Change Table: Inpatient Rehabilitation Facility–Patient Assessment Instrument (IRF-PAI) Version 1.3 to DRAFT Corrected Version 1.4

#	Admission or Discharge Assessment	Item / Text Affected	IRF-PAI Version 1.3	IRF-PAI Corrected Version 1.4	Rationale for Change
1.	**Admission & Discharge**	Version	Version 1.3	Draft Corrected Version 1.4	Updates to Quality Indicators section
2.	**Admission**	**BB0700**	N/A – new item	**Section B Hearing, Speech, and Vision** **BB0700. Expression of Ideas and Wants** (3-day assessment period) **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	New item added to collect data for function quality measures.
3.	**Admission**	**BB0800**	N/A – new item	**BB0800. Understanding Verbal Content** (3-day assessment period) **Understanding 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**	New item added to collect data for function quality measures.

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4.	**Admission**	**C0100**	N/A – new item	**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. 0. **No** (patient is rarely/never understood) → *Skip to C0900. Memory/Recall Ability* 1. **Yes** → *Continue to C0200. Repetition of Three Words*	New item added to collect data for function quality measures.
5.	**Admission**	**C0200**	N/A – new item	**Brief Interview for Mental Status (BIMS)** **C0200. Repetition of Three Words** **Ask patient**: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are**: sock, blue and bed**. Now tell me the three words."* **Number of words repeated by patient after first attempt:** 3. **Three** 2. **Two** 1. **One** 0. **None** After the patient's first attempt say: *"I will repeat each of the three words with a cue and ask you about them later: sock, something to wear; blue, a color; bed, a piece of furniture."* You may repeat the words up to two more times.	New item added to collect data for function quality measures.

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6.	**Admission**	**C0300A** **C0300B** **C0300C**	N/A – new items	**Brief Interview for Mental Status (BIMS)** – Continued **C0300. Temporal Orientation: Year, Month, Day** **A. Ask patient:** *"Please tell me what year it is right now."* Patient's answer is: 3. **Correct** 2. **Missed by 1 year** 1. **Missed by 2 to 5 years** 0. **Missed by more than 5 years or no answer** **B. Ask patient:** *"What month are we in right now?"* Patient's answer is: 2. **Accurate within 5 days** 1. **Missed by 6 days to 1 month** 0. **Missed by more than 1 month or no answer** **C. Ask patient:** *"What day of the week is today?"* Patient's answer is: 1**. Correct** 0**. Incorrect or no answer**	New items added to collect data for function quality measures.

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7.	**Admission**	**C0400A** **C0400B** **C0400C**	N/A – new items	**C0400. Recall** **Ask patient:** *"Let's go back to the first question. What were those three words that I asked you to repeat?"* If unable to remember a word, give cue (i.e., something to wear; a color; a piece of furniture) for that word. **A. Recalls "sock?"** 2. **Yes,** no cue required 1. **Yes,** after cueing ("something to wear") 0. **No,** could not recall **Brief Interview for Mental Status (BIMS)** – Continued **B. Recalls "blue?"** 2. **Yes**, no cue required 1. **Yes**, after cueing ("a color") 0. **No**, could not recall **C. Recalls "bed?"** 2. **Yes**, no cue required 1. **Yes**, after cueing ("a piece of furniture") 0. **No**, could not recall	New items added to collect data for function quality measures.
8.	**Admission**	**C0500**	N/A – new item	**C0500. BIMS Summary 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**	New item added to collect data for function quality measures.

