialysis
☐	D.18	Fistula or Other Drain Management
☐	D.19	Negative Pressure Wound Therapy
☐	D.20	Complex Wound Management with positioning and skin separation/traction that requires at least two persons
☐	D.21	Halo
☐	D.22	Complex External Fixators (e.g., Ilizarov)
☐	D.23	One-on-One 24-Hour Staff Supervision*: Specify reason for 24-hour supervision:_____*
☐	D.24	Specialty Surface or Bed (i.e., air fluidized, bariatric, low air loss, or rotation bed)
☐	D.25	Multiple Types of IV Antibiotic Administration
☐	D.26	IV Vasoactive Medications (e.g., pressors, dilators, medication for pulmonary edema)
☐	D.27	IV Anti-coagulants
☐	D.28	IV Chemotherapy
☐	D.29	Indwelling Bowel Catheter Management System
☐	D.30	Other Major Treatments: *Specify*_____

III. Current Medical Information (cont.)

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

E.1-2 PRESENCE OF PRESSURE ULCERS

E.1 Is this patient at risk of developing pressure ulcers?
- ☐ 0. No
- ☐ 1. Yes, indicated by clinical judgment
- ☐ 2. Yes, indicated high risk by formal assessment (e.g., on Braden or Norton tools) or the patient has a stage 1 or greater ulcer, a scar over a bony prominence, or a non-removable dressing, device, or cast.

E.2 Does this patient have one or more unhealed pressure ulcer(s) at stage 2 or higher or unstageable?
- ☐ 0. No *(If **No**, skip to E.6)*
- ☐ 1. Yes
- ☐ 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.

	NUMBER OF PRESSURE ULCERS PRESENT AT ASSESSMENT									
Pressure ulcer at stage 2, stage 3, stage 4, or unstageable:	0	1	2	3	4	5	6	7	8 +	Unknown
E.2.a 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).	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
E.2.b 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.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
E.2.c 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.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
E.2.d 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.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
E.2.e 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.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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

E.3.b Longest length in any dimension |___|___|.|___| cm

E.3.c Width of SAME unhealed ulcer or eschar |___|___|.|___| cm

E.3.d Depth of SAME unhealed ulcer or eschar |___|___|.|___| cm

E.3.e Date of measurement ____/____/_____
MM DD YYYY

III. Current Medical Information (cont.)

E.4 Indicate if any unhealed stage 3 or stage 4 pressure ulcer(s) has undermining and/or tunneling (sinus tract) present.
- ☐ 0. No
- ☐ 1. Yes
- ☐ 8. Unable to assess

E.5 Do the patient's pressure ulcers interfere with therapy treatments?
- ☐ 0. No
- ☐ 1. Yes
- ☐ 8. Don't Know

E.6 MAJOR WOUND (excluding pressure ulcers)

Does the patient have one or more major wound(s) that require ongoing care because of draining, infection, or delayed healing?
- ☐ 0. No *(If No, skip to E.7)*
- ☐ 1. Yes

E.6.a-e Number of Major Wounds

	Number of Major Wounds					
	0	1	2	3	4+	Type(s) of Major Wound(s)
E.6.a Delayed healing of surgical wound	☐	☐	☐	☐	☐	
E.6.b Trauma-related wound (e.g., burns)	☐	☐	☐	☐	☐	
E.6.c Diabetic foot ulcer(s)	☐	☐	☐	☐	☐	
E.6.d Vascular ulcer (arterial or venous including diabetic ulcers not located on the foot)	☐	☐	☐	☐	☐	
E.6.e Other (e.g., incontinence associated dermatitis, normal surgical wound healing). Please specify: _____	☐	☐	☐	☐	☐	

E.7 TURNING SURFACES NOT INTACT

Check all that apply.

Indicate which of the following turning surfaces have either a pressure ulcer or major wound.
- ☐ a. Skin for all turning surfaces is intact
- ☐ b. Right hip not intact
- ☐ c. Left hip not intact
- ☐ d. Back/buttocks not intact
- ☐ e. Other turning surface(s) not intact

IV. Cognitive Status, Mood, & Pain

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.8)*

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

B.1 Interview Attempted

B.1.a Interview Attempted?

☐ 0. No
☐ 1. Yes *(If **Yes**, skip to B.2)*

B.1.b Indicate reason that the interview was not attempted *and then skip to Section C.*

☐ 1. Unresponsive or minimally conscious
☐ 2. Communication disorder
☐ 3. No interpreter available

B.2 Brief Interview for Mental Status: Any score with an asterisk will require completion of Section C.

