I. Administrative Information

FOR OFFICE USE ONLY

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 patent has difficulty understanding instructions.

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: _____

☐ **8. The patient does <u>not</u> need any assistance and can complete the questionnaire him/herself.**

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

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

II. Patient Information (cont.)

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

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

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?)	**Unable**	**A Lot of Difficulty**	**A Little Difficulty**	**No Difficulty**	**Don't Know**
a. Moving around within one room, including making turns in a wheelchair?	☐	☐	☐	☐	☐
b. Reaching for a high object, using a wheelchair?	☐	☐	☐	☐	☐
c. Opening a door away from a wheelchair?	☐	☐	☐	☐	☐
d. Opening a door toward a wheelchair?	☐	☐	☐	☐	☐
e. Transferring between a wheelchair and other seating surfaces, such as a chair or bed?	☐	☐	☐	☐	☐

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?)	**Unable**	**A Lot of Help Needed**	**A Little Help Needed**	**No Help Needed**	**Don't Know**
a. Taking care of your personal grooming such as brushing teeth, combing hair, etc.?	☐	☐	☐	☐	☐
b. Bathing yourself (including washing, rinsing, drying the body)?	☐	☐	☐	☐	☐
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?)	**Unable**	**A Lot of Difficulty**	**A Little Difficulty**	**No Difficulty**	**Don't Know**
c. Picking up thin, flat objects from a table (e.g., coins, post card, envelope)?	☐	☐	☐	☐	☐
d. Putting on and taking off a shirt or blouse?	☐	☐	☐	☐	☐
e. Putting on and taking off socks?	☐	☐	☐	☐	☐
f. Opening small containers like aspirin or vitamins (regular screw tops)?	☐	☐	☐	☐	☐
g. Tying shoes?	☐	☐	☐	☐	☐

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

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.

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

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**	**Provider NPI**	**Sections Worked On**	**Date(s) of Data collection**
	(Joe Smith)	(PT)	1234567890	Sec. III	(MM/DD/YYYY)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

I. Administrative Items

A. Assessment Type – Admission Assessment

A 1. Admission Date (first day the patient was covered by Medicare Part B)

|__|__| / |__|__| / |__|__|__|__|
M M D D Y Y Y Y

A.2 Assessment Reference Date

|__|__| / |__|__| / |__|__|__|__|
M M D D Y Y Y Y

(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. Patient Information

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.

Enter the race or ethnic category the patient uses to identify him or herself.

☐ 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 Birth Date

|__|__| / |__|__| / |__|__|__|__|
M M D D Y Y Y Y

C.8 Is English the patient's primary language?

☐ No ☐ Yes

C.9 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, Community-Integrated Living Arrangement (CILA)
- ☐ c. Long-term nursing facility
- ☐ d. Skilled nursing facility (SNF/TCU)
- ☐ e. MR/DD facility (Intermediate Care Facility)
- ☐ f. Other facility (e.g., hospital)
- ☐ g. Other (specify)_____

A.1a 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?

☐ **No** ☐ **Yes**

A.2 *In the last 2 months*, what other medical services besides those identified in A.1 has the patient received?

Check all that apply.

- ☐ a. Skilled nursing facility (SNF/TCU)
- ☐ b. Long-term nursing facility
- ☐ c. MR/DD facility (Intermediate Care 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 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)

B.1 What medical condition(s) led to the admission to that facility?

Check all that apply.

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

Complete Items B.3 & B.4 **ONLY** if the patient was admitted from the community (private home, assisted living, etc.)

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

Check all that apply.

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

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

Check all that apply.

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

☐ **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?	☐	☐	☐	☐	☐
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)?	☐	☐	☐	☐	☐
B.5c Stairs (Ambulation): Did the patient need assistance with managing stairs (with or without devices such as cane, crutch, or walker)?	☐	☐	☐	☐	☐
B.5d Mobility (Wheelchair): Did the patient need assistance with moving from room to room using a wheelchair, scooter, or other wheeled mobility device?	☐	☐	☐	☐	☐
B.5e Functional Cognition: Did the patient need assistance with 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

B.7 History of Falls

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

	☐ f. Wheelchair/scooter part time ☐ g. Mechanical lift ☐ h. Other (specify) _____ ☐ i. None apply ☐ j. Unknown	**B.7b** Has the patient had any falls with injury in the past year?	☐	☐	☐

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

A.2 Circulatory

1ary	2ary		
O	O	a.	TIA
O	O	b.	Stroke
O	O	c.	Atrial Fibrillation & Other Dysrhythmia (bradycardia, tachycardia)
O	O	d.	Coronary Artery Disease (angina, myocardial infarction)
O	O	e.	Deep Vein Thrombosis (DVT)
O	O	f.	Heart Failure (including pulmonary edema)
O	O	g.	Hypertension
O	O	h.	Peripheral Vascular Disease/Peripheral Arterial Disease
O	O	i.	Other _____

