

CARE Tool

Master Document

(Core and Supplemental Items)

General Information:

Please note that this instrument uses the term “2-day assessment period” to refer to the first 2 days of admission and the last 2 days prior-to-discharge for look-back periods.

Post OMB Version
10/29/07

Signatures of Persons who Completed a Portion of the Accompanying Assessment

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

- collected in accordance with the guidelines provided by CMS for participation in this Post Acute Care Payment Reform Demonstration,
- an accurate and truthful reflection of assessment information for this patient,
- based on data collection occurring on the dates specified, and
- data-entered accurately.

I understand the importance of submitting only accurate and truthful data.

- This facility’s participation in the Post Acute Care Payment Reform Demonstration is conditioned on the accuracy and truthfulness of the information provided.
- The information provided may be used as a basis for ensuring that the patient receives appropriate and quality care and for conveying information about the patient to a provider in a different setting at the time of transfer.

I am authorized to submit this information by this facility on its behalf.

[I agree] [I do not agree]

	Name/Signature	Credentia l	License # (if required)	Sections Worked On	Date(s) of Data collection
	(Joe Smith)	(RN)	(MA000000)	III A2-6	(MM/DD/ YYYY)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					

12 .					
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I. Administrative Items

A. Assessment Type		B. Provider Information		
Enter <input type="checkbox"/> Code	A1. Reason for assessment 1. Acute discharge 2. PAC admission 3. PAC discharge 4. Interim 5. Expired	B1. Provider's Name <input type="text"/>	B2. Medicare Provider's Identification Number <input type="text"/>	
	A2. Admission Date ____/____/____ MM DD YYYY	B3. National Provider Identification Code (NPI) <input type="text"/>		
	A3. Assessment Reference Date ____/____/____ MM DD YYYY	A4. Expired Date (leave blank if not applicable) ____/____/____ MM DD YYYY		<input type="text"/>
	C. Patient Information			
C1. Patient's First Name <input type="text"/>	C4. Patient's Nickname (optional) <input type="text"/>	C2. Patient's Middle Initial or Name <input type="text"/>	C5. Patient's Medicare Health Insurance Number <input type="text"/>	
C3. Patient's Last Name <input type="text"/>	C6. Patient's Medicaid Number <input type="text"/>	C7. Patient's Identification/Provider Account Number <input type="text"/>		
C8. Birth Date ____/____/____ MM DD YYYY	Enter <input type="checkbox"/> Code	C12. Is English the patient's primary language? 0. No 1. Yes (If Yes, skip to C13.)		
C9. Social Security Number (optional) <input type="text"/>	C12a. If English is not the patient's primary language, what is the patient's primary language? <input type="text"/>			
Enter <input type="checkbox"/> Code	C10. Gender 1. Male 2. Female	Enter <input type="checkbox"/> Code	C13. Does the patient want or need an interpreter (oral or sign language) to communicate with a doctor or health care staff? <input type="text"/>	

Check all that apply	<input type="checkbox"/>	C11. Race/Ethnicity		<input type="checkbox"/>	0. No 1. Yes
	<input type="checkbox"/>	a. American Indian or Alaska Native		<input type="checkbox"/>	
	<input type="checkbox"/>	b. Asian		<input type="checkbox"/>	
	<input type="checkbox"/>	c. Black or African American		<input type="checkbox"/>	
	<input type="checkbox"/>	d. Hispanic or Latino		<input type="checkbox"/>	
	<input type="checkbox"/>	e. Native Hawaiian or Pacific Islander		<input type="checkbox"/>	
	<input type="checkbox"/>	f. White		<input type="checkbox"/>	
	g. Unknown	<input type="checkbox"/>			

I. Administrative Items (cont.)

D. Payer Information: Current Payment Source(s)

Check all that apply	<input type="checkbox"/>	D1. None (no charge for current services)	<input type="checkbox"/>	D8. Other government (e.g., TRICARE, VA, etc.)
	<input type="checkbox"/>	D2. Medicare (traditional fee-for-service)	<input type="checkbox"/>	D9. Private insurance/Medigap
	<input type="checkbox"/>	D3. Medicare (HMO/managed care)	<input type="checkbox"/>	D10. Private HMO/managed care
	<input type="checkbox"/>	D4. Medicaid (traditional fee-for-service)	<input type="checkbox"/>	D11. Self-pay
	<input type="checkbox"/>	D5. Medicaid (HMO/managed care)	<input type="checkbox"/>	D12. Other (specify) _____
	<input type="checkbox"/>	D6. Workers' compensation	<input type="checkbox"/>	D13. Unknown
	<input type="checkbox"/>	D7. Title programs (e.g., Title III, V, or XX)		

T.I How long did it take you to complete this section? _____ (minutes)

II. Admission Information

A. Pre-admission Service Use

A1. Admission Date		A3. If admitted from a medical setting, what was the primary diagnosis being treated in the previous setting?	
<p>____/____/____</p> <p>MM DD YYYY</p>		<p>_____</p>	
Enter Code <input type="text"/>	A2. Admitted From. Immediately preceding this admission, where was the patient?	Check all that apply	A4. In the last 2 months, what medical services other than those identified in A2 has the patient received?
	<ol style="list-style-type: none"> 1. Directly from community (e.g., private home, assisted living, group home, adult foster care) 2. Long-term nursing facility 3. Skilled Nursing Facility (SNF/TCU) 4. Hospital emergency department 5. Short-stay acute hospital 6. Long-term care hospital (LTCH) 7. Inpatient rehabilitation hospital or unit (IRF) 8. Psychiatric hospital or unit 9. Other (specify) _____ 		<ol style="list-style-type: none"> a. Skilled Nursing Facility (SNF/TCU) b. Short-stay acute hospital (IPPS) c. Long-term care hospital (LTCH) d. Inpatient rehabilitation hospital or unit (IRF) e. Psychiatric hospital or unit f. Home health g. Hospice h. Outpatient i. None

B. Patient History Prior To This Current Illness, Exacerbation, or Injury

B1. Prior to this recent illness, where did the patient live?		B3. If the patient lived in the community prior to this illness, what help was used?	
<ol style="list-style-type: none"> 1. Private residence 2. Community based residence (e.g., assisted living residence, group home, adult foster care) 		<ol style="list-style-type: none"> a. No help received or no help necessary b. Unpaid Assistance c. Paid Assistance d. Unknown 	

	<p>3. Permanently in a long-term care facility (e.g., nursing home)</p> <p>4. Other (e.g., shelter, jail, no known address)</p> <p>9. Unknown</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>B3a. If the patient lived in the community prior to this illness, who did the patient live with? (Check all that apply.)</p> <p>a. Lives alone</p> <p>b. Lives with paid helper</p> <p>c. Lives with other(s)</p> <p>d. Unknown</p>
	<p>B2. If the patient lived in the community prior to this illness, please provide the patient's ZIP Code (if patient's residence was in U.S.).</p> <p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </p> <p> <input type="checkbox"/> Lives Outside U.S. <input type="checkbox"/> Unknown </p>		

II. Admission Information (cont.)

B4. If the patient lived in the community prior to this current illness, exacerbation, or injury, are there any structural barriers in the patient's **prior residence** that could interfere with the patient's discharge?

Check all that apply

- a. Structural barriers are **not an issue**.
- b. **Stairs inside the living setting** that must be used by patient (e.g., to get to toileting, sleeping, eating areas).
- c. **Stairs leading from inside to outside** of living setting.
- d. **Narrow or obstructed doorways** for patients using wheelchairs or walkers.
- e. **Insufficient space** to accommodate **extra equipment** (e.g., hospital bed, vent equipment).
- f. **Other** (specify) _____.
- g. **Unknown**

B5. Prior Functioning. Indicate the patient's usual ability with everyday activities prior to this current illness, exacerbation, or injury.