B.2.a Repetition of Three Words

Ask patient: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue and bed. Now tell me the three words."*

Number of words repeated by patient after first attempt:

☐ 3. Three
☐ 2. Two
☐ 1. One
☐ 0. None

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

B.2.b Year, Month, Day

B.2.b.1 Ask patient: *"Please tell me what year it is right now."*

Patient's answer is:

☐ 3. Correct
☐ 2. Missed by 1 year
☐ 1. Missed by 2 to 5 years
☐ 0. Missed by more than 5 years or no answer

B.2.b.2 Ask patient: *"What month are we in right now?"*

Patient's answer is:

☐ 2. Accurate within 5 days
☐ 1. Missed by 6 days to 1 month
☐ 0. Missed by more than 1 month or no answer

B.2.b.3 Ask patient: *"What day of the week is today?"*

Patient's answer is:

☐ 2. Accurate
☐ 1. Incorrect or no answer

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

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

B.2.c Recall
Ask patient: *"Let's go back to the first question. What were those three words that I asked you to repeat?"* If unable to remember a word, give cue (i.e., something to wear; a color; a piece of furniture) for that word.

B.2.c.1 Recalls "sock?"
- ☐ **2. Yes**, no cue required
- ☐ **1. Yes**, after cueing ("something to wear")
- ☐ **0. No**, could not recall

B.2.c.2 Recalls "blue?"
- ☐ **2. Yes**, no cue required
- ☐ **1. Yes**, after cueing ("a color")
- ☐ **0. No**, could not recall

B.2.c.3 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**

B.3.a Observational Assessment of **Cognitive Status**
Answer **only** if you answered "Yes" to B.3

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

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).	☐	☐	☐
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).	☐	☐	☐
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).	☐	☐	☐
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).	☐	☐	☐

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

D. Difficulty Remembering, Organizing, or Attending in Daily Life

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**, please complete D.2 – D.4*)

In Questions D.2 through D.4, please use the following definitions for the frequency with which the patient can perform the indicated activity and for level of assistance:

Frequency Performing Activity	**Never:**	Unable
	Rarely:	Less than 20% of the time
	Sometimes:	Between 20% and 49% of the time
	Usually or Always:	At least 50% of the time
Level of Assistance	**Without Assistance:**	Patient performance **without** cueing, external guidance, assistive device, or other compensatory augmentative intervention.
	With Assistance:	Patient performance **with** cueing, external guidance, assistive device, or other compensatory augmentative intervention.

D.2 Problem Solving

The patient solves:

Simple Problems: Following schedules; requesting assistance; using a call bell; identifying basic wants/needs; preparing a simple cold meal.

Complex problems: Working on a computer; managing personal, medical, and financial affairs; preparing a complex hot meal; grocery shopping; route finding and map reading.

	Simple Problems		Complex Problems	
	D.2.a Without Assistance	**D.2.b With Assistance**	**D.2.c Without Assistance**	**D.2.d With Assistance**
Never	☐	☐	☐	☐
Rarely	☐	☐	☐	☐
Sometimes	☐	☐	☐	☐
Usually or Always	☐	☐	☐	☐

D.3 Memory

The patient recalls:

Basic Information: Personal information (e.g., family members, biographical information, physical location); 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.3.a Without Assistance	**D.3.b With Assistance**	**D.3.c Without Assistance**	**D.3.d With Assistance**
Never	☐	☐	☐	☐
Rarely	☐	☐	☐	☐
Sometimes	☐	☐	☐	☐
Usually or Always	☐	☐	☐	☐

D.4 Attention

The patient maintains attention for:

Simple Activities: Following simple directions; reading environmental signs; 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.4.a Without Assistance	**D.4.b With Assistance**	**D.4.c Without Assistance**	**D.4.d With Assistance**
Never	☐	☐	☐	☐
Rarely	☐	☐	☐	☐
Sometimes	☐	☐	☐	☐
Usually or Always	☐	☐	☐	☐

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

E. Behavioral Signs & Symptoms (Complete during the 2-day assessment period.)

Has the patient exhibited any of the following behaviors during the 2-day assessment period?