A.3 Lymphatic System

1ary	2ary		
O	O	a.	Lymphedema
O	O	b.	Other _____

A.4 Pulmonary/Respiratory System

1ary	2ary		
O	O	a.	Asthma
O	O	b.	Bronchitis
O	O	c.	Pneumonia
O	O	d.	Chronic Obstructive Pulmonary Disease (COPD)
O	O	e.	Cystic Fibrosis
O	O	f.	Other _____

A.5 Integumentary System

1ary	2ary		
O	O	a.	Skin Ulcer/Wound
O	O	b.	Burn
O	O	c.	Other _____

A.6 Genitourinary System

1ary	2ary		
O	O	a	End Stage Renal Disease (ESRD)
O	O	b.	Incontinence
O	O	c.	Pelvic Pain
O	O	d.	Other _____

A.7 Mental Health

1ary	2ary		
O	O	a.	Anxiety Disorder
O	O	b.	Depression
O	O	c.	Bipolar Disease
O	O	d.	Attention Disorder
O	O	e.	Schizophrenia
O	O	f.	Alzheimer's Disease
O	O	g.	Other _____

A.8 Cancer/Other Neoplasms

1ary	2ary		
O	O	a.	Please Specify _____

III. Current Medical Information

A.9 Metabolic System

1ary 2ary
- O O a. Diabetes Mellitus
- O O b. Obesity
- O O c. Other _____

A.10 Generalized Weakness

1ary 2ary
- O O a. Generalized Weakness

A.11 Infectious Diseases

1ary 2ary
- O O a. Please Specify

A.12 HIV

1ary 2ary
- O O a. HIV

A.13 Gastrointestinal Disorders

1ary 2ary
- O O a. Please Specify

A.14 Immune Disorders

1ary 2ary
- O O a. Immune Disorders

A.15 Anemias/Other Hematological Disorders

1ary 2ary
- O O a. Anemia
- O O b. Other _____

A.16 Congenital Abnormalities

1ary 2ary
- O O a. Musculoskeletal Congenital Deformities/ Anomalies
- O O b. Neurological Congenital/Developmental Anomalies
- O O c. Other _____

A.17 Neurological Conditions

1ary 2ary
- O O a. Specific Diseases of Central Nervous System (CNS)
- O O b. Cranial Neuralgia
- O O c. Cranial Nerve Injury
- O O d. Seizure Disorder
- O O e. Paralysis
- O O f. Peripheral Nervous System Disorder (including neuropathy)
- O O g. Complex Regional Syndrome
- O O h. Vertigo
- O O i. Multiple Sclerosis
- O O j. Parkinson's
- O O k. Huntington's Disease
- O O l. Head Injury
- O O m. Traumatic Brain Injury
- O O n. Non-Traumatic Brain Injury
- O O o. Encephalopathy
- O O p. Retinopathy
- O O q. Guillain-Barré Syndrome
- O O r. Other _____

A.18 Cognition/Judgment

1ary 2ary
- O O a. Executive Function Disorder (difficulty with planning, initiating, monitoring, and evaluating goal direct behavior)
- O O b. Memory Impairment
- O O c. Pragmatics Disorder (difficulty with the appropriate use of language in social situations)
- O O d. Dementia
- O O e. Other _____

A.19 Communication, Voice, or Speech Disorder

1ary 2ary
- O O a. Aphasia
- O O b. Apraxia of Speech
- O O c. Reading or Writing Dysfunction
- O O d. Voice Disorder (Dysphonia)
- O O e. Speech Disorder
- O O f. Cognitive-Communication Disorder
- O O g. Other _____

A.20 Swallowing Disorder

1ary 2ary
- O O a. Dysphagia

A.21 Sensory Disorders/Gait or Balance Disorder

1ary 2ary
- O O a. Hearing Impairment
- O O b. Vision Impairment
- O O c. Gait or Balance Disorder
- O O d. Other _____

A.22 Other Condition

1ary 2ary
- O O 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
- ☐ Between 1 week and 1 month
- ☐ Between 1 month and 3 months
- ☐ More than 3 months
- ☐ Unknown