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9.	**Admission**	**C0600**	N/A – new item	**C0600. Should the Staff Assessment for Mental Status (C0900) be Conducted?** 0. **No** (patient was able to complete Brief Interview for Mental Status) → *Skip to GG0100. Prior Functioning: Everyday Activities* 1. **Yes** (patient was unable to complete Brief Interview for Mental Status) → *Continue to C0900. Memory/Recall Ability*	New item added to collect data for function quality measures.
10.	**Admission**	**C0900A** **C0900B** **C0900C** **C0900E** **C0900Z**	N/A – new items	**Staff Assessment for Mental Status** Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed. **C0900. Memory/Recall Ability** **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	New items added to collect data for function quality measures.
11.	**Admission**	**GG0100A** **GG0100B** **GG0100C** **GG0100D**	N/A – new items	**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 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 activities.	New items added to collect data for function quality measures.

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				1. **Dependent** - A helper completed the activities for the patient. 8. **Unknown** 9. **Not Applicable** **A. Self Care:** Did the patient need help bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury? **GG0100. Prior Functioning: Everyday Activities** (Continued) **B. Indoor Mobility (Ambulation):** Did the patient need 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:** Did the patient need 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:** Did the patient need help planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury?	

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12.	**Admission**	**GG0110A** **GG0110B** **GG0110C** **GG0110D** **GG0110E** **GG0110Z**	N/A – new items	**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 or scooter** **C. Mechanical lift** **D. Walker** **E. Orthotics/Prosthetics** **Z. None of the above**	New items added to collect data for function quality measures.
13.	**Admission**	**GG0130A** **GG0130B** **GG0130C** **GG0130E** **GG0130F** **GG0130G** **GG0130H**	N/A – new items	**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.** **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 or TOUCHING/STEADYING assistance as	New items added to collect data for function quality measures.

#	Admission or Discharge Assessment	Item / Text Affected	IRF-PAI Version 1.3	IRF-PAI Corrected Version 1.4	Rationale for Change
				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** 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 to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency. **B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.] **C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet,	

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				commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment. **E. 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. **F. Upper body dressing:** The ability to put on and remove shirt or pajama top; includes buttoning, 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.	
14.	**Admission**	**GG0170A** **GG0170B** **GG0170C** **GG0170D** **GG0170E** **GG0170F** **GG0170G** **GG0170H1** **GG0170I** **GG0170J** **GG0170K** **GG0170L** **GG0170M** **GG0170N** **GG0170O** **GG0170P** **GG0170Q1** **GG0170R** **GG0170RR1** **GG0170S**	N/A – new items	**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.** **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	New items added to collect data for function quality measures.

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		GG0170SS1		prior to or following the activity. 04. **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. 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 the reason:** 07. **Patient refused** 09. **Not applicable** 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. **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 safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support. **D. Sit to stand:** The ability to safely come to a standing	

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				position from sitting in a chair or on the side of the bed. **E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair). **F. Toilet transfer:** The ability to safely 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. **H1. Does the patient walk?** 0. **No,** and walking goal is **not** clinically indicated → *Skip to GG0170Q1. Does the patient use a wheelchair/scooter?* 1. **No,** and walking goal **is** clinically indicated → *Code the patient's discharge goal(s) for items GG0170I, J, K, L, M, N, O, and P. For admission performance, skip to GG0170Q1. Does the patient use a wheelchair/scooter?* 2. **Yes** → *Continue to GG0170I. Walk 10 feet* **I. Walk 10 feet**: Once standing, the ability to walk at least 10 feet in a room, corridor or similar space. **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. **L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces, such as grass or gravel. **M. 1 step (curb):** The ability to step over a curb or up and down one step. **N. 4 steps:** The ability to go up and down four steps with or without a rail. **O. 12 steps:** The ability to go up and down 12 steps with or without a rail.	

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				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/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/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/scooter used.** 1. **Manual** 2. **Motorized**	

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15.	**Admission**	**H0350**	N/A – new item	**Section H Bladder and Bowel** **H0350. Bladder continence** (3-day assessment period) **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)	New item added to collect data for function quality measures.
16.	**Admission**	**H0400**	N/A – new item	**H0400. Bowel Continence** (3-day assessment period) **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	New items added to collect data for function quality measures.

