INPATIENT REHABILITATION FACILITY - PATIENT ASSESSMENT INSTRUMENT

Identification Information

1. Facility Information

A. Facility Name

_____
_____
_____
_____
_____

B. Facility Medicare Provider Number _____

2. Patient Medicare Number _____

3. Patient Medicaid Number _____

4. Patient First Name _____

5A. Patient Last Name _____

5B. Patient Identification Number _____

6. Birth Date ____/____/_____
MM / DD / YYYY

7. Social Security Number _____

8. Gender (*1 - Male; 2 - Female*) _____

10. Marital Status _____
(1 - Never Married; 2 - Married; 3 - Widowed; 4 - Separated; 5 - Divorced)

11. Zip Code of Patient's Pre-Hospital Residence _____

12. Admission Date ____/____/_____
MM / DD / YYYY

13. Assessment Reference Date ____/____/_____
MM / DD / YYYY

14. Admission Class _____
(1 - Initial Rehab; 2 - Evaluation; 3 - Readmission; 4 - Unplanned Discharge; 5 - Continuing Rehabilitation)

15A. Admit From _____
(01- Home (private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements); 02- Short-term General Hospital; 03 - Skilled Nursing Facility (SNF); 04 - Intermediate care; 06 - Home under care of organized home health service organization; 50 - Hospice (home); 51 - Hospice (medical facility); 61 - Swing bed; 62 - Another Inpatient Rehabilitation Facility; 63 - Long-Term Care Hospital (LTCH); 64 - Medicaid Nursing Facility; 65 - Inpatient Psychiatric Facility; 66 - Critical Access Hospital (CAH); 99 - Not Listed)

16A. Pre-hospital Living Setting _____
Use codes from 15A. Admit From

17. Pre-hospital Living With _____
(Code only if item 16A is 01- Home: Code using 01 - Alone; 02 - Family/Relatives; 03 - Friends; 04 - Attendant; 05 - Other)

Payer Information

20. Payment Source
(02 - Medicare Fee For Service; 51- Medicare-Medicare Advantage; 99 - Not Listed)

A. Primary Source _____

B. Secondary Source _____

Medical Information

21. Impairment Group* _____ Admission _____ Discharge

Condition requiring admission to rehabilitation; code according to Appendix A.

22. Etiologic Diagnosis
(*Use ICD codes to indicate the etiologic problem that led to the condition for which the patient is receiving rehabilitation*)
A. _____
B. _____
C. _____

23. Date of Onset of Impairment ____/____/_____
MM / DD / YYYY

24. Comorbid Conditions
Use ICD codes to enter comorbid medical conditions

A. _____	J. _____	S. _____
B. _____	K. _____	T. _____
C. _____	L. _____	U. _____
D. _____	M. _____	V. _____
E. _____	N. _____	W. _____
F. _____	O. _____	X. _____
G. _____	P. _____	Y. _____
H. _____	Q. _____	
I. _____	R. _____	

24A. Are there any arthritis conditions recorded in items #21, #22, or #24 that meet all of the regulatory requirements for IRF classification (in 42 CFR 412.29(b)(2)(x), (xi), and (xii))? _____
(0 - No; 1 - Yes)

Height and Weight

(While measuring if the number is X.1-X.4 round down, X.5 or greater round up)

25A. Height on admission (in inches) _____

26A. Weight on admission (pounds) _____

Measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, with shoes off, etc.)

Discharge Information

40. Discharge Date ____/____/_____
MM / DD / YYYY

41. Patient discharged against medical advice? _____
(0 - No; 1 - Yes)

42. Program Interruption(s) _____
(0 - No; 1 - Yes)

43. Program Interruption Dates
(Code only if item 42 is 1 - Yes)

A. 1st Interruption Date [ ]
MM / DD / YYYY

B. 1st Return Date [ ]
MM / DD / YYYY

C. 2nd Interruption Date [ ]
MM / DD / YYYY

D. 2nd Return Date [ ]
MM / DD / YYYY

E. 3rd Interruption Date [ ]
MM / DD / YYYY

F. 3rd Return Date [ ]
MM / DD / YYYY

44C. Was the patient discharged alive? _____
(0 - No; 1 - Yes)