<p>3. Independent – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.</p> <p>2. Needed partial assistance – Patient needed partial assistance from another person to complete activities.</p> <p>1. Dependent – A helper completed the activity for the patient.</p> <p>8. Not Applicable</p> <p>9. Unknown</p>	Enter <input type="checkbox"/> Code	B5a. Self Care: Did the patient need help bathing, dressing, using the toilet, or eating?
	Enter <input type="checkbox"/> Code	B5b. Mobility (Ambulation): Did the patient need assistance with walking from room to room (with or without devices such as cane, crutch, or walker)?
	Enter <input type="checkbox"/> Code	B5c. Stairs (Ambulation): Did the patient need assistance with stairs (with or without devices such as cane, crutch, or walker)?
	Enter <input type="checkbox"/> Code	B5d. Mobility (Wheelchair): Did the patient need assistance with moving from room to room using a wheelchair, scooter, or other wheeled mobility device?
	Enter <input type="checkbox"/> Code	B5e. Functional Cognition: Did the patient need help planning regular tasks, such as shopping or remembering to take medication?

B6. Mobility Devices and Aids Used Prior to Current Illness, Exacerbation, or Injury (Check all that apply.)

Check all that apply

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

B7. History of Falls. Has the patient had two or more falls in the past year or any fall with

<input type="text"/> Code	injury in the past year? 0. No 1. Yes 9. Unknown
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T.II How long did it take you to complete this section? _____ (minutes)

III. Current Medical

Clinicians:

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

A. Primary and Other Diagnoses, Comorbidities, and Complications

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

A1. Primary Diagnosis at Assessment

B. Other Diagnoses, Comorbidities, and Complications

B1.	
B2.	
B3.	
B4.	
B5.	
B6.	
B7.	
B8.	
B9.	
B10.	
B11.	
B12.	
B13.	
B14.	

Enter

Code

B15. Is this list complete?
0. No
1. Yes

III. Current Medical

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

Enter

Code

C1. Did the patient have one or more major procedures (diagnostic, surgical, and therapeutic interventions) during this admission?

0. No (If **No**, skip to Section D. Treatments.)

1. Yes

List up to 15 procedures (diagnostic, surgical and therapeutic interventions). Indicate if a procedure was left, right, or not applicable (N/A). If procedure was bilateral (e.g., bilateral knee replacement), check both left and right boxes.

Procedure	Left	Right	N/A
C1a.	C1b. <input type="checkbox"/>	C1c. <input type="checkbox"/>	C1d. <input type="checkbox"/>
C2a.	C2b. <input type="checkbox"/>	C2c. <input type="checkbox"/>	C2d. <input type="checkbox"/>
C3a.	C3b. <input type="checkbox"/>	C3c. <input type="checkbox"/>	C3d. <input type="checkbox"/>
C4a.	C4b. <input type="checkbox"/>	C4c. <input type="checkbox"/>	C4d. <input type="checkbox"/>
C5a.	C5b. <input type="checkbox"/>	C5c. <input type="checkbox"/>	C5d. <input type="checkbox"/>
C6a.	C6b. <input type="checkbox"/>	C6c. <input type="checkbox"/>	C6d. <input type="checkbox"/>
C7a.	C7b. <input type="checkbox"/>	C7c. <input type="checkbox"/>	C7d. <input type="checkbox"/>
C8a.	C8b. <input type="checkbox"/>	C8c. <input type="checkbox"/>	C8d. <input type="checkbox"/>
C9a.	C9b. <input type="checkbox"/>	C9c. <input type="checkbox"/>	C9d. <input type="checkbox"/>
C10a.	C10b. <input type="checkbox"/>	C10c. <input type="checkbox"/>	C10d. <input type="checkbox"/>
C11a.	C11b. <input type="checkbox"/>	C11c. <input type="checkbox"/>	C11d. <input type="checkbox"/>
C12a.	C12b. <input type="checkbox"/>	C12c. <input type="checkbox"/>	C12d. <input type="checkbox"/>
C13a.	C13b. <input type="checkbox"/>	C13c. <input type="checkbox"/>	C13d. <input type="checkbox"/>
C14a.	C14b. <input type="checkbox"/>	C14c. <input type="checkbox"/>	C14d. <input type="checkbox"/>
C15a.	C15b. <input type="checkbox"/>	C15c. <input type="checkbox"/>	C15d. <input type="checkbox"/>

Enter

Code

C16. Is this list complete?

0. No

1. Yes

III. Current Medical

D. Major Treatments

Which of the following treatments did the patient receive? (Please note: "Used at any time during stay" is only necessary at discharge.)

Check all that apply

Admitted/ Discharged With:	Used at Any Time During Stay
D1a. <input type="checkbox"/>	D1b. <input type="checkbox"/>
D2a. <input type="checkbox"/>	D2b. <input type="checkbox"/>
D3a. <input type="checkbox"/>	D3b. <input type="checkbox"/>
D4a. <input type="checkbox"/>	D4b. <input type="checkbox"/>
D5a. <input type="checkbox"/>	D5b. <input type="checkbox"/>
D6a. <input type="checkbox"/>	D6b. <input type="checkbox"/>
D7a. <input type="checkbox"/>	D7b. <input type="checkbox"/>
D8a. <input type="checkbox"/>	D8b. <input type="checkbox"/>
D9a. <input type="checkbox"/>	D9b. <input type="checkbox"/>
D10a. <input type="checkbox"/>	D10b. <input type="checkbox"/>
D11a. <input type="checkbox"/>	D11b. <input type="checkbox"/>
D12a. <input type="checkbox"/>	D12b. <input type="checkbox"/>
D13a. <input type="checkbox"/>	D13b. <input type="checkbox"/>
D14a. <input type="checkbox"/>	D14b. <input type="checkbox"/>
D15a. <input type="checkbox"/>	D15b. <input type="checkbox"/>
D16a. <input type="checkbox"/>	D16b. <input type="checkbox"/>
D17a. <input type="checkbox"/>	D17b. <input type="checkbox"/>
D18a. <input type="checkbox"/>	D18b. <input type="checkbox"/>
D19a. <input type="checkbox"/>	D19b. <input type="checkbox"/>
D20a. <input type="checkbox"/>	D20b. <input type="checkbox"/>
D21a. <input type="checkbox"/>	D21b. <input type="checkbox"/>
D22a. <input type="checkbox"/>	D22b. <input type="checkbox"/>
D23a. <input type="checkbox"/>	D23b. <input type="checkbox"/>
D24a. <input type="checkbox"/>	D24b. <input type="checkbox"/>
D25a. <input type="checkbox"/>	D25b. <input type="checkbox"/>
D26a. <input type="checkbox"/>	D26b. <input type="checkbox"/>
D27a. <input type="checkbox"/>	D27b. <input type="checkbox"/>
D28a. <input type="checkbox"/>	D28b. <input type="checkbox"/>
D29a. <input type="checkbox"/>	D29b. <input type="checkbox"/>
D30a. <input type="checkbox"/>	D30b. <input type="checkbox"/>

- D1. None**
- D2. Insulin Drip**
- D3. Total Parenteral Nutrition**
- D4. Central Line Management**
- D5. Blood Transfusion(s)**
- D6. Controlled Parenteral Analgesia - Peripheral**
- D7. Controlled Parenteral Analgesia - Epidural**
- D8. Left Ventricular Assistive Device (LVAD)**
- D9. Continuous Cardiac Monitoring**
D9c. Specify reason for continuous monitoring:

