

### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0842**. The time required to complete this information collection is estimated to average **54.5 minutes** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Identification Information*	Payer Information*																											
<p>1. Facility Information</p> <p>A. Facility Name _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>B. Facility Medicare Provider Number _____</p> <p>2. Patient Medicare Number _____</p> <p>3. Patient Medicaid Number _____</p> <p>4. Patient First Name _____</p> <p>5A. Patient Last Name _____</p> <p>5B. Patient Identification Number _____</p> <p>6. Birth Date _____</p> <p style="text-align: center;">MM / DD / YYYY</p> <p>7. Social Security Number _____</p> <p>8. Gender (1 - Male; 2 - Female) _____</p> <p>9. Race/Ethnicity (Check all that apply)</p> <p style="padding-left: 40px;">American Indian or Alaska Native A. _____</p> <p style="padding-left: 80px;">Asian B. _____</p> <p style="padding-left: 40px;">Black or African American C. _____</p> <p style="padding-left: 40px;">Hispanic or Latino D. _____</p> <p style="padding-left: 40px;">Native Hawaiian or Other Pacific Islander E. _____</p> <p style="padding-left: 40px;">White F. _____</p> <p>10. Marital Status _____</p> <p>(1 - Never Married; 2 - Married; 3 - Widowed; 4 - Separated; 5 - Divorced)</p> <p>11. Zip Code of Patient's Pre-Hospital Residence _____</p> <p>12. Admission Date _____</p> <p style="text-align: center;">MM / DD / YYYY</p> <p>13. Assessment Reference Date _____</p> <p style="text-align: center;">MM / DD / YYYY</p> <p>14. Admission Class _____</p> <p>(1 - Initial Rehab; 2 - Evaluation; 3 - Readmission; 4 - Unplanned Discharge; 5 - Continuing Rehabilitation)</p> <p>15A. Admit From _____</p> <p>(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)</p> <p>16A. Pre-hospital Living Setting _____</p> <p>Use codes from 15A. Admit From</p> <p>17. Pre-hospital Living With _____</p> <p>(Code only if item 16A is 01- Home: Code using 01 - Alone; 02 - Family/Relatives; 03 - Friends; 04 - Attendant; 05 - Other)</p> <p>18. DELETED</p> <p>19. DELETED</p>	<p>20. Payment Source _____</p> <p>(02 - Medicare Fee For Service; 51- Medicare-Medicare Advantage; 99 - Not Listed)</p> <p>A. Primary Source _____</p> <p>B. Secondary Source _____</p>																											
Medical Information*																												
<p>21. Impairment Group _____</p> <p style="text-align: right;">Admission      Discharge</p> <p>Condition requiring admission to rehabilitation; code according to Appendix A.</p> <p>22. Etiologic Diagnosis _____</p> <p>(Use ICD codes to indicate the etiologic problem that led to the condition for which the patient is receiving rehabilitation)</p> <p style="text-align: right;">A. _____ B. _____ C. _____</p> <p>23. Date of Onset of Impairment _____</p> <p style="text-align: right;">MM / DD / YYYY</p> <p>24. Comorbid Conditions _____</p> <p>Use ICD codes to enter comorbid medical conditions</p> <table style="width: 100%; border: none;"> <tr> <td>A. _____</td> <td>J. _____</td> <td>S. _____</td> </tr> <tr> <td>B. _____</td> <td>K. _____</td> <td>T. _____</td> </tr> <tr> <td>C. _____</td> <td>L. _____</td> <td>U. _____</td> </tr> <tr> <td>D. _____</td> <td>M. _____</td> <td>V. _____</td> </tr> <tr> <td>E. _____</td> <td>N. _____</td> <td>W. _____</td> </tr> <tr> <td>F. _____</td> <td>O. _____</td> <td>X. _____</td> </tr> <tr> <td>G. _____</td> <td>P. _____</td> <td>Y. _____</td> </tr> <tr> <td>H. _____</td> <td>Q. _____</td> <td></td> </tr> <tr> <td>I. _____</td> <td>R. _____</td> <td></td> </tr> </table> <p>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))? _____</p> <p style="text-align: right;">(0 - No; 1 - Yes)</p> <p>25. DELETED</p> <p>26. DELETED</p> <p>Height and Weight</p> <p>(While measuring if the number is X.1-X.4 round down, X.5 or greater round up)</p> <p>25A. Height on admission (in inches) _____</p> <p>26A. Weight on admission (in pounds) _____</p> <p>Measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, with shoes off, etc.)</p> <p>27. Swallowing Status _____</p> <p style="text-align: right;">Admission      Discharge</p> <p>3- <u>Regular Food</u>: solids and liquids swallowed safely without supervision or modified food consistency</p> <p>2- <u>Modified Food Consistency/Supervision</u>: subject requires modified food consistency and/or needs supervision for safety</p> <p>1- <u>Tube/Parenteral Feeding</u>: tube/parenteral feeding used wholly or partially as a means of sustenance</p> <p>28. DELETED</p>	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. _____		
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. _____																											

Function Modifiers*	39. FIM™ Instrument*																																																																																																																																																																																																	
<p><b>Complete the following specific functional items prior to scoring the FIM™ Instrument:</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Admission</th> <th style="width: 10%; text-align: center;">Discharge</th> </tr> </thead> <tbody> <tr> <td>29. Bladder Level of Assistance (Score using FIM Levels 1 - 7)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>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 <i>Enter in Item 39G (Bladder) the lower (more dependent) score from Items 29 and 30 above</i></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Admission</th> <th style="width: 10%; text-align: center;">Discharge</th> </tr> <tr> <td>31. Bowel Level of Assistance (Score using FIM Levels 1 - 7)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>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 <i>Enter in Item 39H (Bowel) the lower (more dependent) score of Items 31 and 32 above.</i></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Admission</th> <th style="width: 10%; text-align: center;">Discharge</th> </tr> <tr> <td>33. Tub Transfer</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>34. Shower Transfer (Score Items 33 and 34 using FIM Levels 1 - 7; use 0 if activity does not occur) <i>See training manual for scoring of Item 39K (Tub/Shower Transfer)</i></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Admission</th> <th style="width: 10%; text-align: center;">Discharge</th> </tr> <tr> <td>35. Distance Walked</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>36. Distance Traveled in Wheelchair <i>(Code items 35 and 36 using: 3 - 150 feet; 2 - 50 to 149 feet; 1 - Less than 50 feet; 0 - activity does not occur)</i></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Admission</th> <th style="width: 10%; text-align: center;">Discharge</th> </tr> <tr> <td>37. Walk</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>38. Wheelchair <i>(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)</i></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>		Admission	Discharge	29. Bladder Level of Assistance (Score using FIM Levels 1 - 7)	<input type="checkbox"/>	<input type="checkbox"/>	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 <i>Enter in Item 39G (Bladder) the lower (more dependent) score from Items 29 and 30 above</i>	<input type="checkbox"/>	<input type="checkbox"/>		Admission	Discharge	31. Bowel Level of Assistance (Score using FIM Levels 1 - 7)	<input type="checkbox"/>	<input type="checkbox"/>	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 <i>Enter in Item 39H (Bowel) the lower (more dependent) score of Items 31 and 32 above.