44D. Patient's discharge destination/living setting, using codes below: (answer only if 44C = 1; if 44C = 0, skip to item 46) _____

(01- Home (private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements); 02- Short-term General Hospital; 03 - Skilled Nursing Facility (SNF); 04 - Intermediate care; 06 - Home under care of organized home health service organization; 50 - Hospice (home); 51 - Hospice (medical facility); 61 - Swing bed; 62 - Another Inpatient Rehabilitation Facility; 63 - Long-Term Care Hospital (LTCH); 64 - Medicaid Nursing Facility; 65 - Inpatient Psychiatric Facility; 66 - Critical Access Hospital (CAH); 99 - Not Listed)

45. Discharge to Living With _____
(Code only if item 44C is 1 - Yes and 44D is 01 - Home; Code using 1 - Alone; 2 - Family / Relatives; 3 - Friends; 4 - Attendant; 5 - Other)

46. Diagnosis for Interruption or Death _____
(Code using ICD code)

47. Complications during rehabilitation stay
(Use ICD codes to specify up to six conditions that began with this rehabilitation stay)

A. _____ B. _____
C. _____ D. _____
E. _____ F. _____

Therapy Information

O0401. Week 1: Total Number of Minutes Provided

O0401A: Physical Therapy
a. Total minutes of individual therapy _____
b. Total minutes of concurrent therapy _____
c. Total minutes of group therapy _____
d. Total minutes of co-treatment therapy _____

O0401B: Occupational Therapy
a. Total minutes of individual therapy _____
b. Total minutes of concurrent therapy _____
c. Total minutes of group therapy _____
d. Total minutes of co-treatment therapy _____

O0401C: Speech-Language Pathology
a. Total minutes of individual therapy _____
b. Total minutes of concurrent therapy _____
c. Total minutes of group therapy _____
d. Total minutes of co-treatment therapy _____

O0402. Week 2: Total Number of Minutes Provided

O0402A: Physical Therapy
a. Total minutes of individual therapy _____
b. Total minutes of concurrent therapy _____
c. Total minutes of group therapy _____
d. Total minutes of co-treatment therapy _____

O0402B: Occupational Therapy
a. Total minutes of individual therapy _____
b. Total minutes of concurrent therapy _____
c. Total minutes of group therapy _____
d. Total minutes of co-treatment therapy _____

O0402C: Speech-Language Pathology
a. Total minutes of individual therapy _____
b. Total minutes of concurrent therapy _____
c. Total minutes of group therapy _____
d. Total minutes of co-treatment therapy _____

Patient _____ Identifier _____ Date _____

INPATIENT REHABILITATION FACILITY - PATIENT ASSESSMENT INSTRUMENT QUALITY INDICATORS

ADMISSION

Section A Administrative Information

A1005. Ethnicity
Are you of Hispanic, Latino/a, or Spanish origin?

↓ Check all that apply	
☐	**A. No, not of Hispanic, Latino/a, or Spanish origin**
☐	**B. Yes, Mexican, Mexican American, Chicano/a**
☐	**C. Yes, Puerto Rican**
☐	**D. Yes, Cuban**
☐	**E. Yes, another Hispanic, Latino, or Spanish origin**
☐	**X. Patient unable to respond**

A1010. Race
What is your race?

↓ Check all that apply	
☐	**A. White**
☐	**B. Black or African American**
☐	**C. American Indian or Alaska Native**
☐	**D. Asian Indian**
☐	**E. Chinese**
☐	**F. Filipino**
☐	**G. Japanese**
☐	**H. Korean**
☐	**I. Vietnamese**
☐	**J. Other Asian**
☐	**K. Native Hawaiian**
☐	**L. Guamanian or Chamorro**
☐	**M. Samoan**
☐	**N. Other Pacific Islander**
☐	**X. Patient unable to respond**

A1110. Language

Enter Code	
	A. What is your preferred language?
	B. Do you need or want an interpreter to communicate with a doctor or health care staff? 0. **No** 1. **Yes** 9. **Unable to determine**

