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# INPATIENT REHABILITATION FACILITY - PATIENT ASSESSMENT INSTRUMENT

| Identification Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | Medical Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <p>1. Facility Information</p> <p>A. Facility Name _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>B. Facility Medicare Provider Number _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | <p>21. Impairment Group* _____</p> <p>Admission _____ Discharge _____</p> <p>Condition requiring admission to rehabilitation; code according to Appendix A.</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>MM / DD / YYYY</p> <p>7. Social Security Number _____</p> <p>8. Gender (1 - Male; 2 - Female) _____</p> <p>10. Marital Status _____</p> <p>(1 - Never Married; 2 - Married; 3 - Widowed;<br/>4 - Separated; 5 - Divorced)</p> <p>11. Zip Code of Patient's Pre-Hospital Residence _____</p> <p>12. Admission Date _____ / _____ / _____</p> <p>MM / DD / YYYY</p> <p>13. Assessment Reference Date _____ / _____ / _____</p> <p>MM / DD / YYYY</p> <p>14. Admission Class _____</p> <p>(1 - Initial Rehab;; 3 - Readmission;<br/>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, other residential care arrangements); 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 (medical 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 (CAH); 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;<br/>02 - Family/Relatives; 03 - Friends; 04 - Attendant; 05 - Other)</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>A. _____</p> <p>B. _____</p> <p>C. _____</p> <p>23. Date of Onset of Impairment _____ / _____ / _____</p> <p>MM / DD / YYYY</p> <p>24. Comorbid Conditions</p> <p>Use ICD codes to enter comorbid medical conditions</p> <p>A. _____ J. _____ S. _____</p> <p>B. _____ K. _____ T. _____</p> <p>C. _____ L. _____ U. _____</p> <p>D. _____ M. _____ V. _____</p> <p>E. _____ N. _____ W. _____</p> <p>F. _____ O. _____ X. _____</p> <p>G. _____ P. _____ Y. _____</p> <p>H. _____ Q. _____</p> <p>I. _____ R. _____</p> <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>(0 - No; 1 - Yes)</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> |  |

\* The impairment codes incorporated or referenced herein are the property of U B Foundation Activities, Inc. ©1993, 2001 U B Foundation Activities, Inc

| Discharge Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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| <p>40. Discharge Date <span style="float: right;">____/____/____<br/>MM / DD / YYYY</span></p> <p>41. Patient discharged against medical advice? <span style="float: right;">_____<br/>(0 - No; 1 - Yes)</span></p> <p>42. Program Interruption(s) <span style="float: right;">_____<br/>(0 - No; 1 - Yes)</span></p> <p>43. Program Interruption Dates<br/>(Code only if item 42 is 1 - Yes)</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>A. 1<sup>st</sup> Interruption Date<br/><div style="border: 1px solid black; height: 20px; width: 100%;"></div><br/>MM / DD / YYYY</p> <p>C. 2<sup>nd</sup> Interruption Date<br/><div style="border: 1px solid black; height: 20px; width: 100%;"></div><br/>MM / DD / YYYY</p> <p>E. 3<sup>rd</sup> Interruption Date<br/><div style="border: 1px solid black; height: 20px; width: 100%;"></div><br/>MM / DD / YYYY</p> </div> <div style="width: 45%;"> <p>B. 1<sup>st</sup> Return Date<br/><div style="border: 1px solid black; height: 20px; width: 100%;"></div><br/>MM / DD / YYYY</p> <p>D. 2<sup>nd</sup> Return Date<br/><div style="border: 1px solid black; height: 20px; width: 100%;"></div><br/>MM / DD / YYYY</p> <p>F. 3<sup>rd</sup> Return Date<br/><div style="border: 1px solid black; height: 20px; width: 100%;"></div><br/>MM / DD / YYYY</p> </div> </div> <p>44C. Was the patient discharged alive? <span style="float: right;">_____<br/>(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)<br/><br/> <div style="border: 1px solid black; padding: 5px; font-size: small;"> (01 - Home (private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements); 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 (medical 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 (CAH); 99 - Not Listed) </div> </p> <p>45. Discharge to Living With <span style="float: right;">_____<br/>(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)</span></p> <p>46. Diagnosis for Interruption or Death <span style="float: right;">_____<br/>(Code using ICD code)</span></p> <p>47. Complications during rehabilitation stay<br/>(Use ICD codes to specify up to six conditions that began with this rehabilitation stay)</p> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> <p>A. _____</p> <p>C. _____</p> <p>E. _____</p> </div> <div style="width: 45%;"> <p>B. _____</p> <p>D. _____</p> <p>F. _____</p> </div> </div> | <p><b>O0401. Week 1: Total Number of Minutes Provided</b></p> <p>O0401A: Physical Therapy</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. Total minutes of individual therapy</p> <p>b. Total minutes of concurrent therapy</p> <p>c. Total minutes of group therapy</p> <p>d. Total minutes of co-treatment therapy</p> </div> <div style="width: 15%; text-align: right;"> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> </div> </div> <p>O0401B: Occupational Therapy</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. Total minutes of individual therapy</p> <p>b. Total minutes of concurrent therapy</p> <p>c. Total minutes of group therapy</p> <p>d. Total minutes of co-treatment therapy</p> </div> <div style="width: 15%; text-align: right;"> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> </div> </div> <p>O0401C: Speech-Language Pathology</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. Total minutes of individual therapy</p> <p>b. Total minutes of concurrent therapy</p> <p>c. Total minutes of group therapy</p> <p>d. Total minutes of co-treatment therapy</p> </div> <div style="width: 15%; text-align: right;"> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> </div> </div><br><p><b>O0402. Week 2: Total Number of Minutes Provided</b></p> <p>O0402A: Physical Therapy</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. Total minutes of individual therapy</p> <p>b. Total minutes of concurrent therapy</p> <p>c. Total minutes of group therapy</p> <p>d. Total minutes of co-treatment therapy</p> </div> <div style="width: 15%; text-align: right;"> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> </div> </div> <p>O0402B: Occupational Therapy</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. Total minutes of individual therapy</p> <p>b. Total minutes of concurrent therapy</p> <p>c. Total minutes of group therapy</p> <p>d. Total minutes of co-treatment therapy</p> </div> <div style="width: 15%; text-align: right;"> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> </div> </div> <p>O0402C: Speech-Language Pathology</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. Total minutes of individual therapy</p> <p>b. Total minutes of concurrent therapy</p> <p>c. Total minutes of group therapy</p> <p>d. Total minutes of co-treatment therapy</p> </div> <div style="width: 15%; text-align: right;"> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> </div> </div> |

# INPATIENT REHABILITATION FACILITY - PATIENT ASSESSMENT INSTRUMENT QUALITY INDICATORS

## ADMISSION

### Section A Administrative Information

#### A1005. Ethnicity

Are you of Hispanic, Latino/a, or Spanish origin?



Check all that apply

- ☐ A. No, not of Hispanic, Latino/a, or Spanish origin
- ☐ B. Yes, Mexican, Mexican American, Chicano/a
- ☐ C. Yes, Puerto Rican
- ☐ D. Yes, Cuban
- ☐ E. Yes, another Hispanic, Latino, or Spanish origin
- ☐ X. Patient unable to respond
- ☐ Y. Patient declines to respond

#### A1010. Race

What is your race?