- D10. Chest Tube(s)**
- D11. Trach Tube with Suctioning**
D11c. Specify most intensive frequency of suctioning during stay: Every ___ hours
- D12. High O₂ Concentration Delivery System with FiO₂ > 40%**
- D13. Non-invasive ventilation**
- D14. Ventilator - Weaning**
- D15. Ventilator - Non-Weaning**
- D16. Hemodialysis**
- D17. Peritoneal Dialysis**
- D18. Fistula or Other Drain Management**
- D19. Negative Pressure Wound Therapy**
- D20. Complex Wound Management** with positioning and skin separation/trauma that requires at least two persons
- D21. Halo**
- D22. Complex External Fixators** (e.g., Ilizarov)
- D23. One-on-One 24-Hour Supervision**
D23c. Specify reason for 24-hour supervision:

- D24. Specialty Surface or Bed** (i.e., air fluidized, bariatric, low air loss, or rotation bed)
- D25. Multiple IV Antibiotic Administration**
- D26. IV Vaso-actors** (e.g., pressors, dilators, medication for pulmonary edema)
- D27. IV Anti-coagulants**
- D28. IV Chemotherapy**
- D29. Indwelling Bowel Catheter Management System**
- D30. Other Major Treatments**
D30c. Specify

III. Current Medical

E. Medications

List all current medications for the patient during the 2-day assessment period. These can be exported to an electronic file for merging with the assessment data.

<u>Medication Name</u>	<u>Dose</u>	<u>Route</u>	<u>Frequency</u>	<u>Planned Stop Date</u> <u>(if applicable)</u>
E1a. _____	E1b. _____	E1c. _____	E1d. _____	E1e. ___/___/___
E2a. _____	E2b. _____	E2c. _____	E2d. _____	E2e. ___/___/___
E3a. _____	E3b. _____	E3c. _____	E3d. _____	E3e. ___/___/___
E4a. _____	E4b. _____	E4c. _____	E4d. _____	E4e. ___/___/___
E5a. _____	E5b. _____	E5c. _____	E5d. _____	E5e. ___/___/___
E6a. _____	E6b. _____	E6c. _____	E6d. _____	E6e. ___/___/___
E7a. _____	E7b. _____	E7c. _____	E7d. _____	E7e. ___/___/___
E8a. _____	E8b. _____	E8c. _____	E8d. _____	E8e. ___/___/___
E9a. _____	E9b. _____	E9c. _____	E9d. _____	E9e. ___/___/___
E10a. _____	E10b. _____	E10c. _____	E10d. _____	E10e. ___/___/___
E11a. _____	E11b. _____	E11c. _____	E11d. _____	E11e. ___/___/___
E12a. _____	E12b. _____	E12c. _____	E12d. _____	E12e. ___/___/___
E13a. _____	E13b. _____	E13c. _____	E13d. _____	E13e. ___/___/___
E14a. _____	E14b. _____	E14c. _____	E14d. _____	E14e. ___/___/___
E15a. _____	E15b. _____	E15c. _____	E15d. _____	E15e. ___/___/___
E16a. _____	E16b. _____	E16c. _____	E16d. _____	E16e. ___/___/___
E17a. _____	E17b. _____	E17c. _____	E17d. _____	E17e. ___/___/___
E18a. _____	E18b. _____	E18c. _____	E18d. _____	E18e. ___/___/___
E19a. _____	E19b. _____	E19c. _____	E19d. _____	E19e. ___/___/___
E20a. _____	E20b. _____	E20c. _____	E20d. _____	E20e. ___/___/___
E21a. _____	E21b. _____	E21c. _____	E21d. _____	E21e. ___/___/___
E22a. _____	E22b. _____	E22c. _____	E22d. _____	E22e. ___/___/___
E23a. _____	E23b. _____	E23c. _____	E23d. _____	E23e. ___/___/___
E24a. _____	E24b. _____	E24c. _____	E24d. _____	E24e. ___/___/___
E25a. _____	E25b. _____	E25c. _____	E25d. _____	E25e. ___/___/___
E26a. _____	E26b. _____	E26c. _____	E26d. _____	E26e. ___/___/___
E27a. _____	E27b. _____	E27c. _____	E27d. _____	E27e. ___/___/___
E28a. _____	E28b. _____	E28c. _____	E28d. _____	E28e. ___/___/___
E29a. _____	E29b. _____	E29c. _____	E29d. _____	E29e. ___/___/___
E30a. _____	E30b. _____	E30c. _____	E30d. _____	E30e. ___/___/___

Enter

Code

E31. Is this list complete?
0. No
1. Yes

III. Current Medical

F. Allergies & Adverse Drug Reactions

Enter

Code

F1. Does patient **have allergies or any known adverse drug reactions?**

0. None known (If **Unknown**, skip to Section G. Skin Integrity.)

1. Yes (If **Yes**, list all allergies/causes of reaction [e.g., food, medications, other] and describe the adverse reactions.)

Allergies/Causes of Reaction

F1a. _____
 F2a. _____
 F3a. _____
 F4a. _____
 F5a. _____
 F6a. _____
 F7a. _____
 F8a. _____

Patient Reaction

F1b. _____
 F2b. _____
 F3b. _____
 F4b. _____
 F5b. _____
 F6b. _____
 F7b. _____
 F8b. _____

Enter

Code

F9. Is the list complete?

0. No

1. Yes

G. Skin Integrity

G1-2. PRESENCE OF PRESSURE ULCERS

Enter

Code

G1. 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.**

Enter

Code

G2. Does this patient have one or more unhealed pressure ulcer(s) at stage 2 or higher?

0. No (If **No**, skip to Section G5. Major Wounds.)

1. Yes

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

CODING: Please specify the number of ulcers at each stage: 0 = 0 ulcers 1 = 1 ulcer 2 = 2 ulcers 3 = 3 ulcers 4 = 4 ulcers 5 = 5 ulcers 6 = 6 ulcers 7 = 7 ulcers 8 = 8 or more ulcers	Number present at assessment	Number with onset during this service	Pressure ulcer at stage 2, stage 3, or stage 4 only:
	Stage 2 Enter <input type="checkbox"/> Code	Stage 2 Enter <input type="checkbox"/> Code	G2a. Stage 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister (excludes those resulting from skin tears, tape stripping, or incontinence associated dermatitis).
	Stage 3 Enter <input type="checkbox"/> Code	Stage 3 Enter <input type="checkbox"/> Code	G2b. Stage 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
	Stage 4 Enter <input type="checkbox"/> Code	Stage 4 Enter <input type="checkbox"/> Code	G2c. Stage 4 - Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

9 = Unknown	Unstageable Enter <input type="text"/> Code	Unstageable Enter <input type="text"/> Code	G2d. Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, gray, green, or brown) or eschar (tan, brown, or black) in the wound bed. Include ulcers that are known or likely , but are not stageable due to non-removable dressing, device, cast or suspected deep tissue injury in evolution.
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III. Current Medical

G. Skin Integrity (cont.)

Number of Unhealed Stage 2 Ulcers

G2e. Number of unhealed stage 2 ulcers known to be present for more than 1 month.
If the patient has one or more unhealed stage 2 pressure ulcers, record the number present today that were first observed **more than 1 month ago**, according to the best available records. If the patient has no unhealed stage 2 pressure ulcers, record "0."