</i>	<input type="checkbox"/>	<input type="checkbox"/>		Admission	Discharge	33. Tub Transfer	<input type="checkbox"/>	<input type="checkbox"/>	34. Shower Transfer (Score Items 33 and 34 using FIM Levels 1 - 7; use 0 if activity does not occur) <i>See training manual for scoring of Item 39K (Tub/Shower Transfer)</i>	<input type="checkbox"/>	<input type="checkbox"/>		Admission	Discharge	35. Distance Walked	<input type="checkbox"/>	<input type="checkbox"/>	36. Distance Traveled in Wheelchair <i>(Code items 35 and 36 using: 3 - 150 feet; 2 - 50 to 149 feet; 1 - Less than 50 feet; 0 - activity does not occur)</i>	<input type="checkbox"/>	<input type="checkbox"/>		Admission	Discharge	37. Walk	<input type="checkbox"/>	<input type="checkbox"/>	38. Wheelchair <i>(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)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 10%; text-align: center;">Admission</th> <th style="width: 10%; text-align: center;">Discharge</th> <th style="width: 10%; text-align: center;">Goal</th> </tr> </thead> <tbody> <tr> <td colspan="4"><b>SELF-CARE</b></td> </tr> <tr> <td>A. Eating</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>B. Grooming</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>C. Bathing</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>D. Dressing - Upper</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>E. Dressing - Lower</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>F. Toileting</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="4"><b>SPHINCTER CONTROL</b></td> </tr> <tr> <td>G. Bladder</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>H. Bowel</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="4"><b>TRANSFERS</b></td> </tr> <tr> <td>I. Bed, Chair, Wheelchair</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>J. Toilet</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>K. Tub, Shower</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="4"><b>LOCOMOTION</b></td> </tr> <tr> <td>L. Walk/Wheelchair</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>M. Stairs</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="4"><b>COMMUNICATION</b></td> </tr> <tr> <td>N. Comprehension</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>O. Expression</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="4"><b>SOCIAL COGNITION</b></td> </tr> <tr> <td>P. Social Interaction</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Q. Problem Solving</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>R. Memory</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="4"><b>FIM LEVELS</b></td> </tr> <tr> <td colspan="4"><i>No Helper</i></td> </tr> <tr> <td>7</td> <td colspan="3">Complete Independence (Timely, Safely)</td> </tr> <tr> <td>6</td> <td colspan="3">Modified Independence (Device)</td> </tr> <tr> <td colspan="4"><i>Helper - Modified Dependence</i></td> </tr> <tr> <td>5</td> <td colspan="3">Supervision (Subject = 100%)</td> </tr> <tr> <td>4</td> <td colspan="3">Minimal Assistance (Subject = 75% or more)</td> </tr> <tr> <td>3</td> <td colspan="3">Moderate Assistance (Subject = 50% or more)</td> </tr> <tr> <td colspan="4"><i>Helper - Complete Dependence</i></td> </tr> <tr> <td>2</td> <td colspan="3">Maximal Assistance (Subject = 25% or more)</td> </tr> <tr> <td>1</td> <td colspan="3">Total Assistance (Subject less than 25%)</td> </tr> <tr> <td>0</td> <td colspan="3">Activity does not occur; Use this code only at admission</td> </tr> </tbody> </table>		Admission	Discharge	Goal	<b>SELF-CARE</b>				A. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	B. Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D. Dressing - Upper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E. Dressing - Lower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F. Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>SPHINCTER CONTROL</b>				G. Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H. Bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>TRANSFERS</b>				I. Bed, Chair, Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	J. Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	K. Tub, Shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>LOCOMOTION</b>				L. Walk/Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M. Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>COMMUNICATION</b>				N. Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O. Expression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>SOCIAL COGNITION</b>				P. Social Interaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Q. Problem Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R. Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>FIM LEVELS</b>				<i>No Helper</i>				7	Complete Independence (Timely, Safely)			6	Modified Independence (Device)			<i>Helper - Modified Dependence</i>				5	Supervision (Subject = 100%)			4	Minimal Assistance (Subject = 75% or more)			3	Moderate Assistance (Subject = 50% or more)			<i>Helper - Complete Dependence</i>				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		
	Admission	Discharge																																																																																																																																																																																																
29. Bladder Level of Assistance (Score using FIM Levels 1 - 7)	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																
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 <i>Enter in Item 39G (Bladder) the lower (more dependent) score from Items 29 and 30 above</i>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																
	Admission	Discharge																																																																																																																																																																																																
31. Bowel Level of Assistance (Score using FIM Levels 1 - 7)	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																
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 <i>Enter in Item 39H (Bowel) the lower (more dependent) score of Items 31 and 32 above.</i>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																
