

CARE Tool

Master Document

(Core and Supplemental Items)

General Information: Please note that this instrument uses the term “2-day assessment period” to represent the 2-day admission and 2-day prior-to-discharge look-back periods.

OMB Version
7/17/07

Signatures of Persons who Completed a Portion of the Accompanying Assessment

I certify that the accompanying information accurately reflects patient assessment 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 may be used as a basis for ensuring that the patient receives 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. I also certify that I am authorized to submit this information by this facility on its behalf.

	Name/Signature	Credenti al	License # (if required)	Sections Worked On	Attestation Date
	(Joe Smith)	(RN)	(MA000000)	III A2-6	(MM/DD/YYYY)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

I. Administrative Items

A. Assessment Type		B. Provider Information	
Enter <input type="checkbox"/> Code	A1. Reason for assessment 1. Acute discharge 2. PAC admission 3. PAC discharge 4. Interim 5. Expired	B1. Provider's Name <input type="text"/>	
		B2. Medicare Provider's Identification Number <input type="text"/>	
		B3. National Provider Identification Code (NPI) <input type="text"/>	
C. Patient Information			
C1. Patient's First Name <input type="text"/>		C4. Patient's Nickname (optional) <input type="text"/>	
C2. Patient's Middle Name <input type="text"/>		C5. Patient's Medicare Health Insurance Number <input type="text"/>	
C3. Patient's Last Name <input type="text"/>		C6. Patient's Medicaid Number <input type="text"/>	
C7. Patient's Identification/Provider Account Number <input type="text"/>			
C8. Birth Date <input type="text"/> / <input type="text"/> / <input type="text"/> MM DD YYYY		Enter <input type="checkbox"/> Code Enter <input type="checkbox"/> Code	C12. Is English the patient's primary language? 0. No 1. Yes
C9. Social Security Number (optional) <input type="text"/>			C12a. If not, is an interpreter available? 0. No 1. Yes
Enter <input type="checkbox"/> Code	C10. Gender 1. Male 2. Female		C12b. If not, what is the patient's primary language? <input type="text"/>
	Check all that apply <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	C11. Race/Ethnicity a. American Indian or Alaska Native b. Asian c. Black or African American d. Hispanic or Latino e. Native Hawaiian or Pacific Islander f. White g. Unknown	
		C13b. Does the medical record document who has authority to make decisions if the patient is unable? 0. No 1. Yes	C13c. Does the medical record document whether to resuscitate patient if cardiopulmonary arrest occurs? 0. No 1. Yes

I. Administrative Items (cont.)

D. Payer Information: Current Payment Source(s)

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

T.1 How long did it take you to complete this section? _____ (minutes)

II. Admission Information

A. Pre-admission Service Use

A1. Admission Date		A3. If admitted from a medical setting, what was the primary diagnosis in the previous setting?	
<input type="text"/> / <input type="text"/> / <input type="text"/> <small>MM DD YYYY</small>		A3a. Last Primary Diagnosis	A3b. ICD-9 CM Code
		<input type="text"/>	<input type="text"/>
Enter <input type="text"/> Code	A2. Admitted From. Immediately preceding this admission, where was the patient?	Check all that apply	A4. In the last 2 months, what other medical services besides those identified in A2 has the patient received?
	1. Directly from community (e.g., private home, assisted living, group home, adult foster care, long term nursing facility) 2. Skilled nursing facility (includes subacute SNF, transitional care unit) 3. Short-stay acute hospital (IPPS) 4. Long-term care hospital (LTCH) 5. Inpatient rehabilitation hospital or unit (IRF) 6. Psychiatric hospital or unit 7. Inpatient Hospice 8. Other (specify) _____		a. Skilled nursing facility (includes subacute SNF, transitional care unit) b. Short-stay acute hospital (IPPS) c. Long-term care hospital (LTCH) d. Inpatient rehabilitation hospital or unit (IRF) e. Psychiatric hospital or unit f. Home health g. Hospice h. Outpatient i. None

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

B1. Prior to this recent illness, where did the patient live?		B3. If the patient lived in the community prior to this illness, who did the patient live with?	
Enter <input type="text"/> Code	1. Private residence 2. Community based residence (e.g., assisted living residence, group home, adult foster care) 3. Permanently in a long-term care facility (e.g., nursing home) 4. Other (e.g., shelter, jail, no known address) 9. Unknown	Check all that apply	a. Lives alone b. Spouse or significant other c. Adult child (> 18 years old) d. Other child (≤ 18 years old) e. Other unpaid family member or friend f. Paid help living in the home (other than home care) g. Unknown
	B2. If the patient lived in the community prior to this illness, please provide the patient's ZIP Code (if patient's residence was in U.S.). <input type="text"/>		
<input type="checkbox"/> Lives Outside U.S. <input type="checkbox"/> Unknown			

II. Admission Information (cont.)

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

Check all that apply

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

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

<p>3. Independent – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.</p> <p>2. Needed some help – Patient needed some help from another person to complete activities.</p> <p>1. Dependent – A helper completed the activity for the patient.</p> <p>9. Unknown</p>	<p>Enter <input type="checkbox"/> Code</p>	B5a. Self Care: Did the patient need help bathing, dressing, or eating?
	<p>Enter <input type="checkbox"/> Code</p>	B5b. Mobility (Ambulation): Did the patient need assistance with walking from room to room (with or without devices such as cane, crutch, or walker)?
	<p>Enter <input type="checkbox"/> Code</p>	B5c. Stairs (Ambulation): Did the patient need assistance with stairs (with or without devices such as cane, crutch, or walker)?
	<p>Enter <input type="checkbox"/> Code</p>	B5d. Mobility (Wheelchair): Did the patient need assistance with moving from room to room using a wheelchair, scooter, or other wheeled mobility device?
	<p>Enter <input type="checkbox"/> Code</p>	B5e. Functional Cognition: Did the patient need help planning regular tasks, such as shopping or remembering to take medication?

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

Check all that apply

- a. **Cane/crutch**
- b. **Walker**
- c. **Wheelchair/scooter full time**
- d. **Wheelchair/scooter part time**
- e. **Mechanical lift required**
- f. **Other** (specify) _____

Enter

Code

B7. History of Falls. Does the patient have a history of falls?

- 0. No**
- 1. Yes**
- 9. Unknown**

Enter

Code

B8. Prior Mental Status. Is there any evidence of an acute change in mental status from the patient's status prior to this current illness, exacerbation, or injury?

- 0. No**
- 1. Yes**
- 9. Unknown**

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

III. Current Medical Items

A. Primary Diagnosis

Indicate the **primary diagnosis** at the time of assessment. **Indicate the ICD-9 CM code**, if available. For **V-codes**, also indicate the medical diagnosis and associated ICD-9 CM code. Be as specific as possible.