G5. MAJOR WOUND (excluding pressure ulcers)

Enter

Code

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 Section G6. Turning Surfaces Not Intact.)
- 1. Yes**

Enter Length

 | | |

cm

Enter Width

 | | |

cm

Date Measured

 / /

MM DD YYYY

G3. If any pressure ulcer is stage 3 or 4 (or if eschar is present) during the 2-day assessment period, please record the most recent measurements for the LARGEST ulcer (or eschar):

- a. Longest length in any direction**
- b. Width of SAME unhealed ulcer or eschar**
- c. Date of measurement**

G5a-e. NUMBER OF MAJOR WOUNDS

Number of Major Wounds	Type(s) of Major Wound(s)
<input type="text"/> <input type="text"/>	G5a. Delayed healing of surgical wound
<input type="text"/> <input type="text"/>	G5b. Trauma-related wound
<input type="text"/> <input type="text"/>	G5c. Diabetic foot ulcer(s)
<input type="text"/> <input type="text"/>	G5d. Vascular ulcer (arterial or venous including diabetic ulcers not located on the foot)
<input type="text"/> <input type="text"/>	G5e. Other (e.g., incontinence associated dermatitis, normal surgical wound healing). Please specify.

Enter

Code

G4. 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**

G6. TURNING SURFACES NOT INTACT

Turning Surface	
Check All That Apply	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>

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**

III. Current Medical Information (cont.)

H. Physiologic Factors

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

Date	Complete using format below	Value	Check if NOT tested	Check here if value is estimated	Anthropometric Measures
H1a. <u> </u> / <u> </u> / <u> </u>	<u> xxx.x </u>	H1b. <u> </u>	H1c. <input type="checkbox"/>	H1d. <input type="checkbox"/>	H1. Height (inches) OR H2. Height (cm) H3. Weight (pounds) OR H4. Weight (Kg)
H2a. <u> </u> / <u> </u> / <u> </u>	<u> xxx.x </u>	H2b. <u> </u>	H2c. <input type="checkbox"/>	H2d. <input type="checkbox"/>	
H3a. <u> </u> / <u> </u> / <u> </u>	<u> xxx.x </u>	H3b. <u> </u>	H3c. <input type="checkbox"/>	H3d. <input type="checkbox"/>	
H4a. <u> </u> / <u> </u> / <u> </u>	<u> xxx.x </u>	H4b. <u> </u>	H4c. <input type="checkbox"/>	H4d. <input type="checkbox"/>	
H5a. <u> </u> / <u> </u> / <u> </u>	<u> xxx.x </u>	H5b. <u> </u>	H5c. <input type="checkbox"/>	Vital Signs	
H6a. <u> </u> / <u> </u> / <u> </u>	<u> xx.x </u>	H6b. <u> </u>	H6c. <input type="checkbox"/>	H5. Temperature (°F) OR	
H7a. <u> </u> / <u> </u> / <u> </u>	<u> xxx </u>	H7b. <u> </u>	H7c. <input type="checkbox"/>	H6. Temperature (°C)	
H8a. <u> </u> / <u> </u> / <u> </u>	<u> xx </u>	H8b. <u> </u>	H8c. <input type="checkbox"/>	H7. Heart Rate (beats/min)	
H9a. <u> </u> / <u> </u> / <u> </u>	<u> xxx/xxx </u>	H9b. <u> </u>	H9c. <input type="checkbox"/>	H8. Respiratory Rate (breaths/min)	
H10a. <u> </u> / <u> </u> / <u> </u>	<u> xxx </u>	H10b. <u> </u>	H10c. <input type="checkbox"/>	H9. Blood Pressure mm/Hg	
			H10d. <input type="checkbox"/>	H10. O ₂ saturation (Pulse Oximetry) % <i>H10d. Please specify source and amount of supplemental O₂</i>	

H11a. <u> </u> / <u> </u> / <u> </u>	<u> xx.x </u>	H11b. <u> </u>	H11c. <input type="checkbox"/>	Laboratory	
H12a. <u> </u> / <u> </u> / <u> </u>	<u> xx.x </u>	H12b. <u> </u>	H12c. <input type="checkbox"/>	H11. Hemoglobin (gm/dL)	
H13a. <u> </u> / <u> </u> / <u> </u>	<u> xxx.x </u>	H13b. <u> </u>	H13c. <input type="checkbox"/>	H12. Hematocrit (%)	
H14a. <u> </u> / <u> </u> / <u> </u>	<u> xx.x </u>	H14b. <u> </u>	H14c. <input type="checkbox"/>	H13. WBC (K/mm ³)	
H15a. <u> </u> / <u> </u> / <u> </u>	<u> xxx </u>	H15b. <u> </u>	H15c. <input type="checkbox"/>	H14. HbA1c (%)	
H16a. <u> </u> / <u> </u> / <u> </u>	<u> x.x </u>	H16b. <u> </u>	H16c. <input type="checkbox"/>	H15. Sodium (mEq/L)	
H17a. <u> </u> / <u> </u> / <u> </u>	<u> xx </u>	H17b. <u> </u>	H17c. <input type="checkbox"/>	H16. Potassium (mEq/L)	
H18a. <u> </u> / <u> </u> / <u> </u>	<u> x.x </u>	H18b. <u> </u>	H18c. <input type="checkbox"/>	H17. BUN (mg/dL)	
H19a. <u> </u> / <u> </u> / <u> </u>	<u> x.x </u>	H19b. <u> </u>	H19c. <input type="checkbox"/>	H18. Creatinine (mg/dL)	
H20a. <u> </u> / <u> </u> / <u> </u>	<u> xx.x </u>	H20b. <u> </u>	H20c. <input type="checkbox"/>	H19. Albumin (gm/dL)	
H21a. <u> </u> / <u> </u> / <u> </u>	<u> x.x </u>	H21b. <u> </u>	H21c. <input type="checkbox"/>	H20. Prealbumin (mg/dL)	
			H21d. <input type="checkbox"/>	H21. INR	
H22a. <u> </u> / <u> </u> / <u> </u>	<u> xx </u>	H22b. <u> </u>	H22c. <input type="checkbox"/>	Other	
			H22d. <input type="checkbox"/>	H22. Left Ventricular Ejection Fraction (%)	
H23a. <u> </u> / <u> </u> / <u> </u>			H23c. <input type="checkbox"/>	Arterial Blood Gases (ABGs)	
H24. <u> </u> / <u> </u> / <u> </u>	<u> x.xx </u>	H24b. <u> </u>	H24c. <input type="checkbox"/>	H23d. Please specify source and amount of supplemental O ₂	
H25. <u> </u> / <u> </u> / <u> </u>	<u> xxx </u>	H25b. <u> </u>	H25c. <input type="checkbox"/>	_____	
H26. <u> </u> / <u> </u> / <u> </u>	<u> xxx </u>	H26b. <u> </u>	H26c. <input type="checkbox"/>	H24. pH	
H27. <u> </u> / <u> </u> / <u> </u>	<u> xxx </u>	H27b. <u> </u>	H27c. <input type="checkbox"/>	H25. PaCO ₂ (mm/Hg)	
H28. <u> </u> / <u> </u> / <u> </u>	<u> xx </u>	H28b. <u> </u>	H28c. <input type="checkbox"/>	H26. HCO ₃ (mEq/L)	
H29. <u> </u> / <u> </u> / <u> </u>	<u> xx </u>	H29b. <u> </u>	H29c. <input type="checkbox"/>	H27. PaO ₂ (mm/Hg)	
H30a. <u> </u> / <u> </u> / <u> </u>			H30c. <input type="checkbox"/>	H28. SaO ₂ (%)	
H31. <u> </u> / <u> </u> / <u> </u>	<u> xxxx </u>	H31b. <u> </u>	H31c. <input type="checkbox"/>	H29. B.E. (base excess) (mEq/L)	
H32. <u> </u> / <u> </u> / <u> </u>	<u> xxx </u>	H32b. <u> </u>	H32c. <input type="checkbox"/>	Pulmonary Function Tests	
H33. <u> </u> / <u> </u> / <u> </u>	<u> xxx </u>	H33b. <u> </u>	H33c. <input type="checkbox"/>	H31. FVC (cc's)	
H34. <u> </u> / <u> </u> / <u> </u>	<u> xxx </u>	H34b. <u> </u>	H34c. <input type="checkbox"/>	H32. FEV (% of FVC)	
H35. <u> </u> / <u> </u> / <u> </u>	<u> xxx </u>	H35b. <u> </u>	H35c. <input type="checkbox"/>	H33. FEV ₁ (% of FVC in 1 second)	
H36. <u> </u> / <u> </u> / <u> </u>	<u> xxx </u>	H36b. <u> </u>	H36c. <input type="checkbox"/>	H34. FEV ₂ (% of FVC in 2 seconds)	
H37. <u> </u> / <u> </u> / <u> </u>	<u> xx,x </u>	H37b. <u> </u>	H37c. <input type="checkbox"/>	H35. FEV ₃ (% of FVC in 3 seconds)	
H38. <u> </u> / <u> </u> / <u> </u>	<u> xxxx </u>	H38b. <u> </u>	H38c. <input type="checkbox"/>	H36. PEF (liters per minute)	
H39. <u> </u> / <u> </u> / <u> </u>	<u> xxxx </u>	H39b. <u> </u>	H39c. <input type="checkbox"/>	H37. MVV (liters per minute)	
H40. <u> </u> / <u> </u> / <u> </u>	<u> xxxx </u>	H40b. <u> </u>	H40c. <input type="checkbox"/>	H38. SVC (cc's)	
H41. <u> </u> / <u> </u> / <u> </u>	<u> xxxx </u>	H41b. <u> </u>	H41c. <input type="checkbox"/>	H39. TLC (cc's)	
H42. <u> </u> / <u> </u> / <u> </u>	<u> xxxx </u>	H42b. <u> </u>	H42c. <input type="checkbox"/>	H40. FRC (cc's)	

