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INPATIENT REHABILITATION FACILITY - PATIENT ASSESSMENT INSTRUMENT

Identification Information*

1. Facility Information

   A. Facility Name

   _____
   _____
   _____
   _____
   _____

   B. Facility Medicare Provider Number _____

2. Patient Medicare Number _____

3. Patient Medicaid Number _____

4. Patient First Name _____

5A. Patient Last Name _____

5B. Patient Identification Number _____

6. Birth Date ____/____/_____
   MM / DD / YYYY

7. Social Security Number _____

8. Gender (*1 - Male; 2 - Female*) _____

9. Race/Ethnicity (*Check all that apply*)

   American Indian or Alaska Native A. _____
   Asian B. _____
   Black or African American C. _____
   Hispanic or Latino D. _____
   Native Hawaiian or Other Pacific Islander E. _____
   White F. _____

10. Marital Status _____
    (1 - Never Married; 2 - Married; 3 - Widowed; 4 - Separated; 5 - Divorced)

11. Zip Code of Patient's Pre-Hospital Residence _____

12. Admission Date ____/____/_____
    MM / DD / YYYY

13. Assessment Reference Date ____/____/_____
    MM / DD / YYYY

14. Admission Class
    (1 - Initial Rehab; 2 - Evaluation; 3 - Readmission; 4 - Unplanned Discharge; 5 - Continuing Rehabilitation)

15A. Admit From
(01- Home (private home/apt., board/care, assisted living, group home, transitional living); 02- Short-term General Hospital; 03 - Skilled Nursing Facility (SNF); 04 - Intermediate care; 06 - Home under care of organized home health service organization; 50 - Hospice (home); 51 - Hospice (institutional facility); 61 - Swing bed; 62 - Another Inpatient Rehabilitation Facility; 63 - Long-Term Care Hospital (LTCH); 64 - Medicaid Nursing Facility; 65 - Inpatient Psychiatric Facility; 66 - Critical Access Hospital; 99 - Not Listed)

16A. Pre-hospital Living Setting _____
Use codes from 15A. Admit From

17. Pre-hospital Living With _____
(Code only if item 16A is 01- Home: Code using 01 - Alone; 02 - Family/Relatives; 03 - Friends; 04 - Attendant; 05 - Other)

18. DELETED

19. DELETED

Payer Information*

20. Payment Source
(02 - Medicare Fee For Service; 51- Medicare-Medicare Advantage; 99 - Not Listed)

   A. Primary Source _____

   B. Secondary Source _____

Medical Information*

21. Impairment Group _____ _____
    Admission Discharge

    Condition requiring admission to rehabilitation; code according to Appendix A.

22. Etiologic Diagnosis (*Use ICD codes to indicate the etiologic problem that led to the condition for which the patient is receiving rehabilitation*)
    A. ___.___
    B. _____
    C. _____

23. Date of Onset of Impairment ____/____/_____
    MM / DD / YYYY

24. Comorbid Conditions

    Use ICD codes to enter comorbid medical conditions

A. _____	J. _____	S. _____
B. _____	K. _____	T. _____
C. _____	L. _____	U. _____
D. _____	M. _____	V. _____
E. _____	N. _____	W. _____
F. _____	O. _____	X. _____
G. _____	P. _____	Y. _____
H. _____	Q. _____	
I. _____	R. _____	

24A. Are there any arthritis conditions recorded in items #21, #22, or #24 that meet all of the regulatory requirements for IRF classification (in 42 CFR 412.29(b)(2)(x), (xi), and (xii))? _____ _____
(0 - No; 1 - Yes)

25. DELETED

26. DELETED

Height and Weight

(While measuring if the number is X.1-X.4 round down, X.5 or greater round up)

25A. Height on admission (in inches) _____

26A. Weight on admission (in pounds) _____
Measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, with shoes off, etc.)