A1. Primary Diagnosis at Assessment <input type="text"/>	A2a. If Primary Diagnosis was a V-code, what was the primary medical condition or injury being treated? <input type="text"/>
A2. ICD-9 CM Code <input type="text"/>	A2b. ICD-9 CM Code <input type="text"/>

B. Other Diagnoses, Comorbidities, and Complications

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

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

Enter <input type="text"/> Code	B16. Is this list complete? 0. No 1. Yes
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III. Current Medical Items (cont.)

C. Procedures (Diagnostic and Therapeutic Interventions) (If home health agency, skip to Section D. Treatments.)

Enter <input type="checkbox"/> Code	C1. Did the patient have one or more therapeutic or major procedures during this admission? 0. No (If No , skip to Section D. Treatments.) 1. Yes
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List up to 15 procedures (diagnostic and therapeutic interventions) performed during this admission and report the appropriate procedure code. Indicate if an orthopedic procedure was bilateral (e.g., bilateral knee replacement, bilateral hip replacement).

Procedure	ICD-9 CM Procedure Code	Bilateral
C1a. <input type="text"/>	C1b. <input type="text"/>	C1c. <input type="checkbox"/>
C2a. <input type="text"/>	C2b. <input type="text"/>	C2c. <input type="checkbox"/>
C3a. <input type="text"/>	C3b. <input type="text"/>	C3c. <input type="checkbox"/>
C4a. <input type="text"/>	C4b. <input type="text"/>	C4c. <input type="checkbox"/>
C5a. <input type="text"/>	C5b. <input type="text"/>	C5c. <input type="checkbox"/>
C6a. <input type="text"/>	C6b. <input type="text"/>	C6c. <input type="checkbox"/>
C7a. <input type="text"/>	C7b. <input type="text"/>	C7c. <input type="checkbox"/>
C8a. <input type="text"/>	C8b. <input type="text"/>	C8c. <input type="checkbox"/>
C9a. <input type="text"/>	C9b. <input type="text"/>	C9c. <input type="checkbox"/>
C10a. <input type="text"/>	C10b. <input type="text"/>	C10c. <input type="checkbox"/>
C11a. <input type="text"/>	C11b. <input type="text"/>	C11c. <input type="checkbox"/>
C12a. <input type="text"/>	C12b. <input type="text"/>	C12c. <input type="checkbox"/>
C13a. <input type="text"/>	C13b. <input type="text"/>	C13c. <input type="checkbox"/>
C14a. <input type="text"/>	C14b. <input type="text"/>	C14c. <input type="checkbox"/>
C15a. <input type="text"/>	C15b. <input type="text"/>	C15c. <input type="checkbox"/>

Enter <input type="checkbox"/> Code	C16. Is this list complete? 0. No 1. Yes
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III. Current Medical Items (cont.)

D. Treatments

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

Check all that apply	Admitted/Discharged With:	Used at Any Time During Stay	
	D1a. <input type="checkbox"/>	D1b. <input type="checkbox"/>	D1. None
	D2a. <input type="checkbox"/>	D2b. <input type="checkbox"/>	D2. Insulin Drip
	D3a. <input type="checkbox"/>	D3b. <input type="checkbox"/>	D3. Total Parenteral Nutrition
	D4a. <input type="checkbox"/>	D4b. <input type="checkbox"/>	D4. Central Line Management
	D5a. <input type="checkbox"/>	D5b. <input type="checkbox"/>	D5. Blood Transfusion(s)
	D6a. <input type="checkbox"/>	D6b. <input type="checkbox"/>	D6. Controlled Parenteral Analgesia – Peripheral
	D7a. <input type="checkbox"/>	D7b. <input type="checkbox"/>	D7. Controlled Parenteral Analgesia – Epidural
	D8a. <input type="checkbox"/>	D8b. <input type="checkbox"/>	D8. Left Ventricular Assistive Device (LVAD)
	D9a. <input type="checkbox"/>	D9b. <input type="checkbox"/>	D9. Continuous Cardiac Monitoring
			D9c. Specify reason for continuous monitoring: _____
	D10a. <input type="checkbox"/>	D10b. <input type="checkbox"/>	D10. Chest Tube(s)
	D11a. <input type="checkbox"/>	D11b. <input type="checkbox"/>	D11. ET Tube Care and Management
	D12a. <input type="checkbox"/>	D12b. <input type="checkbox"/>	D12. Trach Tube with Suctioning
			D12c. Specify frequency of suctioning: Every _____ hours
	D13a. <input type="checkbox"/>	D13b. <input type="checkbox"/>	D13. High O ₂ Concentration Delivery System with FiO ₂ > 40%
	D14a. <input type="checkbox"/>	D14b. <input type="checkbox"/>	D14. Ventilator – Weaning
	D15a. <input type="checkbox"/>	D15b. <input type="checkbox"/>	D15. Ventilator – Non-Weaning
	D16a. <input type="checkbox"/>	D16b. <input type="checkbox"/>	D16. Hemodialysis
	D17a. <input type="checkbox"/>	D17b. <input type="checkbox"/>	D17. Peritoneal Dialysis
	D18a. <input type="checkbox"/>	D18b. <input type="checkbox"/>	D18. Fistula or Other Drain Management
	D19a. <input type="checkbox"/>	D19b. <input type="checkbox"/>	D19. Negative Pressure Wound Therapy
	D20a. <input type="checkbox"/>	D20b. <input type="checkbox"/>	D20. Complex Dressing Changes with positioning and skin separation/traction that requires at least two persons
	D21a. <input type="checkbox"/>	D21b. <input type="checkbox"/>	D21. Halo
	D22a. <input type="checkbox"/>	D22b. <input type="checkbox"/>	D22. Complex External Fixators (e.g., Ilizarov)
	D23a. <input type="checkbox"/>	D23b. <input type="checkbox"/>	D23. One-on-One 24-Hour Supervision
			D23c. Specify reason for 24-hour supervision: _____
	D24a. <input type="checkbox"/>	D24b. <input type="checkbox"/>	D24. Specialty Bed (e.g., air fluidized, bariatric, low air loss, or rotation bed)
	D25a. <input type="checkbox"/>	D25b. <input type="checkbox"/>	D25. Multiple IV Antibiotic Administration
	D26a. <input type="checkbox"/>	D26b. <input type="checkbox"/>	D26. IV Vaso-actors (e.g., pressors, dilators, Flolan for pulmonary edema)
	D27a. <input type="checkbox"/>	D27b. <input type="checkbox"/>	D27. IV Anti-coagulants
	D28a. <input type="checkbox"/>	D28b. <input type="checkbox"/>	D28. IV Chemotherapy
	D29a. <input type="checkbox"/>	D29b. <input type="checkbox"/>	D29. Indwelling Urinary Catheter
	D30a. <input type="checkbox"/>	D30b. <input type="checkbox"/>	D30. Intermittent Urinary Catheterization
	D31a. <input type="checkbox"/>	D31b. <input type="checkbox"/>	D31. Ostomy
	D32a. <input type="checkbox"/>	D32b. <input type="checkbox"/>	D32. External Fecal Management System

III. Current Medical Items (cont.)

E. Medications

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

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

Enter

Code

E31. Is this list complete?

