CARE Tool
Discharge

This instrument uses the phrase "2-day assessment period" referring to either:

1) **The day of discharge and the calendar day before the day of discharge (beginning at 12:00 AM);**

or

2) **For Home Health, the day of the last visit or the day before the last visit.**

Signatures of Clinicians who Completed a Portion of the Accompanying Assessment

I certify, to the best of my knowledge, the information in this assessment is

- collected in accordance with the guidelines provided by CMS for participation in this Post Acute Care Payment Reform Demonstration,
- an accurate and truthful reflection of assessment information for this patient,
- based on data collection occurring on the dates specified, and
- data-entered accurately.

I understand the importance of submitting only accurate and truthful data.

- This facility's participation in the Post Acute Care Payment Reform Demonstration is conditioned on the accuracy and truthfulness of the information provided.
- The information provided may be used as a basis for ensuring that the patient receives appropriate and quality care and for conveying information about the patient to a provider in a different setting at the time of transfer.

I am authorized to submit this information by this facility on its behalf.

[I agree] [I do not agree]

	Name/Signature	Credential	License # (if required)	Sections Worked On	Date(s) of Data collection
	(Joe Smith)	(RN)	(MA000000)	Medical Information	(MM/DD/YYYY)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

I. Administrative Items

A. Assessment Type

Enter **3** Code

A1. Reason for assessment

1. Admit
2. Interim
3. Discharge
4. Expired

A3. Assessment Reference Date

_____/_____/_____
MM DD YYYY

(The first date of the discharge assessment period. It is the day before the day of discharge.)

B. Provider Information

B1. Provider's Name

C. Patient Information

C1. Patient's First Name

C2. Patient's Middle Initial or Name

C3. Patient's Last Name

C4. Patient's Nickname (Optional)

C5. Patient's Medicare Health Insurance Number

|___|___|___|___|___|___|___|___|___|___|___|___|

C6. Patient's Medicaid Number (if applicable)

|___|___|___|___|___|___|___|___|___|___|

C7. Patient's Facility/Agency Identification Number (for internal tracking)

|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

C8a. Admission Date

_____/_____/_____
MM DD YYYY

C8b. Birth Date

_____/_____/_____
MM DD YYYY

C9. Social Security Number (Optional)

|___|___|___|-|___|___|-|___|___|___|___|

Enter ☐ Code

C10. Gender

1. Male
2. Female

D. Payer Information: Current Payment Source(s)

Check all that apply.

- ☐ **D1. None** (no charge for current services)
- ☐ **D2. Medicare** (traditional fee-for-service)
- ☐ **D3. Medicare** (managed care/Part C/Medicare Advantage)
- ☐ **D4. Medicaid** (traditional fee-for-service)
- ☐ **D5. Medicaid** (managed care)
- ☐ **D6. Workers' compensation**
- ☐ **D7. Title programs** (e.g., Title III, V, or XX)
- ☐ **D8. Other government** (e.g., TRICARE, VA, etc.)
- ☐ **D9. Private insurance/Medigap**
- ☐ **D10. Private managed care**
- ☐ **D11. Self-pay**
- ☐ **D12. Other** (specify) _____
- ☐ **D13. Unknown**

*T.I How long did it take you to complete the **I. Administrative Items** section?* _____ *(minutes)*
Clinician Name(s) _____

III. Current Medical Information

Clinicians:

For this section, please provide a listing of medical diagnoses, comorbid diseases and complications, and procedures based on a review of the patient's clinical records available at the time of assessment. This information is intended to enhance continuity of care. For discharge only, these lists can be added to throughout the stay and will be specific to each setting.

A. Primary and Other Diagnoses, Comorbidities, and Complications

Indicate the primary diagnosis at Assessment. Be as specific as possible.

A1. Primary Diagnosis at Assessment

_____

B. Other Diagnoses, Comorbidities, and Complications

List other diagnoses being treated, managed, or monitored in this setting. Please include all diagnoses (e.g., depression, schizophrenia, dementia, protein calorie malnutrition).

B1.	
B2.	
B3.	
B4.	
B5.	
B6.	
B7.	
B8.	
B9.	
B10.	
B11.	
B12.	
B13.	
B14.	

Enter Code

B15. Is this list complete?

0. No

1. Yes

III. Current Medical Information (cont.)

C. Major Procedures (Diagnostic, Surgical, and Therapeutic Interventions)

Enter Code

C1. Did the patient have one or more major procedures (e.g., G-tube placement, EEG, abdominal cat scans; do not include x-rays, EKGs, ultrasounds) during this admission?

0. No *(If **No**, skip to Section D. Major Treatments.)*

1. Yes

List up to 15 procedures (diagnostic, surgical and therapeutic interventions). Indicate if a procedure was left, right, or not applicable (N/A). If procedure was bilateral (e.g., bilateral knee replacement), check both left and right boxes.

Procedure		Left	Right	N/A
C1a.		C1b. ☐	C1c. ☐	C1d. ☐
C2a.		C2b. ☐	C2c. ☐	C2d. ☐
C3a.		C3b. ☐	C3c. ☐	C3d. ☐
C4a.		C4b. ☐	C4c. ☐	C4d. ☐
C5a.		C5b. ☐	C5c. ☐	C5d. ☐
C6a.		C6b. ☐	C6c. ☐	C6d. ☐
C7a.		C7b. ☐	C7c. ☐	C7d. ☐
C8a.		C8b. ☐	C8c. ☐	C8d. ☐
C9a.		C9b. ☐	C9c. ☐	C9d. ☐
C10a.		C10b. ☐	C10c. ☐	C10d. ☐
C11a.		C11b. ☐	C11c. ☐	C11d. ☐
C12a.		C12b. ☐	C12c. ☐	C12d. ☐
C13a.		C13b. ☐	C13c. ☐	C13d. ☐
C14a.		C14b. ☐	C14c. ☐	C14d. ☐
C15a.		C15b. ☐	C15c. ☐	C15d. ☐

Enter Code

C16. Is this list complete?