			H32c. <input type="checkbox"/> H33c. <input type="checkbox"/> H34c. <input type="checkbox"/> H35c. <input type="checkbox"/> H36c. <input type="checkbox"/> H37c. <input type="checkbox"/> H38c. <input type="checkbox"/> H39c. <input type="checkbox"/> H40c. <input type="checkbox"/> H41c. <input type="checkbox"/> H42c. <input type="checkbox"/>	H41. RV (cc's) H42. ERV (cc's)
--	--	--	---	---

T.III How long did it take you to complete this section? _____ (minutes)

IV. Cognitive Status, Mood

A. Comatose

Enter

 Code

A1. Persistent vegetative state/no discernible consciousness at time of admission (discharge)
0. No
1. Yes (If Yes, skip to G6. Pain Observational Assessment.)

B. Temporal Orientation/Mental Status

B1. Interview Completed

Enter

 Code

B1a. Interview Attempted?
0. No
1. Yes (If Yes, skip to B2a. [for acute care discharges] or B3. BIMS (for PAC admissions.)

Enter

 Code

B3b. Year, Month, Day
B3b.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

Enter

 Code

B1b. Indicate reason that the interview was not attempted and then skip to Section C. Observational Assessment of Cognitive Status:
1. Unresponsive or minimally conscious
2. Communication disorder
3. No interpreter available

Enter

 Code

B3b.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

B2. Temporal Orientation Complete only for acute care discharges.

Enter

 Code

B2a. 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

Enter

 Code

B3b.3. Ask patient: "What day of the week is today?"
 Patient's answer is:
2. Accurate
1. Incorrect or no answer

Enter

 Code

B2b. 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

Enter

 Code

B3c. 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.

B3c.1. Recalls "sock?"
2. Yes, no cue required
1. Yes, after cueing ("something to wear")
0. No, could not recall

B3. BIMS Complete only for PAC admission.

Enter

 Code

B3a. 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

Enter

 Code

B3c.2. Recalls "blue?"
2. Yes, no cue required
1. Yes, after cueing ("a color")
0. No, could not recall

	1. One 0. None		
	<p>After the patient's first attempt say: <i>"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."</i> You may repeat the words up to two more times.</p>	Enter <input data-bbox="820 184 878 239" type="text"/> Code	B3c.3. Recalls "bed?" 2. Yes , no cue required 1. Yes , after cueing ("a piece of furniture") 0. No , could not recall

IV. Cognitive Status, Mood &

C. Observational Assessment of Cognitive Status at 2-Day Assessment

Period: Complete this section only if patient could not be interviewed.

Check all that apply

C1. Memory/recall ability: Check all that the patient normally recalled during the 2-day assessment period:

- C1a. Current season**
- C1b. Location of own room**
- C1c. Staff names and faces**
- C1d. That he or she is in a hospital, nursing home, or home**
- C1e. None of the above are recalled**
- C1f. Unable to assess**
Specify reason _____

D. Confusion Assessment Method: Complete this section only if patient scored 0 or 1 on B2a. or B2b. (for acute care discharges) or B3b.1., B3b.2., or B3b.3 (for PAC admissions).

Code the following behaviors during the 2-day assessment period.

CODING:

- 0.** Behavior **is not present.**
- 1.** Behavior **continuously present** does not fluctuate.
- 2.** Behavior **present, fluctuates** (e.g., comes and goes, changes in severity).



Enter Code in Boxes



Enter

Code

D1. Inattention: The patient has difficulty focusing attention (e.g., easily distracted, out of touch, or difficulty keeping track of what is said).

Enter

Code

D2. 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).

Enter

Code

D3. 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).

Enter

Code

D4. 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 &

E. Behavioral Signs & Symptoms: PAC Admission and Discharge

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

Enter Code
E1. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing).
0. No
1. Yes

Enter Code
E2. Verbal behavioral symptoms directed towards others (e.g., threatening, screaming at others).
0. No
1. Yes

Enter Code
E3. Other disruptive or dangerous behavioral symptoms not directed towards others, including self-injurious behaviors (e.g., hitting or scratching self, attempts to pull out IVs, pacing).
0. No
1. Yes

F2. Patient Health Questionnaire (PHQ2) (cont.)

Enter Code
F2c. Feeling down, depressed, or hopeless?
0. No (If **No**, skip to question F3.)
1. Yes
8. Unable to respond (If **Unable**, skip to question F3.)

Enter Code
F2d. If Yes, how many days in the last 2 weeks?
0. Not at all (0 to 1 days)
1. Several days (2 to 6 days)
2. More than half of the days (7 to 11 days)
3. Nearly every day (12 to 14 days)

F3. Feeling Sad: PAC Admission and Discharge

Enter Code
F3a. 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

F. Mood: PAC Admission and Discharge

Enter Code
F1. Mood Interview Attempted?
0. No (If **No**, skip to Section G1. Pain Interview.)
1. Yes

F2. Patient Health Questionnaire (PHQ2): PAC Admission and Discharge

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

Enter Code
F2a. Little interest or pleasure in doing things?
0. No (If **No**, skip to question F2c.)
1. Yes
8. Unable to respond (If **Unable**, skip to question F2c.)