Patient _____ Identifier _____ Date _____

ADMISSION

Section A Administrative Information

A1250. Transportation (from NACHC©)
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

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

Patient _____ Identifier _____ Date _____

ADMISSION

Section B Hearing, Speech, and Vision

B0200. Hearing

Enter Code

Ability to hear (with hearing aid or hearing appliances if normally used)

0. **Adequate** - no difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty** - difficulty in some environments (e.g., when person speaks softly or setting is noisy)
2. **Moderate difficulty** - speaker has to increase volume and speak distinctly
3. **Highly impaired** - absence of useful hearing

B1000. Vision

Enter Code

Ability to see in adequate light (with glasses or other visual appliances)

0. **Adequate** - sees fine detail, such as regular print in newspapers/books
1. **Impaired** - sees large print, but not regular print in newspapers/books
2. **Moderately impaired** - limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired** - object identification in question, but eyes appear to follow objects
4. **Severely impaired** - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

B1300. Health Literacy

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

Enter Code

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

BB0700. Expression of Ideas and Wants (3-day assessment period)

Enter Code

Expression of ideas and wants (consider both verbal and non-verbal expression and excluding language barriers)

4. Expresses complex messages **without difficulty** and with speech that is clear and easy to understand
3. Exhibits some **difficulty** with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear
2. **Frequently** exhibits difficulty with expressing needs and ideas
1. **Rarely/Never** expresses self or speech is very difficult to understand.

BB0800. Understanding Verbal and Non-Verbal Content (3-day assessment period)

Enter Code

Understanding verbal and non-verbal content (with hearing aid or device, if used, and excluding language barriers)

4. **Understands:** Clear comprehension without cues or repetitions
3. **Usually understands:** Understands most conversations, but misses some part/intent of message. Requires cues at times to understand
2. **Sometimes understands:** Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand
1. **Rarely/never understands**

Patient _____ Identifier _____ Date _____

ADMISSION

Section C Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted? (3-day assessment period)
Attempt to conduct interview with all patients.

Enter Code

0. **No** (patient is rarely/never understood) → *Skip to C0900, Memory/Recall Ability*
1. **Yes** → *Continue to C0200, Repetition of Three Words*

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code

Ask patient: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue and bed****. Now tell me the three words."*

Number of words repeated after first attempt

3. **Three**
2. **Two**
1. **One**
0. **None**

After the patient's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture")*. You may repeat the words up to two more times.

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

Enter Code

Ask patient: *"Please tell me what year it is right now."*

A. Able to report correct year

3. **Correct**
2. **Missed by 1 year**
1. **Missed by 2 - 5 years**
0. **Missed by > 5 years** or no answer

Enter Code

Ask patient: *"What month are we in right now?"*

B. Able to report correct month

2. **Accurate within 5 days**
1. **Missed by 6 days to 1 month**
0. **Missed by > 1 month** or no answer

Enter Code

Ask patient: *"What day of the week is today?"*

C. Able to report correct day of the week

1. **Correct**
0. **Incorrect** or no answer

C0400. Recall

Enter Code

Ask patient: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"* If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

A. Able to recall "sock"

2. **Yes, no cue required**
1. **Yes, after cueing** ("something to wear")
0. **No** - could not recall

Enter Code

B. Able to recall "blue"

2. **Yes, no cue required**
1. **Yes, after cueing** ("a color")
0. **No** - could not recall

Enter Code

C. Able to recall "bed"

2. **Yes, no cue required**
1. **Yes, after cueing** ("a piece of furniture")
0. **No** - could not recall

Patient _____ Identifier _____ Date _____

ADMISSION

Section C Cognitive Patterns

Brief Interview for Mental Status (BIMS) - Continued

C0500. BIMS Summary Score

Enter Score

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the patient was unable to complete the interview

C0600. Should the Staff Assessment for Mental Status (C0900) be Conducted?

Enter Code

0. **No** (patient was able to complete Brief Interview for Mental Status) → *Skip to C1310, Signs and Symptoms of Delirium*
1. **Yes** (patient was unable to complete Brief Interview for Mental Status) → *Continue to C0900, Memory/Recall Ability*

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed.