0. No

1. Yes

III. Current Medical Information (cont.)

D. Major Treatments

Which of the following treatments did the patient receive a) at the time of discharge or b) at any time during their admission?

Check all that apply.

Discharged With:	Used at Any Time During Stay:	
D1a. ☐	D1b. ☐	**D1. None**
D2a. ☐	D2b. ☐	**D2. Insulin Drip**
D3a. ☐	D3b. ☐	**D3. Total Parenteral Nutrition**
D4a. ☐	D4b. ☐	**D4. Central Line Management**
D5a. ☐	D5b. ☐	**D5. Blood Transfusion(s)**
D6a. ☐	D6b. ☐	**D6. Controlled Parenteral Analgesia – Peripheral**
D7a. ☐	D7b. ☐	**D7. Controlled Parenteral Analgesia – Epidural**
D8a. ☐	D8b. ☐	**D8. Left Ventricular Assistive Device** (LVAD)
D9a. ☐	D9b. ☐	**D9. Continuous Cardiac Monitoring** ***D9c.*** *Specify reason for continuous monitoring:* _____
D10a. ☐	D10b. ☐	**D10. Chest Tube(s)**
D11a. ☐	D11b. ☐	**D11. Trach Tube with Suctioning** ***D11c.*** *Specify most intensive frequency of suctioning during stay:* *Every_____ hours*
D12a. ☐	D12b. ☐	**D12. High O2 Concentration Delivery System with FiO2 > 40%**
D13a. ☐	D13b. ☐	**D13. Non-invasive ventilation (CPAP)**
D14a. ☐	D14b. ☐	**D14. Ventilator – Weaning**
D15a. ☐	D15b. ☐	**D15. Ventilator – Non-Weaning**
D16a. ☐	D16b. ☐	**D16. Hemodialysis**
D17a. ☐	D17b. ☐	**D17. Peritoneal Dialysis**
D18a. ☐	D18b. ☐	**D18. Fistula or Other Drain Management**
D19a. ☐	D19b. ☐	**D19. Negative Pressure Wound Therapy**
D20a. ☐	D20b. ☐	**D20. Complex Wound Management** with positioning and skin separation/traction that requires at least two persons or extensive and complex wound management by one person
D21a. ☐	D21b. ☐	**D21. Halo**
D22a. ☐	D22b. ☐	**D22. Complex External Fixators** (e.g., Ilizarov)
D23a. ☐	D23b. ☐	**D23. One-on-One 24-Hour Staff Supervision** ***D23c.*** *Specify reason for 24-hour supervision:* _____
D24a. ☐	D24b. ☐	**D24. Specialty Surface or Bed** (e.g., air fluidized, bariatric, low air loss, or rotation bed)
D25a. ☐	D25b. ☐	**D25. Multiple Types of IV Antibiotic Administration**
D26a. ☐	D26b. ☐	**D26. IV Vasoactive Medications** (e.g., pressors, dilators, medication for pulmonary edema)
D27a. ☐	D27b. ☐	**D27. IV Anti-coagulants**
D28a. ☐	D28b. ☐	**D28. IV Chemotherapy**
D29a. ☐	D29b. ☐	**D29. Indwelling Bowel Catheter Management System**
D30a. ☐	D30b. ☐	**D30. Other Major Treatments** (e.g., isolation, hyperthermia blanket) ***D30c.*** *Specify*_____

III. Current Medical Information (cont.)

E. Medications (Optional)

Please list the **ten** most clinically relevant medications for the patient during the 2-day assessment period.

Medication Name	Dose	Route	Frequency	Planned Stop Date (if applicable)
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

Enter "1" if this section skipped due to OPTIONAL status.

III. Current Medical Information (cont.)

F. Allergies & Adverse Drug Reactions

Enter Code

F1. Does patient **have allergies or any known adverse drug reactions?**
0. None known *(If **None known**, skip to Section G. Skin Integrity.)*
1. Yes *(If **Yes**, list all allergies/causes of reaction [e.g., food, medications, other] and describe the adverse reactions.)*

Allergies/Causes of Reaction	Patient Reaction
F1a. _____	**F1b.** _____
F2a. _____	**F2b.** _____
F3a. _____	**F3b.** _____
F4a. _____	**F4b** _____
F5a. _____	**F5b.** _____
F6a. _____	**F6b.** _____
F7a. _____	**F7b.** _____
F8a. _____	**F8b.** _____

Enter Code

F9. Is the list complete?
0. No
1. Yes

G. Skin Integrity (Complete during the 2-day assessment period.)

G1-2. PRESENCE OF PRESSURE ULCERS - Do not "reverse" stage

Enter Code

G1. Is this patient at **risk of developing pressure ulcers?**
0. No
1. Yes, indicated by clinical judgment
2. Yes, indicated high risk by formal assessment (e.g., on Braden or Norton tools) **or the patient has a stage 1 or greater ulcer, a scar over a bony prominence, or a non-removable dressing, device, or cast.**

Enter Code

G2. Does this patient have one or more unhealed pressure ulcer(s) at stage 2 or higher or unstageable?
0. No *(If **No**, skip to G5. Major Wounds.)*
1. Yes