	Admission	Discharge																																																																																																																																																																																																
33. Tub Transfer	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																
34. Shower Transfer (Score Items 33 and 34 using FIM Levels 1 - 7; use 0 if activity does not occur) <i>See training manual for scoring of Item 39K (Tub/Shower Transfer)</i>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																
	Admission	Discharge																																																																																																																																																																																																
35. Distance Walked	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																
36. Distance Traveled in Wheelchair <i>(Code items 35 and 36 using: 3 - 150 feet; 2 - 50 to 149 feet; 1 - Less than 50 feet; 0 - activity does not occur)</i>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																
	Admission	Discharge																																																																																																																																																																																																
37. Walk	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																
38. Wheelchair <i>(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)</i>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																
	Admission	Discharge	Goal																																																																																																																																																																																															
<b>SELF-CARE</b>																																																																																																																																																																																																		
A. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																															
B. Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																															
C. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																															
D. Dressing - Upper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																															
E. Dressing - Lower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																															
F. Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																															
<b>SPHINCTER CONTROL</b>																																																																																																																																																																																																		
G. Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																															
H. Bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																															
<b>TRANSFERS</b>																																																																																																																																																																																																		
I. Bed, Chair, Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																															
J. Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																															
K. Tub, Shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																															
<b>LOCOMOTION</b>																																																																																																																																																																																																		
L. Walk/Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																															
M. Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																															
<b>COMMUNICATION</b>																																																																																																																																																																																																		
N. Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																															
O. Expression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																															
<b>SOCIAL COGNITION</b>																																																																																																																																																																																																		
P. Social Interaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																															
Q. Problem Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																															
R. Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																															
<b>FIM LEVELS</b>																																																																																																																																																																																																		
<i>No Helper</i>																																																																																																																																																																																																		
7	Complete Independence (Timely, Safely)																																																																																																																																																																																																	
6	Modified Independence (Device)																																																																																																																																																																																																	
<i>Helper - Modified Dependence</i>																																																																																																																																																																																																		
5	Supervision (Subject = 100%)																																																																																																																																																																																																	
4	Minimal Assistance (Subject = 75% or more)																																																																																																																																																																																																	
3	Moderate Assistance (Subject = 50% or more)																																																																																																																																																																																																	
<i>Helper - Complete Dependence</i>																																																																																																																																																																																																		
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																																																																																																																																																																																																	

\* 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.