Check all that apply

- ☐ A. White
- ☐ B. Black or African American
- ☐ C. American Indian or Alaska Native
- ☐ D. Asian Indian
- ☐ E. Chinese
- ☐ F. Filipino
- ☐ G. Japanese
- ☐ H. Korean
- ☐ I. Vietnamese
- ☐ J. Other Asian
- ☐ K. Native Hawaiian
- ☐ L. Guamanian or Chamorro
- ☐ M. Samoan
- ☐ N. Other Pacific Islander
- ☐ X. Patient unable to respond
- ☐ Y. Patient declines to respond
- ☐ Z. None of the above

| A1110. Language                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Code<br><div></div>                                                                                                                                                                                                                                                                                 | <p><b>A. What is your preferred language?</b></p> <div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div> |
|                                                                                                                                                                                                                                                                                                           | <p><b>B. Do you need or want an interpreter to communicate with a doctor or health care staff?</b></p> <p>0. No</p> <p>1. Yes</p> <p>9. Unable to determine</p>                        |
| A1250. Transportation (from NACHC®)                                                                                                                                                                                                                                                                       |                                                                                                                                                                                        |
| Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?                                                                                                                                                                            |                                                                                                                                                                                        |
| ↓                                                                                                                                                                                                                                                                                                         | Check all that apply                                                                                                                                                                   |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                  | A. Yes, it has kept me from medical appointments or from getting my medications                                                                                                        |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                  | B. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need                                                                               |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                  | C. No                                                                                                                                                                                  |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                  | X. Patient unable to respond                                                                                                                                                           |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                  | Y. Patient declines to respond                                                                                                                                                         |
| Adapted from: © 2019. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. PRAPARE and its resources are proprietary information of NACHC and its partners, intended for use by NACHC, its partners, and |                                                                                                                                                                                        |
| A1400. Payer Information                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                        |
| ↓                                                                                                                                                                                                                                                                                                         | Check all that apply                                                                                                                                                                   |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                  | A. Medicare (traditional fee-for-service)                                                                                                                                              |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                  | B. Medicare (managed care/Part C/Medicare Advantage)                                                                                                                                   |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                  | C. Medicaid (traditional fee-for-services)                                                                                                                                             |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                  | D. Medicaid (managed care)                                                                                                                                                             |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                  | E. Workers' compensation                                                                                                                                                               |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                  | F. Title programs (e.g., Title III, V, or XX)                                                                                                                                          |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                  | G. Other government (e.g., TRICARE, VA, etc.)                                                                                                                                          |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                  | H. Private insurance/Medigap                                                                                                                                                           |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                  | I. Private managed care                                                                                                                                                                |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                  | J. Self-pay                                                                                                                                                                            |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                  | K. No Payer source                                                                                                                                                                     |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                  | X. Unknown                                                                                                                                                                             |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                  | Y. Other                                                                                                                                                                               |

# ADMISSION

## Section B Hearing, Speech, and Vision

### B0200. Hearing

- 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

- 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

### B1300. Health Literacy (from Creative Commons©)

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

- Enter Code
0. **Never**
  1. **Rarely**
  2. **Sometimes**
  3. **Often**
  4. **Always**
  7. **Patient declines to respond**
  8. **Patient unable to respond**

*The Single Item Literacy Screener is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.*

### 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**

Patient \_\_\_\_\_ Identifier \_\_\_\_\_ Date \_\_\_\_\_

# ADMISSION

## 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<br><input type="text"/> | <p>0. <b>No</b> (patient is rarely/never understood) → <i>Skip to C0900, Memory/Recall Ability</i></p> <p>1. <b>Yes</b> → <i>Continue to C0200, Repetition of Three Words</i></p> |
|------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

### Brief Interview for Mental Status (BIMS)

#### C0200. Repetition of Three Words

|                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Code<br><input type="text"/> | <p>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: <b>sock, blue and bed</b>. Now tell me the three words."</p> <p><b>Number of words repeated after first attempt</b></p> <p>3. <b>Three</b></p> <p>2. <b>Two</b></p> <p>1. <b>One</b></p> <p>0. <b>None</b></p> <p>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.</p> |
|------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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

|                                    |                                                                                                                                                                                                                                                                     |
|------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Code<br><input type="text"/> | <p>Ask patient: "Please tell me what year it is right now."</p> <p><b>A. Able to report correct year</b></p> <p>3. <b>Correct</b></p> <p>2. <b>Missed by 1 year</b></p> <p>1. <b>Missed by 2 - 5 years</b></p> <p>0. <b>Missed by &gt; 5 years</b> or no answer</p> |
| Enter Code<br><input type="text"/> | <p>Ask patient: "What month are we in right now?"</p> <p><b>B. Able to report correct month</b></p> <p>2. <b>Accurate within 5 days</b></p> <p>1. <b>Missed by 6 days to 1 month</b></p> <p>0. <b>Missed by &gt; 1 month</b> or no answer</p>                       |
| Enter Code<br><input type="text"/> | <p>Ask patient: "What day of the week is today?"</p> <p><b>C. Able to report correct day of the week</b></p> <p>1. <b>Correct</b></p> <p>0. <b>Incorrect</b> or no answer</p>                                                                                       |

#### C0400. Recall

|                                    |                                                                                                                                                                                                                                                                                                                                                                                                           |
|------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Code<br><input type="text"/> | <p>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.</p> <p><b>A. Able to recall "sock"</b></p> <p>2. <b>Yes, no cue required</b></p> <p>1. <b>Yes, after cueing</b> ("something to wear")</p> <p>0. <b>No</b> - could not recall</p> |
| Enter Code<br><input type="text"/> | <p><b>B. Able to recall "blue"</b></p> <p>2. <b>Yes, no cue required</b></p> <p>1. <b>Yes, after cueing</b> ("a color")</p> <p>0. <b>No</b> - could not recall</p>                                                                                                                                                                                                                                        |
| Enter Code<br><input type="text"/> | <p><b>C. Able to recall "bed"</b></p> <p>2. <b>Yes, no cue required</b></p> <p>1. <b>Yes, after cueing</b> ("a piece of furniture")</p> <p>0. <b>No</b> - could not recall</p>                                                                                                                                                                                                                            |

Patient \_\_\_\_\_ Identifier \_\_\_\_\_ Date \_\_\_\_\_

# ADMISSION

## Section C Cognitive Patterns

### Brief Interview for Mental Status (BIMS) – Continued

#### 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

### 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 they are 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.

#### 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  
.. 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

Adapted from: Inouye SK, et al. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment Method. Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.



Patient \_\_\_\_\_ Identifier \_\_\_\_\_ Date \_\_\_\_\_

# ADMISSION

## Section D

## Mood

### D0150. Patient Mood Interview (PHQ-2 to 9) (from Pfizer Inc. ©)

Determine if the patient is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, code D0150A1 and D0150B1 as 9, No response, leave D0150A2 and D0150B2 blank, end the PHQ-2 interview, and leave D0160, Total Severity Score blank. Otherwise, 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.<br>Symptom<br>Presence | 2.<br>Symptom<br>Frequency |
|---------------------------|----------------------------|
|---------------------------|----------------------------|

↓ Enter Scores in Boxes ↓

A. Little interest or pleasure in doing things

|  |  |
|--|--|
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B. Feeling down, depressed, or hopeless

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If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise, continue.