IF THE PATIENT HAS ONE OR MORE STAGE 2-4 OR UNSTAGEABLE PRESSURE ULCERS, indicate the number of **unhealed pressure ulcers at each stage.**

CODING:

Please specify the number of ulcers at each stage:

0 = 0 ulcers
1 = 1 ulcer
2 = 2 ulcers
3 = 3 ulcers
4 = 4 ulcers
5 = 5 ulcers
6 = 6 ulcers
7 = 7 ulcers
8 = 8 or more ulcers
9 = Unknown

Number present at assessment	Number with onset during this service	Pressure ulcer at stage 2, stage 3, stage 4, or unstageable:
Stage 2 Enter Code	Stage 2 Enter Code	**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 (excludes those resulting from skin tears, tape stripping, or incontinence associated dermatitis).
Stage 3 Enter Code	Stage 3 Enter Code	**G2b. Stage 3** – Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
Stage 4 Enter Code	Stage 4 Enter Code	**G2c. Stage 4** – Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.
Unstageable Enter Code	Unstageable Enter Code	**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, device, cast or suspected deep tissue injury in evolution.

III. Current Medical Information (cont.)

G. Skin Integrity (Complete during the 2-day assessment period.) (cont.)

Number of Unhealed Stage 2 Ulcers ☐

G2e. Number of unhealed stage 2 ulcers known to be present for more than 1 month.

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." If the patient has 8 or more unhealed stage 2 pressure ulcers, record "8." If unknown, record "9."

	G3. If any unhealed pressure ulcer is stage 3 or 4 (or if eschar is present), record the most recent measurements for the LARGEST ulcer (or eschar):	Enter Code	G4. Indicate if any unhealed stage 3 or stage 4 pressure ulcer(s) has undermining and/or tunneling (sinus tract) present.
Enter Length |___|___|.|___|cm	a. Longest length in any direction (Enter 99.9 if the largest ulcer is unstageable and is not eschar.)	☐	0. No 1. Yes 8. Unable to assess
Enter Width |___|___|.|___|cm	b. Width of SAME unhealed ulcer or eschar (Enter 99.9 if the largest ulcer is unstageable and is not eschar.)		
Enter Depth |___|___|.|___|cm	c. Depth of SAME unhealed ulcer or eschar (Enter 99.9 if the largest ulcer is unstageable and is not eschar.)		
Date Measured ____/____/____ MM DD YYYY	d. Date of measurement		

G5a–e. NUMBER OF MAJOR WOUNDS (excluding pressure ulcers)

Number of Major Wounds	Type(s) of Major Wound(s)
☐	G5a. Delayed healing of surgical wound
☐	G5b. Trauma-related wound (e.g., burns)
☐	G5c. Diabetic foot ulcer(s)
☐	G5d. Vascular ulcer (arterial or venous including diabetic ulcers not located on the foot)
☐	G5e. Other (e.g., incontinence associated dermatitis, normal surgical wound healing). Please specify: _____

G6. TURNING SURFACES NOT INTACT

Check all that apply.

Turning Surface	Indicate which of the following turning surfaces have either a pressure ulcer or major wound.
☐	a. Skin for all turning surfaces is intact
☐	b. Right hip not intact
☐	c. Left hip not intact
☐	d. Back/buttocks not intact
☐	e. Other turning surface(s) not intact

III. Current Medical Information (cont.)

H. Physiologic Factors (Complete during the 2-day assessment period.)

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

Anthropometric Measures	Date	Value (Complete Using Format Listed)	Check if NOT tested	Check here if value is estimated
H1/H2. Height	H2a. ___/___/___	H2b. _____ (xxx.x) ☐ inches ☐ cm	H2c. ☐	H2d. ☐
H3/H4. Weight	H3a. ___/___/___	H3b. _____ (xxx.x) ☐ pounds ☐ Kg	H3c. ☐	H3d. ☐