Enter Code
F2b. If Yes, how many days in the last 2 weeks?

Code	<ul style="list-style-type: none">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)
------	--

IV. Cognitive Status, Mood &

G. Pain

Enter <input type="checkbox"/> Code	G1. Pain Interview Attempted? 0. No (If No, skip to G6. Pain Observational Assessment.) 1. Yes	Enter <input type="checkbox"/> Code	G4. Pain Effect on Function Ask patient: "During the past 2 days, has pain made it hard for you to sleep?" 0. No 1. Yes 8. Unable to answer or no response
Enter <input type="checkbox"/> Code	G2. Pain Presence Ask patient: "Have you had pain or hurting at any time during the last 2 days?" 0. No (If No, skip to Section V. Impairments.) 1. Yes 8. Unable to answer or no response (Skip to G6. Pain Observational Assessment.)		
Enter <input type="checkbox"/> Code	G3. Pain Severity Ask patient: "Please rate your worst pain during the last 2 days on a zero to 10 scale, with zero being no pain and 10 as the worst pain you can imagine." Enter 88 if patient does not answer or is unable to respond and skip to G6. Pain Observational Assessment.	Enter <input type="checkbox"/> Code	G5. Ask patient: "During the past 2 days, have you limited your activities because of pain?" 0. No 1. Yes 8. Unable to answer or no response
G6. Pain Observational Assessment. If patient could not be interviewed for pain assessment, check all indicators of pain or possible pain at the 2-day assessment period.			
Check all that	<input type="checkbox"/> G6a. Non-verbal sounds (e.g., crying, whining, gasping, moaning, or groaning) <input type="checkbox"/> G6b. Vocal complaints of pain (e.g., "that hurts, ouch, stop") <input type="checkbox"/> G6c. Facial Expressions (e.g., grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw) <input type="checkbox"/> G6d. Protective body movements or postures (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement) <input type="checkbox"/> G6e. None of these signs observed or documented		

T.IV How long did it take you to complete this section? _____ (minutes)

V. Impairments

A. Bladder and Bowel Management: Use of Device(s) and Incontinence

Enter

Code

A1. Does the patient have any impairments with bladder or bowel management?
0. No (If **No** impairments, skip to Section B. Swallowing.)
1. Yes (If **Yes**, please complete this section.)

Bladder

Bowel

Enter
Code
A2a.

Enter Code
A2b.

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

Enter
Code
A3a.

Enter Code
A3b.

A3. Indicate the **frequency of incontinence** during the 2-day assessment period.
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 during the 2-day assessment period (e.g., renal failure)

Enter
Code
A4a.

Enter Code
A4b.

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

Enter
Code
A5a.

Enter Code
A5b.

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

B. Swallowing

Enter

Code

B1. Does the patient have any impairments with swallowing?
0. No (If **No** impairments, skip to Section C. Hearing, Vision, and Communication.)
1. Yes (If **Yes**, please complete this section.)

Check all that apply

B1. Swallowing Disorder: Signs and symptoms of possible swallowing disorder.
B1a. Complaints of difficulty or pain with swallowing
B1b. Coughing or choking during meals or when swallowing medications
B1c. Holding food in mouth/cheeks or residual food in mouth after meals
B1d. Loss of liquids/solids from mouth when eating or drinking
B1e. NPO: intake not by mouth
B1f. Other (specify) _____

B2. Swallowing: Describe the patient's usual ability with swallowing.
B2a. Regular food: Solids and liquids swallowed safely without supervision and without modified food or liquid consistency.
B2b. Modified food consistency/supervision: Patient requires modified food or liquid consistency and/or needs supervision during eating for safety.
B2c. Tube/parenteral feeding: Tube/parenteral feeding used wholly or partially as a means of sustenance.

V. Impairments (cont.)

C. Hearing, Vision, and Communication

Enter Code
C1. Does the patient have any impairments with hearing, vision, or communication?
0. No (If **No** impairments, skip to Section D. Weight-bearing.)
1. Yes (If **Yes**, please complete this section.)

C1a. Understanding Verbal Content

Enter Code

4. Understands: Clear comprehension without cues or repetitions

3. Usually Understands: Understands most conversations, but misses some part/intent of message. Requires cues at times to understand

2. Sometimes Understands: Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand

1. Rarely/Never Understands

8. Unable to assess

9. Unknown

C1c. Ability to See in Adequate Light (with glasses or other visual appliances)

Enter Code

3. Adequate: Sees fine detail, including regular print in newspapers/books

2. Mildly to Moderately Impaired: Can identify objects; may see large print

1. Severely Impaired: No vision or object identification questionable

8. Unable to assess

9. Unknown

C1b. Expression of Ideas and Wants

Enter Code

4. Expresses complex messages **without difficulty** and with speech that is clear and easy to understand

3. Exhibits some **difficulty** with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear

2. Frequently exhibits difficulty with expressing needs and ideas

1. Rarely/Never expresses self or speech is very difficult to understand.

8. Unable to assess

9. Unknown

C1d. Ability to Hear (with hearing aid or hearing appliance if normally used)

Enter Code

3. Adequate: Hears normal conversation and TV without difficulty

2. Mildly to Moderately Impaired: Difficulty hearing in some environments or speaker may need to increase volume or speak distinctly

1. Severely Impaired: Absence of useful hearing

8. Unable to assess

9. Unknown

V. Impairments (cont.)

D. Weight-bearing

Enter

Code

D1. Does the patient have any impairments with weight-bearing?
0. No (If **No** impairments, skip to Section E.. Grip Strength.)
1. Yes (If **Yes**, please complete this section.)

CODING: Indicate all the patient's weight-bearing restrictions in the 2-day assessment period.

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

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

E. Grip Strength

Enter

Code

E1. Does the patient have any impairments with grip strength?
0. No (If **No** impairments, skip to Section F. Respiratory Status.)
1. Yes (If **Yes**, please complete this section.)

CODING: Indicate the patient's ability to squeeze your hand in the 2-day assessment period.

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

E1a. Left Hand	E1b. Right Hand
Enter <input type="text"/> Code	Enter <input type="text"/> Code

F. Respiratory Status

Enter

Code

F1. Does the patient have any impairments with respiratory status?
0. No (If **No** impairments, skip to Section G. Endurance.)
1. Yes (If **Yes**, please complete this section.)

With Supplemental O ₂	Without Supplemental O ₂
Enter <input type="text"/> Code	Enter <input type="text"/> Code
F1a.	F1b.

Respiratory Status: Was the patient dyspneic or noticeably **Short of Breath** in the 2-day assessment period?

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

V. Impairments (cont.)

G. Endurance

Enter

 Code

G1. Does the patient have any impairments with endurance?
0. No (If **No** impairments, skip to Section H. Mobility Devices and Aids Needed.)
1. Yes (If **Yes**, please complete this section.)

Enter

 Code

G1a. Mobility Endurance: Was the patient able to walk or wheel 50 feet (15 meters) in the 2-day assessment period?
0. No, could not do
1. Yes, can do with rest
2. Yes, can do without rest
8. Not assessed due to medical counter indication

Enter

 Code

G1b. Sitting Endurance: Was the patient able to tolerate sitting for 15 minutes during the 2-day assessment period?
0. No
1. Yes, with support
2. Yes, without support
8. Not assessed due to medical counter indication

H. Mobility Devices and Aids Needed

Check all that apply

H1. Indicate all mobility devices and aids needed at time of assessment. (Check all that apply.)