C. Trouble falling or staying asleep, or sleeping too much

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D. Feeling tired or having little energy

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E. Poor appetite or overeating

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F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down

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G. Trouble concentrating on things, such as reading the newspaper or watching television

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H. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual

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I. Thoughts that you would be better off dead, or of hurting yourself in some way

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### D0160. Total Severity Score

Enter Score

|  |
|--|
|  |
|--|

Add scores for all frequency responses in column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)

### D0700. Social Isolation

How often do you feel lonely or isolated from those around you?

Enter Code

|  |
|--|
|  |
|--|

- 0. Never
- 1. Rarely
- 2. Sometimes
- 3. Often
- 4. Always
- 7. Patient declines to respond
- 8. Patient unable to respond

Patient \_\_\_\_\_

Identifier \_\_\_\_\_

Date \_\_\_\_\_

## ADMISSION

| Section | Functional Abilities |
|---------|----------------------|
|---------|----------------------|

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

|                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                         |                                                                                                                                                                         |                                                         |                                                                                                                                                                                                                                 |                                                         |                                                                                                                                                                                                             |                                                         |                                                                                                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Coding:</b><br>3. <b>Independent</b> - Patient completed all the activities by themselves, with or without an assistive device, with no assistance from a helper.<br>2. <b>Needed Some Help</b> - Patient needed partial assistance from another person to complete any activities.<br>1. <b>Dependent</b> - A helper completed all the activities for the patient.<br>8. <b>Unknown</b><br>9. <b>Not Applicable</b> | <div style="text-align: center; margin-bottom: 5px;">↓ Enter Codes in Boxes</div> <table style="width: 100%;"> <tr> <td style="width: 10%; text-align: center; vertical-align: middle;"><input style="width: 30px; height: 30px;" type="text"/></td> <td><b>A. Self-Care:</b> Code the patient's need for assistance with bathing, dressing, using the toilet, and eating prior to the current illness, exacerbation, or injury.</td> </tr> <tr> <td style="text-align: center; vertical-align: middle;"><input style="width: 30px; height: 30px;" type="text"/></td> <td><b>B. Indoor Mobility (Ambulation):</b> 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.</td> </tr> <tr> <td style="text-align: center; vertical-align: middle;"><input style="width: 30px; height: 30px;" type="text"/></td> <td><b>C. Stairs:</b> 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.</td> </tr> <tr> <td style="text-align: center; vertical-align: middle;"><input style="width: 30px; height: 30px;" type="text"/></td> <td><b>D. Functional Cognition:</b> 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.</td> </tr> </table> | <input style="width: 30px; height: 30px;" type="text"/> | <b>A. Self-Care:</b> Code the patient's need for assistance with bathing, dressing, using the toilet, and eating prior to the current illness, exacerbation, or injury. | <input style="width: 30px; height: 30px;" type="text"/> | <b>B. Indoor Mobility (Ambulation):</b> 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. | <input style="width: 30px; height: 30px;" type="text"/> | <b>C. Stairs:</b> 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. | <input style="width: 30px; height: 30px;" type="text"/> | <b>D. Functional Cognition:</b> 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. |
| <input style="width: 30px; height: 30px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                 | <b>A. Self-Care:</b> Code the patient's need for assistance with bathing, dressing, using the toilet, and eating prior to the current illness, exacerbation, or injury.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                         |                                                                                                                                                                         |                                                         |                                                                                                                                                                                                                                 |                                                         |                                                                                                                                                                                                             |                                                         |                                                                                                                                                                                                               |
| <input style="width: 30px; height: 30px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                 | <b>B. Indoor Mobility (Ambulation):</b> 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                         |                                                                                                                                                                         |                                                         |                                                                                                                                                                                                                                 |                                                         |                                                                                                                                                                                                             |                                                         |                                                                                                                                                                                                               |
| <input style="width: 30px; height: 30px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                 | <b>C. Stairs:</b> 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                         |                                                                                                                                                                         |                                                         |                                                                                                                                                                                                                                 |                                                         |                                                                                                                                                                                                             |                                                         |                                                                                                                                                                                                               |
| <input style="width: 30px; height: 30px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                 | <b>D. Functional Cognition:</b> 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.

|                                                             |                                               |
|-------------------------------------------------------------|-----------------------------------------------|
| ↓                                                           | <b>Check all that apply</b>                   |
| <input style="width: 30px; height: 30px;" type="checkbox"/> | <b>A. Manual wheelchair</b>                   |
| <input style="width: 30px; height: 30px;" type="checkbox"/> | <b>B. Motorized wheelchair and/or scooter</b> |
| <input style="width: 30px; height: 30px;" type="checkbox"/> | <b>C. Mechanical lift</b>                     |
| <input style="width: 30px; height: 30px;" type="checkbox"/> | <b>D. Walker</b>                              |
| <input style="width: 30px; height: 30px;" type="checkbox"/> | <b>E. Orthotics/Prosthetics</b>               |
| <input style="width: 30px; height: 30px;" type="checkbox"/> | <b>Z. None of the above</b>                   |

Patient \_\_\_\_\_

Identifier \_\_\_\_\_

Date \_\_\_\_\_

# ADMISSION

## Section

## Functional Abilities

### 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.

#### 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 themselves 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**

| Admission Performance    |                      |                                                                                                                                                                                                                                      |
|--------------------------|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ↓ Enter Codes in Boxes ↓ |                      |                                                                                                                                                                                                                                      |
| <input type="text"/>     | <input type="text"/> | <b>A. Eating:</b> 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.                                                           |
| <input type="text"/>     | <input type="text"/> | <b>B. Oral hygiene:</b> 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. |
| <input type="text"/>     | <input type="text"/> | <b>C. Toileting hygiene:</b> 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.             |
| <input type="text"/>     | <input type="text"/> | <b>E. Shower/bathe self:</b> 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.                                         |
| <input type="text"/>     | <input type="text"/> | <b>F. Upper body dressing:</b> The ability to dress and undress above the waist; including fasteners, if applicable.                                                                                                                 |
| <input type="text"/>     | <input type="text"/> | <b>G. Lower body dressing:</b> The ability to dress and undress below the waist, including fasteners; does not include footwear.                                                                                                     |
| <input type="text"/>     | <input type="text"/> | <b>H. Putting on/taking off footwear:</b> 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

## Functional Abilities

### 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.

#### 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 themselves 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**