27. DELETED

28. DELETED

Function Modifiers*

Complete the following specific functional items prior to scoring the FIM™ Instrument:

		Admission	Discharge
29.	Bladder Level of Assistance (Score using FIM Levels 1 - 7)	☐	☐
30.	Bladder Frequency of Accidents (Score as below)	☐	☐

7 - No accidents
6 - No accidents; uses device such as a catheter
5 - One accident in the past 7 days
4 - Two accidents in the past 7 days
3 - Three accidents in the past 7 days
2 - Four accidents in the past 7 days
1 - Five or more accidents in the past 7 days

Enter in Item 39G (Bladder) the lower *(more dependent) score from Items 29 and 30 above*

		Admission	Discharge
31.	Bowel Level of Assistance (Score using FIM Levels 1 - 7)	☐	☐
32.	Bowel Frequency of Accidents (Score as below)	☐	☐

7 - No accidents
6 - No accidents; uses device such as a ostomy
5 - One accident in the past 7 days
4 - Two accidents in the past 7 days
3 - Three accidents in the past 7 days
2 - Four accidents in the past 7 days
1 - Five or more accidents in the past 7 days

Enter in Item 39H (Bowel) the lower (more dependent) score of Items 31and 32 above.

		Admission	Discharge
33.	Tub Transfer	☐	☐
34.	Shower Transfer	☐	☐

(Score Items 33 and 34 using FIM Levels 1 - 7; use 0 if activity does not occur) *See training manual for scoring of Item 39K (Tub/Shower Transfer)*

		Admission	Discharge
35.	Distance Walked	☐	☐
36.	Distance Traveled in Wheelchair	☐	☐

(Code items 35 and 36 using: 3 - 150 feet; 2 - 50 to 149 feet; 1 - Less than 50 feet; 0 – activity does not occur)

		Admission	Discharge
37.	Walk	☐	☐
38.	Wheelchair	☐	☐

(Score Items 37 and 38 using FIM Levels 1 - 7; 0 if activity does not occur) See training manual for scoring of Item 39L (Walk/Wheelchair)

39. FIM™ Instrument*

		Admission	Discharge	Goal
SELF-CARE				
A.	Eating	☐	☐	☐
B.	Grooming	☐	☐	☐
C.	Bathing	☐	☐	☐
D.	Dressing - Upper	☐	☐	☐
E.	Dressing - Lower	☐	☐	☐
F.	Toileting	☐	☐	☐
SPHINCTER CONTROL				
G.	Bladder	☐	☐	☐
H.	Bowel	☐	☐	☐
TRANSFERS				
I.	Bed, Chair, Wheelchair	☐	☐	☐
J.	Toilet	☐	☐	☐
K.	Tub, Shower	☐	☐	☐
LOCOMOTION	(W - Walk, C - Wheelchair, B - Both)			
L.	Walk/Wheelchair	☐☐	☐☐	☐
M.	Stairs	☐	☐	☐
COMMUNICATION	(A - Auditory, V - Visual, B - Both)			
N.	Comprehension	☐☐	☐☐	☐
O.	Expression	☐☐	☐☐	☐
	(V - Vocal, N - Nonvocal, B - Both)			
SOCIAL COGNITION				
P.	Social Interaction	☐	☐	☐
Q.	Problem Solving	☐	☐	☐
R.	Memory	☐	☐	☐

FIM LEVELS

No Helper

7 Complete Independence (Timely, Safely)
6 Modified Independence (Device)

Helper - Modified Dependence

5 Supervision (Subject = 100%)
4 Minimal Assistance (Subject = 75% or more)
3 Moderate Assistance (Subject = 50% or more)

Helper - Complete Dependence

2 Maximal Assistance (Subject = 25% or more)
1 Total Assistance (Subject less than 25%)

0 Activity does not occur; Use this code only at admission

Discharge Information*

40. Discharge Date ____/____/_____
MM / DD / YYYY

41. Patient discharged against medical advice? _____
(0 - No; 1 - Yes)

42. Program Interruption(s) _____
(0 - No; 1 - Yes)

43. Program Interruption Dates
(Code only if item 42 is 1 - Yes)

A. 1st Interruption Date
MM / DD / YYYY

B. 1st Return Date
MM / DD / YYYY

C. 2nd Interruption Date
MM / DD / YYYY

D. 2nd Return Date
MM / DD / YYYY

E. 3rd Interruption Date
MM / DD / YYYY

F. 3rd Return Date
MM / DD / YYYY

44C. Was the patient discharged alive? _____
(0 - No; 1 - Yes)