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17.	**Admission**	**I0900** **I0900A** **I0900B** **I2900** **I2900A** **I2900B** **I2900C** **I2900D** **I7900**	**I0900. Pressure Ulcer Risk Conditions- Admission** Indicate below if the patient has any of the following pressure ulcer risk conditions: (**NOTE:** You must also document the appropriate ICD codes for any pressure ulcer risk conditions documented below in Item 24 "Comorbid Conditions" above.) **I0900A**. Peripheral Vascular Disease (PVD) 0. No 1. Yes **I0900B.** Peripheral Arterial Disease(PAD) 0. No 1. Yes **I2900A.** Diabetes Mellitus (DM) ***If I2900A = 0, skip I2900B-D*** 0. No 1. Yes **I2900B.** Diabetic Retinopathy 0. No 1. Yes **I2900C.** Diabetic Nephropathy 0. No 1. Yes **I2900D.** Diabetic Neuropathy 0. No 1. Yes	**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**	To align with the Draft LTCH Care Data Set Corrected V.3.00, items I0900A, I0900B, I2900A, I2900B, I2900C, and I2900D were deleted and replaced with items I0900, I2900, and I17900.
18.	**Admission**	**J1750**	N/A – new item	**Section J Health Conditions** **J1750. History of Falls** 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**	New item added to collect data for function quality measures.

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19.	**Admission**	**J2000**	N/A – new item	**J2000. Prior Surgery** Did the patient have major surgery during the 100 days prior to admission? 0**. No** 1**. Yes** 8**. Unknown**	New item added to collect data for function quality measures.
20.	**Admission**	**K0110A** **K0110B** **K0110C**	N/A – new item	**Section K Swallowing/Nutritional Status** **K0110. Swallowing/Nutritional Status** (3-day assessment period) Indicate the patient's usual ability to swallow. **Check all that apply** **A. Regular food -** Solids and liquids swallowed safely without supervision or modified food or liquid consistency. **B. Modified food consistency/supervision -** Patient requires modified food or liquid consistency and/or needs supervision during eating for safety. **C. Tube/parenteral feeding -** Tube/parenteral feeding used wholly or partially as a means of sustenance.	New items added to collect data for function quality measures.
21.	**Admission**	**M0210**	**Unhealed Pressure Ulcer(s)- Admission** **M0210. Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher at Admission?** **0. No** → skip to question **I0900 on Admission Assessment** **1. Yes** → continue to question **M0300A on Admission Assessment**	**Section M Skin Conditions** Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage **M0210. Unhealed Pressure Ulcer(s)** **Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher?** 0. **No** → *Skip to O0100. Special Treatments, Procedures, and Programs* 1. **Yes** → *Continue to M0300. Current Number of Unhealed Pressure Ulcers at Each Stage.*	Section M - Skin Conditions: Language and formatting revised to align with the Draft LTCH Care Data Set Corrected V.3.00.

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22.	**Admission**	**M0300A** **M0300A1**	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage- Admission** **M0300A. 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 it may appear with persistent blue or purple hues. **M0300A1. Number of Stage 1 pressure ulcers:** enter how many were noted at the time of admission	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage** **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. **Number of Stage 1 pressure ulcers**	Revised to align language and formatting with the Draft LTCH Care Data Set Corrected V.3.00.
23.	**Admission**	**M0300B1**	**M0300B. 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. **M0300B1.** Number of Stage 2 pressure ulcers: enter how many were noted at the time of admission	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage** **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**	Revised to align language and formatting with the Draft LTCH Care Data Set Corrected V.3.00.
24.	**Admission**	**M0300C1**	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage- Admission, Continued** **M0300C. 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. **M0300C1. Number of Stage 3 pressure ulcers**: enter how many were noted at the time of admission	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage** **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**	Revised to align language and formatting with the Draft LTCH Care Data Set Corrected V.3.00.