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

T.V How long did it take you to complete this section? _____ (minutes)

VI. Functional Status: Usual

A. Core Self Care: The core self care items should be completed on ALL patients.

Code the patient's most usual performance for the 2-day assessment period using the 6-point scale below.

CODING:

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

Code for the most usual performance in the 2-day assessment period.

Activities may be completed with or without assistive devices.

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

If activity was not attempted code:

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

Enter Code in Boxes

Enter

Code

A1. Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.

Enter

Code

A2. Tube feeding: The ability to manage all equipment/supplies related to obtaining nutrition.

Enter

Code

A3. Oral hygiene: The ability to use suitable items to clean teeth. Dentures: The ability to remove and replace dentures from and to mouth, and manage equipment for soaking and rinsing.

Enter

Code

A4. Toilet hygiene: The ability to maintain perineal hygiene, adjust clothes before and after using toilet, commode, bedpan, urinal. If managing ostomy, include wiping opening but not managing equipment.

Enter

Code

A5. Upper body dressing: The ability to put on and remove shirt or pajama top. Includes buttoning three buttons.

Enter

Code

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

VI. Functional Status (cont.)

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

Complete for ALL patients: Code the patient's most usual performance for the 2-day assessment period using the 6-point scale below.

CODING:

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

Code for the most usual performance in the 2-day assessment period.

Activities may be completed with or without assistive devices.

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

If activity was not attempted code:

- M.** Not attempted due to **medical condition**
- S.** Not attempted due to **safety concerns**
- A.** Task **attempted** but not completed



Enter Code in Boxes



Enter

Code

B1. Lying to Sitting on Side of Bed: The ability to safely move from lying on the back to sitting on side of bed with feet flat on the floor, no back support.

Enter

Code

B2. Sit to Stand: The ability to safely come to a standing position from sitting in a chair or on the side of a bed.

Enter

Code

B3. Chair/Bed-to-Chair Transfer: The ability to safely transfer to and from a chair (or wheelchair). The chairs are placed at right angles to each other.

Enter

Code

B4. Toilet Transfer: The ability to safely get on and off a toilet or commode.

MODE OF MOBILITY

Enter

Code

B5. Does this patient primarily use a wheelchair for mobility?

- 0. No** (If No, code B5a for the longest distance completed.)
- 1. Yes** (If Yes, code B5b for the longest distance completed.)

Enter

Code

B5a. Select the longest distance the patient walks and code his/her level of independence (Level 1-6) on that distance (observe their performance):

- 1. Walk 150 ft (45 m):** Once standing, can walk at least 150 feet (45 meters) in corridor or similar space.
- 2. Walk 100 ft (30 m):** Once standing, can walk at least 100 feet (30 meters) in corridor or similar space
- 3. Walk 50 ft (15 m):** Once standing, can walk at least 50 feet (15 meters) in corridor or similar space
- 4. Walk in Room Once Standing:** Once standing, can walk at least 10 feet (3 meters) in room, corridor or similar space.

Enter

Code

Enter

Code

Enter

Code

N. Not applicable
P. Patient Refused

Enter

Code

Enter

Code

Enter

Code

Enter

Code

B5b. Select the longest distance the patient wheels and code his/her level of independence (Level 1-6) (observe their performance):

- 1. Wheel 150 ft (45 m):** Once sitting, can wheel at least 150 feet (45 meters) in corridor or similar space.
- 2. Wheel 100 ft (30 m):** Once sitting, can wheel at least 100 feet (30 meters) in corridor or similar space
- 3. Wheel 50 ft (15 m):** Once sitting, can wheel at least 50 feet (15 meters) in corridor or similar space
- 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 only for patients who will need post-acute care to improve their functional ability or personal assistance following discharge.

Please code patient on all activities they are able to participate in and which you can observe, or have assessed by other means, using the 6-point scale below.

CODING:

Safety and Quality of Performance

- If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Code for the most usual performance in the 2-day assessment period.

Activities may be completed with or without assistive devices.

6. Independent - Patient completes the activity by him/herself with no assistance from a helper.

5. Setup or clean-up assistance - Helper SETS UP OR CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.

4. Supervision or touching assistance -Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.

3. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.

2. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

1. Dependent - Helper does ALL of the effort. Patient does none of the effort to complete the task.

If activity was not attempted code:

M. Not attempted due to **medical condition**

Enter Code in Boxes → Enter Code in Boxes →	<input type="text"/> Enter <input type="checkbox"/> Code	C1. Wash Upper Body: The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.
	<input type="text"/> Enter <input type="checkbox"/> Code	C2. Shower/bathe self: The ability to bathe self in shower or tub, including washing and drying self. Does not include transferring in/out of tub/shower.
	<input type="text"/> Enter <input type="checkbox"/> Code	C3. Roll left and right: The ability to roll from lying on back to left and right side, and roll back to back.
	<input type="text"/> Enter <input type="checkbox"/> Code	C4. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
	<input type="text"/> Enter <input type="checkbox"/> Code	C5. Picking up object: The ability to bend/stoop from a standing position to pick up small object such as a spoon from the floor.
	<input type="text"/> Enter <input type="checkbox"/> Code	C6. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that are appropriate for safe mobility.
	MODE OF MOBILITY	
	<input type="text"/> Enter <input type="checkbox"/> Code	C7. Does this patient primarily use a wheelchair for mobility? 0. No (If No, code C7a-C7f.) 1. Yes (If Yes, code C7f-C7h.)
	<input type="text"/> Enter <input type="checkbox"/> Code	C7a. 1 step (curb): The ability to step over a curb or up and down one step.
	<input type="text"/> Enter <input type="checkbox"/> Code	C7b. Walk 50 feet with two turns: The ability to walk 50 feet and make two turns.
	<input type="text"/> Enter <input type="checkbox"/> Code	C7c. 12 steps-interior: The ability to go up and down 12 interior steps with a rail.
	<input type="text"/> Enter <input type="checkbox"/> Code	C7d. Four steps-exterior: The ability to go up and down 4 exterior steps with a rail.
	<input type="text"/> Enter <input type="checkbox"/> Code	C7e. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces, such as grass, gravel, ice or snow.
<input type="text"/> Enter <input type="checkbox"/> Code	C7f. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.	
<input type="text"/> Enter <input type="checkbox"/> Code	C7g. Wheel short ramp: Once seated in wheelchair, goes up and down a ramp of less than 12 feet (4 meters).	

<p>S. Not attempted due to safety concerns</p> <p>E. Not attempted due to environmental constraints</p> <p>A. Task attempted but not completed</p> <p>N. Not applicable</p> <p>P. Patient Refused</p>	<div style="text-align: center;"> <input data-bbox="727 163 776 226" type="text"/> Enter Code </div>	<p>C7h. Wheel long ramp: Once seated in wheelchair, goes up and down a ramp of more than 12 feet (4 meters).</p>
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VI. Functional Status (cont.)

C. Supplemental Functional Ability (cont.): Complete only for patients who will need post-acute care to improve their functional ability or personal assistance following discharge.

Please code patient on all activities they are able to participate in and which you can observe, or have assessed by other means, using the 6-point scale below.

CODING:

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

Code for the most usual performance in the first 2-day assessment period.

Activities may be completed with or without assistive devices.