0. No

1. Yes

III. Current Medical Items (cont.)

F. Allergies & Adverse Drug Reactions

Enter <input type="text"/> Code	<p>F1. Does patient have allergies or any known adverse drug reactions?</p> <p>0. None known (If Unknown, skip to Section G. Skin Integrity.)</p> <p>1. Yes (If Yes, list all allergies [e.g., food, medications, other] and describe the adverse drug reactions.)</p>
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Allergies/Cause of Reaction	Patient Reactions
F1a. _____	F1b. _____
F2a. _____	F2b. _____
F3a. _____	F3b. _____
F4a. _____	F4b. _____
F5a. _____	F5b. _____
F6a. _____	F6b. _____
F7a. _____	F7b. _____
F8a. _____	F8b. _____

Enter <input type="text"/> Code	<p>F9. If all eight lines are used, is the list complete?</p> <p>0. No</p> <p>1. Yes</p>
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G. Skin Integrity

G1-2. PRESENCE OF PRESSURE ULCERS

Enter <input type="text"/> Code	<p>G1. Has this patient had a formal evaluation for risk of developing pressure ulcers?</p> <p>0. No</p> <p>1. Yes, it indicated not high risk</p> <p>2. Yes, it indicated high risk (e.g., on Braden or Norton tools) or healed scars or active pressure ulcers are present.</p>	Enter <input type="text"/> Code	<p>G2. Does this patient have one or more unhealed pressure ulcer(s) at stage 2 or higher?</p> <p>0. No (If No, skip to G3. Major Wounds.)</p> <p>1. Yes</p>
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IF THE PATIENT HAS ONE OR MORE STAGE 2-4 PRESSURE ULCERS, indicate the number of unhealed pressure ulcers at each stage.

CODING:	Number of unhealed pressure ulcers present	Pressure ulcer at stage 2, stage 3, or stage 4 only:
<p>Please specify the number of ulcers at each stage:</p> <p>0 = 0 ulcers</p> <p>1 = 1 ulcer</p> <p>2 = 2 ulcers</p> <p>3 = 3 ulcers</p> <p>4 = 4 ulcers</p> <p>5 = 5 ulcers</p> <p>6 = 6 ulcers</p> <p>7 = 7 ulcers</p> <p>8 = 8 or more ulcers</p> <p>9 = Unknown</p>	Stage 2 Enter <input type="text"/> Code	<p>G2a. Stage 2 – Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.</p>
	Stage 3 Enter <input type="text"/> Code	<p>G2b. Stage 3 – Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.</p>
	Stage 4 Enter <input type="text"/> Code	<p>G2c. Stage 4 – Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.</p>
	Unstageable Enter <input type="text"/> Code	<p>G2d. Unstageable – Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, gray, green, or brown) or eschar (tan, brown, or black) in the wound bed. Include ulcers that are known or likely, but are not stageable due to non-removable dressing or cast or possible deep tissue injury in evolution.</p>

III. Current Medical Items (cont.)

G. Skin Integrity (cont.)

<p>Number of Unhealed Stage 2 Ulcers</p> <input type="text"/>	<p>G2e. Number of unhealed stage 2 ulcers known to be present for more than 1 month.</p> <p>If the patient has one or more unhealed stage 2 pressure ulcers, record the number present today that were first observed more than 1 month ago, according to the best available records. If the patient has no unhealed stage 2 pressure ulcers, record "0."</p>	<p>G5. MAJOR WOUND (excluding pressure ulcers)</p>													
<p>G3. If any pressure ulcer is stage 3 or 4 (or if eschar is present) during the 2-day assessment period, please record the most recent measurements for the LARGEST ulcer (or eschar):</p> <p>a. Longest length in any direction</p> <p>b. Width of SAME unhealed ulcer or eschar</p> <p>c. Date of most recent measurement date of SAME ulcer or eschar</p>		<p>G5a-e. NUMBER OF MAJOR WOUNDS</p>	<table border="1"> <thead> <tr> <th>Number of Major Wounds</th> <th>Type(s) of Major Wound(s)</th> </tr> </thead> <tbody> <tr> <td><input type="text"/> <input type="text"/></td> <td>G5a. Non-healing surgical wound</td> </tr> <tr> <td><input type="text"/> <input type="text"/></td> <td>G5b. Trauma-related wound</td> </tr> <tr> <td><input type="text"/> <input type="text"/></td> <td>G5c. Diabetic foot ulcer(s)</td> </tr> <tr> <td><input type="text"/> <input type="text"/></td> <td>G5d. Vascular ulcer (arterial or venous including diabetic ulcers not located on the foot)</td> </tr> <tr> <td><input type="text"/> <input type="text"/></td> <td>G5e. Other (specify) _____</td> </tr> </tbody> </table>	Number of Major Wounds	Type(s) of Major Wound(s)	<input type="text"/> <input type="text"/>	G5a. Non-healing surgical wound	<input type="text"/> <input type="text"/>	G5b. Trauma-related wound	<input type="text"/> <input type="text"/>	G5c. Diabetic foot ulcer(s)	<input type="text"/> <input type="text"/>	G5d. Vascular ulcer (arterial or venous including diabetic ulcers not located on the foot)	<input type="text"/> <input type="text"/>	G5e. Other (specify) _____
Number of Major Wounds	Type(s) of Major Wound(s)														
<input type="text"/> <input type="text"/>	G5a. Non-healing surgical wound														
<input type="text"/> <input type="text"/>	G5b. Trauma-related wound														
<input type="text"/> <input type="text"/>	G5c. Diabetic foot ulcer(s)														
<input type="text"/> <input type="text"/>	G5d. Vascular ulcer (arterial or venous including diabetic ulcers not located on the foot)														
<input type="text"/> <input type="text"/>	G5e. Other (specify) _____														
<p>Enter <input type="text"/> Code</p>	<p>G4. Indicate if any unhealed stage 3 or stage 4 pressure ulcer(s) has tunneling (sinus tract) present.</p> <p>0. No 1. Yes 8. Unable to assess</p>	<p>G6. TURNING SURFACES NOT INTACT</p>													
		<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Check All That Apply</p> <p>Turning Surface</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Indicate which of the following turning surfaces have either a pressure ulcer or major wound.</p> <p>a. Skin for all turning surfaces is intact</p> <p>b. Right hip not intact</p> <p>c. Left hip not intact</p> <p>d. Back/buttocks not intact</p> <p>e. None of the above apply.</p>												