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	
☐	**C.1 None**
☐	**C.2 Total Parenteral Nutrition**
☐	**C.3 Central Line Management**
☐	**C.4 Left Ventricular Assistive Device (LVAD)**
☐	**C.5 Trach Tube with Suctioning:** *Specify most intensive frequency of suctioning during stay: Every____ hrs*
☐	**C.6 Non-invasive ventilation (C-PAP)**
☐	**C.7 Hemodialysis**
☐	**C.8 Peritoneal Dialysis**
☐	**C.9 Fistula or Other Drain Management**
☐	**C.10 Negative Pressure Wound Therapy**
☐	**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
☐	**C.12 Halo**
☐	**C.13 Complex External Fixators (e.g., Ilizarov)**
☐	**C.14 Specialty Surface or Bed** (i.e., air fluidized, bariatric, low air loss, or rotation bed)
☐	**C.15 IV Vasoactive Medications** (e.g., pressors, dilators, medication for pulmonary edema)
☐	**C.16 IV Chemotherapy**

☐	**C.17 Other Major Treatments** (e.g., PIC line, isolation, hyperthermia blanket) *Specify*_____

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

D.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):

D.3a Longest length in any dimension |___|___|.|___| cm

D.3b Width of SAME unhealed ulcer or eschar |___|___|.|___| cm

D.3c Depth of SAME unhealed ulcer or eschar |___|___|.|___| cm

D.3d Date of measurement |__|__| / |__|__| / |__|__|__|__|
M M D D Y Y Y Y

III. Current Medical Information

D.4 Indicate if any unhealed stage 3 or stage 4 pressure ulcer(s) has undermining and/or tunneling (sinus tract) present.	**D.5 Do the patient's pressure ulcers interfere with therapy treatments?**
☐ **0. No** ☐ **1. Yes** ☐ **8. Unable to assess**	☐ **0. No** ☐ **1. Yes** ☐ **8. Don't Know**

D.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* ➔ *D.7*)
☐ **1. Yes**

D.6a-e Number of Major Wounds

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

D.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, &

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).	☐	☐	☐
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 (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: Following basic 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.2a Without Assistance	**D.2b With Assistance**	**D.2c Without Assistance**	**D.2d With Assistance**
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	☐	☐	☐	☐
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 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	☐	☐	☐	☐
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 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).	E.2 Verbal behavioral symptoms directed towards others (e.g., threatening, screaming at others).
☐ 0. No ☐ 1. Yes	☐ 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)*

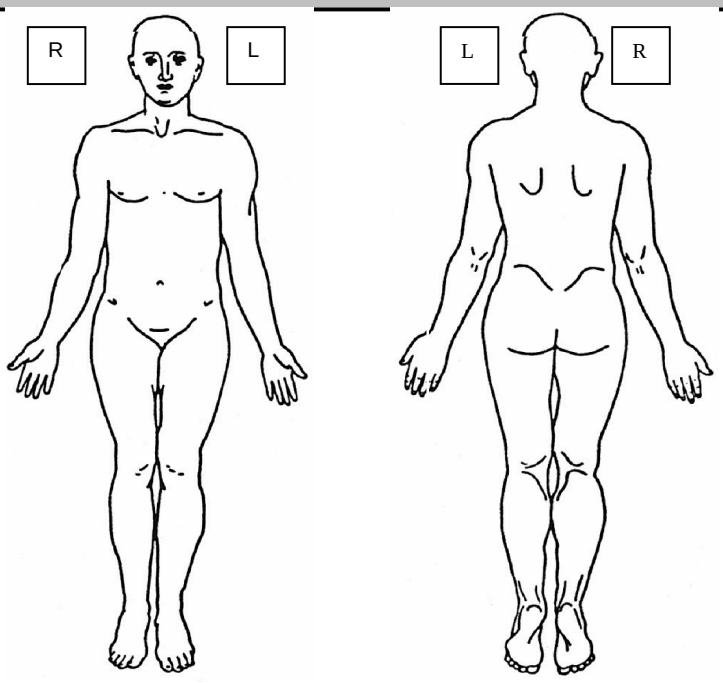
G.3 Pain Severity

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."*

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 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.)**

☐ 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 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, winces, 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)*

	Check one box. A.2a Bladder	Check one box. A.2b Bowel
A.2 Does this patient use an external or indwelling device or require intermittent catheterization?	☐ **0. No** ☐ **1. Yes**	☐ **0. No** ☐ **1. Yes**

	Check one option only. A.3a Bladder	Check one option only. A.3b Bowel
A.3 Indicate the frequency of incontinence. Please check one option under both Bladder and 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)	☐	☐

	Check one box. A.4a Bladder	Check one box. A.4b Bowel
A.4 Does the incontinence interfere with therapy treatments?	☐ **0. No** ☐ **1. Yes** ☐ **9. Unknown**	☐ **0. No** ☐ **1. Yes** ☐ **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
☐ Both Liquids & Solids	☐ Maximal
☐ Either Liquids or Solids	☐ Moderate
☐ None	☐ Minimal
	☐ None