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

Patient \_\_\_\_\_

Identifier \_\_\_\_\_

Date \_\_\_\_\_

# ADMISSION

## Section Functional Abilities

### 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.

#### 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 themselves 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**

|                          |                      |                                                                                                                                                                                          |
|--------------------------|----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Admission Performance    |                      |                                                                                                                                                                                          |
| ↓ Enter Codes in Boxes ↓ |                      |                                                                                                                                                                                          |
| <input type="text"/>     |                      | <b>L. Walking 10 feet on uneven surfaces:</b> The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.                                     |
| <input type="text"/>     |                      | <b>M. 1 step (curb):</b> The ability to go up and down a curb or up and down one step.<br><i>If admission performance is coded 07, 09, 10, or 8 → Skip to GG0170P, Picking up object</i> |
| <input type="text"/>     |                      | <b>N. 4 steps:</b> The ability to go up and down four steps with or without a rail.<br><i>If admission performance is coded 07, 09, 10, or 8 → Skip to GG0170P, Picking up object</i>    |
| <input type="text"/>     |                      | <b>O. 12 steps:</b> The ability to go up and down 12 steps with or without a rail.                                                                                                       |
| <input type="text"/>     |                      | <b>P. Picking up object:</b> The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.                                              |
|                          | <input type="text"/> | <b>Q1. Does the patient use a wheelchair and/or scooter?</b><br>0. No → Skip to H0350, Bladder Continence<br>1. Yes → Continue to GG0170R, Wheel 50 feet with two turns                  |
| <input type="text"/>     |                      | <b>R. Wheel 50 feet with two turns:</b> Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.                                                     |
|                          | <input type="text"/> | <b>RR1. Indicate the type of wheelchair or scooter used.</b><br>1. Manual<br>2. Motorized                                                                                                |
| <input type="text"/>     |                      | <b>S. Wheel 150 feet:</b> Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.                                                      |
|                          | <input type="text"/> | <b>SS1. Indicate the type of wheelchair or scooter used.</b><br>1. Manual<br>2. Motorized                                                                                                |

Patient \_\_\_\_\_

Identifier \_\_\_\_\_

Date \_\_\_\_\_

## ADMISSION

### Section Bladder and Bowel

#### H0350. Bladder Continence (3-day assessment period)

|                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Code<br><div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div> | <b>Bladder continence</b> - Select the one category that best describes the patient. <ol style="list-style-type: none"> <li>0. <b>Always continent</b> (no documented incontinence)</li> <li>1. <b>Stress incontinence only</b></li> <li>2. <b>Incontinent less than daily</b> (e.g., once or twice during the 3-day assessment period)</li> <li>3. <b>Incontinent daily</b> (at least once a day)</li> <li>4. <b>Always incontinent</b></li> <li>5. <b>No urine output</b> (e.g., renal failure)</li> <li>9. <b>Not applicable</b> (e.g., indwelling catheter)</li> </ol> |
|------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

#### H0400. Bowel Continence (3-day assessment period)

|                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Code<br><div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div> | <b>Bowel continence</b> - Select the one category that best describes the patient. <ol style="list-style-type: none"> <li>0. <b>Always continent</b></li> <li>1. <b>Occasionally incontinent</b> (one episode of bowel incontinence)</li> <li>2. <b>Frequently incontinent</b> (2 or more episodes of bowel incontinence, but at least one continent bowel movement)</li> <li>3. <b>Always incontinent</b> (no episodes of continent bowel movements)</li> <li>9. <b>Not rated</b>, patient had an ostomy or did not have a bowel movement for the entire 3 days</li> </ol> |
|------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

### Section I Active Diagnoses

#### Comorbidities and Co-existing Conditions

↓ Check all that apply

|                          |                                                                                         |
|--------------------------|-----------------------------------------------------------------------------------------|
| <input type="checkbox"/> | I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)           |
| <input type="checkbox"/> | I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy) |
| <input type="checkbox"/> | I7900. None of the above                                                                |

### Section J Health Conditions

#### J0510. Pain Effect on Sleep

|                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Code<br><div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div> | <b>Ask patient: "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"</b> <ol style="list-style-type: none"> <li>0. <b>Does not apply</b> - I have not had any pain or hurting in the past 5 days → Skip to J1750, History of Falls</li> <li>1. <b>Rarely or not at all</b></li> <li>2. <b>Occasionally</b></li> <li>3. <b>Frequently</b></li> <li>4. <b>Almost constantly</b></li> <li>8. <b>Unable to answer</b></li> </ol> |
|------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

#### J0520. Pain Interference with Therapy Activities

|                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Code<br><div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div> | <b>Ask patient: "Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?"</b> <ol style="list-style-type: none"> <li>0. <b>Does not apply</b> - I have not received rehabilitation therapy in the past 5 days</li> <li>1. <b>Rarely or not at all</b></li> <li>2. <b>Occasionally</b></li> <li>3. <b>Frequently</b></li> <li>4. <b>Almost constantly</b></li> <li>8. <b>Unable to answer</b></li> </ol> |
|------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Patient \_\_\_\_\_ Identifier \_\_\_\_\_ Date \_\_\_\_\_

## ADMISSION

### Section J Health Conditions

#### J0530. Pain Interference with Day-to-Day Activities

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                   |
|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Code<br><input style="width: 40px; height: 20px;" type="text"/> | <p>Ask patient: "Over the past 5 days, <b>how often have you limited your day-to-day activities (<u>excluding</u> rehabilitation therapy sessions) because of pain?"</b></p> <ol style="list-style-type: none"> <li>1. Rarely or not at all</li> <li>2. Occasionally</li> <li>3. Frequently</li> <li>4. Almost constantly</li> <li>8. Unable to answer</li> </ol> |
|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

#### J1750. History of Falls

|                                                                       |                                                                                                                                                                                                     |
|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Code<br><input style="width: 40px; height: 20px;" type="text"/> | <p>Has the patient had two or more falls in the past year or any fall with injury in the past year?</p> <ol style="list-style-type: none"> <li>0. No</li> <li>1. Yes</li> <li>8. Unknown</li> </ol> |
|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

#### J2000. Prior Surgery

|                                                                       |                                                                                                                                                                                      |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Code<br><input style="width: 40px; height: 20px;" type="text"/> | <p>Did the patient have major surgery during the <b>100 days prior to admission?</b></p> <ol style="list-style-type: none"> <li>0. No</li> <li>1. Yes</li> <li>8. Unknown</li> </ol> |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

### Section K Swallowing/Nutritional Status

#### K0520. Nutritional Approaches

Check all of the following nutritional approaches that apply on admission.

|                                                                                                                    | 1.<br>On Admission        |
|--------------------------------------------------------------------------------------------------------------------|---------------------------|
|                                                                                                                    | Check all that apply<br>↓ |
| A. Parenteral/IV feeding                                                                                           | <input type="checkbox"/>  |
| B. Feeding tube (e.g., nasogastric or abdominal (PEG))                                                             | <input type="checkbox"/>  |
| C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids) | <input type="checkbox"/>  |
| D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)                                                    | <input type="checkbox"/>  |
| Z. None of the above                                                                                               | <input type="checkbox"/>  |

### 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<br><input style="width: 40px; height: 20px;" type="text"/> | <p>Does this patient have one or more unhealed pressure ulcers/injuries?</p> <ol style="list-style-type: none"> <li>0. No → Skip to N0415, High-Risk Drug Classes: Use and Indication</li> <li>1. Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</li> </ol> |
|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Patient \_\_\_\_\_

Identifier \_\_\_\_\_

Date \_\_\_\_\_

**ADMISSION****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**

|                                      |                                                                                                                                                                                                                                                                                                    |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Number<br><input type="text"/> | <b>A. 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 only it may appear with persistent blue or purple hues.<br><b>1. Number of Stage 1 pressure injuries</b> |
| Enter Number<br><input type="text"/> | <b>B. 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.<br><b>1. Number of Stage 2 pressure ulcers</b>                                                        |
| Enter Number<br><input type="text"/> | <b>C. 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.<br><b>1. Number of Stage 3 pressure ulcers</b>               |
| Enter Number<br><input type="text"/> | <b>D. 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.<br><b>1. Number of Stage 4 pressure ulcers</b>                                                        |
| Enter Number<br><input type="text"/> | <b>E. Unstageable - Non-removable dressing/device:</b> Known but not stageable due to non-removable dressing/device<br><b>1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device</b>                                                                               |
| Enter Number<br><input type="text"/> | <b>F. Unstageable - Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar<br><b>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</b>                                                                 |
| Enter Number<br><input type="text"/> | <b>G. Unstageable - Deep tissue injury</b><br><b>1. Number of unstageable pressure injuries presenting as deep tissue injury</b>                                                                                                                                                                   |