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.2.a Little interest or pleasure in doing things?
☐ 0. No *(If **No**, skip to F2c)*
☐ 1. Yes
☐ 8. Unable to respond *(If **Unable**, skip to F2c)*

F.2.b 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.2.c Feeling down, depressed, or hopeless?
☐0. No *(If **No**, skip to F3)*
☐1. Yes
☐8. Unable to respond *(If **Unable**, skip to F3)*

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

G.1 Pain Interview Attempted?

☐ **0. No** *Specify Reason: _____*
*(If **No**, skip to G.8)*

☐ **1. Yes**

G.2 Pain Presence

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

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

G.3 Pain Severity

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

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

No Pain — Moderate Pain — Worst Pain

G.4 Pain Effect on Sleep

Ask patient: *"During the past 2 days, has pain made it hard for you to sleep?"*

☐ **0. No**
☐ **1. Yes**
☐ **8. Unable to answer or no response**

G.5 Pain Effect on Activities

Ask patient: *"During the past 2 days, have you limited your activities because of pain?"*

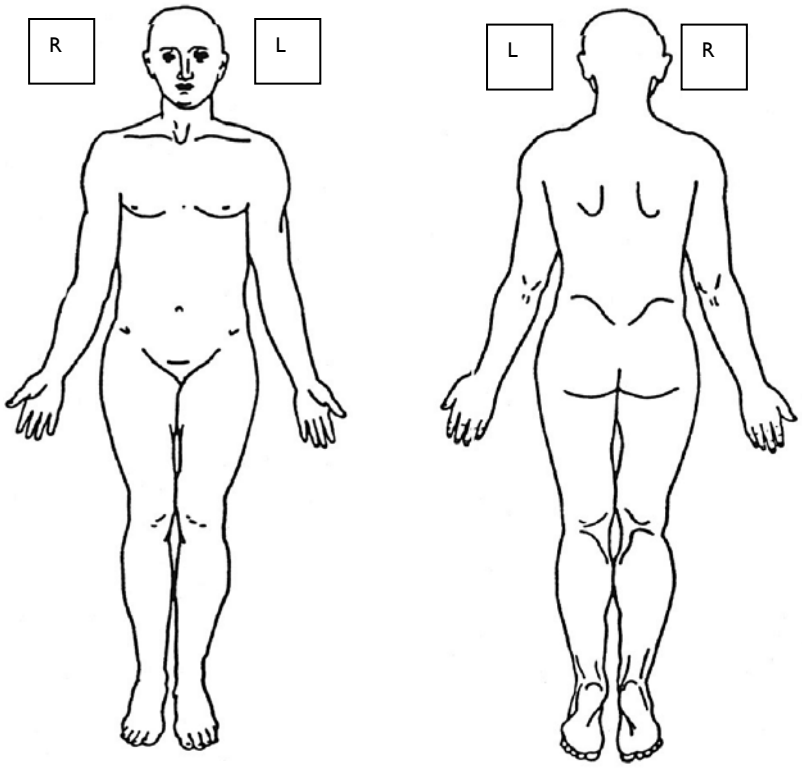
☐ **0. No**
☐ **1. Yes**
☐ **8. Unable to answer or no response**

G.6 How does the patient describe their pain? (Check all that apply.)

☐ a. Constant	☐ e. Burning	☐ i. Ache/Throb	☐ m. Tightness
☐ b. Intermittent	☐ f. Pinching	☐ j. Stabbing	☐ n. Stiffness
☐ c. Sharp	☐ g. Numbness	☐ k. Pulling	☐ o. Other: Please write in
☐ d. Dull	☐ h. Tingling	☐ l. Cramping	_____

G.7 Pain Location

Please ask the patient where they have pain or hurting and mark with an X the indicated area(s).



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

G.8 Pain Observational Assessment. If patient could not be interviewed for pain assessment, check all indicators of pain or possible pain.

Check all that apply

- ☐ **G.8.a Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)
- ☐ **G.8.b Vocal complaints of pain** (e.g., "that hurts, ouch, stop")
- ☐ **G.8.c Facial expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
- ☐ **G.8.d 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.8.e 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.a Bladder	A.2.b Bowel
A.2	**Does this patient use an external or indwelling device or require intermittent catheterization?**	☐ 0. No ☐ 1. Yes	☐ 0. No ☐ 1. Yes
A.3	**Indicate the frequency of incontinence. Please check one option under both Bladder and Bowel.**	**A.3.a Bladder**	**A.3.b Bowel**
0.	**Continent** (no documented incontinence)	☐	☐
1.	**Stress incontinence only** (bladder only)	☐	
2.	**Incontinent less than daily** (only once during the 2-day assessment period)	☐	☐
3.	**Incontinent daily** (at least once a day)	☐	☐
4.	**Always incontinent**	☐	☐
5.	**No urine/bowel output** (e.g., renal failure)	☐	☐
9.	**Not applicable** (e.g., indwelling catheter)	☐	☐
A.4	**Does the incontinence interfere with therapy treatments?**	**A.4.a Bladder** ☐ 0. No ☐ 1. Yes ☐ 9. Unknown	**A.4.b Bowel** ☐ 0. No ☐ 1. Yes ☐ 9. Unknown