C0900. Memory/Recall Ability (3-day assessment period)

Check all that the patient was normally able to recall

- ☐ **A. Current season**
- ☐ **B. Location of own room**
- ☐ **C. Staff names and faces**
- ☐ **E. That he or she is in a hospital/hospital unit**
- ☐ **Z. None of the above** were recalled

C1310. Signs and Symptoms of Delirium (from CAM©)

Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record.

A. Acute Onset Mental Status Change

Enter Code

Is there evidence of an acute change in mental status from the patient's baseline?
0. **No**
1. **Yes**

Coding:
0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

Enter Code in Boxes

B. Inattention - Did the patient have difficulty focusing attention, for example being easily distractible or having difficulty keeping track of what was being said?

C. Disorganized thinking - Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

D. Altered level of consciousness - Did the patient have altered level of consciousness as indicated by any of the following criteria?

- **vigilant** - startled easily to any sound or touch
- **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch
- **stuporous** - very difficult to arouse and keep aroused for the interview
- **comatose** - could not be aroused

Patient _____ Identifier _____ Date _____

ADMISSION

Section D Mood

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

Say to patient: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the patient: *"About **how often** have you been bothered by this?"*
Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence
0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)
9. **No response** (leave column 2 blank)

2. Symptom Frequency
0. **Never or 1 day**
1. **2-6 days** (several days)
2. **7-11 days** (half or more of the days)
3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. ***Little interest or pleasure in doing things***		
B. ***Feeling down, depressed, or hopeless***		
If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.		
C. ***Trouble falling or staying asleep, or sleeping too much***		
D. ***Feeling tired or having little energy***		
E. ***Poor appetite or overeating***		
F. ***Feeling bad about yourself – or that you are a failure or have let yourself or your family down***		
G. ***Trouble concentrating on things, such as reading the newspaper or watching television***		
H. ***Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual***		
I. ***Thoughts that you would be better off dead, or of hurting yourself in some way***		

D0160. Total Severity Score

Enter Score

Add scores for all frequency responses in column 2, Symptom Frequency. Total score must be between 02 and 27.
Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)

D0700. Social Isolation (from Creative Commons©)

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

Enter Code

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

Patient _____ Identifier _____ Date _____

ADMISSION

Section GG Functional Abilities and Goals

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

Coding:

3. **Independent** - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.
2. **Needed Some Help** - Patient needed partial assistance from another person to complete any activities.
1. **Dependent** - A helper completed all the activities for the patient.
8. **Unknown**
9. **Not Applicable**

↓ Enter Codes in Boxes	
	A. Self-Care: Code the patient's need for assistance with bathing, dressing, using the toilet, and eating prior to the current illness, exacerbation, or injury.
	B. Indoor Mobility (Ambulation): Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
	C. Stairs: Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
	D. Functional Cognition: Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.

↓ Check all that apply	
☐	**A. Manual wheelchair**
☐	**B. Motorized wheelchair and/or scooter**
☐	**C. Mechanical lift**
☐	**D. Walker**
☐	**E. Orthotics/Prosthetics**
☐	**Z. None of the above**

Patient _____ Identifier _____ Date _____

ADMISSION

Section GG Functional Abilities and Goals

GG0130. Self-Care (3-day assessment period)

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code discharge goal(s).

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

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

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

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
		A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
		B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
		C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
		E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
		F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.
		G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
		H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Patient _____ Identifier _____ Date _____

ADMISSION

Section GG Functional Abilities and Goals

GG0170. Mobility (3-day assessment period)

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code discharge goal(s).

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

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

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

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
		A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
		B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
		C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with no back support.
		D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
		E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
		F. Toilet transfer: The ability to get on and off a toilet or commode.
		G. 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.
		I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)*
		J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
		K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Patient _____ Identifier _____ Date _____

ADMISSION

Section GG Functional Abilities and Goals

GG0170. Mobility (3-day assessment period) - Continued

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code discharge goal(s).