Patient \_\_\_\_\_ Identifier \_\_\_\_\_ Date \_\_\_\_\_

**ADMISSION****Section N****Medications****N0415. High-Risk Drug Classes: Use and Indication**

| 1. <b>Is taking</b><br>Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes | 1. <b>Is taking</b><br>Check all that apply<br>↓ | 2. <b>Indication noted</b><br>Check all that apply<br>↓ |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------|
| 2. <b>Indication noted</b><br>If column 1 is checked, check if there is an indication noted for all medications in the drug class                     |                                                  |                                                         |
| <b>A. Antipsychotic</b>                                                                                                                               | <input type="checkbox"/>                         | <input type="checkbox"/>                                |
| <b>E. Anticoagulant</b>                                                                                                                               | <input type="checkbox"/>                         | <input type="checkbox"/>                                |
| <b>F. Antibiotic</b>                                                                                                                                  | <input type="checkbox"/>                         | <input type="checkbox"/>                                |
| <b>H. Opioid</b>                                                                                                                                      | <input type="checkbox"/>                         | <input type="checkbox"/>                                |
| <b>I. Antiplatelet</b>                                                                                                                                | <input type="checkbox"/>                         | <input type="checkbox"/>                                |
| <b>J. Hypoglycemic (including insulin)</b>                                                                                                            | <input type="checkbox"/>                         | <input type="checkbox"/>                                |
| <b>Z. None of the above</b>                                                                                                                           | <input type="checkbox"/>                         |                                                         |

**N2001. Drug Regimen Review**

|                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Code<br><input type="checkbox"/> | <b>Did a complete drug regimen review identify potential clinically significant medication issues?</b><br>0. <b>No - No issues found during review</b> → Skip to O0110, Special Treatments, Procedures, and Programs<br>1. <b>Yes - Issues found during review</b> → Continue to N2003, Medication Follow-up<br>9. <b>Not applicable - Patient is not taking any medications</b> → Skip to O0110, Special Treatments, Procedures, and Programs |
|----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**N2003. Medication Follow-up**

|                                        |                                                                                                                                                                                                                                                                         |
|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Code<br><input type="checkbox"/> | <b>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?</b><br>0. <b>No</b><br>1. <b>Yes</b> |
|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**Section O****Special Treatments, Procedures, and Programs****O0110. Special Treatments, Procedures, and Programs**

Check all of the following treatments, procedures, and programs that apply on admission.

|                               | a. <b>On Admission</b><br>Check all that apply<br>↓ |
|-------------------------------|-----------------------------------------------------|
| <b>Cancer Treatments</b>      |                                                     |
| <b>A1. Chemotherapy</b>       | <input type="checkbox"/>                            |
| <b>A2. IV</b>                 | <input type="checkbox"/>                            |
| <b>A3. Oral</b>               | <input type="checkbox"/>                            |
| <b>A10. Other</b>             | <input type="checkbox"/>                            |
| <b>B1. Radiation</b>          | <input type="checkbox"/>                            |
| <b>Respiratory Therapies</b>  |                                                     |
| <b>C1. Oxygen Therapy</b>     | <input type="checkbox"/>                            |
| <b>C2. Continuous</b>         | <input type="checkbox"/>                            |
| <b>C3. Intermittent</b>       | <input type="checkbox"/>                            |
| <b>C4. High-concentration</b> | <input type="checkbox"/>                            |

Patient \_\_\_\_\_

Identifier \_\_\_\_\_

Date \_\_\_\_\_

## ADMISSION

### Section O Special Treatments, Procedures, and Programs

#### O0110. Special Treatments, Procedures, and Programs - Continued

Check all of the following treatments, procedures, and programs that apply on admission.

|                                                               | a.<br>On Admission<br>Check all that apply<br>↓ |
|---------------------------------------------------------------|-------------------------------------------------|
| <b>Respiratory Therapies (continued)</b>                      |                                                 |
| D1. Suctioning                                                | <input type="checkbox"/>                        |
| D2. Scheduled                                                 | <input type="checkbox"/>                        |
| D3. As Needed                                                 | <input type="checkbox"/>                        |
| E1. Tracheostomy care                                         | <input type="checkbox"/>                        |
| F1. Invasive Mechanical Ventilator (ventilator or respirator) | <input type="checkbox"/>                        |
| G1. Non-Invasive Mechanical Ventilator                        | <input type="checkbox"/>                        |
| G2. BiPAP                                                     | <input type="checkbox"/>                        |
| G3. CPAP                                                      | <input type="checkbox"/>                        |
| <b>Other</b>                                                  |                                                 |
| H1. IV Medications                                            | <input type="checkbox"/>                        |
| H2. Vasoactive medications                                    | <input type="checkbox"/>                        |
| H3. Antibiotics                                               | <input type="checkbox"/>                        |
| H4. Anticoagulation                                           | <input type="checkbox"/>                        |
| H10. Other                                                    | <input type="checkbox"/>                        |
| I1. Transfusions                                              | <input type="checkbox"/>                        |
| J1. Dialysis                                                  | <input type="checkbox"/>                        |
| J2. Hemodialysis                                              | <input type="checkbox"/>                        |
| J3. Peritoneal dialysis                                       | <input type="checkbox"/>                        |
| O1. IV Access                                                 | <input type="checkbox"/>                        |
| O2. Peripheral                                                | <input type="checkbox"/>                        |
| O3. Midline                                                   | <input type="checkbox"/>                        |
| O4. Central (e.g., PICC, tunneled, port)                      | <input type="checkbox"/>                        |
| <b>None of the Above</b>                                      |                                                 |
| Z1. None of the above                                         | <input type="checkbox"/>                        |

Patient

Identifier

Date

**DISCHARGE****Section A****Administrative Information****A1250. Transportation (from NACHC®)**

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?



Check all that apply

- ☐ A. Yes, it has kept me from medical appointments or from getting my medications
- ☐ B. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
- ☐ C. No
- ☐ X. Patient unable to respond
- ☐ Y. Patient declines to respond

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**A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge**

Complete only if 44D = 02, 03, 04, 06, 50, 51, 61, 62, 63, 64, 65, or 66

|                          |                                                                                                                                                                             |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Code               | At the time of discharge to another provider, did your facility provide the patient's current reconciled medication list to the subsequent provider?                        |
| <input type="checkbox"/> | 0. No – Current reconciled medication list not provided to the subsequent provider → Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge |
| <input type="checkbox"/> | 1. Yes – Current reconciled medication list provided to the subsequent provider                                                                                             |

**A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider**

Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Complete only if A2121 = 1

| Route of Transmission                                      | Check all that apply     |
|------------------------------------------------------------|--------------------------|
| A. Electronic Health Record                                | <input type="checkbox"/> |
| B. Health Information Exchange                             | <input type="checkbox"/> |
| C. Verbal (e.g., in-person, telephone, video conferencing) | <input type="checkbox"/> |
| D. Paper-based (e.g., fax, copies, printouts)              | <input type="checkbox"/> |
| E. Other Methods (e.g., texting, email, CDs)               | <input type="checkbox"/> |

**A2123. Provision of Current Reconciled Medication List to Patient at Discharge**

Complete only if 44D = 01 or 99

|                          |                                                                                                                                               |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Code               | At the time of discharge, did your facility provide the patient's current reconciled medication list to the patient, family and/or caregiver? |
| <input type="checkbox"/> | 0. No – Current reconciled medication list not provided to the patient, family and/or caregiver → Skip to B1300, Health Literacy              |
| <input type="checkbox"/> | 1. Yes – Current reconciled medication list provided to the patient, family and/or caregiver                                                  |

**A2124. Route of Current Reconciled Medication List Transmission to Patient**

Indicate the route(s) of transmission of the current reconciled medication list to the patient/family/caregiver.