V. Impairments (cont.)

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

Check all that apply

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

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

B.2 Describe the patient's usual ability with swallowing. (Check one option ONLY.)

- ☐ **B.2.a Regular food:** Solids and liquids swallowed safely without supervision and without modified food or liquid consistency.
- ☐ **B.2.b Modified food consistency/supervision:** Patient requires modified food or liquid consistency and/or needs supervision during eating for safety.
- ☐ **B.2.c 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, honey, or pudding)

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

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

Minimal Cueing: Subtle and only one type of cueing

B.3.a Diet Modification	B.3.b Level of Cueing or Assistance
☐ Both Liquids & Solids	☐ Maximal
☐ Either Liquids or Solids	☐ Minimal
☐ None	☐ None

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

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

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

C.1.a 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.1.b 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**

V. Impairments (cont.)

C.1.c 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.1.d 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**

D. Difficulty Communicating in Daily Life

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:

Frequency Performing Activity	**Never:**	Unable
	Rarely:	Less than 20% of the time
	Sometimes:	Between 20% and 49% of the time
	Usually or Always:	At least 50% of the time
Level of Assistance	**Without Assistance:**	Patient performance **without** cueing, external guidance, assistive device, or other compensatory augmentative intervention.
	With Assistance:	Patient performance **with** cueing, external guidance, assistive device, or other compensatory augmentative intervention.

D.2 Language Comprehension

The patient comprehends:

Basic Information: Simple directions; simple yes/no questions; simple words or phrases.

Complex Information: Complex sentences/directions/ messages; conversations about routine daily activities.

	Basic Information		Complex Information	
	D.2.a Without Assistance	**D.2.b With Assistance**	**D.2.c Without Assistance**	**D.2.d With Assistance**
Never	☐	☐	☐	☐
Rarely	☐	☐	☐	☐
Sometimes	☐	☐	☐	☐
Usually or Always	☐	☐	☐	☐

D.3 Language Expression

The patient comprehends:

Basic Information: Simple directions; simple yes/no questions; simple words or phrases.

Complex Information: Complex sentences/ directions/messages; conversations about routine daily activities.

	Basic Information		Complex Information	
	D.3.a Without Assistance	**D.3.b With Assistance**	**D.3.c Without Assistance**	**D.3.d With Assistance**
Never	☐	☐	☐	☐
Rarely	☐	☐	☐	☐
Sometimes	☐	☐	☐	☐
Usually or Always	☐	☐	☐	☐

V. Impairments (cont.)

D.4 Motor Speech Production

The patient's speech is:

Intelligible in Short Utterances: Short consonant-vowel combinations; automatic words; simple words or predictable phrases.

Intelligible in Conversation: Long utterances; low predictability sentences; communication in vocational, avocational, and social activities.

	Intelligible in Short Utterances		Intelligible in Conversation	
	D.4.a Without Assistance	D.4.b With Assistance	D.4.c Without Assistance	D.4.d With Assistance
Never	☐	☐	☐	☐
Rarely	☐	☐	☐	☐
Sometimes	☐	☐	☐	☐
Usually or Always	☐	☐	☐	☐

D.5 Voice

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.5.a Without Assistance	D.5.b With Assistance	D.5.c Without Assistance	D.5.d With Assistance
Never	☐	☐	☐	☐
Rarely	☐	☐	☐	☐
Sometimes	☐	☐	☐	☐
Usually or Always	☐	☐	☐	☐

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.