Discharge Information*	Therapy Information																																																												
<p>40. Discharge Date <span style="float: right;">____/____/____ MM / DD / YYYY</span></p> <p>41. Patient discharged against medical advice? <span style="float: right;">_____ (0 - No; 1 - Yes)</span></p> <p>42. Program Interruption(s) <span style="float: right;">_____ (0 - No; 1 - Yes)</span></p> <p>43. Program Interruption Dates (Code only if item 42 is 1 - Yes)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>A. 1<sup>st</sup> Interruption Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p> </td> <td style="width: 50%; vertical-align: top;"> <p>B. 1<sup>st</sup> Return Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p> </td> </tr> <tr> <td style="vertical-align: top;"> <p>C. 2<sup>nd</sup> Interruption Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p> </td> <td style="vertical-align: top;"> <p>D. 2<sup>nd</sup> Return Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p> </td> </tr> <tr> <td style="vertical-align: top;"> <p>E. 3<sup>rd</sup> Interruption Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p> </td> <td style="vertical-align: top;"> <p>F. 3<sup>rd</sup> Return Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p> </td> </tr> </table> <p>44C. Was the patient discharged alive? <span style="float: right;">_____ (0 - No; 1 - Yes)</span></p> <p>44D. Patient's discharge destination/living setting, using codes below: (answer only if 44C = 1; if 44C = 0, skip to item 46)  <span style="float: right;">_____</span>  <i>(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)</i></p> <p>45. Discharge to Living With <span style="float: right;">_____</span>  <i>(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)</i></p> <p>46. Diagnosis for Interruption or Death <span style="float: right;">_____</span>  <i>(Code using ICD code)</i></p> <p>47. Complications during rehabilitation stay  <i>(Use ICD codes to specify up to six conditions that began with this rehabilitation stay)</i></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">A. _____</td> <td style="width: 50%;">B. _____</td> </tr> <tr> <td>C. _____</td> <td>D. _____</td> </tr> <tr> <td>E. _____</td> <td>F. _____</td> </tr> </table>	<p>A. 1<sup>st</sup> Interruption Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p>	<p>B. 1<sup>st</sup> Return Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p>	<p>C. 2<sup>nd</sup> Interruption Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p>	<p>D. 2<sup>nd</sup> Return Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p>	<p>E. 3<sup>rd</sup> Interruption Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p>	<p>F. 3<sup>rd</sup> Return Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p>	A. _____	B. _____	C. _____	D. _____	E. _____	F. _____	<p><b>O0401. Week 1: Total Number of Minutes Provided</b></p> <p>O0401A: Physical Therapy</p> <table style="width: 100%; border: none;"> <tr><td>a. Total minutes of individual therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>b. Total minutes of concurrent therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>c. Total minutes of group therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>d. Total minutes of co-treatment therapy</td><td style="text-align: right;">_____</td></tr> </table> <p>O0401B: Occupational Therapy</p> <table style="width: 100%; border: none;"> <tr><td>a. Total minutes of individual therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>b. Total minutes of concurrent therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>c. Total minutes of group therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>d. Total minutes of co-treatment therapy</td><td style="text-align: right;">_____</td></tr> </table> <p>O0401C: Speech-Language Pathology</p> <table style="width: 100%; border: none;"> <tr><td>a. Total minutes of individual therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>b. Total minutes of concurrent therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>c. Total minutes of group therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>d. Total minutes of co-treatment therapy</td><td style="text-align: right;">_____</td></tr> </table> <p><b>O0402. Week 2: Total Number of Minutes Provided</b></p> <p>O0402A: Physical Therapy</p> <table style="width: 100%; border: none;"> <tr><td>a. Total minutes of individual therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>b. Total minutes of concurrent therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>c. Total minutes of group therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>d. Total minutes of co-treatment therapy</td><td style="text-align: right;">_____</td></tr> </table> <p>O0402B: Occupational Therapy</p> <table style="width: 100%; border: none;"> <tr><td>a. Total minutes of individual therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>b. Total minutes of concurrent therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>c. Total minutes of group therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>d. Total minutes of co-treatment therapy</td><td style="text-align: right;">_____</td></tr> </table> <p>O0402C: Speech-Language Pathology</p> <table style="width: 100%; border: none;"> <tr><td>a. Total minutes of individual therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>b. Total minutes of concurrent therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>c. Total minutes of group therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>d. Total minutes of co-treatment therapy</td><td style="text-align: right;">_____</td></tr> </table>	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	_____	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	_____	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	_____	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	_____	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	_____	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	_____
<p>A. 1<sup>st</sup> Interruption Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p>	<p>B. 1<sup>st</sup> Return Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p>																																																												
<p>C. 2<sup>nd</sup> Interruption Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p>	<p>D. 2<sup>nd</sup> Return Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p>																																																												
<p>E. 3<sup>rd</sup> Interruption Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p>	<p>F. 3<sup>rd</sup> Return Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p>																																																												
A. _____	B. _____																																																												
C. _____	D. _____																																																												
E. _____	F. _____																																																												
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	_____																																																												
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	_____																																																												
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	_____																																																												
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	_____																																																												
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	_____																																																												
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	_____																																																												

\* 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.

Quality Indicators- Admission Assessment		Quality Indicators- Discharge Assessment	
Enter Code <input type="checkbox"/>	<p><b>Unhealed Pressure Ulcer(s)- Admission</b></p> <p><b>M0210.</b> Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher at Admission?</p> <p><b>0. No</b> → skip to question <b>I0900 on Admission Assessment</b></p> <p><b>1. Yes</b> → continue to question <b>M0300A on Admission Assessment</b></p>	Enter Code <input type="checkbox"/>	<p><b>Unhealed Pressure Ulcer(s)- Discharge</b></p> <p><b>M0210.</b> Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher on Discharge?</p> <p><b>0. No</b> → skip to question <b>M0900A on Discharge Assessment</b></p> <p><b>1. Yes</b> → continue to question <b>M0300A on Discharge Assessment</b></p>
<b>M0300. Current Number of Unhealed Pressure Ulcers at Each Stage- Admission</b>		<b>M0300. Current Number of Unhealed Pressure Ulcers at Each Stage- Discharge</b>	