Complete only if A2123 = 1

| Route of Transmission                                                   | Check all that apply     |
|-------------------------------------------------------------------------|--------------------------|
| A. Electronic Health Record (e.g., electronic access to patient portal) | <input type="checkbox"/> |
| B. Health Information Exchange                                          | <input type="checkbox"/> |
| C. Verbal (e.g., in-person, telephone, video conferencing)              | <input type="checkbox"/> |

**Quality Indicators - Discharge**

| Patient                                              | Identifier | Date                     |
|------------------------------------------------------|------------|--------------------------|
| <b>D. Paper-based</b> (e.g., fax, copies, printouts) |            | <input type="checkbox"/> |
| <b>E. Other Methods</b> (e.g., texting, email, CDs)  |            | <input type="checkbox"/> |

Patient

Identifier

Date

**DISCHARGE****Section B      Hearing, Speech, and Vision****B1300. Health Literacy (from Creative Commons©)**

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Enter Code

- 0. **Never**
- 1. **Rarely**
- 2. **Sometimes**
- 3. **Often**
- 4. **Always**
- 7. **Patient declines to respond**
- 8. **Patient unable to respond**

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**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 C1310, Signs and Symptoms of Delirium*
- 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.

**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

Patient

Identifier

Date

**DISCHARGE****Section C Cognitive Patterns****C0400. Recall**

|                                    |                                                                                                                                                                                                                                                                                                                                                                                    |
|------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Code<br><input type="text"/> | 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.<br><b>A. Able to recall "sock"</b><br>2. <b>Yes, no cue required</b><br>1. <b>Yes, after cueing</b> ("something to wear")<br>0. <b>No</b> - could not recall |
| Enter Code<br><input type="text"/> | <b>B. Able to recall "blue"</b><br>2. <b>Yes, no cue required</b><br>1. <b>Yes, after cueing</b> ("a color")<br>0. <b>No</b> - could not recall                                                                                                                                                                                                                                    |
| Enter Code<br><input type="text"/> | <b>C. Able to recall "bed"</b><br>2. <b>Yes, no cue required</b><br>1. <b>Yes, after cueing</b> ("a piece of furniture")<br>0. <b>No</b> - could not recall                                                                                                                                                                                                                        |

**C0500. BIMS Summary Score**

|                                     |                                                                                                                                                    |
|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Score<br><input type="text"/> | <b>Add scores</b> for questions C0200-C0400 and fill in total score (00-15)<br><b>Enter 99 if the patient was unable to complete the interview</b> |
|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|

**C1310. Signs and Symptoms of Delirium (from CAM©)**Code **after completing** Brief Interview for Mental Status and reviewing medical record.**A. Acute Onset Mental Status Change**

|                                    |                                                                                                                            |
|------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| Enter Code<br><input type="text"/> | <b>Is there evidence of an acute change in mental status</b> from the patient's baseline?<br>0. <b>No</b><br>1. <b>Yes</b> |
|------------------------------------|----------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                                 |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Coding:</b><br>0. <b>Behavior not present</b><br>1. <b>Behavior continuously present, does not fluctuate</b><br>2. <b>Behavior present, fluctuates</b> (comes and goes, changes in severity) | <b>↓ Enter Code in Boxes</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                 | <input type="text"/>         | <b>B. Inattention</b> - Did the patient have difficulty focusing attention, for example being easily distractible or having difficulty keeping track of what was being said?                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                 | <input type="text"/>         | <b>C. Disorganized thinking</b> - 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)?                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                 | <input type="text"/>         | <b>D. Altered level of consciousness</b> - Did the patient have altered level of consciousness as indicated by any of the following criteria?<br><ul style="list-style-type: none"> <li><b>vigilant</b> - startled easily to any sound or touch</li> <li><b>lethargic</b> - repeatedly dozed off when being asked questions, but responded to voice or touch</li> <li><b>stuporous</b> - very difficult to arouse and keep aroused for the interview</li> <li><b>comatose</b> - could not be aroused</li> </ul> |

Adapted from: Inouye SK, et al. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment Method. Copyright 2003, Hospital Elder Life Program, LLC.  
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Patient \_\_\_\_\_ Identifier \_\_\_\_\_ Date \_\_\_\_\_

**DISCHARGE****Section D Mood****D0150. Patient Mood Interview (PHQ-2 to 9) (from Pfizer Inc.©)**

Determine if the patient is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, code D0150A1 and D0150B1 as 9, No response, leave D0150A2 and D0150B2 blank, end the PHQ-2 interview, and leave D0160, Total Severity Score blank. Otherwise, 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.<br>Symptom<br>Presence | 2.<br>Symptom<br>Frequency |
|---------------------------|----------------------------|
|---------------------------|----------------------------|

↓ Enter Scores in Boxes ↓

A. Little interest or pleasure in doing things

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

B. Feeling down, depressed, or hopeless

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise, continue.

C. Trouble falling or staying asleep, or sleeping too much

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

D. Feeling tired or having little energy

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

E. Poor appetite or overeating

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

G. Trouble concentrating on things, such as reading the newspaper or watching television

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

H. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

I. Thoughts that you would be better off dead, or of hurting yourself in some way

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

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**D0160. Total Severity Score**

Enter Score

Add scores for all frequency responses in column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)

**D0700. Social Isolation**

How often do you feel lonely or isolated from those around you?

Enter Code

- 0. Never
- 1. Rarely
- 2. Sometimes
- 3. Often
- 4. Always
- 7. Patient declines to respond
- 8. Patient unable to respond

Patient \_\_\_\_\_ Identifier \_\_\_\_\_ Date \_\_\_\_\_

**DISCHARGE****Section GG****Functional Abilities****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. If the patient has an incomplete stay, skip discharge GG0130 items.**

**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 themselves 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**

|                                         |                                                                                                                                                                                                                                      |
|-----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>3.<br/>Discharge<br/>Performance</b> |                                                                                                                                                                                                                                      |
| <b>Enter Codes in Boxes</b><br>↓        |                                                                                                                                                                                                                                      |
| <input type="text"/>                    | <b>A. Eating:</b> 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.                                                           |
| <input type="text"/>                    | <b>B. Oral hygiene:</b> 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. |
| <input type="text"/>                    | <b>C. Toileting hygiene:</b> 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.             |
| <input type="text"/>                    | <b>E. Shower/bathe self:</b> 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.                                         |
| <input type="text"/>                    | <b>F. Upper body dressing:</b> The ability to dress and undress above the waist; including fasteners, if applicable.                                                                                                                 |
| <input type="text"/>                    | <b>G. Lower body dressing:</b> The ability to dress and undress below the waist, including fasteners; does not include footwear.                                                                                                     |
| <input type="text"/>                    | <b>H. Putting on/taking off footwear:</b> 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****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. If the patient has an incomplete stay, skip discharge GG0170 items.