III. Current Medical Items (cont.)

H. Physiologic Factors

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

Date	Please complete using format below	Value	Please check if NOT tested	Check here if value is estimated	Measures
Anthropometric Measures					
H1a.	___/___/___	xxx.x	H1b.	<input type="checkbox"/>	H1d. <input type="checkbox"/>
H2a.	___/___/___	xxx.x	H2b.	<input type="checkbox"/>	H2d. <input type="checkbox"/>
H3a.	___/___/___	xxx.x	H3b.	<input type="checkbox"/>	H3d. <input type="checkbox"/>
H4a.	___/___/___	xxx.x	H4b.	<input type="checkbox"/>	H4d. <input type="checkbox"/>
Vital Signs					
H5a.	___/___/___	xxx.x	H5b.	<input type="checkbox"/>	H5. Temperature (°F) OR
H6a.	___/___/___	xx.x	H6b.	<input type="checkbox"/>	H6. Temperature (°C)
H7a.	___/___/___	xxx	H7b.	<input type="checkbox"/>	H7. Heart Rate (beats/min)
H8a.	___/___/___	xx	H8b.	<input type="checkbox"/>	H8. Respiratory Rate (breaths/min)
H9a.	___/___/___	xxx/xxx	H9b.	<input type="checkbox"/>	H9. Blood Pressure mm/Hg
H10a.	___/___/___	xxx	H10b.	<input type="checkbox"/>	H10. O ₂ saturation (Pulse Oximetry) %
Laboratory					
H11a.	___/___/___	xx	H11b.	<input type="checkbox"/>	H11. Hemoglobin (gm/dL)
H12a.	___/___/___	xx	H12b.	<input type="checkbox"/>	H12. Hematocrit (%)
H13a.	___/___/___	xx.x	H13b.	<input type="checkbox"/>	H13. WBC (K/mm ³)
H14a.	___/___/___	xx.x	H14b.	<input type="checkbox"/>	H14. HbA1c (%)
H15a.	___/___/___	xxx	H15b.	<input type="checkbox"/>	H15. Sodium (mEq/L)
H16a.	___/___/___	x.x	H16b.	<input type="checkbox"/>	H16. Potassium (mEq/L)
H17a.	___/___/___	xx	H17b.	<input type="checkbox"/>	H17. BUN (mg/dL)
H18a.	___/___/___	x.x	H18b.	<input type="checkbox"/>	H18. Creatinine (mg/dL)
H19a.	___/___/___	x.x	H19b.	<input type="checkbox"/>	H19. Albumin (gm/dL)
H20a.	___/___/___	xx.x	H20b.	<input type="checkbox"/>	H20. Prealbumin (mg/dL)
H21a.	___/___/___	x.x	H21b.	<input type="checkbox"/>	H21. INR
Arterial Blood Gases (ABGs)					
H22a.	___/___/___	x.xx	H22b.	<input type="checkbox"/>	H22. pH
H23a.	___/___/___	xxx	H23b.	<input type="checkbox"/>	H23. PaCO ₂ (mm/Hg)
H24a.	___/___/___	xxx	H24b.	<input type="checkbox"/>	H24. HCO ₃ (mEq/L)
H25a.	___/___/___	xxx	H25b.	<input type="checkbox"/>	H25. PaO ₂ (mm/Hg)
H26a.	___/___/___	xx	H26b.	<input type="checkbox"/>	H26. SaO ₂ (%)
H27a.	___/___/___	xx	H27b.	<input type="checkbox"/>	H27. B.E. (base excess) (mEq/L)
Other					
H28a.	___/___/___	xx	H28b.	<input type="checkbox"/>	H28. Left Ventricular Ejection Fraction (%)

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

IV. Cognitive Status

A. Comatose		B. Brief Interview for Mental Status (BIMS) (cont.)	
AI. Persistent vegetative state/no discernible consciousness at time of admission (discharge)		B3. Temporal Orientation (orientation to year and month)	
Enter <input type="text"/> Code	0. No 1. Yes (If Yes, skip to G6.)	Enter <input type="text"/> Code	B3a. Ask patient: "Please tell me what year it is right now." Patient's answer is: 3. Correct 2. Missed by 1 year 1. Missed by 2 to 5 years 0. Missed by more than 5 years or no answer
B. Brief Interview for Mental Status (BIMS)			
B1. BIMS Interview Attempted?			
Enter <input type="text"/> Code	0. No 1. Yes (If Yes, skip to B2. Repetition of three words.)	Enter <input type="text"/> Code	B3b. Ask patient: "What month are we in right now?" Patient's answer is: 2. Accurate within 5 days 1. Missed by 6 days to 1 month 0. Missed by more than 1 month or no answer
Enter <input type="text"/> Code	B1a. Indicate reason that BIMS interview was not attempted and then skip to Section C. Observational Assessment: 1. Unresponsive or minimally conscious 2. Communication disorder 3. No interpreter available 4. Other (specify) _____	Enter <input type="text"/> Code	
B2. Repetition of Three Words		B4. Recall	
Enter <input type="text"/> 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 by patient after first attempt: 3. Three 2. Two 1. One 0. None After the patient's first attempt say: "I will repeat each of the three words with a cue and ask you about them later: sock, something to wear; blue, a color; bed, a piece of furniture." You may repeat the words up to two more times.	Enter <input type="text"/> Code	Ask patient: "Let's go back to the first question. What were those three words that I asked you to repeat?" If unable to remember a word, give cue (i.e., something to wear; a color; a piece of furniture for that word).
Enter <input type="text"/> Code		Enter <input type="text"/> Code	B4a. Recalls "sock?" 2. Yes, no cue required 1. Yes, after cueing ("something to wear") 0. No, could not recall
Enter <input type="text"/> Code		Enter <input type="text"/> Code	B4b. Recalls "blue?" 2. Yes, no cue required 1. Yes, after cueing ("a color") 0. No, could not recall
Enter <input type="text"/> Code		Enter <input type="text"/> Code	B4c. Recalls "bed?" 2. Yes, no cue required 1. Yes, after cueing ("a piece of furniture") 0. No, could not recall