44D. Patient's discharge destination/living setting, using codes below: (answer only if 44C = 1; if 44C = 0, skip to item 46)

_____

(01- Home (private home/apt., board/care, assisted living, group home, transitional living); 02- Short-term General Hospital; 03 - Skilled Nursing Facility (SNF); 04 - Intermediate care; 06 - Home under care of organized home health service organization; 50 - Hospice (home); 51 - Hospice (institutional facility); 61 - Swing bed; 62 - Another Inpatient Rehabilitation Facility; 63 - Long-Term Care Hospital (LTCH); 64 - Medicaid Nursing Facility; 65 - Inpatient Psychiatric Facility; 66 - Critical Access Hospital; 99 - Not Listed)

45. Discharge to Living With _____
(Code only if item 44C is 1 - Yes and 44D is 01 - Home; Code using 1 - Alone; 2 - Family / Relatives; 3 - Friends; 4 - Attendant; 5 - Other)

46. Diagnosis for Interruption or Death _____
(Code using ICD code)

47. Complications during rehabilitation stay
(Use ICD codes to specify up to six conditions that began with this rehabilitation stay)

A. _____ B. _____
C. _____ D. _____
E. _____ F. _____

* The FIM data set, measurement scale and impairment codes incorporated or referenced herein are the property of U B Foundation Activities, Inc. © 1993, 2001 U B Foundation Activities, Inc. The FIM mark is owned by UBFA, Inc.

Therapy Information

O0401. Week 1: Total Number of Minutes Provided

O0401A: Physical Therapy
a. Total minutes of individual therapy _____
b. Total minutes of concurrent therapy _____
c. Total minutes of group therapy _____
d. Total minutes of co-treatment therapy _____

O0401B: Occupational Therapy
a. Total minutes of individual therapy _____
b. Total minutes of concurrent therapy _____
c. Total minutes of group therapy _____
d. Total minutes of co-treatment therapy _____

O0401C: Speech-Language Pathology
a. Total minutes of individual therapy _____
b. Total minutes of concurrent therapy _____
c. Total minutes of group therapy _____
d. Total minutes of co-treatment therapy _____

O0402. Week 2: Total Number of Minutes Provided

O0402A: Physical Therapy
a. Total minutes of individual therapy _____
b. Total minutes of concurrent therapy _____
c. Total minutes of group therapy _____
d. Total minutes of co-treatment therapy _____

O0402B: Occupational Therapy
a. Total minutes of individual therapy _____
b. Total minutes of concurrent therapy _____
c. Total minutes of group therapy _____
d. Total minutes of co-treatment therapy _____

O0402C: Speech-Language Pathology
a. Total minutes of individual therapy _____
b. Total minutes of concurrent therapy _____
c. Total minutes of group therapy _____
d. Total minutes of co-treatment therapy _____

Patient _____ Identifier _____ Date _____

ADMISSION

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code ☐

Persistent vegetative state/no discernible consciousness

0. **No** → *Continue to B0200, Hearing*
1. **Yes** → *Skip to GG0100, Prior Functioning: Everyday Activities*

B0200. Hearing (3-day assessment period)

Enter Code ☐

Ability to Hear (with hearing aid or hearing appliances if normally used)

0. **Adequate:** No difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty:** Difficulty in some environments (e.g., when person speaks softly or setting is noisy)
2. **Moderate difficulty:** Speaker has to increase volume and speak distinctly
3. **Highly impaired:** Absence of useful hearing

B1000. Vision (3-day assessment period)

Enter Code ☐

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

0. **Adequate:** Sees fine detail, such as regular print in newspapers/books
1. **Impaired:** Sees large print, but not regular print in newspapers/books
2. **Moderately impaired:** Limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired:** Object identification in question, but eyes appear to follow objects
4. **Severely impaired:** No vision or sees only light, colors or shapes; eyes do not appear to follow objects