Enter Number <input type="checkbox"/>	<p><b>M0300A. Stage 1:</b> 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 it may appear with persistent blue or purple hues.</p> <p><b>M0300A1. Number of Stage 1 pressure ulcers:</b> enter how many were noted at the time of admission</p>	Enter Number <input type="checkbox"/>  Enter Number <input type="checkbox"/>  Enter Number <input type="checkbox"/>	<p><b>M0300A. Stage 1:</b> 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 it may appear with persistent blue or purple hues.</p> <p><b>M0300A1.</b> Enter <b>total</b> number of pressure ulcers currently at <b>Stage 1. If patient has no Stage 1 pressure ulcers at discharge, skip to Item M0300B1.</b></p> <p><b>M0300A2.</b> Of <b>these Stage 1</b> pressure ulcers present at discharge, enter number that were: (a) present on admission as a Stage 1 <b>and</b> (b) remained at Stage 1 at discharge.</p> <p><b>M0300A3.</b> Of <b>these Stage 1</b> pressure ulcers, enter the number that were <b>not present on admission.</b> (i.e. – New stage 1 pressure ulcers that have developed during the IRF stay)</p>
Enter Number <input type="checkbox"/>	<p><b>M0300B. Stage 2:</b> 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.</p> <p><b>M0300B1. Number of Stage 2 pressure ulcers:</b> enter how many were noted at the time of admission</p>	Enter Number <input type="checkbox"/>  Enter Number <input type="checkbox"/>  Enter Number <input type="checkbox"/>  Enter Number <input type="checkbox"/>	<p><b>M0300B. Stage 2:</b> 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.</p> <p><b>M0300B1.</b> Enter <b>total</b> number of pressure ulcers currently at <b>Stage 2. (If patient has no Stage 2 pressure ulcers at discharge, skip to Item M0300C1.)</b></p> <p><b>M0300B2.</b> Of <b>these Stage 2</b> pressure ulcers present at discharge, enter the number that were: (a) present on admission, <b>and</b> (b) remained at Stage 2 at discharge.</p> <p><b>M0300B3.</b> Of <b>these Stage 2</b> pressure ulcers present at discharge, enter the number that were: (a) present on admission as an <b>unstageable pressure ulcer</b> due to the presence of a <b>non-removable device and</b> (b) when it became stageable, the pressure ulcer was staged as a Stage 2, <b>and</b> (c) it remained at Stage 2 at the time of discharge.</p> <p><b>M0300B4.</b> Of <b>these Stage 2</b> pressure ulcers present at discharge, enter the number that were: (a) not present on admission; <b>or</b> (b) were at a lesser stage at admission and worsened to a Stage 2 during the IRF stay</p>

Quality Indicators- Admission Assessment, Continued		Quality Indicators-Discharge Assessment, Continued	
	<p><b>M0300. Current Number of Unhealed Pressure Ulcers at Each Stage- Admission, Continued</b></p> <p><b>M0300C. Stage 3:</b> 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.</p> <p><b>M0300C1. Number of Stage 3 pressure ulcers:</b> enter how many were noted at the time of admission</p>		<p><b>M0300. Current Number of Unhealed Pressure Ulcers at Each Stage-Discharge, Continued</b></p> <p><b>M0300C. Stage 3:</b> 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.</p> <p><b>M0300C1.</b> Enter <b>total</b> number of pressure ulcers currently at <b>Stage 3. (If patient has no Stage 3 pressure ulcers at discharge, skip to Item M0300D1.)</b></p> <p><b>M0300C2.</b> Of <b>these Stage 3</b> pressure ulcers present at discharge, enter the number that were: (a) present on admission, <b>and</b> (b) remained at Stage 3 at discharge.</p> <p><b>M0300C3.</b> Of <b>these Stage 3</b> pressure ulcers present at discharge, enter the number that were: (a) present on admission as an <b>unstageable pressure ulcer, and</b> (b) when it became stageable, it was staged as a <b>Stage 3; and</b> (c) it remained at <b>Stage 3</b> at the time of discharge.</p> <p><b>M0300C4.</b> Of <b>these Stage 3</b> pressure ulcers present at discharge, enter the number that were: (a) not present on admission; <b>or</b> (b) were at a lesser stage at admission and worsened to a Stage 3 during the IRF stay; <b>or</b> (c) were unstageable due to a non-removeable device at admission, initially became stageable at a lesser stage, , but then progressed to a Stage 3 by the time of discharge.</p>
<p>Enter Number</p> <input type="text"/>		<p>Enter Number</p> <input type="text"/> <p>Enter Number</p> <input type="text"/> <p>Enter Number</p> <input type="text"/> <p>Enter Number</p> <input type="text"/>	