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

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

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

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
		L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
		M. 1 step (curb): The ability to go up and down a curb or up and down one step. *If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object*
		N. 4 steps: The ability to go up and down four steps with or without a rail. *If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object*
		O. 12 steps: The ability to go up and down 12 steps with or without a rail.
		P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
		Q1. Does the patient use a wheelchair and/or scooter? 0. **No** → *Skip to H0350, Bladder Continence* 1. **Yes** → *Continue to GG0170R, Wheel 50 feet with two turns*
		R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
		RR1. Indicate the type of wheelchair or scooter used. 1. **Manual** 2. **Motorized**
		S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
		SS1. Indicate the type of wheelchair or scooter used. 1. **Manual** 2. **Motorized**

Patient _____ Identifier _____ Date _____

ADMISSION

Section H Bladder and Bowel

H0350. Bladder Continence (3-day assessment period)

Enter Code

Bladder continence - Select the one category that best describes the patient.
0. **Always continent** (no documented incontinence)
1. **Stress incontinence only**
2. **Incontinent less than daily** (e.g., once or twice during the 3-day assessment period)
3. **Incontinent daily** (at least once a day)
4. **Always incontinent**
5. **No urine output** (e.g., renal failure)
9. **Not applicable** (e.g., indwelling catheter)

H0400. Bowel Continence (3-day assessment period)

Enter Code

Bowel continence - Select the one category that best describes the patient.
0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** patient had an ostomy or did not have a bowel movement for the entire 3 days

Section I Active Diagnoses

Comorbidities and Co-existing Conditions

↓ **Check all that apply**

- ☐ **I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**
- ☐ **I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
- ☐ **I7900. None of the above**

Section J Health Conditions

J0510. Pain Effect on Sleep

Enter Code

Ask patient: "Over the past 5 days, ***how much of the time has pain made it hard for you to sleep at night?"***
0. **Does not apply – I have not had any pain or hurting in the past 5 days** → *Skip to J1750, History of Falls*
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

J0520. Pain Interference with Therapy Activities

Enter Code

Ask patient: "Over the past 5 days, ***how often have you limited your participation in rehabilitation therapy sessions due to pain?"***
0. **Does not apply – I have not received rehabilitation therapy in the past 5 days**
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

Patient _____ Identifier _____ Date _____

ADMISSION

Section J Health Conditions

J0530. Pain Interference with Day-to-Day Activities

Enter Code

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

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

J1750. History of Falls

Enter Code

Has the patient had two or more falls in the past year or any fall with injury in the past year?

0. **No**
1. **Yes**
8. **Unknown**

J2000. Prior Surgery

Enter Code

Did the patient have major surgery during the **100 days prior to admission**?

0. **No**
1. **Yes**
8. **Unknown**

Section K Swallowing/Nutritional Status

K0520. Nutritional Approaches

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

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

Section M Skin Conditions

Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code

Does this patient have one or more unhealed pressure ulcers/injuries?

0. **No** → *Skip to N0415, High-Risk Drug Classes: Use and Indication*
1. **Yes** → *Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage*

Patient _____ Identifier _____ Date _____

ADMISSION

Section M | Skin Conditions

Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
Enter Number	**A. Stage 1:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. **1. Number of Stage 1 pressure injuries**
Enter Number	**B. Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **1. Number of Stage 2 pressure ulcers**
Enter Number	**C. Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **1. Number of Stage 3 pressure ulcers**
Enter Number	**D. 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 includes undermining and tunneling. **1. Number of Stage 4 pressure ulcers**
Enter Number	**E. Unstageable - Non-removable dressing/device:** Known but not stageable due to non-removable dressing/device **1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device**
Enter Number	**F. Unstageable - Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar **1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**
Enter Number	**G. Unstageable - Deep tissue injury** **1. Number of unstageable pressure injuries presenting as deep tissue injury**

Patient _____ Identifier _____ Date _____

ADMISSION

Section N Medications

N0415. High-Risk Drug Classes: Use and Indication

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

N2001. Drug Regimen Review

Enter Code ☐

Did a complete drug regimen review identify potential clinically significant medication issues?