BB0700. Expression of Ideas and Wants (3-day assessment period)

Enter Code ☐

Expression of Ideas and Wants (consider both verbal and non-verbal expression and excluding language barriers)

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

BB0800. Understanding Verbal and Non-Verbal Content (3-day assessment period)

Enter Code ☐

Understanding Verbal and Non-Verbal Content (with hearing aid or device, if used, and 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**

Section C Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted? (3-day assessment period)
Attempt to conduct interview with all patients.

Enter Code ☐

0. **No** (patient is rarely/never understood) → *Skip to C0900, Memory/Recall Ability*
1. **Yes** → *Continue to C0200, Repetition of Three Words*

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code ☐

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 after first attempt

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

After the patient's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.

Patient _____ Identifier _____ Date _____

ADMISSION

Section C Cognitive Patterns

Brief Interview for Mental Status (BIMS) - Continued

C0300. Temporal Orientation (orientation to year, month, and day)

Enter Code ☐

Ask patient: *"Please tell me what year it is right now."*

A. Able to report correct year
3. **Correct**
2. **Missed by 1 year**
1. **Missed by 2 - 5 years**
0. **Missed by > 5 years** or no answer

Enter Code ☐

Ask patient: *"What month are we in right now?"*

B. Able to report correct month
2. **Accurate within 5 days**
1. **Missed by 6 days to 1 month**
0. **Missed by > 1 month** or no answer

Enter Code ☐

Ask patient: *"What day of the week is today?"*

C. Able to report correct day of the week
1. **Correct**
0. **Incorrect** or no answer

C0400. Recall

Enter Code ☐

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

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

Enter Code ☐

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

Enter Code ☐

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

C0500. BIMS Summary Score

Enter Score ☐☐

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the patient was unable to complete the interview

C0600. Should the Staff Assessment for Mental Status (C0900) be Conducted?

Enter Code ☐

0. **No** (patient was able to complete Brief Interview for Mental Status) → *Skip to C1310, Signs and Symptoms of Delirium*
1. **Yes** (patient was unable to complete Brief Interview for Mental Status) → *Continue to C0900, Memory/Recall Ability*

Patient _____ Identifier _____ Date _____

ADMISSION

Section C Cognitive Patterns

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed.

C0900. Memory/Recall Ability (3-day assessment period)

↓ **Check all that the patient was normally able to recall**

- ☐ **A. Current season**
- ☐ **B. Location of own room**
- ☐ **C. Staff names and faces**
- ☐ **E. That he or she is in a hospital/hospital unit**
- ☐ **Z. None of the above** were recalled

C1310. Signs and Symptoms of Delirium (from CAM©)

Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record (3-day assessment period).

A. Acute Onset Mental Status Change

Enter Code ☐

Is there evidence of an acute change in mental status from the patient's baseline?
0. **No**
1. **Yes**

Coding:
0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

↓ **Enter Code in Boxes**

- ☐ **B. Inattention -** Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
- ☐ **C. Disorganized Thinking -** Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
- ☐ **D. Altered Level of Consciousness -** Did the patient have altered level of consciousness as indicated by any of the following criteria?
  - ■ **vigilant** - startled easily to any sound or touch
  - ■ **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch
  - ■ **stuporous** - very difficult to arouse and keep aroused for the interview
  - ■ **comatose** - could not be aroused

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Section D Mood

D0150. Patient Health Questionnaire 2 (PHQ-2©)

Say to patient: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the patient: "About how often have you been bothered by this?"
Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence
0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)
9. **No response** (leave column 2 blank)

2. Symptom Frequency
0. **Never or 1 day**
1. **2-6 days** (several days)
2. **7-11 days** (half or more of the days)
3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things?*	☐	☐
B. *Feeling down, depressed, or hopeless?*	☐	☐

Patient _____ Identifier _____ Date _____

ADMISSION

Section E Behavioral Symptoms

E0200. Behavioral Symptom - Presence & Frequency
Note presence of symptoms and their frequency.