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25.	**Admission**	**M0300D1**	**M0300D. 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. **M0300D1. Number of Stage 4 pressure ulcers**: enter how many were noted at the time of admission	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage** **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**	Revised to align language and formatting with the Draft LTCH Care Data Set Corrected V.3.00.
26.	**Admission**	**M0300E1**	**M0300E. Unstageable Pressure Ulcers due to non-removable dressing/device**: Known but not stageable due to the presence of a non-removable dressing/device. **M0300E1**. **Number of unstageable pressure ulcers due to non-removable dressing/device**: enter how many were noted at the time of admission	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage** **E. Unstageable - Non-removable dressing:** Known but not stageable due to non-removable dressing/device **1. Number of unstageable pressure ulcers due to non-removable dressing/device**	Revised to align language and formatting with the Draft LTCH Care Data Set Corrected V.3.00.
27.	**Admission**	**M0300F1**	**M0300F. Unstageable Pressure Ulcers due to slough and/or eschar:** pressure ulcers that are known but not stageable due to coverage of wound bed by slough and/or eschar. **M0300F1. Number of unstageable pressure ulcers due to slough and/ or eschar**: enter how many were noted at the time of admission	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage** **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**	Revised to align language and formatting with the Draft LTCH Care Data Set Corrected V.3.00.

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28.	**Admission**	**M0300G1**	**M0300G. Unstageable Pressure Ulcers with Suspected Deep Tissue Injury (DTI) in evolution:** suspected deep tissue injury in evolution. **M0300G1. Number of unstageable pressure ulcers with Suspected Deep Tissue Injury in evolution:** enter how many were noted at the time of admission	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage** **G. Unstageable - Deep tissue injury:** Suspected deep tissue injury in evolution **1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution**	Revised to align language and formatting with the Draft LTCH Care Data Set Corrected V.3.00.
29.	**Admission**	**O0100**	N/A – new item	**Section O Special Treatments, Procedures, and Programs** **O0100. Special Treatments, Procedures, and Programs** **Check if treatment applies at admission** **N. Total Parenteral Nutrition**	New items added to collect data for function quality measures.
30.	**Discharge**	**GG0130A** **GG0130B** **GG0130C** **GG0130E** **GG0130F** **GG0130G** **GG0130H**	N/A – new items	**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.** **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	New items added to collect data for function quality measures.

#	Admission or Discharge Assessment	Item / Text Affected	IRF-PAI Version 1.3	IRF-PAI Corrected Version 1.4	Rationale for Change
				VERBAL CUES or TOUCHING/STEADYING 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 the reason:** 07. **Patient refused** 09. **Not applicable** 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 to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency. **B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.] **C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment.	

#	Admission or Discharge Assessment	Item / Text Affected	IRF-PAI Version 1.3	IRF-PAI Corrected Version 1.4	Rationale for Change
				E. 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. **F. Upper body dressing:** The ability to put on and remove shirt or pajama top; includes buttoning, 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.	
31.	**Discharge**	**GG0170A** **GG0170B** **GG0170C** **GG0170D** **GG0170E** **GG0170F** **GG0170G** **GG0170H3** **GG0170I** **GG0170J** **GG0170K** **GG0170L** **GG0170M** **GG0170N** **GG0170O** **GG0170P** **GG0170Q3** **GG0170R** **GG0170RR3** **GG0170S** **GG0170SS3**	N/A – new items	**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.** **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 or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided	New items added to collect data for function quality measures.

#	Admission or Discharge Assessment	Item / Text Affected	IRF-PAI Version 1.3	IRF-PAI Corrected Version 1.4	Rationale for Change
				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 the reason:** 07. **Patient refused** 09. **Not applicable** 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. **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 safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support. **D. Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed. **E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair). **F. Toilet transfer:** The ability to safely get on and off a toilet or commode.	