IV. Cognitive Status (cont.)

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

Enter <input type="text"/> Code	C1. Short-term memory: Seems or appears to recall after 5 minutes. 0. Memory OK 1. Memory problem 8. Unable to assess	Check all that apply	C3. Memory/recall ability: Check all that the patient normally recalled during the 2-day assessment period: C3a. Current season C3b. Location of own room C3c. Staff names and faces C3d. That he or she is in a hospital, nursing home, or home C3e. None of the above are recalled or unable to assess
Enter <input type="text"/> Code	C2. Long-term memory: Seems or appears to recall long past. 0. Memory OK 1. Memory problem 8. Unable to assess	Enter <input type="text"/> Code	C4. Cognitive skills for daily decision making: Makes decisions regarding tasks of daily life: 0. Independent: decisions consistently reasonable 1. Impaired: some difficulty or decisions poor; supervision required 8. Unable to assess

D. Confusion Assessment Method

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

CODING: 0. Behavior is not present. 1. Behavior continuously present , does not fluctuate. 2. Behavior present, fluctuates (e.g., comes and goes, changes in severity)	↓ Enter Code in Boxes ↓	Enter <input type="text"/> Code	D1. Inattention: The patient has difficulty focusing attention (e.g., easily distracted, out of touch, or difficulty keeping track of what is said).
		Enter <input type="text"/> Code	D2. Disorganized thinking: The patient's thinking is disorganized or incoherent (e.g., rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching of topics or ideas).
		Enter <input type="text"/> Code	D3. Altered level of consciousness/alertness: The patient has an altered level of consciousness: vigilant (e.g., startles easily to any sound or touch), lethargic (e.g., repeatedly dozes off when asked questions, but responds to voice or touch), stuporous (e.g., very difficult to arouse and keep aroused for the interview), or comatose (e.g., cannot be aroused).
		Enter <input type="text"/> Code	D4. Psychomotor retardation: Patient has an unusually decreased level of activity (e.g., sluggishness, staring into space, staying in one position, moving very slowly).

IV. Cognitive Status (cont.)

E. Behavioral Signs & Symptoms		F2. Patient Health Questionnaire (PHQ2) cont.	
Has the patient exhibited any of the following behaviors during the 2-day assessment period?		Enter <input type="text"/> Code	F2c. Feeling down, depressed, or hopeless? 0. No (If No, skip to question F3.) 1. Yes 8. Unable to respond (If Unable, skip to question F3.)
Enter <input type="text"/> Code	E1. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing). 0. No 1. Yes	Enter <input type="text"/> Code	F2d. If Yes, how many days in the last 2 weeks? 0. Not at all (0 to 1 days) 1. Several days (2 to 6 days) 2. More than half of the days (7 to 11 days) 3. Nearly every day (12 to 14 days)
Enter <input type="text"/> Code	E3. Other disruptive or dangerous behavioral symptoms not directed towards others, including self-injurious behaviors (e.g., hitting or scratching self, attempts to pull out IVs, pacing). 0. No 1. Yes	Enter <input type="text"/> Code	F3. Feeling Sad Ask patient: "During the past 2 weeks, how often would you say, 'I feel sad'?" 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 8. Unable to respond
F. Mood			
Enter <input type="text"/> Code	F1. Mood Interview Attempted? 0. No (If No, skip to Section G6. Observed Pain.) 1. Yes		
F2. Patient Health Questionnaire (PHQ2)			
Ask patient: "During the last 2 weeks, have you been bothered by any of the following problems?"			
Enter <input type="text"/> Code	F2a. Little interest or pleasure in doing things? 0. No (If No, skip to question F2c.) 1. Yes 8. Unable to respond (If Unable, skip to question F2c.)		
Enter <input type="text"/> Code	F2b. If Yes, how many days in the last 2 weeks? 0. Not at all (0 to 1 days) 1. Several days (2 to 6 days) 2. More than half of the days (7 to 11 days) 3. Nearly every day (12 to 14 days)		

IV. Cognitive Status (cont.)

G. Pain

Enter <input type="checkbox"/> Code	G1. Pain Interview Attempted? 0. No (If No, skip to G6. Pain Observational Assessment.) 1. Yes	Enter <input type="checkbox"/> Code	G4. Pain Severity Ask patient: "Please rate the intensity of your worst pain during the last 2 days." 1. Mild 2. Moderate 3. Severe 4. Very severe, horrible 8. Unable to answer or no response. (Skip to G6. Pain Observational Assessment.)
Enter <input type="checkbox"/> Code	G2. Pain Presence Ask patient: "Have you had pain or hurting at any time during the last 2 days?" 0. No (If No, skip to Section V. Impairments.) 1. Yes 8. Unable to answer or no response (Skip to G6. Pain Observational Assessment.)	Enter <input type="checkbox"/> Code	G5a. Pain Effect on Function Ask patient: "During the past 2 days, has pain made it hard for you to sleep at night?" 0. No 1. Yes 8. Unable to answer or no response
Enter <input type="checkbox"/> Code	G3. Pain Severity Ask patient: "Please rate your worst pain during the last 2 days on a zero to 10 scale, with zero being no pain and 10 as the worst pain you can imagine." Enter 8 if patient does not answer or is unable to respond and skip to G6. Pain Observational Assessment.	Enter <input type="checkbox"/> Code	G5b. Ask patient: "During the past 2 days, have you limited your activities because of pain?" 0. No 1. Yes 8. Unable to answer or no response

G6. Pain Observational Assessment

Check all indicators of pain or possible pain at the 2-day assessment period.

Check all that apply	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	G6a. Non-verbal sounds (e.g., crying, whining, gasping, moaning, or groaning) G6b. Vocal complaints of pain (e.g., "that hurts, ouch, stop") G6c. Facial Expressions (e.g., grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw) G6d. Protective body movements or postures (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement) G6e. None of these signs observed or documented
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T.IV How long did it take you to complete this section? _____ (minutes)

V. Impairments

A. Impairments

Enter

Code

A1. Does the patient have any impairments in bladder or bowel management, hearing, vision, communication, range of motion, weight-bearing, grip strength, respiratory status, or endurance?
0. No (If **No** impairments, skip to section VI. Functional Status.)
1. Yes