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

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

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**		**Complex Information**	
Basic Information: Basic information regarding wants/needs or daily routines; using 1-2 words or short phrases		**D.3a Without Assistance**	**D.3b With Assistance**	**D.3c Without Assistance**	**D.3d With Assistance**
Complex Information: Thoughts/ideas using sentences; in conversations about routine daily activities or a variety of topics	Never or Rarely	☐	☐	☐	☐
	Sometimes	☐	☐	☐	☐
	Usually	☐	☐	☐	☐
	Always	☐	☐	☐	☐

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

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 Longer Utterances: Spontaneous production of multisyllabic words in sentences

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

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	☐	☐	☐	☐
Sometimes	☐	☐	☐	☐
Usually	☐	☐	☐	☐
Always	☐	☐	☐	☐

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	☐	☐	☐	☐
0. Not fully weight-bearing: Patient has clinician-ordered restrictions	☐	☐	☐	☐

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.	**F.1b Check one option only.**	
With Supplemental O_2	**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, unsafe to remove oxygen from patient)
☐	☐	**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 6 = Independent 1 = Dependent						Activity Not Assessed Code
	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.	☐	☐	☐	☐	☐	☐	☐
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.	☐	☐	☐	☐	☐	☐	☐
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.	☐	☐	☐	☐	☐	☐	☐
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.	☐	☐	☐	☐	☐	☐	☐
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.	☐	☐	☐	☐	☐	☐	☐
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.	☐	☐	☐	☐	☐	☐	☐
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.	☐	☐	☐	☐	☐	☐	☐

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.	☐	☐	☐	☐	☐	☐	☐

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

☐ a. Canes/crutch	☐ e. Wheelchair/scooter part time
☐ b. Walker	☐ f. Mechanical lift
☐ c. Orthotics/prosthetic	☐ g. Other (specify) _____
☐ d. Wheelchair/scooter full time	☐ 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 6 = Independent 1 = Dependent						Activity Not Assessed Code
	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.	☐	☐	☐	☐	☐	☐	☐
C.2 Roll left and right: The ability to roll from lying on back to left and right side, and roll back to back.	☐	☐	☐	☐	☐	☐	☐
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.	☐	☐	☐	☐	☐	☐	☐
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.	☐	☐	☐	☐	☐	☐	☐
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.	☐	☐	☐	☐	☐	☐	☐
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.	☐	☐	☐	☐	☐	☐	☐
C.7 Walk 50 feet with two turns: The ability to walk 50 feet and make two turns without a rest break.	☐	☐	☐	☐	☐	☐	☐
C.8 Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping	☐	☐	☐	☐	☐	☐	☐

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.	☐	☐	☐	☐	☐	☐	☐
C.10 **Four steps:** The ability to go up and down 4 steps with or without a rail without a rest break.	☐	☐	☐	☐	☐	☐	☐
C.11 **Twelve steps:** The ability to go up and down 12 steps with or without a rail without a rest break.	☐	☐	☐	☐	☐	☐	☐
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.	☐	☐	☐	☐	☐	☐	☐

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.	☐	☐	☐	☐	☐	☐	☐
C.13b Walk 100 ft (30 m): Once standing, can walk at least 100 feet (30 meters) in corridor or similar space.	☐	☐	☐	☐	☐	☐	☐
C.13c Walk 50 ft (15 m): Once standing, can walk at least 50 feet (15 meters) in corridor or similar space.	☐	☐	☐	☐	☐	☐	☐
C.13d Walk in room once standing: once standing, can walk at least 10 feet (3 meters) in room, corridor or similar space.	☐	☐	☐	☐	☐	☐	☐

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.	☐	☐	☐	☐	☐	☐	☐
C.14b Wheel 100 ft (30 m): Once seated, can wheel at least 100 feet (30 meters) in corridor or similar space.	☐	☐	☐	☐	☐	☐	☐
C.14c Wheel 50 ft (15 m): Once seated, can wheel at least 50 feet (15 meters) in corridor	☐	☐	☐	☐	☐	☐	☐

	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.	☐	☐	☐	☐	☐	☐	☐

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 6 = Independent 1 = Dependent						Activity Not Assessed Code
	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.	☐	☐	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐	☐	☐
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.	☐	☐	☐	☐	☐	☐	☐
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.	☐	☐	☐	☐	☐	☐	☐
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.	☐	☐	☐	☐	☐	☐	☐
D.6 Make light meal: The ability to plan and prepare all aspects of a light meal such as a sandwich and cold drink.	☐	☐	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐	☐	☐

	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.	☐	☐	☐	☐	☐	☐	☐

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)

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

A.2 Body Structures (Check at least one)

Structures Related to Movement

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

L: Left Side; R: Right Side

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

Structures Involved in Voice, Speech, & Swallowing

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

Other Structures

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

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

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

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