Measures	Date	Value (Complete Using Format Listed)	Check if NOT tested
Vital Signs			
H5/H6. Temperature	H5a. ___/___/___	H5b. _____ (xxx.x) ☐ °F ☐ °C	H5c. ☐
H7. Heart Rate (beats/min)	H7a. ___/___/___	H7b. _____ (xxx)	H7c. ☐
H8. Respiratory Rate (breaths/min)	H8a. ___/___/___	H8b. _____ (xx)	H8c. ☐
H9. Blood Pressure mm/Hg	H9a. ___/___/___	H9b. _____ (xxx/xxx)	H9c. ☐
H10. O_2 saturation (Pulse Oximetry) %	H10a. ___/___/___	H10b. _____ (xxx)	H10c. ☐
H10d. Please specify source and amount of supplemental O_2 (e.g., room air, nasal cannula, trach collar) _____			
Laboratory			
H11. Hemoglobin (gm/dL)	H11a. ___/___/___	H11b. _____ (xx.x)	H11c. ☐
H12. Hematocrit (%)	H12a. ___/___/___	H12b. _____ (xx.x)	H12c. ☐
H13. WBC (K/mm3)	H13a. ___/___/___	H13b. _____ (xxx.x)	H13c. ☐
H14. HbA1c (%)	H14a. ___/___/___	H14b. _____ (xx.x)	H14c. ☐
H15. Sodium (mEq/L)	H15a. ___/___/___	H15b. _____ (xxx)	H15c. ☐
H16. Potassium (mEq/L)	H16a. ___/___/___	H16b. _____ (x.x)	H16c. ☐
H17. BUN (mg/dL)	H17a. ___/___/___	H17b. _____ (xxx)	H17c. ☐
H18. Creatinine (mg/dL)	H18a. ___/___/___	H18b. _____ (xx.x)	H18c. ☐
H19. Albumin (gm/dL)	H19a. ___/___/___	H19b. _____ (xx.x)	H19c. ☐
H20. Prealbumin (mg/dL)	H20a. ___/___/___	H20b. _____ (xx.x)	H20c. ☐
H21. INR	H21a. ___/___/___	H21b. _____ (x.x)	H21c. ☐
Other			
H22. Left Ventricular Ejection Fraction (%) (This or prior setting acceptable.)	H22a. ___/___/___	H22b. _____ (xx)	H22c. ☐
Arterial Blood Gases (ABGs)			
H23d. Please specify source and amount of supplemental O_2 (e.g., room air, nasal cannula, trach collar) _____	H23a. ___/___/___		H23c. ☐
H24. pH	H24.	H24b. _____ (x.xx)	H24c. ☐
H25. PaCO2 (mm/Hg)	H25.	H25b. _____ (xxx)	H25c. ☐
H26. HCO3 (mEq/L)	H26.	H26b. _____ (xxx)	H26c. ☐
H27. PaO2 (mm/Hg)	H27.	H27b. _____ (xxx)	H27c. ☐
H28. SaO2 (%)	H28.	H28b. _____ (xx)	H28c. ☐
H29. B.E. (base excess) (mEq/L)	H29.	H29b. _____ (xx)	H29c. ☐
Pulmonary Function Tests	H30a. ___/___/___		H30c. ☐
H31. FVC (liters)	H31.	H31b. _____ (x.xx)	H31c. ☐
H32. FEV1% or FEV1/FVC (%)	H32.	H32b. _____ (xx)	H32c. ☐
H33. FEV1 (liters)	H33.	H33b. _____ (x.xx)	H33c. ☐
H34. PEF (liters per minute)	H34.	H34b. _____ (x.xx)	H34c. ☐
H35. MVV (liters per minute)	H35.	H35b. _____ (xxx)	H35c. ☐
H36. TLC (liters)	H36.	H36b. _____ (x.xx)	H36c. ☐
H37. FRC (liters)	H37.	H37b. _____ (x.xx)	H37c. ☐
H38. RV (liters)	H38.	H38b. _____ (x.xx)	H38c. ☐
H39. ERV (liters)	H39.	H39b. _____ (x.xx)	H39c. ☐

*T.III How long did it take you to complete the **III. Current Medical Information** section?* _____ *(minutes)*
Clinician Name(s) _____

IV. Cognitive Status, Mood & Pain (cont.)

E. Behavioral Signs & Symptoms (Complete during the 2-day assessment period.)

Has the patient exhibited any of the following behaviors during the 2-day assessment period?

Enter Code

E1. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing).
- **0. No**
- **1. Yes**

Enter Code

E2. Verbal behavioral symptoms directed towards others (e.g., threatening, screaming at others).
- **0. No**
- **1. Yes**

Enter 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**

F. Mood (Interview during the 2-day assessment period.)

Enter Code

F1. Mood Interview Attempted? (Complete the mood interview if you are an IRF, SNF, LTCH, or Home Health agency only. All other providers may enter "0" and skip the Mood Interview.)
- **0. No** *(If **No**, skip to G1. Pain Interview.)*
- **1. Yes**

F2. Patient Health Questionnaire (PHQ-2©)

Ask patient: *"During the last 2 weeks, have you been bothered by any of the following problems?"*

Enter 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 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)**

Enter 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 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)**

F3. Feeling Sad

Enter Code

F3. 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**

IV. Cognitive Status, Mood & Pain (cont.)

G. Pain (Interview during the 2-day assessment period.)

Enter Code

G1. Pain Interview Attempted?
- **0. No** *(If **No**, skip to G6. Pain Observational Assessment.)*
- **1. Yes**

Enter 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 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 88 if patient does not answer or is unable to respond and *skip to G6. Pain Observational Assessment.*

Enter Code

G4. Pain Effect on Sleep
Ask patient: *"During the past 2 days, has pain made it hard for you to sleep?"*
- **0. No**
- **1. Yes**
- **8. Unable to answer or no response**

Enter Code

G5. Pain Effect on Activities
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. If patient could not be interviewed for pain assessment, check all indicators of pain or possible pain.

Check all that apply.

- ☐ **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, winces, 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

*T.IV How long did it take you to complete the **IV. Cognitive Status, Mood & Pain** section? _____ (minutes)*
Clinician Name(s) _____

V. Impairments

A. Bladder and Bowel Management: Use of Device(s) and Incontinence (Complete during the 2-day assessment period.)

Enter Code

A1. Does the patient have any impairments with bladder or bowel management (e.g., use of a device or incontinence)?
0. No *(If* **No** *impairments, skip to Section B. Swallowing.)*
1. Yes *(If* **Yes**, *please complete this section.)*

Bladder	Bowel
A2a. Enter Code	A2b. Enter Code
A3a. Enter Code	A3b. Enter Code
A4a. Enter Code	A4b. Enter Code
A5a. Enter Code	A5b. Enter Code

A2. Does this patient use an **external or indwelling device** or require intermittent catheterization?
0. No
1. Yes

A3. Indicate the **frequency of incontinence**.
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 (e.g., renal failure)
9. Not applicable (e.g., indwelling catheter)

A4. 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, incontinence pads/undergarments)?
0. No
1. Yes

A5. If the patient is incontinent or has an indwelling device, was the patient incontinent (excluding stress incontinence) immediately prior to the current illness, exacerbation, or injury?
0. No
1. Yes
9. Unknown

B. Swallowing (Complete during the 2-day assessment period.)

Check all that apply.