Coding:
0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

↓ Enter Code in Boxes	
☐	**A. Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
☐	**B. Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)
☐	**C. Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

Section GG Functional Abilities and Goals

GG0100. Prior Functioning: Everyday Activities. Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.

Coding:
3. **Independent** - Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
2. **Needed Some Help** - Patient needed partial assistance from another person to complete activities.
1. **Dependent** - A helper completed the activities for the patient.
8. **Unknown**
9. **Not Applicable**

↓ Enter Codes in Boxes	
☐	**A. Self-Care:** Code the patient's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.
☐	**B. Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
☐	**C. Stairs:** Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
☐	**D. Functional Cognition:** Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.

↓ Check all that apply	
☐	**A. Manual wheelchair**
☐	**B. Motorized wheelchair and/or scooter**
☐	**C. Mechanical lift**
☐	**D. Walker**
☐	**E. Orthotics/Prosthetics**
☐	**Z. None of the above**

Patient _____ Identifier _____ Date _____

ADMISSION

Section GG Functional Abilities and Goals

GG0130. Self-Care (3-day assessment period)

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code discharge goal(s).

Coding:

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

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **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.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

07. **Patient refused**
09. **Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
☐☐	☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	☐☐	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	☐☐	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	☐☐	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	☐☐	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Patient _____ Identifier _____ Date _____

ADMISSION

Section GG Functional Abilities and Goals

GG0170. Mobility (3-day assessment period)

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code discharge goal(s).

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

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **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.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:
07. **Patient refused**
09. **Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	☐☐	**G. 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.
☐☐	☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb).*
☐☐	☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Patient _____ Identifier _____ Date _____

ADMISSION

Section GG Functional Abilities and Goals

GG0170. Mobility (3-day assessment period) - Continued

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code discharge goal(s).

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

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **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.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:
07. **Patient refused**
09. **Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	☐☐	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step.
☐☐	☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail.
☐☐	☐☐	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	☐☐	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	☐	**Q1. Does the patient use a wheelchair and/or scooter?** 0. **No** → *Skip to H0350, Bladder Continence* 1. **Yes** → *Continue to GG0170R, Wheel 50 feet with two turns*
☐☐	☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	☐	**RR1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐☐	☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	☐	**SS1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

Patient _____ Identifier _____ Date _____

ADMISSION

Section H Bladder and Bowel

H0350. Bladder Continence (3-day assessment period)

Enter Code ☐

Bladder continence - Select the one category that best describes the patient.
0. **Always continent** (no documented incontinence)
1. **Stress incontinence only**
2. **Incontinent less than daily** (e.g., once or twice during the 3-day assessment period)
3. **Incontinent daily** (at least once a day)
4. **Always incontinent**
5. **No urine output** (e.g., renal failure)
9. **Not applicable** (e.g., indwelling catheter)

H0400. Bowel Continence (3-day assessment period)

Enter Code ☐

Bowel continence - Select the one category that best describes the patient.
0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** patient had an ostomy or did not have a bowel movement for the entire 3 days

Section I Active Diagnoses

Comorbidities and Co-existing Conditions

↓ **Check all that apply**

☐ **I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**

☐ **I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)

☐ **I7900. None of the above**

Section J Health Conditions

J1750. History of Falls

Enter Code ☐

Has the patient had two or more falls in the past year or any fall with injury in the past year?
0. **No**
1. **Yes**
8. **Unknown**

J2000. Prior Surgery

Enter Code ☐

Did the patient have major surgery during the **100 days prior to admission**?
0. **No**
1. **Yes**
8. **Unknown**

Patient _____ Identifier _____ Date _____

ADMISSION

Section K Swallowing/Nutritional Status

K0520. Nutritional Approaches

Check all of the following nutritional approaches that were performed during the first 3 days of admission.

	1. Performed during the first 3 days of admission Check all that apply ↓
A. Parenteral/IV feeding	☐
B. Feeding tube - nasogastric or abdominal (e.g., PEG)	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	☐
Z. None of the above	☐

Section M Skin Conditions

Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage.