	<p><b>M0300D. Stage 4:</b> 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.</p> <p><b>M0300D1. Number of Stage 4 pressure ulcers:</b> enter how many were noted at the time of admission</p>		<p><b>M0300D. Stage 4:</b> 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.</p> <p><b>M0300D1.</b> Enter <b>total</b> number of pressure ulcers currently at <b>Stage 4. (If patient has no Stage 4 pressure ulcers at discharge, skip to Item M0300E1.)</b></p> <p><b>M0300D2.</b> Of <b>these Stage 4</b> pressure ulcers present at discharge, enter number that were: (a) present on admission at Stage 4 , <b>and</b> (b) remained at Stage 4 at discharge.</p> <p><b>M0300D3.</b> Of <b>these Stage 4</b> pressure ulcers present at discharge, enter the number that were: (a) present on admission as an <b>unstageable pressure ulcer, and</b> (b) when it became stageable, it was staged as a <b>Stage 4, and</b> (c) it remained at <b>Stage 4</b> at the time of discharge.</p> <p><b>M0300D4.</b> Of <b>these Stage 4</b> pressure ulcers present at discharge, enter the number that were: (a) not present on admission); <b>or</b> (b) were at a lesser stage at admission and worsened to a Stage 4 by discharge; <b>or</b> (c) were unstageable on admission, initially became stageable at a lesser stage, and then progressed to a Stage 4 by the time of discharge.</p>
<p>Enter Number</p> <input type="text"/>		<p>Enter Number</p> <input type="text"/> <p>Enter Number</p> <input type="text"/> <p>Enter Number</p> <input type="text"/> <p>Enter Number</p> <input type="text"/>	

Quality Indicators-Admission Assessment, Continued		Quality Indicators-Discharge Assessment, Continued	
<p>Enter Number</p> <input type="text"/>	<p><b>M0300E. Unstageable Pressure Ulcers due to non-removable dressing/device:</b> Known but not stageable due to the presence of a non-removable dressing/device.</p> <p><b>M0300E1. Number of unstageable pressure ulcers due to non-removable dressing/device:</b> enter how many were noted at the time of admission</p>	<p>Enter Number</p> <input type="text"/>  <p>Enter Number</p> <input type="text"/>  <p>Enter Number</p> <input type="text"/>	<p><b>M0300E. Unstageable Pressure Ulcers due to a non-removable dressing or device:</b> pressure ulcers that are known but not stageable due to the presence of a non-removable dressing or device.</p> <p><b>M0300E1.</b> Enter <b>total</b> number of pressure ulcers currently <b>Unstageable</b> due to a <b>Non-removable dressing or device</b>. (If patient has no pressure ulcers <b>Unstageable</b> due to <b>Non-Removable Device</b> at discharge, skip to Item M0300F1.)</p> <p><b>M0300E2.</b> Of <b>these Unstageable</b> pressure ulcers due to a <b>non-removable dressing or device</b> present at discharge, enter number that were:(a) present on admission as an unstageable pressure ulcer due to <b>non-removable dressing or device</b>; and (b) remained unstageable due to <b>non-removable dressing or device</b> until discharge.</p> <p><b>M0300E3.</b> Of <b>these Unstageable</b> pressure ulcers due to <b>non-removable dressing or device</b> present at discharge, enter number that were (a) present on admission as a stageable pressure ulcer <b>and</b> became <b>unstageable due to non-removable dressing or device</b> during the IRF stay; and (b) remained unstageable due to a <b>non-removable dressing or device</b> until discharge.</p>
<p>Enter Number</p> <input type="text"/>	<p><b>M0300F. Unstageable Pressure Ulcers due to slough and/or eschar:</b> pressure ulcers that are known but not stageable due to coverage of wound bed by slough and/or eschar.</p> <p><b>M0300F1. Number of unstageable pressure ulcers due to slough and/ or eschar:</b> enter how many were noted at the time of admission</p>	<p>Enter Number</p> <input type="text"/>  <p>Enter Number</p> <input type="text"/>  <p>Enter Number</p> <input type="text"/>	<p><b>M0300F. Unstageable Pressure Ulcers due to slough or eschar:</b> pressure ulcers that are known but not stageable due to coverage of wound bed by slough and/or eschar.</p> <p><b>M0300F1.</b> Enter <b>total</b> number of pressure ulcers currently <b>Unstageable</b> due to a <b>Slough and/or Eschar</b>. ( If patient has no pressure ulcers <b>Unstageable</b> due to <b>Slough and/or Eschar</b> at discharge, skip to Item M0300G1.)</p> <p><b>M0300F2.</b> Of <b>these Unstageable</b> pressure ulcers due to <b>slough and/or eschar</b> present at discharge, enter number that were: (a) present on admission as an unstageable pressure ulcer due to <b>slough and/or eschar</b>; and (b) remained unstageable due to <b>slough and/or eschar</b> until discharge.</p> <p><b>M0300F3.</b> Of <b>these Unstageable</b> pressure ulcers due to <b>slough or eschar</b> present at discharge, enter number that were: (a) present on admission as a stageable pressure ulcer <b>and</b> became unstageable due to <b>slough and/or eschar</b>, during the IRF stay; <b>and</b> (b) remained unstageable due to <b>slough and/or eschar</b> until discharge.</p>