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

Bladder		Bowel		
B1a.	Enter Code <input type="text"/>	B1b.	Enter Code <input type="text"/>	<p>B1. Does this patient use an external or indwelling device or require intermittent catheterization? 0. No 1. Yes</p>
B2a.	Enter Code <input type="text"/>	B2b.	Enter Code <input type="text"/>	<p>B2. Indicate the frequency of incontinence during the 2-day assessment period. 0. Continent (no documented incontinence) 1. Stress incontinence only (bladder only) 2. Incontinent less than daily (only once during the 2-day assessment period) 3. Incontinent daily (at least once a day) 4. Always incontinent 5. No urine/bowel output during the 2-day assessment period (e.g., renal failure)</p>
B3a.	Enter Code <input type="text"/>	B3b.	Enter Code <input type="text"/>	<p>B3. Does the patient need assistance to manage equipment or devices related to bladder or bowel care (e.g., urinal, bedpan, indwelling catheter, intermittent catheterization, ostomy)? 0. No 1. Yes</p>
B4a.	Enter Code <input type="text"/>	B4b.	Enter Code <input type="text"/>	<p>B4. If the patient is incontinent or has an indwelling catheter, does the patient have a history of incontinence (excluding stress incontinence) prior to the current illness, exacerbation, or injury? 0. No 1. Bladder only 2. Bowel only 3. Bladder and bowel 9. Unknown</p>

C. Swallowing

Check all that apply

C1. Swallowing Disorder: Signs and symptoms of possible swallowing disorder.

C1a. No signs or symptoms of a possible swallowing disorder
C1b. Complaints of difficulty or pain with swallowing
C1c. Coughing or choking during meals or when swallowing medications
C1d. Holding food in mouth/cheeks or residual food in mouth after meals
C1e. Loss of liquids/solids from mouth when eating or drinking
C1f. NPO: intake not by mouth
C1g. Other (specify) _____

V. Impairments (cont.)

C. Swallowing (cont.)

Check all that apply

C2. Swallowing: Describe the patient's usual ability with swallowing.

- a. **Regular food:** Solids and liquids swallowed safely without supervision and without modified food or liquid consistency.
- b. **Modified food consistency/supervision:** Patient requires modified food or liquid consistency and/or needs supervision during eating for safety.
- c. **Tube/parenteral feeding:** Tube/parenteral feeding used wholly or partially as a means of sustenance.

D. Impairments – Hearing, Vision & Communication Comprehension

D1. Understanding verbal content (with hearing aid or device if used)		D3. Ability to see in adequate light (with glasses or other visual appliances)	
Enter <input type="text"/> Code	3. Understands: clear comprehension without cues or repetitions 2. Usually/Sometimes Understands: comprehends only basic conversations or simple, direct phrases or requires cues to understand 1. Rarely/Never Understands 8. Unable to assess 9. Unknown	Enter <input type="text"/> Code	3. Adequate: sees fine detail, including regular print in newspapers/books 2. Mildly to Moderately Impaired: can identify objects; may see large print 1. Severely Impaired: no vision or object identification questionable 8. Unable to assess 9. Unknown
D2. Expression of ideas and wants		D4. Ability to hear (with hearing aid or hearing appliance if normally used)	
Enter <input type="text"/> Code	3. Expresses complex messages without difficulty and with speech that is clear and easy to understand 2. Exhibits difficulty with expressing needs and ideas or speech is not clear 1. Rarely/Never expresses self or speech is very difficult to understand. 8. Unable to assess 9. Unknown	Enter <input type="text"/> Code	3. Adequate: hears normal conversation and TV without difficulty 2. Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly 1. Severely Impaired: absence of useful hearing 8. Unable to assess 9. Unknown

E. Upper Extremity Range of Motion

CODING:

Indicate the patient's usual ability in functional range of motion in the 2-day assessment period.

- 1. **Within Normal Limits:** Range of motion is within normal limits.
- 0. **Limited Range of Motion:** Patient's range of motion is not within normal limits.

Indicate if the patient has functional range of motion within normal limits in the following joints:

E1a. Left Shoulder	E1b. Left Elbow	E1c. Right Shoulder	E1d. Right Elbow
Enter <input type="text"/> Code	Enter <input type="text"/> Code	Enter <input type="text"/> Code	Enter <input type="text"/> Code

V. Impairments (cont.)

F. Weight-bearing

CODING:

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

- 1. **Fully weight-bearing:** No medical restrictions
- 0. **Not fully weight-bearing:** Patient has medical restrictions

Indicate if the patient has weight-bearing restrictions in the following extremities:

Upper Extremity		Lower Extremity	
Fl a. Left	Fl b. Right	Fl c. Left	Fl d. Right
Enter <input type="text"/> Code	Enter <input type="text"/> Code	Enter <input type="text"/> Code	Enter <input type="text"/> Code

G. Grip Strength

CODING:

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

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

Indicate the patient's ability to squeeze your hand.

Gl a. Left Hand	Gl b. Right Hand
Enter <input type="text"/> Code	Enter <input type="text"/> Code

H. Respiratory Status

Enter

Code

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

- 5. **Severe, with evidence the patient is struggling to breathe at rest**
- 4. **Mild at rest** (during day or night)
- 3. **With minimal exertion** (e.g., while eating, talking, or performing other ADLs) **or with agitation**
- 2. **With moderate exertion** (e.g., while dressing, using commode or bedpan, walking between rooms)
- 1. **When climbing stairs**
- 0. **Never, patient was not short of breath**
- 8. **Not assessed** (e.g., on ventilator)

I. Endurance

Enter

Code

II. Mobility Endurance: Did the patient have to stop and rest two or more times when walking or wheeling 50 feet (15 meters) in the 2-day assessment period?

- 0. **No**
- 1. **Yes**
- 8. **Not assessed**

Enter

Code

12. Sitting Endurance: Was the patient able to tolerate sitting at the edge of the bed for 3 minutes in the 2-day assessment period?

- 0. **No**
- 1. **Yes**
- 8. **Not assessed**

J. Mobility Devices and Aides Needed

Check all that apply

Indicate all mobility devices and aides needed (check all that apply):

- a. **Canes/crutch**
- b. **Walker**
- c. **Wheelchair/scooter full time**
- d. **Wheelchair/scooter part time**
- e. **Mechanical lift required**
- f. **Other** (specify) _____

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

VI. Functional Status

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

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

CODING:

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

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

Activities may be completed with or without assistive devices.

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

If activity was not attempted code:

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



Enter Code in Boxes



Enter

Code

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

Enter

Code

A2. Tube feeding: The ability to manage all equipment/supplies related to obtaining nutrition once they are presented to the patient.

Enter

Code

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

Enter

Code

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

Enter

Code

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

Enter

Code

A6. Lower body dressing: The ability to dress and undress below the waist, including fasteners.

VI. Functional Status (cont.)

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

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

CODING:

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

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

Activities may be completed with or without assistive devices.