B1. Does the patient have any signs or symptoms of a possible swallowing disorder?

- ☐ **B1a. Complaints of difficulty or pain with swallowing**
- ☐ **B1b. Coughing or choking during meals or when swallowing medications**
- ☐ **B1c. Holding food in mouth/cheeks or residual food in mouth after meals**
- ☐ **B1d. Loss of liquids/solids from mouth when eating or drinking**
- ☐ **B1e. NPO: intake not by mouth**
- ☐ **B1f. Other** (specify) _____
- ☐ **B1g. None**

B2. Describe the patient's usual ability with swallowing. (Check one option ONLY.)

- ☐ **B2a. Regular food:** Solids and liquids swallowed safely without supervision and without modified food or liquid consistency.
- ☐ **B2b. Modified food consistency/supervision:** Patient requires modified food or liquid consistency and/or needs supervision during eating for safety.
- ☐ **B2c. Tube/parenteral feeding:** Tube/parenteral feeding used wholly or partially as a means of sustenance.

V. Impairments (cont.)

C. Hearing, Vision, and Communication (Complete during the 2-day assessment period.)

Enter Code

C1. Does the patient have any impairments with hearing, vision, or communication?
0. No *(If* **No** *impairments, skip to Section D. Weight-bearing.)*
1. Yes *(If* **Yes**, *please complete this section.)*

C1a. Understanding Verbal Content (excluding language barriers)

Enter Code

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**
8. **Unable to assess**
9. **Unknown**

C1b. Expression of Ideas and Wants

Enter Code

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.
8. **Unable to assess**
9. **Unknown**

C1c. Ability to See in Adequate Light (with glasses or other visual appliances)

Enter 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**

C1d. Ability to Hear (with hearing aid or hearing appliance, if normally used)

Enter 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**

D. Weight-bearing (Complete during the 2-day assessment period.)

Enter Code

D1. Does the patient have any clinician-ordered weight bearing or limb/spinal loading restrictions (including upper body lift, push, pull, or carry restrictions)?
0. No *(If* **No**, *skip to Section E.. Grip Strength.)*
1. Yes *(If* **Yes**, *please complete this section.)*

CODING: Indicate all the patient's weight-bearing restrictions.

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

Upper Extremity		Lower Extremity	
D1a. Left	**D1b. Right**	**D1c. Left**	**D1d. Right**
Enter Code	Enter Code	Enter Code	Enter Code

V. Impairments (cont.)

E. Grip Strength (Complete during the 2-day assessment period.)

Enter Code

E1. Does the patient have any impairments with grip strength (e.g., reduced/limited or absent)?
- **0. No** *(If **No** impairments, skip to Section F. Respiratory Status.)*
- **1. Yes** *(If **Yes**, please complete this section.)*

CODING: Indicate the patient's ability to squeeze your hand.

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

E1a. Left Hand	E1b. Right Hand
Enter Code	Enter Code

F. Respiratory Status (Complete during the 2-day assessment period.)

Enter Code

F1. Does the patient have any impairments with respiratory status?
- **0. No** *(If **No** impairments, skip to Section G. Endurance.)*
- **1. Yes** *(If **Yes**, please complete this section.)*

With Supplemental O_2	Without Supplemental O_2
Enter Code	Enter Code
F1a.	**F1b.**

Respiratory Status: Was the patient dyspneic or noticeably **short of breath**?
- **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)
- **9. Not applicable**

G. Endurance (Complete during the 2-day assessment period.)

Enter Code

G1. Does the patient have any impairments with endurance?
- **0. No** *(If **No** impairments, skip to Section H. Mobility Devices and Aids Needed.)*
- **1. Yes** *(If **Yes**, please complete this section.)*

Enter Code

G1a. Mobility Endurance: Was the patient able to walk or wheel 50 feet (15 meters)?
- **0. No, could not do**
- **1. Yes, can do with rest**
- **2. Yes, can do without rest**
- **8. Not assessed due to medical restriction**

Enter Code

G1b. Sitting Endurance: Was the patient able to tolerate sitting for 15 minutes?
- **0. No**
- **1. Yes, with support**
- **2. Yes, without support**
- **8. Not assessed due to medical restriction**

V. Impairments (cont.)

H. Mobility Devices and Aids Needed (Complete during the 2-day assessment period.)

Check all that apply.

H1. Indicate all mobility devices and aids needed at time of assessment.

- ☐ **a. Canes/crutch**
- ☐ **b. Walker**
- ☐ **c. Orthotics/prosthetics**
- ☐ **d. Wheelchair/scooter full time**
- ☐ **e. Wheelchair/scooter part time**
- ☐ **f. Mechanical lift**
- ☐ **g. Other** (specify) _____
- ☐ **h. None apply**

*T.V How long did it take you to complete the **V. Impairments** section?* _____ *(minutes) Clinician Name(s)* _____

VI. Functional Status: Usual Performance

A. Core Self Care: The core self care items should be completed on ALL patients. (Complete during the 2-day assessment period.)

Code the patient's most usual performance 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.

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.
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 if applicable.
Enter Code	**A6. Lower body dressing:** The ability to dress and undress below the waist, including fasteners. Does not include footwear.

VI. Functional Status (cont.)

B. Core Functional Mobility: The core functional mobility items should be completed on ALL patients. (Complete during the 2-day assessment period.)