<p>Enter Number</p> <input type="text"/>	<p><b>M0300G. Unstageable Pressure Ulcers with Suspected Deep Tissue Injury (DTI) in evolution:</b> suspected deep tissue injury in evolution.</p> <p><b>M0300G1. Number of unstageable pressure ulcers with Suspected Deep Tissue Injury in evolution:</b> enter how many were noted at the time of admission</p>	<p>Enter Number</p> <input type="text"/>  <p>Enter Number</p> <input type="text"/>	<p><b>M0300G. Unstageable Pressure Ulcers with Suspected Deep Tissue Injury (DTI) in evolution:</b> suspected deep tissue injury in evolution.</p> <p><b>M0300G1.</b> Enter <b>total</b> number of <b>unstageable pressure ulcers with Suspected Deep Tissue Injury</b>. (If patient has no <b>Unstageable pressure ulcers with Suspected Deep Tissue Injury</b> at discharge, skip to Item M0900A.)</p> <p><b>M0300G2.</b> Of <b>these unstageable pressure ulcers with Suspected DTI</b> present at discharge, enter number that were:(a) present on admission as an unstageable pressure ulcer due to a <b>suspected deep tissue injury</b>; and (b) remained unstageable due to a <b>suspected DTI</b> until discharge.</p>

Quality Indicators- Admission Assessment, Continued		Quality Indicators-Discharge Assessment, Continued	
	I0900. Pressure Ulcer Risk Conditions- Admission		M0900. Healed Pressure Ulcers- Discharge
<p>Indicate below if the patient has any of the following pressure ulcer risk conditions:                  (NOTE: You must also document the appropriate ICD codes for any pressure ulcer risk conditions documented below in Item 24 "Comorbid Conditions" above.)</p> <p>Enter Number <input type="checkbox"/></p> <p>Enter Number <input type="checkbox"/></p> <p>Enter Number <input type="checkbox"/></p> <p>Enter Number <input type="checkbox"/></p> <p>Enter Number <input type="checkbox"/></p> <p>Enter Number <input type="checkbox"/></p>	<p><b>I0900A.</b> Peripheral Vascular Disease (PVD) 0. No 1. Yes</p> <p><b>I0900B.</b> Peripheral Arterial Disease(PAD) 0. No 1. Yes</p> <p><b>I2900A.</b> Diabetes Mellitus (DM) <i>If I2900A = 0, skip I2900B-D</i> 0. No 1. Yes</p> <p><b>I2900B.</b> Diabetic Retinopathy 0. No 1. Yes</p> <p><b>I2900C.</b> Diabetic Nephropathy 0. No 1. Yes</p> <p><b>I2900D.</b> Diabetic Neuropathy 0. No 1. Yes</p>	<p>Enter Number <input type="checkbox"/></p> <p>Enter Number <input type="checkbox"/></p> <p>Enter Number <input type="checkbox"/></p> <p>Enter Number <input type="checkbox"/></p>	<p>Indicate the number of pressure ulcers that were: (a) present on <b>Admission</b>; and (b) have completely closed (resurfaced with epithelium) upon <b>Discharge</b>. If there are no healed pressure ulcers noted at a given stage, enter 0.</p> <p><b>M0900A.</b> Stage 1</p> <p><b>M0900B.</b> Stage 2</p> <p><b>M0900C.</b> Stage 3</p> <p><b>M0900D.</b> Stage 4</p>
		<b>O0250. Influenza Vaccine – Discharge - Refer to current version of IRF-PAI Training Manual for current influenza vaccination season and reporting period.</b>	
		<p>Enter Code <input type="checkbox"/></p> <p>Enter Code <input type="checkbox"/></p>	<p><b>O0250A.</b> Did the patient receive the influenza vaccine <i>in this facility</i> 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</p> <p><b>O0250B.</b> Date influenza vaccine received → Complete date and skip to Z0400A, Signature of Persons Completing the Assessment</p> <p style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>                  MM DD YYYY             </p> <p><b>O0250C.</b> If influenza vaccine not received, state reason:</p> <ol style="list-style-type: none"> <li>1. Patient not in this facility during this year's influenza vaccination season</li> <li>2. Received outside of this facility</li> <li>3. Not eligible - medical contraindication</li> <li>4. Offered and declined</li> <li>5. Not offered</li> <li>6. Inability to obtain influenza vaccine due to a declared shortage.</li> <li>9. None of the above</li> </ol>



**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.			