0. **No - No issues found during review** → *Skip to O0110, Special Treatments, Procedures, and Programs*
1. **Yes - Issues found during review** → *Continue to N2003, Medication Follow-up*
9. **Not applicable - Patient is not taking any medications** → *Skip to O0110, Special Treatments, Procedures, and Programs*

N2003. Medication Follow-up

Enter Code ☐

Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

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

Section O Special Treatments, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs

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

	a. On Admission Check all that apply ↓
Cancer Treatments	
A1. Chemotherapy	☐
A2. IV	☐
A3. Oral	☐
A10. Other	☐
B1. Radiation	☐
Respiratory Therapies	
C1. Oxygen Therapy	☐
C2. Continuous	☐
C3. Intermittent	☐
C4. High-concentration	☐

Patient _____ Identifier _____ Date _____

ADMISSION

Section O Special Treatments, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs - Continued
Check all of the following treatments, procedures, and programs that apply on admission.

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

Patient _____ Identifier _____ Date _____

DISCHARGE

Section A Administrative Information

A1250. Transportation (from NACHC©)
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

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

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
At the time of discharge to another provider, did your facility provide the patient's current reconciled medication list to the subsequent provider?

Enter Code	
	0. **No** – Current reconciled medication list not provided to the subsequent provider → *Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge* 1. **Yes** – Current reconciled medication list provided to the subsequent provider

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Route of Transmission	Check all that apply ↓
A. Electronic Health Record	☐
B. Health Information Exchange Organization	☐
C. Verbal (e.g., in-person, telephone, video conferencing)	☐
D. Paper-based (e.g., fax, copies, printouts)	☐
E. Other Methods (e.g., texting, email, CDs)	☐

A2123. Provision of Current Reconciled Medication List to Patient at Discharge
At the time of discharge, did your facility provide the patient's current reconciled medication list to the patient, family and/or caregiver?

Enter Code	
	0. **No** – Current reconciled medication list not provided to the patient, family and/or caregiver → *Skip to B1300, Health Literacy* 1. **Yes** – Current reconciled medication list provided to the patient, family and/or caregiver

A2124. Route of Current Reconciled Medication List Transmission to Patient
Indicate the route(s) of transmission of the current reconciled medication list to the patient/family/caregiver.

Route of Transmission	Check all that apply ↓
A. Electronic Health Record (e.g., electronic access to patient portal)	☐
B. Health Information Exchange Organization	☐
C. Verbal (e.g., in-person, telephone, video conferencing)	☐
D. Paper-based (e.g., fax, copies, printouts)	☐
E. Other Methods (e.g., texting, email, CDs)	☐

Patient _____ Identifier _____ Date _____

DISCHARGE

Section B Hearing, Speech, and Vision

B1300. Health Literacy
How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Enter Code

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

Section C Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted? (3-day assessment period)
Attempt to conduct interview with all patients.

Enter Code

0. **No** (patient is rarely/never understood) → *Skip to C1310, Signs and Symptoms of Delirium*
1. **Yes** → *Continue to C0200, Repetition of Three Words*

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code

Ask patient: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue and bed****. Now tell me the three words."*

Number of words repeated after first attempt

3. **Three**
2. **Two**
1. **One**
0. **None**

After the patient's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture"*). You may repeat the words up to two more times.

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

Enter Code

Ask patient: *"Please tell me what year it is right now."*

A. Able to report correct year

3. **Correct**
2. **Missed by 1 year**
1. **Missed by 2 - 5 years**
0. **Missed by > 5 years** or no answer

Enter Code

Ask patient: *"What month are we in right now?"*

B. Able to report correct month

2. **Accurate within 5 days**
1. **Missed by 6 days to 1 month**
0. **Missed by > 1 month** or no answer

Enter Code

Ask patient: *"What day of the week is today?"*

C. Able to report correct day of the week

1. **Correct**
0. **Incorrect** or no answer

Patient _____ Identifier _____ Date _____

DISCHARGE

Section C Cognitive Patterns

C0400. Recall

Enter Code

Ask patient: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"* If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

A. Able to recall "sock"

2. **Yes, no cue required**
1. **Yes, after cueing** ("something to wear")
0. **No** - could not recall

Enter Code

B. Able to recall "blue"

2. **Yes, no cue required**
1. **Yes, after cueing** ("a color")
0. **No** - could not recall

Enter Code

C. Able to recall "bed"

2. **Yes, no cue required**
1. **Yes, after cueing** ("a piece of furniture")
0. **No** - could not recall

C0500. BIMS Summary Score

Enter Score

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the patient was unable to complete the interview

C1310. Signs and Symptoms of Delirium (from CAM©)

Code **after completing** Brief Interview for Mental Status and reviewing medical record.