Complete for ALL patients: Code the patient's most usual performance 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.

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 safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.

Enter Code

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

Enter Code

B3. Chair/Bed-to-Chair Transfer: The ability to safely 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 safely 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.)*

B5a. Select the longest distance the patient walks and code his/her level of independence (Level 1–6) on that distance. Observe performance. (Select only one.)

Enter Code
1. **Walk 150 ft (45 m):** Once standing, can walk at least 150 feet (45 meters) in corridor or similar space.

Enter Code
2. **Walk 100 ft (30 m):** Once standing, can walk at least 100 feet (30 meters) in corridor or similar space

Enter Code
3. **Walk 50 ft (15 m):** Once standing, can walk at least 50 feet (15 meters) in corridor or similar space

Enter Code
4. **Walk in Room Once Standing:** Once standing, can walk at least 10 feet (3 meters) in room, corridor or similar space.

B5b. Select the longest distance the patient wheels and code his/her level of independence (Level 1–6). Observe performance. (Select only one.)

Enter Code
1. **Wheel 150 ft (45 m):** Once sitting, can wheel at least 150 feet (45 meters) in corridor or similar space.

Enter Code
2. **Wheel 100 ft (30 m):** Once sitting, can wheel at least 100 feet (30 meters) in corridor or similar space

Enter Code
3. **Wheel 50 ft (15 m):** Once sitting, can wheel at least 50 feet (15 meters) in corridor or similar space

Enter Code
4. **Wheel in Room Once Seated:** Once seated, can wheel at least 10 feet (3 meters) in room, corridor, or similar space.

VI. Functional Status (cont.)

C. Supplemental Functional Ability (Complete during the 2-day assessment period.)

Enter Code: 1

C. Following discharge, is it anticipated that the patient will need post-acute care to improve their functional ability or other types of personal assistance?

0. **No** *(If* **No***, skip to Section VII. Overall Plan of Care/Advance Care Directives.)*
1. **Yes**

Please code the patient on all activities they are able to participate in and which you can observe, or have assessed by other means, 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**
- **E.** Not attempted due to **environmental constraints**
- **A.** Task **attempted** but not completed
- **N.** **Not applicable**
- **P.** **Patient Refused**

→ **Enter Code in Boxes** →

Enter Code	
Enter Code	**C1. Wash Upper Body:** The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.
Enter Code	**C2. Shower/bathe self:** The ability to bathe self in shower or tub, including washing, rinsing, and drying, self. Does not include transferring in/out of tub/shower.
Enter Code	**C3. Roll left and right:** The ability to roll from lying on back to left and right side, and roll back to back.
Enter Code	**C4. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
Enter Code	**C5. Picking up object:** The ability to bend/stoop from a standing position to pick up small object such as a spoon from the floor.
Enter Code	**C6. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that are appropriate for safe mobility.
	MODE OF MOBILITY
Enter Code	**C7.** Does this patient primarily use a wheelchair for mobility? **0. No** *(If* **No***, code C7a–C7f.)* **1. Yes** *(If* **Yes***, code C7f–C7h.)*
Enter Code	**C7a. 1 step (curb):** The ability to step over a curb or up and down one step.
Enter Code	**C7b. Walk 50 feet with two turns:** The ability to walk 50 feet and make two turns.
Enter Code	**C7c. 12 steps:** The ability to go up and down 12 steps with or without a rail.
Enter Code	**C7d. 4 steps:** The ability to go up and down 4 steps with or without a rail.
Enter Code	**C7e. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces, such as grass or gravel.
Enter Code	**C7f. Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
Enter Code	**C7g. Wheel short ramp:** Once seated in wheelchair, goes up and down a ramp of less than 12 feet (4 meters).
Enter Code	**C7h. Wheel long ramp:** Once seated in wheelchair, goes up and down a ramp of more than 12 feet (4 meters).

VI. Functional Status (cont.)

C. Supplemental Functional Ability (Complete during the 2-day assessment period.) (cont.)

Please code patient on all activities they are able to participate in and which you can observe, or have assessed by other means, 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 first 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**
E. Not attempted due to **environmental constraints**
A. Task **attempted** but not completed
N. **Not applicable**
P. **Patient Refused**

→ **Enter Code in Boxes** →

Enter Code	**C8. Telephone-answering:** The ability to pick up call in patient's customary manner and maintain for 1 minute or longer. Does not include getting to the phone.
Enter Code	**C9. Telephone-placing call:** The ability to pick up and place call in patient's customary manner and maintain for 1 minute or longer. Does not include getting to the phone.
Enter Code	**C10. 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	**C11. 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	**C12. 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	**C13. Make light meal:** The ability to plan and prepare all aspects of a light meal such as a bowl of cereal or a sandwich and cold drink, or reheat a prepared meal.
Enter Code	**C14. Wipe down surface:** The 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	**C15. Light shopping:** Once at store, can locate and select up to five needed goods, take to check out, and complete purchasing transaction.
Enter Code	**C16. Laundry:** Includes all aspects of completing a load of laundry using a washer and dryer. Includes sorting, loading and unloading, and adding laundry detergent.
Enter Code	**C17. Use public transportation:** The ability to plan and use public transportation. Includes boarding, riding, and alighting from transportation.

*T.VI How long did it take you to complete the **VI. Functional Status** section? _____ (minutes)*
Clinician Name(s) _____

VII. Overall Plan of Care/Advance Care Directives

A. Overall Plan of Care/Advance Care Directives

Enter ☐ Code

A1. Have the patient (or representative) and the care team (or physician) documented agreed-upon care goals and expected dates of completion or re-evaluation?

