Inpatient Psychiatric Facilities Patient Assessment Instrument (IPF-PAI) Version 1.0 - Admission

Admission assessment period is *the first three (3) calendar days of the IPF stay (includes day of admission and two (2) calendar days after).*

Section A Identification Information

A0050. Type of Record

Enter Code ☐

1. **Add new record**
2. **Modify existing record**
3. **Inactivate existing record**

A0100. Facility Provider Numbers

A. **National Provider Identifier (NPI)** ☐☐☐☐☐☐☐☐☐☐

B. **CMS Certification Number (CCN):** ☐☐☐☐☐☐▒▒▒▒▒▒

A0210. Assessment Reference Date

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

A0220. Admission Date

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

A0250. Reason for Assessment

Enter Code ☐

1. **Admission**
4. **Admission lasting less than 3 calendar days**

A0255. Type of Admission

Enter Code ☐

1. **Voluntary**
2. **Involuntary**

A0260. Type of Discharge *(Complete only if A0250 = 4)*

Enter Code ☐

1. **Planned - Following court order**
2. **Planned - Not following court order**
3. **Against medical advice (AMA)**
4. **Unplanned**
5. **Expired**

A0270. Discharge Date *(Complete only if A0250 = 4)*

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

A0500. Legal Name of Patient

A. **First name:**

B. **Middle initial:**

C. **Last name:**

D. **Suffix:**

A0600. Medicare Number

B. **Medicare Number**

A0810. Sex

Enter Code

1. **Male**
2. **Female**

A0900. Birth Date

Month – Day – Year

A1405. Payer Information - Primary Payer

Enter Code

01. **Medicare - Part A** (traditional fee-for-service)
02. **Medicare - Part C** (Medicare Advantage)
03. **Medicaid fee-for-service**
04. **Medicaid - other** (e.g., managed care)
05. **Workers' compensation**
06. **Title Programs** (e.g., Title III, V, XX)
07. **Other government** (e.g., TRICARE, VA, etc.)
08. **Private insurance - not managed care**
09. **Private insurance - managed care** (e.g., PPO, HMO)
10. **Self-pay**
98. **Other payer**
99. **Unknown**

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

B0600. Speech Clarity

Enter Code	
☐	**Select best description of speech pattern** 0. **Clear speech**—distinct intelligible words 1. **Unclear speech**—slurred or mumbled words 2. **No speech**—absence of spoken words

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

Section D | Mood

D1000. Suicide Screening

Enter Code	
☐	**Has the patient been screened for suicide risk?** 1. **Yes**—using a standardized tool 2. **Yes**—through clinical assessment 7. Patient declined to respond 9. Patient unable to be assessed

Section GG Functional Abilities

GG0170. Mobility

For the activity, code the patient's performance using the 6-point scale. If the activity was not attempted, 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 themself 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 and provides more than half the effort.
02. **Substantial/maximal assistance**—Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent**—Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

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

1. Admission Performance **Enter Codes in Boxes ↓**	
☐☐	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).

Section I Active Diagnoses

I0060. Indicate the patient's primary medical condition category

Enter Code ☐☐

Indicate the patient's primary medical condition category that best describes the primary reason for admission.

01. **Anxiety disorders**
02. **Delirium, dementia, and amnestic and other cognitive disorders**
03. **Eating disorders**
04. **Mood disorders**
05. **Schizophrenia and other psychotic disorders**
06. **Substance-related disorders including alcohol-related disorders**
09. **Other diagnosis—not included in one of the above categories**

Section OO | Special Services, Treatments, and Interventions

OO0115. Special Services, Treatments, and Interventions in the Inpatient Psychiatric Setting *(Complete only if A0250 = 4)*

Indicate all of the following services, treatments, and interventions received during *the entire IPF stay.*

	b. Discharge
	Check all that apply ↓
Psychiatric Treatments	
A1. **Medications**	☐
B1. **Brain Stimulation**	☐
B2. **Electroconvulsive Therapy (ECT)**	☐
B3. **Transcranial Magnetic Stimulation (rTMS)**	☐
B4. **Other**	☐
C1. **Non-Pharmacological Treatment (Other than Brain Stimulation)**	☐
C2. **Therapy (Individual or Group)**	☐
C3. **Therapeutic Activities**	☐
C4. **Other**	☐
Restrictive Interventions	
D1. **Seclusion**	☐
E1. **Restraint**	☐
E2. **Chemical Restraints**	☐
E3. **Physical Restraints**	☐
E4. **Other**	☐
F1. **Other Interventions**	☐
F2. **Unit Restrictions**	☐
F3. **Line of Sight Supervision**	☐
F4. **1:1 Observation**	☐
F5. **Other**	☐
None of the Above	
Z1. **None of the Above**	☐

Section Z | Record Administration

Z0510. IPF-PAI Completion Date

This date represents completion of the IPF-PAI for this patient record.

B. **Date**

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year