A. Acute Onset Mental Status Change

Enter Code

Is there evidence of an acute change in mental status from the patient's baseline?

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

Coding:

0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

↓ **Enter Code in Boxes**

B. Inattention - Did the patient have difficulty focusing attention, for example being easily distractible or having difficulty keeping track of what was being said?

C. Disorganized thinking - Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

D. Altered level of consciousness - Did the patient have altered level of consciousness as indicated by any of the following criteria?

- **vigilant** - startled easily to any sound or touch
- **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch
- **stuporous** - very difficult to arouse and keep aroused for the interview
- **comatose** - could not be aroused

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

Patient _____ Identifier _____ Date _____

DISCHARGE

Section D Mood

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

Say to patient: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the patient: *"About **how often** have you been bothered by this?"*
Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence
0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)
9. **No response** (leave column 2 blank)

2. Symptom Frequency
0. **Never or 1 day**
1. **2-6 days** (several days)
2. **7-11 days** (half or more of the days)
3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. ***Little interest or pleasure in doing things***		
B. ***Feeling down, depressed, or hopeless***		
If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.		
C. ***Trouble falling or staying asleep, or sleeping too much***		
D. ***Feeling tired or having little energy***		
E. ***Poor appetite or overeating***		
F. ***Feeling bad about yourself – or that you are a failure or have let yourself or your family down***		
G. ***Trouble concentrating on things, such as reading the newspaper or watching television***		
H. ***Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual***		
I. ***Thoughts that you would be better off dead, or of hurting yourself in some way***		

D0160. Total Severity Score

Enter Score

Add scores for all frequency responses in column 2, Symptom Frequency. Total score must be between 02 and 27.
Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)

D0700. Social Isolation (from Creative Commons©)

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

Enter Code

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

Patient _____ Identifier _____ Date _____

DISCHARGE

Section GG Functional Abilities and Goals

GG0130. Self-Care (3-day assessment period)

Code the patient's usual performance at discharge for each activity using the 6-point scale. If activity was not attempted at discharge, code the reason. If the patient has an incomplete stay, skip discharge GG0130 items.

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

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

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

3. Discharge Performance **Enter Codes in Boxes** ↓	
	A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
	B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
	C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
	E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
	F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.
	G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
	H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Patient _____ Identifier _____ Date _____

DISCHARGE

Section GG | Functional Abilities and Goals

GG0170. Mobility (3-day assessment period)

Code the patient's usual performance at discharge for each activity using the 6-point scale. If activity was not attempted at discharge, code the reason. If the patient has an incomplete stay, skip discharge GG0170 items.

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

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

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

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

Patient _____ Identifier _____ Date _____

DISCHARGE

Section GG Functional Abilities and Goals

GG0170. Mobility (3-day assessment period) - Continued

Code the patient's usual performance at discharge for each activity using the 6-point scale. If activity was not attempted at discharge, code the reason. If the patient has an incomplete stay, skip discharge GG0170 items.

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

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

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

3. Discharge Performance **Enter Codes in Boxes** ↓	
	L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
	M. 1 step (curb): The ability to go up and down a curb or up and down one step. *If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object*
	N. 4 steps: The ability to go up and down four steps with or without a rail. *If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object*
	O. 12 steps: The ability to go up and down 12 steps with or without a rail.
	P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	Q3. Does the patient use a wheelchair and/or scooter? 0. **No** → *Skip to J0510, Pain Effect on Sleep* 1. **Yes** → *Continue to GG0170R, Wheel 50 feet with two turns*
	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	RR3. Indicate the type of wheelchair or scooter used. 1. **Manual** 2. **Motorized**
	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	SS3. Indicate the type of wheelchair or scooter used. 1. **Manual** 2. **Motorized**