0. No, but this work is in process
1. Yes
9. Unclear or unknown

Enter ☐ Code

A2. Which description best fits the patient's overall status?

1. The patient is stable with no risk for serious complications and death (beyond those typical of the patient's age).
2. The patient is temporarily facing high health risks but likely to return to being stable without risk for serious complications and death (beyond those typical of the patient's age).
3. The patient is likely to remain in fragile health and have ongoing high risks of serious complications and death.
4. The patient has serious progressive conditions that could lead to death within a year.
9. The patient's condition is unknown or unclear to the respondent.

Check all that apply.

A3. In anticipation of serious clinical complications, has the patient made care decisions which are documented in the medical record?

☐ **1. The patient has designated a decision-maker (if the patient is unable to make decisions) which is documented in the medical record.**

☐ **2. The patient (or surrogate) has made a decision to forgo resuscitation which is documented in the medical record.**

*T.VII How long did it take you to complete the **VII. Overall Plan of Care/Advance Care Directives** section? _____ (minutes)*
Clinician Name(s) _____

VIII. Discharge Status

A. Discharge Information

A1. Discharge Date

_____/_____/_____
MM DD YYYY

A2. Attending Physician (at this location)

A3. Discharge Location

Where will the patient be discharged to?

Enter Code

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

A4. Frequency of Assistance at Discharge

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

Enter Code

1. Patient **does not require assistance** *(Skip to Section B. Residential Information.)*
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** and predictably 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, or standby services

A5. Caregiver(s) Availability

Enter Code

Was the discharge destination decision influenced by the availability of a family member or friend to provide assistance?

0. **No** *(If* **No,** *skip to Section B. Residential Information.)*
1. **Yes**

A6. Willing Caregiver(s)

Does the patient have one or more willing caregiver(s)?

Enter Code

0. **No** *(If* **No,** *skip to Section B. Residential Information.)*
1. **Yes, confirmed by caregiver**
2. **Yes, confirmed only by patient**
9. **Unclear from patient; no confirmation from caregiver** *(If* **Unclear,** *skip to Section B. Residential Information.)*

A7. Types of Caregiver(s)

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

Check all that apply.

- ☐ a. **Spouse or significant other**
- ☐ b. **Child**
- ☐ c. **Other unpaid family member or friend**
- ☐ d. **Paid help**

B. Residential Information: Complete only if patient is discharged to a private residence or other community-based setting.

B1. Patient Lives With at Discharge

Upon discharge (admission), who will the patient live with?

Check all that apply.

- ☐ a. **Lives alone**
- ☐ b. **Lives with paid helper**
- ☐ c. **Lives with other(s)**
- ☐ d. **Unknown**

VIII. Discharge Status (cont.)

C. Support Needs/Caregiver (CG) Assistance

Type of Assistance Needed Patient needs assistance with (check all that apply)		Support Needs/Caregiver Assistance (If patient needs assistance, check one on each row)			
		CG able	CG will need training and/or other supportive services	CG not likely to be able/CG not available	CG ability unclear
☐ C1a	a. ADL assistance (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)	☐ C2a	☐ C3a	☐ C4a	☐ C5a
☐ C1b	b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	☐ C2b	☐ C3b	☐ C4b	☐ C5b
☐ C1c	c. Medication administration (e.g., oral, inhaled, or injectable)	☐ C2c	☐ C3c	☐ C4c	☐ C5c
☐ C1d	d. Medical procedures/treatments (e.g., changing wound dressing)	☐ C2d	☐ C3d	☐ C4d	☐ C5d
☐ C1e	e. Management of equipment (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment, or supplies)	☐ C2e	☐ C3e	☐ C4e	☐ C5e
☐ C1f	f. Supervision and safety	☐ C2f	☐ C3f	☐ C4f	☐ C5f
☐ C1g	g. Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from appointments)	☐ C2g	☐ C3g	☐ C4g	☐ C5g
☐ C1h	h. None of the above or non-residential setting				

VIII. Discharge Status (cont.)

D. Discharge Care Options

Please indicate whether the team considered the following services appropriate for the patient at discharge; for those identified as potentially appropriate, were they: unavailable, refused by family, or not covered by insurance. (Check all that apply.)

Type of Service	Considered Appropriate by the Provider	No Bed/Services Available	Refused by Patient/Family	Not Covered by Insurance
a. Home Health Agency (HHA)	☐ D1a	☐ D2a	☐ D3a	☐ D4a
b. Skilled Nursing Facility (SNF/TCU)	☐ D1b	☐ D2b	☐ D3b	☐ D4b
c. Inpatient Rehabilitation Hospital or Unit (IRF)	☐ D1c	☐ D2c	☐ D3c	☐ D4c
d. Long-Term Care Hospital (LTCH)	☐ D1d	☐ D2d	☐ D3d	☐ D4d
e. Psychiatric Hospital or Unit	☐ D1e	☐ D2e	☐ D3e	☐ D4e
f. Outpatient Services	☐ D1f	☐ D2f	☐ D3f	☐ D4f
g. Acute Hospital Admission	☐ D1g	☐ D2g	☐ D3g	☐ D4g
h. Hospice	☐ D1h	☐ D2h	☐ D3h	☐ D4h
i. Long-term Personal Care Services	☐ D1i	☐ D2i	☐ D3i	☐ D4i
j. Long-Term Nursing Facility	☐ D1j	☐ D2j	☐ D3j	☐ D4j
k. Other (specify) _____	☐ D1k	☐ D2k	☐ D3k	☐ D4k
l. No Services Needed After Discharge	☐ D1l			

VIII. Discharge Status (cont.)

E. Discharge Location Information

Enter Code

E1. Is the patient being discharged with referral for additional services?