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code ☐

Does this patient have one or more unhealed pressure ulcers/injuries?

0. **No** → *Skip to N2001, Drug Regimen Review*
1. **Yes** → *Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage*

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Enter Number ☐

A. Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

1. Number of Stage 1 pressure injuries

Enter Number ☐

B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.

1. Number of Stage 2 pressure ulcers

Enter Number ☐

C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

1. Number of Stage 3 pressure ulcers

Enter Number ☐

D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

1. Number of Stage 4 pressure ulcers

Enter Number ☐

E. Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device

1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device

Enter Number ☐

F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar

Enter Number ☐

G. Unstageable - Deep tissue injury

1. Number of unstageable pressure injuries presenting as deep tissue injury

Patient _____ Identifier _____ Date _____

ADMISSION

Section N Medications

N2001. Drug Regimen Review

Enter Code ☐

Did a complete drug regimen review identify potential clinically significant medication issues?

0. **No - No issues found during review** → *Skip to O0110, Special Treatments, Procedures, and Programs*
1. **Yes - Issues found during review** → *Continue to N2003, Medication Follow-up*
9. **NA - Patient is not taking any medications** → *Skip to O0110, Special Treatments, Procedures, and Programs*

N2003. Medication Follow-up

Enter Code ☐

Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/ recommended actions in response to the identified potential clinically significant medication issues?

0. **No**
1. **Yes**

Section O Special Treatments, Procedures, and Programs

O0100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the first 3 days of admission. For chemotherapy and dialysis, check if it is part of the patient's treatment plan.

	3. Performed during the first 3 days of admission Check all that apply ↓
Cancer Treatments	
A. Chemotherapy (if checked, please specify below)	☐
A2a. IV	☐
A3a. Oral	☐
A10a. Other	☐
B. Radiation	☐
Respiratory Treatments	
C. Oxygen Therapy (if checked, please specify below)	☐
C2a. Continuous	☐
C3a. Intermittent	☐
D. Suctioning (if checked, please specify below)	☐
D2a. Scheduled	☐
D3a. As needed	☐
E. Tracheostomy Care	☐
F. Invasive Mechanical Ventilator	☐
G. Non-invasive Mechanical Ventilator (BiPAP/CPAP) (if checked, please specify below)	☐
G2a. BiPAP	☐
G3a. CPAP	☐

Patient _____ Identifier _____ Date _____

ADMISSION

Section O Special Treatments, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the first 3 days of admission. For chemotherapy and dialysis, check if it is part of the patient's treatment plan.

	3. Performed during the first 3 days of admission Check all that apply ↓
Other Treatments	
H. IV Medications (if checked, please specify below)	☐
H3a. Antibiotics	☐
H4a. Anticoagulation	☐
H10a. Other	☐
I. Transfusions	☐
J. Dialysis (if checked, please specify below)	☐
J2a. Hemodialysis	☐
J3a. Peritoneal dialysis	☐
O. IV Access (if checked, please specify below)	☐
O2a. Peripheral IV	☐
O3a. Midline	☐
O4a. Central line (e.g., PICC, tunneled, port)	☐
O10a. Other	☐
None of the Above	
Z. None of the above	☐

Patient _____ Identifier _____ Date _____

DISCHARGE

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code ☐

Persistent vegetative state/no discernible consciousness

0. **No** → *Continue to C1310, Signs and Symptoms of Delirium*
1. **Yes** → *Skip to GG0130, Self-Care*

Section C Cognitive Patterns

C1310. Signs and Symptoms of Delirium (from CAM©) (within the last 7 days)

A. Acute Onset Mental Status Change

Enter Code ☐

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

0. **No**
1. **Yes**

Coding:

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

↓ **Enter Code in Boxes**

☐	**B. Inattention -** Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
☐	**C. Disorganized Thinking -** Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
☐	**D. Altered Level of Consciousness -** Did the patient have altered level of consciousness as indicated by any of the following criteria? ■ **vigilant** - startled easily to any sound or touch ■ **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch ■ **stuporous** - very difficult to arouse and keep aroused for the interview ■ **comatose** - could not be aroused