	Upper Extremity		Lower Extremity	
	E.1.a Left	E.1.b Right	E.1.c Left	E.1.d Right
1. **Fully weight-bearing:** No clinician-ordered restrictions	☐	☐	☐	☐
0. **Not fully weight-bearing:** Patient has clinician-ordered restrictions	☐	☐	☐	☐

V. Impairments (cont.)

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.1.a With Supplemental O_2	F.1.b Without Supplemental O_2	Respiratory Status: Was the patient dyspneic or noticeably short of breath?
☐	☐	**5. Severe, with evidence the patient is struggling to breathe at rest**
☐	☐	**4. Mild at rest** (during day or night)
☐	☐	**3. With minimal exertion** (e.g., while eating, talking, or performing other ADLs) **or with agitation**
☐	☐	**2. With moderate exertion** (e.g., while dressing, using commode or bedpan, walking between rooms)
☐	☐	**1. When climbing stairs**
☐	☐	**0. Never, patient was not short of breath**
☐	☐	**8. Not assessed** (e.g., on ventilator)
☐	☐	**9. Not applicable**

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

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

☐ **0. No** *(If **No**, skip to Section H)*

☐ **1. Yes** *(If **Yes**, please complete this section)*

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

☐ **0. No**

☐ **1. Yes, with support**

☐ **2. Yes, without support**

☐ **8. Not assessed due to medical restriction**

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

H.1 Indicate all mobility devices and aids needed at time of assessment.

Check all that apply

☐ **a. Canes/crutch**

☐ **b.Walker**

☐ **c. Orthotics/prosthetic**

☐ **d.Wheelchair/scooter full time**

☐ **e. Wheelchair/scooter part time**

☐ **f. Mechanical lift**

☐ **g.Other (specify)** _____

☐ **h.None apply**

VI. Functional Status: Usual Performance

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

Code the patient's most usual performance using the 6-point scale below.

CODING:
Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

6. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
5. **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
4. **Supervision or touching assistance** –Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
3. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
2. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
1. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the task.

If activity was not attempted code:
M. Not attempted due to **medical condition**
S. Not attempted due to **safety concerns**
A. Task **attempted** but not completed
N. **Not applicable**
P. **Patient Refused**

	Patient's Most Usual Performance						Activity Not Attempted Code				
	6	5	4	3	2	1	M	S	A	N	P
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.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A.2 **Tube feeding:** The ability to manage all equipment/supplies related to obtaining nutrition.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A.3 **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.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A.4 **Toilet hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using toilet, commode, bedpan, urinal. If managing ostomy, include wiping opening but not managing equipment.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A.5 **Upper body dressing:** The ability to put on and remove shirt or pajama top. Includes buttoning three buttons.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A.6 **Lower body dressing:** The ability to dress and undress below the waist, including fasteners. Does not include footwear.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

VI. Functional Status (cont.)

B. Core Functional Mobility: The core functional mobility items should be completed on ALL patients. (Complete during the 2-day assessment period.)

Code the patient's most usual performance using the 6-point scale below.

Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

6. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
5. **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
4. **Supervision or touching assistance** –Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
3. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
2. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
1. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the task.

If activity was not attempted code:

M. Not attempted due to **medical condition**
S. Not attempted due to **safety concerns**
A. Task **attempted** but not completed
N. **Not applicable**
P. **Patient Refused**

		Patient's Most Usual Performance						Activity Not Attempted Code				
		6	5	4	3	2	1	M	S	A	N	P
B.1	**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.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
B.2	**Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
B.3	**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.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
B.4	**Toilet tansfer:** The ability to safely get on and off a toilet or commode.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

B.5 Does this patient primarily use a wheelchair for mobility?
☐ **0. No** *(If **No**, code B.5.a for the longest distance completed)*
☐ **1. Yes** *(If **Yes**, code B.5.b for the longest distance completed)*

B.5.a Select the longest distance the patient walks and code his/her level of independence (Level 1-6) on that distance. Observe performance. (Select only one.)

		6	5	4	3	2	1	M	S	A	N	P
B.5.a.1	**Walk 150 ft (45 m):** Once standing, can walk at least 150 feet (45 meters) in corridor or similar space.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
B.5.a.2	**Walk 100 ft (30 m):** Once standing, can walk at least 100 feet (30 meters) in corridor or similar space.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
B.5.a.3	**Walk 50 ft (15 m):** Once standing, can walk at least 50 feet (15 meters) in corridor or similar space.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
B.5.a.4	**Walk in room once standing:** once standing, can walk at least 10 feet (3 meters) in room, corridor or similar space.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

B.5.b Select the longest distance the patient wheels and code his/her level of independence (Level 1-6). Observe performance. (Select only one.)