- 6. Independent** – Patient completes the activity by him/herself with no assistance from a helper.
 - 5. Setup or clean-up assistance** – Helper SETS UP OR CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
 - 4. Supervision or touching assistance** –Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
 - 3. Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
 - 2. Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
 - 1. Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the task.
- If activity was not attempted code:**
- M.** Not attempted due to **medical condition**
 - S.** Not attempted due to **safety concerns**
 - E.** Not attempted due to **environmental constraints**
 - A.** Task **attempted** but not completed
 - N.** **Not applicable**

Enter <input type="checkbox"/> Code	C8. Telephone-answering: The ability to pick up call in patient’s customary manner and maintain for 3 minutes. Does not include getting to the phone.
Enter <input type="checkbox"/> Code	C9. Telephone-placing call: The ability to pick up and place call in patient’s customary manner and maintain for 3 minutes. Does not include getting to the phone.
Enter <input type="checkbox"/> Code	C10. Medication management-oral medications: The ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.
Enter <input type="checkbox"/> Code	C11. Medication management-inhalant/mist medications: The ability to prepare and take all prescribed inhalant/mist medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.
Enter <input type="checkbox"/> Code	C12. Medication management-injectable medications: The ability to prepare and take all prescribed injectable medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.
Enter <input type="checkbox"/> Code	C13. Make light meal: The ability to plan and prepare all aspects of a light meal such as bowl of cereal or sandwich and cold drink, or reheat a prepared meal.
Enter <input type="checkbox"/> Code	C14. Wipe down surface: The ability to use a damp cloth to wipe down surface such as table top or bench to remove small amounts of liquid or crumbs. Includes ability to clean cloth of debris in patient’s customary manner.
Enter <input type="checkbox"/> Code	C15. Light shopping: Once at store, can locate and select up to five needed goods, take to check out, and complete purchasing transaction.
Enter <input type="checkbox"/> Code	C16. Laundry: Includes all aspects of completing a load of laundry using a washer and dryer. Includes sorting, loading and unloading, and adding laundry detergent.
Enter <input type="checkbox"/> Code	C17. Use public transportation: The ability to plan and use public transportation. Includes boarding, riding, and alighting from transportation.

Enter Code in Boxes

P. Patient Refused

T.VI How long did it take you to complete this section? _____ (minutes)

VII. Overall Plan of Care/Advance Care

A. Overall Plan of Care/Advance Care Directives

Enter <input type="checkbox"/> Code	<p>A1. Have the patient (or representative) and the care team (or physician) documented agreed-upon care goals and expected dates of completion or re-evaluation?</p> <p>0. No, but this work is in process 1. Yes 9. Unclear or unknown</p>	Check all that apply <input type="checkbox"/> <input type="checkbox"/>	<p>A3. In anticipation of serious clinical complications, has the patient made and documented care decisions?</p> <p>1. The patient has designated and documented a decision-maker (if the patient is unable to make decisions). 2. The patient (or surrogate) has made and documented a decision to forgo resuscitation.</p>
Enter <input type="checkbox"/> Code	<p>A2. Which description best fits the patient's overall status?</p> <p>1. The patient is stable with no risk for serious complications and death (beyond those typical of the patient's age). 2. The patient is temporarily facing high health risks but likely to return to being stable without risk for serious complications and death (beyond those typical of the patient's age). 3. The patient is likely to remain in fragile health and have ongoing high risks of serious complications and death. 4. The patient has serious progressive conditions that could lead to death within a year. 9. The patient's situation is unknown or unclear to the respondent.</p>		

T.VIII How long did it take you to complete this section? _____ (minutes)

VIII. Discharge Status

A. Discharge Information: Items with an asterisk (*) relating to assistance/support needs and caregiver availability are also included in home health admission assessments.

A1. Discharge Date

/ /
 MM DD YYYY

A6. Willing Caregiver(s)*

A2. Attending Physician

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

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

A3. Discharge Location

Where will the patient be discharged to?

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

A7. Types of Caregiver(s)*

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

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

A4. * Frequency of Assistance at Discharge (or admission for HH)

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

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

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

B1. * Patient Lives With at Discharge (or admission for HH)

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

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

A5. Caregiver(s) Availability

Enter <input type="checkbox"/> Code	<p>Was the discharge destination decision influenced by the availability of a family member or friend to provide assistance?</p> <p>0. No (<i>If No, skip to Section B. Residential Information.</i>)</p> <p>1. Yes</p>
---	--

VIII. Discharge Status (cont.)

C. Support Needs/Caregiver Assistance*

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

VIII. Discharge Status (cont.)

D. Discharge Care Options

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

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

VIII. Discharge Status (cont.)

E. Discharge Location Information

Enter

Code

- E1.** Is the patient being discharged with referral for additional services?
0. No (If No, skip to E7. Discharge Delay.)
1. Yes (If yes, please identify the name, location, and type of service to which the patient is discharged.)

E2. Provider's Name

E4. Provider City

Enter

Code

E3. Provider Type

1. Home Health Care (HHA)
2. Skilled Nursing Facility (SNF)
3. Inpatient Rehabilitation Hospital (IRF)
4. Long-Term Care Hospital (LTCH)
5. Psychiatric Hospital
6. Outpatient Services
7. Acute Hospital
8. Hospice
9. LTC Nursing Facility
10. Other (specify) _____

E5. Provider State

E6. Medicare Provider's Identification Number

E7. Discharge Delay

E8. Reason for Discharge Delay

Enter

Code

- Was the patient's discharge delayed for at least 24 hours?
0. No
1. Yes

Enter

Code

1. No bed available
2. Services, equipment or medications not available (e.g., home health care, durable medical equipment, IV medications)
3. Family/support (e.g., family could not pick patient up)
4. Medical (patient condition changed)
5. Other (specify) _____

E9. In the situation that the patient or an authorized representative has requested this information

not be shared with the next provider, check here:

T.IX How long did it take you to complete this section? _____ (minutes)

IX. Medical Coding

Coders:

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

A. Principal Diagnosis

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

A1. ICD-9 CM code for Principal Diagnosis at Assessment <input type="text" value=" _ _ _ . _ _ "/>	A2. If Principal Diagnosis was a V-code, what was the ICD-9 CM code for the primary medical condition or injury being treated? <input type="text" value=" _ _ _ . _ _ "/>
A1a. Principal Diagnosis at Assessment <input type="text"/>	A2a. If Principal Diagnosis was a V-code, what was the primary medical condition or injury being treated? <input type="text"/>

B. Other Diagnoses, Comorbidities, and Complications

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

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

Enter <input type="checkbox"/> Code	B16. Is this list complete? 0. No 1. Yes
---	---

IX. Medical Coding Information

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

Enter <input type="checkbox"/> Code	C1. Did the patient have one or more major procedures (diagnostic, surgical, and therapeutic interventions) during this admission? 0. No (If No , skip section) 1. Yes
---	--

List up to 15 **ICD-9 CM codes** and associated procedures (diagnostic, surgical, and therapeutic interventions) performed during this admission.

	ICD-9 CM code	Procedure
C1a.	_ _ . _ _	C1b.
C2a.	_ _ . _ _	C2b.
C3a.	_ _ . _ _	C3b.
C4a.	_ _ . _ _	C4b.
C5a.	_ _ . _ _	C5b.
C6a.	_ _ . _ _	C6b.
C7a.	_ _ . _ _	C7b.
C8a.	_ _ . _ _	C8b.
C9a.	_ _ . _ _	C9b.
C10a.	_ _ . _ _	C10b.
C11a.	_ _ . _ _	C11b.
C12a.	_ _ . _ _	C12b.
C13a.	_ _ . _ _	C13b.
C14a.	_ _ . _ _	C14b.
C15a.	_ _ . _ _	C15b.

Enter <input type="checkbox"/> Code	C16. Is this list complete? 0. No 1. Yes
---	---

X. Other Useful Information

A1. Is there other useful information about this patient that you want to add?

XI. Feedback

A. Notes

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