Patient _____ Identifier _____ Date _____

DISCHARGE

Section D Mood

D0150. Patient Health Questionnaire 2 (PHQ-2©)

Say to patient: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*
If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the patient: "About how often have you been bothered by this?"
Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence 0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) 9. **No response** (leave column 2 blank)	**2. Symptom Frequency** 0. **Never or 1 day** 1. **2-6 days** (several days) 2. **7-11 days** (half or more of the days) 3. **12-14 days** (nearly every day)	**1. Symptom Presence**	**2. Symptom Frequency**
		↓ **Enter Scores in Boxes** ↓	
A. *Little interest or pleasure in doing things?*		☐	☐
B. *Feeling down, depressed, or hopeless?*		☐	☐

Section E Behavioral Symptoms

E0200. Behavioral Symptom - Presence & Frequency

Note presence of symptoms and their frequency.

Coding:
0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

↓ **Enter Code in Boxes**	
☐	**A. Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
☐	**B. Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)
☐	**C. Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

Patient _____ Identifier _____ Date _____

DISCHARGE

Section GG Functional Abilities and Goals

GG0130. Self-Care (3-day assessment period)

Code the patient's usual performance at discharge for each activity using the 6-point scale. If activity was not attempted at discharge, code the reason.

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

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **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.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:
07. **Patient refused**
09. **Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance **Enter Codes in Boxes ↓**	
☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Patient _____ Identifier _____ Date _____

DISCHARGE

Section GG Functional Abilities and Goals

GG0170. Mobility (3-day assessment period)

Code the patient's usual performance at discharge for each activity using the 6-point scale. If activity was not attempted at discharge, code the reason.

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

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **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.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:
07. **Patient refused**
09. **Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance Enter Codes in Boxes ↓	
☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	**G. 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.
☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb).*
☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Patient _____ Identifier _____ Date _____

DISCHARGE

Section GG Functional Abilities and Goals

GG0170. Mobility (3-day assessment period) - Continued

Code the patient's usual performance at discharge for each activity using the 6-point scale. If activity was not attempted at discharge, code the reason.

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

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **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.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:
07. **Patient refused**
09. **Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance **Enter Codes in Boxes ↓**	
☐☐	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step.
☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail.
☐☐	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	☐ **Q3. Does the patient use a wheelchair and/or scooter?** 0. **No** → *Skip to J1800, Any Falls Since Admission* 1. **Yes** → *Continue to GG0170R, Wheel 50 feet with two turns*
☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	☐ **RR3. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	☐ **SS3. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

Patient _____ Identifier _____ Date _____

DISCHARGE

Section J Health Conditions

J1800. Any Falls Since Admission

Enter Code ☐

Has the patient **had any falls since admission?**

0. **No** → *Skip to K0520, Nutritional Approaches*
1. **Yes** → *Continue to J1900, Number of Falls Since Admission*

J1900. Number of Falls Since Admission

Coding:
0. None
1. One
2. Two or more

Enter Codes in Boxes

☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
☐	**C. Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Section K Swallowing/Nutritional Status

K0520. Nutritional Approaches

Check all of the following nutritional approaches that were performed during the last 7 days.

	2. Performed during the last 7 days — **Check all that apply**
A. Parenteral/IV feeding	☐
B. Feeding tube - nasogastric or abdominal (e.g., PEG)	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	☐
Z. None of the above	☐

Section M Skin Conditions

Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage.

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code ☐

Does this patient have one or more unhealed pressure ulcers/injuries?

0. **No** → *Skip to N2005, Medication Intervention*
1. **Yes** → *Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage*

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Enter Number ☐

A. Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

1. Number of Stage 1 pressure injuries

Patient _____ Identifier _____ Date _____

DISCHARGE

Section M Skin Conditions

Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage.

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued

Enter Number ☐

B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.