		6	5	4	3	2	1	M	S	A	N	P
B.5.b.1	**Wheel 150 ft (45 m):** Once standing, can wheel at least 150 feet (45 meters) in corridor or similar space.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
B.5.b.2	**Wheel 100 ft (30 m):** Once standing, can wheel at least 100 feet (30 meters) in corridor or similar space.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
B.5.b.3	**Wheel 50 ft (15 m):** Once standing, can wheel at least 50 feet (15 meters) in corridor or similar space.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
B.5.b.4	**Wheel in room once seated:** Once seated, can wheel at least 10 feet (3 meters) in room, corridor, or similar space.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

VI. Functional Status (cont.)

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

Code the patient's most usual performance using the 6-point scale below.

Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

6. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
5. **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
4. **Supervision or touching assistance** –Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
3. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
2. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
1. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the task.

If activity was not attempted code:

M. Not attempted due to **medical condition**
S. Not attempted due to **safety concerns**
E. Not attempted due to **environmental constraints**
A. Task **attempted** but not completed
N. **Not applicable**
P. **Patient Refused**

		Patient's Most Usual Performance						Activity Not Attempted Code					
		6	5	4	3	2	1	M	S	E	A	N	P
C.1	**Wash upper body:** The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.2	**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.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.3	**Roll left and right:** The ability to roll from lying on back to left and right side, and roll back to back.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.4	**Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.5	**Picking up object:** The ability to bend/stoop from a standing position to pick up small object such as a spoon from the floor.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.6	**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.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.7	**Does this patient primarily use a wheelchair for mobility?** ☐ **0. No** *(If **No**, code C.7.a–C.7.f)* ☐ **1. Yes** *(If **Yes**, code C.7.f–C.7.h)*												
		6	5	4	3	2	1	M	S	E	A	N	P
C.7.a	**1 step (curb):** The ability to step over a curb or up and down one step.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.7.b	**Walk 50 feet with two turns:** The ability to walk 50 feet and make two turns.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.7.c	**12 steps-interior:** The ability to go up and down 12 interior steps with a rail.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.7.d	**Four steps-exterior:** The ability to go up and down 4 exterior steps with a rail.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.7.e	**Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces, such as grass or gravel.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.7.f	**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.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.7.g	**Wheel short ramp:** Once seated in wheelchair, goes up and down a ramp of less than 12 feet (4 meters).	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.7.h	**Wheel long ramp:** Once seated in wheelchair, goes up and down a ramp of more than 12 feet (4 meters).	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

VI. Functional Status (cont.)

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

Code the patient's most usual performance using the 6-point scale below.

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S. Not attempted due to **safety concerns**
A. Task **attempted** but not completed
N. **Not applicable**
P. **Patient Refused**

	Patient's Most Usual Performance						Activity Not Attempted Code					
	6	5	4	3	2	1	M	S	E	A	N	P
C.8 **Telephone-answering:** The ability to pick up call in patient's customary manner and maintain for 3 minutes. Does not include getting to the phone.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.9 **Telephone-placing call:** The ability to pick up and place call in patient's customary manner and maintain for 3 minutes. Does not include getting to the phone.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.10 **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.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.11 **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.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.12 **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.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.13 **Make light meal:** The ability to plan and prepare all aspects of a light meal such as a bowl of cereal or a sandwich and cold drink, or reheat a prepared meal.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.14 **Wipe down surface:** The ability to use a damp cloth to wipe down surface such as table top or bench to remove small amounts of liquid or crumbs. Includes ability to clean cloth of debris in patient's customary manner.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.15 **Light shopping:** Once at store, can locate and select up to five needed goods, take to check out, and complete purchasing transaction.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.16 **Laundry:** Includes all aspects of completing a load of laundry using a washer and dryer. Includes sorting, loading and unloading, and adding laundry detergent.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C.17 **Use public transportation:** The ability to plan and use public transportation. Includes boarding, riding, and alighting from transportation.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

VI. Functional Status (cont.)

D. Participation

D.1 Social Participation

Ask patient: *"Think about how you currently socialize 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 socially.
☐ I maintain my usual pattern of social activities, despite some difficulties.
☐ I am somewhat restricted in the amount or type of social activities I do.
☐ I am very restricted in the amount or type of social activities I do.
☐ I do not see family or friends, and I only see those who provide care to me.

IX. Other Useful Information

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

X. Feedback

A. Notes

Thank you for your participation in this important project. So that we may improve the form for future use, please comment on any areas of concern or things you would change about the form.