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

If activity was not attempted code:

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



Enter Code in Boxes



Enter

Code

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

Enter

Code

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

Enter

Code

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

Enter

Code

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

MODE OF MOBILITY

Enter

Code

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

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

Enter

Code

B5a. Code for the longest distance the patient can walk (observe their performance):

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

Enter

Code

B5b. Code for the longest distance the patient can wheel (observe their performance):

1. **Wheel 150 ft (45 m):** Once sitting can wheel 150 feet (45 meters) in corridor or similar space.
2. **Wheel 100 ft (30 m):** Once standing can wheel 100 feet (30 meters) in corridor or similar space
3. **Wheel 50 ft (15 m):** Once standing can wheel 50 feet (15 meters) in corridor or similar space
4. **Wheel in Room Once Seated:** Once seated can wheel 10 feet (3 meters) in room, corridor or similar space.

VI. Functional Status (cont.)

C. Supplemental Functional Ability: Complete only for patients who had therapy consult or who will need post-acute care or personal assistance following discharge.

Please code patient on all activities they are able to participate in and which you can observe using the 6-point scale below.

CODING:

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

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

Activities may be completed with or without assistive devices.

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

If activity was not attempted code:

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

Enter <input type="checkbox"/> Code	C1. Sponge bathe: The ability to wash, rinse, and dry body from neck down (excluding back) while sitting in a chair or bed.
Enter <input type="checkbox"/> Code	C2. Shower/bathe self: The ability to bathe self in shower or tub, including washing and drying self. Does not include transferring in/out of tub/shower.
Enter <input type="checkbox"/> Code	C3. Roll left or right: Ability to roll from lying on back to left or right side and roll back to back.
Enter <input type="checkbox"/> Code	C4. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
Enter <input type="checkbox"/> Code	C5. Picking up object: Ability to bend/stoop to pick up small object such as a spoon from the floor.
MODE OF MOBILITY	
Enter <input type="checkbox"/> Code	C6. Does this patient primarily use a wheelchair for mobility? 0. No (If No, code C6a–C6d.) 1. Yes (If Yes, code C6e–C6f.)
Enter <input type="checkbox"/> Code	C6a. 1 step (curb): The ability to step over a curb or up and down one step.
Enter <input type="checkbox"/> Code	C6b. Walk 50 feet with two turns: The ability to walk 50 feet and make two turns.
Enter <input type="checkbox"/> Code	C6c. 12 steps-interior: The ability to go up and down 12 interior steps.
Enter <input type="checkbox"/> Code	C6d. Four steps-exterior: The ability to go up and down 4 exterior steps with or without a rail.
Enter <input type="checkbox"/> Code	C6e. Wheel short ramp: Once seated in wheelchair is able to go up and down a ramp of less than 12 feet (4 meters).
Enter <input type="checkbox"/> Code	C6f. Wheel long ramp: The ability to go up or down a ramp of more than 12 feet (4 meters).

Enter Code in Boxes

VI. Functional Status (cont.)

C. Supplemental Functional Ability (cont.): Complete only for patients who had therapy consult or who will need post-acute care or personal assistance following discharge.

Please code patient on all activities they are able to participate in and which you can observe using the **4-point** scale below.

CODING:

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

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

Activities may be completed with or without assistive devices.

- 4. Independent** – Patient completes the activity by him/herself with no assistance from a helper.
- 3. Minimal Assistance** – Patient completes the activity with assistance. Helper provides less than half of the effort.
- 2. Maximum Assistance** – Patient completes the activity with assistance. Helper provides more than half of the effort.
- 1. Dependent (Total Assistance)** – Helper does ALL of the effort. Patient does none of the effort to complete the task.

If activity was not attempted code:

- M.** Not attempted due to **medical restrictions**
- S.** Not attempted due to **safety concerns**
- A.** Task **attempted** but not completed
- N.** **Not applicable** or cannot be observed in patient’s current environment.
- P.** **Patient Refused**
- R.** Patient did not perform the task before the current illness, exacerbation, or injury.

Enter Code in Boxes

Enter

Code

C7. Telephone-answering: Ability to pick up call in patient’s customary manner and maintain for 3 minutes. Does not include getting to the phone.

Enter

Code

C8. Telephone-placing call: Ability to pick up and place call in patient’s customary manner and maintain for 3 minutes. Does not include getting to the phone.

Enter

Code

C9. Medication management-oral medications: The ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.

Enter

Code

C10. Medication management-inhalant/mist medications: The ability to prepare and take all prescribed inhalant/mist medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.

Enter

Code

C11. Medication management-injectable medications: The ability to prepare and take all prescribed injectable medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.

Enter

Code

C12. Make light meal: Ability to plan and prepare all aspects of a light meal such as bowl of cereal or sandwich and cold drink, or reheat a prepared meal.

Enter

Code

C13. Wipe down surface: Ability to use a damp cloth to wipe down surface such as table top or bench to remove small amounts of liquid or crumbs. Includes ability to clean cloth of debris in patient’s customary manner.

Enter

Code

C14. Light shopping: Once at store, can locate and select up to five needed goods, take to check out, and complete purchasing transaction.

Enter

Code

C15. Laundry: Includes all aspects of completing a load of laundry using a washer and dryer. Includes sorting, loading and unloading, and adding laundry liquid.

Enter

Code

C16. Get in/out of car: The ability to get into and out of a car or van on the passenger side. Does not include open/close door or fasten seat belt.

Enter

Code

C17. Drive a car: Ability to drive a car in local community.

Enter

Code

C18. Use public transportation: Ability to use public transportation. Includes boarding, riding, and alighting from transportation.

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

VII. Engagement

A. Engagement

Enter

Code

A1. Indicate the patient's cognitive and emotional resources to comprehend current services, tolerate typical frustrations of care, and participate actively in the treatments.

- 6. **No Problem:** Participates willingly in treatment; appreciates value of care; places frustrations in perspective.
- 5. **Minimal Problem:** Participates in treatments; infrequently questions value of activities; infrequent difficulty with frustrations.
- 4. **Mild Problem:** Requires occasional encouragement; occasionally questions value of activities/occasional difficulty with frustrations.
- 3. **Moderate Problem:** Requires frequent encouragement; frequently questions value of activities/difficulty dealing with frustrations; much time spent explaining goals/rationale rather than executing treatment plan.
- 2. **Moderate to Severe problem:** Requires consistent encouragement; does not value treatment; continuous difficulty dealing with frustrations.
- 1. **Severe Problem:** Refuses to participate, requests discharge.
- 8. **Not assessed**

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

VIII. Frailty/Life Expectancy

A. Frailty/Life Expectancy

Enter

Code

A1. Would you be surprised if the patient was readmitted to an acute care hospital in the next 6 months?