0. **No** (*If* **No,** *skip to E7. Discharge Delay.*)
1. **Yes** (*If* **yes,** *please identify the name, location, and type of service to which the patient is discharged.*)

E2. Provider's Name

E6. Medicare Provider's Identification Number (optional)

Enter Code

E3. Provider Type

1. **Home health agency** (HHA)
2. **Skilled nursing facility** (SNF/TCU)
3. **Inpatient rehabilitation hospital or unit** (IRF)
4. **Long-term care hospital** (LTCH)
5. **Psychiatric hospital or unit**
6. **Outpatient services**
7. **General acute hospital** (IPPS)
8. **Hospice**
9. **Long-term nursing facility**
10. **Other** (specify) _____
11. Transfer within IPPS to **Critical/Intensive Care Unit (ICU)** (1-2 pts per nurse)
12. Transfer within IPPS to **Step Down/ Intermediate Care Unit** (includes Progressive Care) (3-6 pts per nurse)
13. Transfer within IPPS to **General Medical/Surgical Unit** (6 or more pts per nurse)

E7. Discharge Delay

Enter Code

Was the patient's discharge delayed for at least **24** hours?

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

E8. Reason for Discharge Delay

Enter Code

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)_____

E4. Provider City

E5. Provider State

E9. In the situation that the patient or an authorized representative has requested this information not be shared with the next provider, check here: ☐

T.VIII How long did it take you to complete the ***VIII. Discharge Status*** *section?* _____ *(minutes)*
Clinician Name(s) _____

IX. ICD-9 Coding Information

Coders:

For this section, please provide a listing of principal diagnosis, comorbid diseases and complications, and procedures based on a review of the patient's clinical records at the time of assessment or at the time of a significant change in the patient's status affecting Medicare payment.

A. Principal Diagnosis

Indicate the **principal diagnosis for billing purposes. Indicate the ICD-9 CM code**. For **V-codes**, also indicate the medical diagnosis and associated ICD-9 CM code. Be as specific as possible.

A1. ICD-9 CM code for Principal Diagnosis at Assessment |___|___|___|.|___|___|	**A2. If Principal Diagnosis was a V-code, what was the ICD-9 CM code for the primary medical condition or injury being treated?** |___|___|___|.|___|___|
A1a. Principal Diagnosis at Assessment _____	**A2a. If Principal Diagnosis was a V-code, what was the primary medical condition or injury being treated?** _____

B. Other Diagnoses, Comorbidities, and Complications

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

ICD-9 CM code		Diagnosis	
B1a.	|___|___|___|.|___|___|	**B1b.**	
B2a.	|___|___|___|.|___|___|	**B2b.**	
B3a.	|___|___|___|.|___|___|	**B3b.**	
B4a.	|___|___|___|.|___|___|	**B4b.**	
B5a.	|___|___|___|.|___|___|	**B5b.**	
B6a.	|___|___|___|.|___|___|	**B6b.**	
B7a.	|___|___|___|.|___|___|	**B7b.**	
B8a.	|___|___|___|.|___|___|	**B8b.**	
B9a.	|___|___|___|.|___|___|	**B9b.**	
B10a.	|___|___|___|.|___|___|	**B10b.**	
B11a.	|___|___|___|.|___|___|	**B11b.**	
B12a.	|___|___|___|.|___|___|	**B12b.**	
B13a.	|___|___|___|.|___|___|	**B13b.**	
B14a.	|___|___|___|.|___|___|	**B14b.**	
B15a.	|___|___|___|.|___|___|	**B15b.**	

Enter Code

B16. Is this list complete?
0. No
1. Yes

IX. ICD-9 Coding Information (cont.)

C. Major Procedures (Diagnostic, Surgical, and Therapeutic Interventions)

Enter Code

C1. Did the patient have one or more major procedures (diagnostic, surgical, and therapeutic interventions) during this admission?

0. No *(If **No**, skip to Section X, Other Useful Information.)*

1. Yes

List up to 15 **ICD-9 CM codes** and associated procedures (diagnostic, surgical, and therapeutic interventions) performed during this admission.

	ICD-9 CM Code		Procedure
C2a.	|___|___|.|___|___|	C2b.	
C3a.	|___|___|.|___|___|	C3b.	
C4a.	|___|___|.|___|___|	C4b.	
C5a.	|___|___|.|___|___|	C5b.	
C6a.	|___|___|.|___|___|	C6b.	
C7a.	|___|___|.|___|___|	C7b.	
C8a.	|___|___|.|___|___|	C8b.	
C9a.	|___|___|.|___|___|	C9b.	
C10a.	|___|___|.|___|___|	C10b.	
C11a.	|___|___|.|___|___|	C11b.	
C12a.	|___|___|.|___|___|	C12b.	
C13a.	|___|___|.|___|___|	C13b.	
C14a.	|___|___|.|___|___|	C14b.	
C15a.	|___|___|.|___|___|	C15b.	
C16a.	|___|___|.|___|___|	C16b.	

Enter Code

C17. Is this list complete?

0. No

1. Yes

D. Coding Complete

Enter Code

D1. Is this coding section complete?

0. No

1. Yes

*T.IX How long did it take you to complete the **IX. ICD-9 Coding Information** section? _____ (minutes)*

Clinician Name(s) _____

X. Other Useful Information

A. 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.