**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 themselves 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.<br>Discharge<br>Performance |                                                                                                                                                                                                                  |
|--------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Codes in Boxes<br>↓      |                                                                                                                                                                                                                  |
| <input type="text"/>           | <b>A. Roll left and right:</b> The ability to roll from lying on back to left and right side, and return to lying on back on the bed.                                                                            |
| <input type="text"/>           | <b>B. Sit to lying:</b> The ability to move from sitting on side of bed to lying flat on the bed.                                                                                                                |
| <input type="text"/>           | <b>C. Lying to sitting on side of bed:</b> The ability to move from lying on the back to sitting on the side of the bed with no back support.                                                                    |
| <input type="text"/>           | <b>D. Sit to stand:</b> The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.                                                                               |
| <input type="text"/>           | <b>E. Chair/bed-to-chair transfer:</b> The ability to transfer to and from a bed to a chair (or wheelchair).                                                                                                     |
| <input type="text"/>           | <b>F. Toilet transfer:</b> The ability to get on and off a toilet or commode.                                                                                                                                    |
| <input type="text"/>           | <b>G. Car transfer:</b> The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/ close door or fasten seat belt.                                          |
| <input type="text"/>           | <b>I. Walk 10 feet:</b> Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space.<br><i>If discharge performance is coded 07, 09, 10, or 8 → Skip to GG0170M, 1 step (curb)</i> |
| <input type="text"/>           | <b>J. Walk 50 feet with two turns:</b> Once standing, the ability to walk at least 50 feet and make two turns.                                                                                                   |
| <input type="text"/>           | <b>K. Walk 150 feet:</b> Once standing, the ability to walk at least 150 feet in a corridor or similar space.                                                                                                    |

Patient \_\_\_\_\_

Identifier \_\_\_\_\_

Date \_\_\_\_\_

**DISCHARGE****Section GG****Functional Abilities****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. If the patient has an incomplete stay, skip discharge GG0170 items.

**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 themselves 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**

|                                                              |                                                                                                                                                                                          |                                                                                                                                                                           |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>3. Discharge Performance</b><br>Enter Codes in Boxes<br>↓ |                                                                                                                                                                                          |                                                                                                                                                                           |
| <input type="text"/>                                         | <b>L. Walking 10 feet on uneven surfaces:</b> The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.                                     |                                                                                                                                                                           |
| <input type="text"/>                                         | <b>M. 1 step (curb):</b> The ability to go up and down a curb or up and down one step.<br><i>If discharge performance is coded 07, 09, 10, or 8 → Skip to GG0170P, Picking up object</i> |                                                                                                                                                                           |
| <input type="text"/>                                         | <b>N. 4 steps:</b> The ability to go up and down four steps with or without a rail.<br><i>If discharge performance is coded 07, 09, 10, or 8 → Skip to GG0170P, Picking up object</i>    |                                                                                                                                                                           |
| <input type="text"/>                                         | <b>O. 12 steps:</b> The ability to go up and down 12 steps with or without a rail.                                                                                                       |                                                                                                                                                                           |
| <input type="text"/>                                         | <b>P. Picking up object:</b> The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.                                              |                                                                                                                                                                           |
| <input type="text"/>                                         | <input type="text"/>                                                                                                                                                                     | <b>Q3. Does the patient use a wheelchair and/or scooter?</b><br>0. No → Skip to J0510, Pain Effect on Sleep<br>1. Yes → Continue to GG0170R, Wheel 50 feet with two turns |
| <input type="text"/>                                         | <b>R. Wheel 50 feet with two turns:</b> Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.                                                     |                                                                                                                                                                           |
| <input type="text"/>                                         | <input type="text"/>                                                                                                                                                                     | <b>RR3. Indicate the type of wheelchair or scooter used.</b><br>1. Manual<br>2. Motorized                                                                                 |
| <input type="text"/>                                         | <b>S. Wheel 150 feet:</b> Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.                                                      |                                                                                                                                                                           |
| <input type="text"/>                                         | <input type="text"/>                                                                                                                                                                     | <b>SS3. Indicate the type of wheelchair or scooter used.</b><br>1. Manual<br>2. Motorized                                                                                 |

**Quality Indicators - Discharge**

Patient \_\_\_\_\_ Identifier \_\_\_\_\_ Date \_\_\_\_\_

**DISCHARGE****Section J****Health Conditions****J0510. Pain Effect on Sleep**

Enter Code

Ask patient: "Over the past 5 days, **how much of the time has pain made it hard for you to sleep at night?**"

0. **Does not apply** – I have not had any pain or hurting in the past 5 days → Skip to J1800, Any Falls Since Admission
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

**J0520. Pain Interference with Therapy Activities**

Enter Code

Ask patient: "Over the past 5 days, **how often have you limited your participation in rehabilitation therapy sessions due to pain?**"

0. **Does not apply** – I have not received rehabilitation therapy in the past 5 days
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

**J0530. Pain Interference with Day-to-Day Activities**

Enter Code

Ask patient: "Over the past 5 days, **how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?**"

1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

**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

Patient \_\_\_\_\_ Identifier \_\_\_\_\_ Date \_\_\_\_\_

**DISCHARGE****Section K Swallowing/Nutritional Status****K0520. Nutritional Approaches**

| 4. Last 7 Days<br>Check all of the nutritional approaches that were received in the last 7 days                    | 4.<br>Last 7 Days         | 5.<br>At Discharge       |
|--------------------------------------------------------------------------------------------------------------------|---------------------------|--------------------------|
| 5. At Discharge<br>Check all of the nutritional approaches that were being received at discharge                   | Check all that apply<br>↓ | ↓                        |
| A. Parenteral/IV feeding                                                                                           | <input type="checkbox"/>  | <input type="checkbox"/> |
| B. Feeding tube (e.g., nasogastric or abdominal (PEG))                                                             | <input type="checkbox"/>  | <input type="checkbox"/> |
| C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids) | <input type="checkbox"/>  | <input type="checkbox"/> |
| D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)                                                    | <input type="checkbox"/>  | <input type="checkbox"/> |
| Z. None of the above                                                                                               | <input type="checkbox"/>  | <input type="checkbox"/> |

**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<br><input type="checkbox"/> | <b>Does this patient have one or more unhealed pressure ulcers/injuries?</b><br>0. No → Skip to N0415, High-Risk Drug Classes: Use and Indication<br>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<br><input type="checkbox"/> | <b>A. 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 only it may appear with persistent blue or purple hues.<br><b>1. Number of Stage 1 pressure injuries</b>                                                                                                                                                                       |
| Enter Number<br><input type="checkbox"/> | <b>B. 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.<br><b>1. Number of Stage 2 pressure ulcers</b><br>If 0 → Skip to M0300C, Stage 3<br><b>2. Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission</b> - enter how many were noted at the time of admission                                          |
| Enter Number<br><input type="checkbox"/> | <b>C. 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.<br><b>1. Number of Stage 3 pressure ulcers</b><br>If 0 → Skip to M0300D, Stage 4<br><b>2. Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission</b> - enter how many were noted at the time of admission |
| Enter Number<br><input type="checkbox"/> | <b>D. 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.<br><b>1. Number of Stage 4 pressure ulcers</b><br>If 0 → Skip to M0300E, Unstageable - Non-removable dressing/device<br><b>2. Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission</b> - enter how many were noted at the time of admission      |