Patient _____ Identifier _____ Date _____

DISCHARGE

Section J Health Conditions

J0510. Pain Effect on Sleep

Enter Code

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

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

J0520. Pain Interference with Therapy Activities

Enter Code

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

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

J0530. Pain Interference with Day-to-Day Activities

Enter Code

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

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

J1800. Any Falls Since Admission

Enter Code

Has the patient **had any falls since admission?**

0. **No** → *Skip to K0520, Nutritional Approaches*
1. **Yes** → *Continue to J1900, Number of Falls Since Admission*

J1900. Number of Falls Since Admission

Coding:

0. **None**
1. **One**
2. **Two or more**

↓ **Enter Codes in Boxes**

	A. No injury: No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	B. Injury (except major): Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Patient _____ Identifier _____ Date _____

DISCHARGE

Section K Swallowing/Nutritional Status

K0520. Nutritional Approaches

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

Section M Skin Conditions

Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code

Does this patient have one or more unhealed pressure ulcers/injuries?

0. **No** → *Skip to N0415, High-Risk Drug Classes: Use and Indication*
1. **Yes** → *Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage*

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Enter Number

A. Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

1. Number of Stage 1 pressure injuries

Enter Number

Enter Number

B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.

1. Number of Stage 2 pressure ulcers
If 0 → *Skip to M0300C, Stage 3*

2. Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission - enter how many were noted at the time of admission

Enter Number

Enter Number

C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

1. Number of Stage 3 pressure ulcers
If 0 → *Skip to M0300D, Stage 4*

2. Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission - enter how many were noted at the time of admission

Enter Number

Enter Number

D. 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 includes undermining and tunneling.

1. Number of Stage 4 pressure ulcers
If 0 → *Skip to M0300E, Unstageable - Non-removable dressing/device*

2. Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission - enter how many were noted at the time of admission

Patient _____ Identifier _____ Date _____

DISCHARGE

Section M Skin Conditions

Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued

Enter Number

E. Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device

1. **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device**
   If 0 → Skip to M0300F, Unstageable - Slough and/or eschar
2. **Number of <u>these</u> unstageable pressure ulcers/injuries that were present upon admission** - enter how many were noted at the time of admission

Enter Number

Enter Number

F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**
   If 0 → Skip to M0300G, Unstageable - Deep tissue injury
2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

Enter Number

Enter Number

G. Unstageable - Deep tissue injury

1. **Number of unstageable pressure injuries presenting as deep tissue injury**
   If 0 → Skip to N0415, High-Risk Drug Classes: Use and Indication
2. **Number of <u>these</u> unstageable pressure injuries that were present upon admission** - enter how many were noted at the time of admission

Section N Medications

N0415. High-Risk Drug Classes: Use and Indication

1. Is taking
Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes

2. Indication noted
If column 1 is checked, check if there is an indication noted for all medications in the drug class

	1. Is taking Check all that apply ↓	2. Indication noted ↓
A. Antipsychotic	☐	☐
E. Anticoagulant	☐	☐
F. Antibiotic	☐	☐
H. Opioid	☐	☐
I. Antiplatelet	☐	☐
J. Hypoglycemic (including insulin)	☐	☐
Z. None of the above	☐	

N2005. Medication Intervention

Enter Code

Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?

0. **No**
1. **Yes**
9. **Not applicable - There were no potential clinically significant medication issues identified since admission or patient is not taking any medications.**

Patient _____ Identifier _____ Date _____

DISCHARGE

Section O Special Treatments, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs
Check all of the following treatments, procedures, and programs that apply at discharge.

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

Patient _____ Identifier _____ Date _____

DISCHARGE

Section O Special Treatments, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs
Check all of the following treatments, procedures, and programs that apply at discharge.

	c. At Discharge Check all that apply ↓
None of the Above	
Z1. None of the above	☐

Section Z Assessment Administration

Item Z0400A. Signature of Persons Completing the Assessment

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that patients receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information.

Signature	Title	Date Information is Provided	Time
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			