1. **Number of Stage 2 pressure ulcers**
   If 0 → Skip to M0300C, Stage 3
2. **Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

Enter Number ☐

Enter Number ☐

C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

1. **Number of Stage 3 pressure ulcers**
   If 0 → Skip to M0300D, Stage 4
2. **Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

Enter Number ☐

Enter Number ☐

D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

1. **Number of Stage 4 pressure ulcers**
   If 0 → Skip to M0300E, Unstageable - Non-removable dressing/device
2. **Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

Enter Number ☐

Enter Number ☐

E. Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device

1. **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device**
   If 0 → Skip to M0300F, Unstageable - Slough and/or eschar
2. **Number of <u>these</u> unstageable pressure ulcers/injuries that were present upon admission** - enter how many were noted at the time of admission

Enter Number ☐

Enter Number ☐

F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**
   If 0 → Skip to M0300G, Unstageable - Deep tissue injury
2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

Enter Number ☐

Enter Number ☐

G. Unstageable - Deep tissue injury

1. **Number of unstageable pressure injuries presenting as deep tissue injury**
   If 0 → Skip to N2005, Medication Intervention
2. **Number of <u>these</u> unstageable pressure injuries that were present upon admission** - enter how many were noted at the time of admission

Section N Medications

N2005. Medication Intervention

Enter Code ☐

Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?

0. **No**
1. **Yes**
9. **NA - There were no potential clinically significant medication issues identified since admission or patient is not taking any medications.**

Patient _____ Identifier _____ Date _____

DISCHARGE

Section O Special Treatments, Procedures, and Programs

O0100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the last 14 days.

	4. Performed during the last 14 days Check all that apply ↓
Cancer Treatments	
A. Chemotherapy (if checked, please specify below)	☐
A2a. IV	☐
A3a. Oral	☐
A10a. Other	☐
B. Radiation	☐
Respiratory Treatments	
C. Oxygen Therapy (if checked, please specify below)	☐
C2a. Continuous	☐
C3a. Intermittent	☐
D. Suctioning (if checked, please specify below)	☐
D2a. Scheduled	☐
D3a. As needed	☐
E. Tracheostomy Care	☐
F. Invasive Mechanical Ventilator	☐
G. Non-invasive Mechanical Ventilator (BiPAP/CPAP) (if checked, please specify below)	☐
G2a. BiPAP	☐
G3a. CPAP	☐
Other Treatments	
H. IV Medications (if checked, please specify below)	☐
H3a. Antibiotics	☐
H4a. Anticoagulation	☐
H10a. Other	☐
I. Transfusions	☐
J. Dialysis (if checked, please specify below)	☐
J2a. Hemodialysis	☐
J3a. Peritoneal dialysis	☐
O. IV Access (if checked, please specify below)	☐
O2a. Peripheral IV	☐
O3a. Midline	☐
O4a. Central line (e.g., PICC, tunneled, port)	☐
O10a. Other	☐
None of the Above	
Z. None of the above	☐

Patient _____ Identifier _____ Date _____

DISCHARGE

Section O Special Treatments, Procedures, and Programs

O0250. Influenza Vaccine - Refer to current version of IRF-PAI Training Manual for current influenza vaccination season and reporting period.

Enter Code ☐

A. Did the **patient receive the influenza vaccine *in this facility*** for this year's influenza vaccination season?

0. **No** → *Skip to O0250C, If influenza vaccine not received, state reason*
1. **Yes** → *Continue to O0250B, Date influenza vaccine received*

B. Date influenza vaccine received → *Complete date and skip to Z0400A, Signature of Persons Completing the Assessment*

☐☐ - ☐☐ - ☐☐☐☐
M M D D Y Y Y Y

Enter Code ☐

C. If influenza vaccine not received, state reason:

1. **Patient not in this facility** during this year's influenza vaccination season
2. **Received outside of this facility**
3. **Not eligible -** medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain influenza vaccine** due to a declared shortage
9. **None of the above**

Item Z0400A. Signature of Persons Completing the Assessment*			
I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that patients receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information.			
Signature	**Title**	**Date Information is Provided**	**Time**
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			