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<br><input type="text"/><br>Enter Number<br><input type="text"/> | <b>E. Unstageable - Non-removable dressing/device:</b> Known but not stageable due to non-removable dressing/device<br><b>1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device</b><br><i>If 0 → Skip to M0300F, Unstageable - Slough and/or eschar</i><br><b>2. Number of <u>these</u> unstageable pressure ulcers/injuries that were present upon admission</b> - enter how many were noted at the time of admission    |
| Enter Number<br><input type="text"/><br>Enter Number<br><input type="text"/> | <b>F. Unstageable - Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar<br><b>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</b><br><i>If 0 → Skip to M0300G, Unstageable - Deep tissue injury</i><br><b>2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission</b> - enter how many were noted at the time of admission |
| Enter Number<br><input type="text"/><br>Enter Number<br><input type="text"/> | <b>G. Unstageable - Deep tissue injury</b><br><b>1. Number of unstageable pressure injuries presenting as deep tissue injury</b><br><i>If 0 → Skip to N0415, High-Risk Drug Classes: Use and Indication</i><br><b>2. Number of <u>these</u> unstageable pressure injuries that were present upon admission</b> - enter how many were noted at the time of admission                                                                                        |

**Section N****Medications****N0415. High-Risk Drug Classes: Use and Indication**

| <b>1. Is taking</b><br>Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes<br><b>2. Indication noted</b><br>If column 1 is checked, check if there is an indication noted for all medications in the drug class | <b>1. Is taking</b><br>Check all that apply<br>↓ | <b>2. Indication noted</b><br>↓ |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------|
| <b>A. Antipsychotic</b>                                                                                                                                                                                                                                                                    | <input type="checkbox"/>                         | <input type="checkbox"/>        |
| <b>E. Anticoagulant</b>                                                                                                                                                                                                                                                                    | <input type="checkbox"/>                         | <input type="checkbox"/>        |
| <b>F. Antibiotic</b>                                                                                                                                                                                                                                                                       | <input type="checkbox"/>                         | <input type="checkbox"/>        |
| <b>H. Opioid</b>                                                                                                                                                                                                                                                                           | <input type="checkbox"/>                         | <input type="checkbox"/>        |
| <b>I. Antiplatelet</b>                                                                                                                                                                                                                                                                     | <input type="checkbox"/>                         | <input type="checkbox"/>        |
| <b>J. Hypoglycemic (including insulin)</b>                                                                                                                                                                                                                                                 | <input type="checkbox"/>                         | <input type="checkbox"/>        |
| <b>Z. None of the above</b>                                                                                                                                                                                                                                                                | <input type="checkbox"/>                         |                                 |

**N2005. Medication Intervention**

|                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Enter Code<br><input type="text"/> | <b>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?</b><br>0. No<br>1. Yes<br>9. Not applicable - There were no potential clinically significant medication issues identified since admission or patient is not taking any medications |
|------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Patient \_\_\_\_\_ Identifier \_\_\_\_\_ Date \_\_\_\_\_

**Section O****Special Treatments, Procedures, and Programs****O0110. Special Treatments, Procedures, and Programs**

Check all of the following treatments, procedures, and programs that apply at discharge.

|                                                                      | c.<br>At Discharge<br>Check all that apply<br>↓ |
|----------------------------------------------------------------------|-------------------------------------------------|
| <b>Cancer Treatments</b>                                             |                                                 |
| <b>A1. Chemotherapy</b>                                              |                                                 |
| A2. IV                                                               | <input type="checkbox"/>                        |
| A3. Oral                                                             | <input type="checkbox"/>                        |
| A10. Other                                                           | <input type="checkbox"/>                        |
| <b>B1. Radiation</b>                                                 | <input type="checkbox"/>                        |
| <b>Respiratory Therapies</b>                                         |                                                 |
| <b>C1. Oxygen Therapy</b>                                            | <input type="checkbox"/>                        |
| C2. Continuous                                                       | <input type="checkbox"/>                        |
| C3. Intermittent                                                     | <input type="checkbox"/>                        |
| C4. High-concentration                                               | <input type="checkbox"/>                        |
| <b>D1. Suctioning</b>                                                | <input type="checkbox"/>                        |
| D2. Scheduled                                                        | <input type="checkbox"/>                        |
| D3. As Needed                                                        | <input type="checkbox"/>                        |
| <b>E1. Tracheostomy care</b>                                         | <input type="checkbox"/>                        |
| <b>F1. Invasive Mechanical Ventilator</b> (ventilator or respirator) | <input type="checkbox"/>                        |
| <b>G1. Non-Invasive Mechanical Ventilator</b>                        | <input type="checkbox"/>                        |
| G2. BiPAP                                                            | <input type="checkbox"/>                        |
| G3. CPAP                                                             | <input type="checkbox"/>                        |
| <b>Other</b>                                                         |                                                 |
| <b>H1. IV Medications</b>                                            | <input type="checkbox"/>                        |
| H2. Vasoactive medications                                           | <input type="checkbox"/>                        |
| H3. Antibiotics                                                      | <input type="checkbox"/>                        |
| H4. Anticoagulation                                                  | <input type="checkbox"/>                        |
| H10. Other                                                           | <input type="checkbox"/>                        |
| <b>I1. Transfusions</b>                                              | <input type="checkbox"/>                        |
| <b>J1. Dialysis</b>                                                  | <input type="checkbox"/>                        |
| J2. Hemodialysis                                                     | <input type="checkbox"/>                        |
| J3. Peritoneal dialysis                                              | <input type="checkbox"/>                        |
| <b>O1. IV Access</b>                                                 | <input type="checkbox"/>                        |
| O2. Peripheral                                                       | <input type="checkbox"/>                        |
| O3. Midline                                                          | <input type="checkbox"/>                        |
| O4. Central (e.g., PICC, tunneled, port)                             | <input type="checkbox"/>                        |

Patient \_\_\_\_\_ Identifier \_\_\_\_\_ Date \_\_\_\_\_

**DISCHARGE****Section O****Special Treatments, Procedures, and Programs****O0110. Special Treatments, Procedures, and Programs**

Check all of the following treatments, procedures, and programs that apply at discharge.

|                              |                                  |
|------------------------------|----------------------------------|
|                              | <b>c.<br/>At Discharge</b>       |
|                              | <b>Check all that apply</b><br>↓ |
| <b>None of the Above</b>     |                                  |
| <b>Z1. None of the above</b> | <input type="checkbox"/>         |

**O0350. Patient's COVID-19 vaccination is up to date.**

|                          |                                                                                 |
|--------------------------|---------------------------------------------------------------------------------|
| <b>Enter Code</b>        | <b>0.</b> No, patient is not up to date<br><b>1.</b> Yes, patient is up to date |
| <input type="checkbox"/> |                                                                                 |

## Section Z

## Assessment Administration

### 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.        |       |                              |      |