- 0. **No**
- 1. **Yes**
- 8. **Not assessed**
- 9. **Unknown**

Enter

Code

A2. Would you be surprised if the patient were to die in the next 12 months?

- 0. **No**
- 1. **Yes**
- 8. **Not assessed**
- 9. **Unknown**

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

IX. Discharge Status

A. Discharge Information

A1. Discharge Date

MM / DD / YYYY

B. Caregiver Information: If patient is discharged to a private residence or other community-based setting, please complete this section.

B1. Patient Lives With at Discharge

Upon discharge, who will the patient live with?

- B1a. Will live alone
- B1b. Spouse or significant other
- B1c. Adult child (> 18 years old)
- B1d. Other child (≤ 18 years old)
- B1e. Other unpaid family member or friend
- B1f. Paid help living in the home
- B1g. Unknown

Check all that apply

A2. Discharge Location

Where will the patient be discharged to?

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

B2. Caregiver(s) Availability at Discharge

- Enter
Code
- Does the patient currently have one or more caregiver(s) both **willing and able** to provide the necessary care?
0. No (If No, skip to C1. Other Discharge Needs.)
 1. Yes

A3. Frequency of Assistance at Discharge

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

- Enter
Code
1. Patient **does not require assistance** (If selected, skip to C1. Other Discharge Needs.)
 2. **Weekly** or less (e.g., requires help with grocery shopping or errands, etc.)
 3. **Less than daily** but more often than weekly
 4. **Intermittently** during the day or night
 5. **All night** but not during the day
 6. **All day** but not at night
 7. **24 hours** per day

B3. Types of Caregiver(s)

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

- B4a. Spouse or Significant other
- B4b. Child
- B4c. Other unpaid family member or friend
- B4d. Paid help

Check all that apply

IX. Discharge Status (cont.)

C. Other Discharge Needs

Enter <input type="checkbox"/> Code	C1. Will the patient be able to pay for their medications after discharge? 0. No 1. Yes 8. Unable to assess (e.g., patient unresponsive, communication disorder, no interpreter available, other) 9. Unknown to patient	Enter <input type="checkbox"/> Code	C3. How will the patient be transported to any follow up physician appointments and/or outpatient therapies or treatments? 1. No follow up physician appointments and/or outpatient therapies or treatments planned 2. Can drive self 3. Family member or friend will drive patient 4. Public transportation 5. Other (specify) _____ 8. Unable to assess (e.g., patient unresponsive, communication disorder, no interpreter available, other) 9. Unknown to patient
Enter <input type="checkbox"/> Code	C2. Will the patient be able to manage their medications after discharge? 1. Yes, able to manage medications independently 2. Yes, able to manage medications with assistance 3. No, unable to manage medications 4. Not applicable, no medications 9. Unknown	Enter <input type="checkbox"/> Code	C4. If the patient lived in the community prior to this current illness, exacerbation, or injury, will the availability (or lack of availability) of a willing and able caregiver affect their discharge care options? 0. No 1. Yes 9. Unknown

D. Discharge Care Options

Please indicate whether the following services were considered appropriate for the patient at discharge (check all that apply).

Type of Service	Deemed Appropriate by the Provider	Bed/Services Available	Refused by Patient/Family	Not Covered by Insurance
a. Home Health Care (HHA)	<input type="checkbox"/> D1a	<input type="checkbox"/> D2a	<input type="checkbox"/> D3a	<input type="checkbox"/> D4a
b. Skilled Nursing Facility (SNF)	<input type="checkbox"/> D1b	<input type="checkbox"/> D2b	<input type="checkbox"/> D3b	<input type="checkbox"/> D4b
c. Inpatient Rehabilitation Hospital (IRF)	<input type="checkbox"/> D1c	<input type="checkbox"/> D2c	<input type="checkbox"/> D3c	<input type="checkbox"/> D4c
d. Long-Term Care Hospital (LTCH)	<input type="checkbox"/> D1d	<input type="checkbox"/> D2d	<input type="checkbox"/> D3d	<input type="checkbox"/> D4d
e. Psychiatric Hospital	<input type="checkbox"/> D1e	<input type="checkbox"/> D2e	<input type="checkbox"/> D3e	<input type="checkbox"/> D4e
f. Outpatient Services	<input type="checkbox"/> D1f	<input type="checkbox"/> D2f	<input type="checkbox"/> D3f	<input type="checkbox"/> D4f
g. Acute Hospital Admission	<input type="checkbox"/> D1g	<input type="checkbox"/> D2g	<input type="checkbox"/> D3g	<input type="checkbox"/> D4g
h. Hospice	<input type="checkbox"/> D1h	<input type="checkbox"/> D2h	<input type="checkbox"/> D3h	<input type="checkbox"/> D4h

IX. Discharge Status (cont.)

D. Discharge Care Options (cont.)

Please indicate whether the following services were considered appropriate for the patient at discharge (check all that apply).

i. LTC Nursing Facility	<input type="checkbox"/> D1i	<input type="checkbox"/> D2i	<input type="checkbox"/> D3i	<input type="checkbox"/> D4i
j. Other (specify) _____	<input type="checkbox"/> D1j	<input type="checkbox"/> D2j	<input type="checkbox"/> D3j	<input type="checkbox"/> D4j

E. Discharge Location Information: Please identify the name, location, and type of service to which the patient is discharged.

E1. Provider's Name <input type="text"/>		E3. Provider City <input type="text"/>	
Enter <input type="checkbox"/> Code	E2. Provider Type		E4. Provider State <input type="text"/>
	<ol style="list-style-type: none"> 1. Home Health Care (HHA) 2. Skilled Nursing Facility (SNF) 3. Inpatient Rehabilitation Hospital (IRF) 4. Long-Term Care Hospital (LTCH) 5. Psychiatric Hospital 6. Outpatient Services 7. Acute Hospital Admission 8. Hospice 9. LTC Nursing Facility 10. Other (specify) _____ 		E5. Medicare Provider's Identification Number <input type="text"/>

E6. In the situation that the patient or an authorized representative has requested this information not be shared with the next provider, check here:

E7. Discharge Delay		E8. Reason for Discharge Delay	
Enter <input type="checkbox"/> Code	Was the patient's discharge delayed for at least 24 hours? 0. No 1. Yes	Enter <input type="checkbox"/> Code	<ol style="list-style-type: none"> 1. No bed available 2. Services, equipment or medications not available (e.g., home health care, durable medical equipment, IV medications) 3. Family/support (e.g., family could not pick patient up) 4. Medical (patient condition changed) 5. Other (specify) _____

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

X. Other Useful Information

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

XI. Feedback

A. Notes

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