#	Admission or Discharge Assessment	Item / Text Affected	IRF-PAI Version 1.3	IRF-PAI Corrected Version 1.4	Rationale for Change
				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. **H3. Does the patient walk?** 0. **No** → *Skip to GG0170Q3. Does the patient use a wheelchair/scooter?* 2. **Yes** → *Continue to GG0170I. Walk 10 feet* **I. Walk 10 feet**: Once standing, the ability to walk at least 10 feet in a room, corridor or similar space **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 **L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces, such as grass or gravel. **M. 1 step (curb):** The ability to step over a curb or up and down one step. **N. 4 steps:** The ability to go up and down four steps with or without a rail. **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/scooter?** 0. **No** → *Skip to J1800. Any Falls Since Admission* 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.	

#	Admission or Discharge Assessment	Item / Text Affected	IRF-PAI Version 1.3	IRF-PAI Corrected Version 1.4	Rationale for Change
				RR3. Indicate the type of wheelchair/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/scooter used.** 1. **Manual** 2. **Motorized**	
32.	**Discharge**	**J1800**	N/A – new item	**Section J Health Conditions** **J1800. Any Falls Since Admission** Has the patient **had any falls since admission?** 0. **No** → *Skip to M0210. Unhealed Pressure Ulcer(s)* 1. **Yes** → *Continue to J1900. Number of Falls Since Admission*	New item added to collect data for falls quality measure.

Change Table: Inpatient Rehabilitation Facility–Patient Assessment Instrument (IRF-PAI) Version 1.3 to DRAFT Corrected Version 1.4

#	Admission or Discharge Assessment	Item / Text Affected	IRF-PAI Version 1.3	IRF-PAI Corrected Version 1.4	Rationale for Change
33.	**Discharge**	**J1900**	N/A – new item	**J1900. Number of Falls Since Admission** **Enter Codes in Boxes** **CODING:** 0. None 1. One 2. Two or more **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	New item added to collect data for falls quality measure.
34.	**Discharge**	**M0210**	**Unhealed Pressure Ulcer(s)- Discharge** **M0210**. Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher on Discharge? 0. **No** → skip to question **M0900A on Discharge Assessment** 1. **Yes** → continue to question **M0300A on Discharge Assessment**	**Section M Skin Conditions** **Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage** **M0210. Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher?** 0. **No** → *Skip to M0900A. Healed Pressure Ulcer(s)* 1. **Yes** → *Continue to M0300. Current Number of Unhealed Pressure Ulcers at Each Stage*	Revised to align language and formatting with the Draft LTCH Care Data Set Corrected V.3.00.

Change Table: Inpatient Rehabilitation Facility–Patient Assessment Instrument (IRF-PAI) Version 1.3 to DRAFT Corrected Version 1.4

#	Admission or Discharge Assessment	Item / Text Affected	IRF-PAI Version 1.3	IRF-PAI Corrected Version 1.4	Rationale for Change
35.	**Discharge**	**M0300A** **M0300A1** **M0300A2** **M0300A3**	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage- Discharge** **M0300A. 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 it may appear with persistent blue or purple hues. **M0300A1.** Enter **total** number of pressure ulcers currently at **Stage 1**. **If patient has no Stage 1 pressure ulcers at discharge, skip to Item M0300B1.** **M0300A2.** Of **these Stage 1** pressure ulcers present at discharge, enter number that were: (a) present on admission as a Stage 1 **and** (b) remained at Stage 1 at discharge. **M0300A3.** Of **these Stage 1** pressure ulcers, enter the number that were **not present on admission**. (i.e. – New stage 1 pressure ulcers that have developed during the IRF stay)	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage** **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. **Number of Stage 1 pressure ulcers**	To align language and formatting with the Draft LTCH Care Data Set Corrected V.3.00, items M0300A2 and M0300A3 were deleted.

#	Admission or Discharge Assessment	Item / Text Affected	IRF-PAI Version 1.3	IRF-PAI Corrected Version 1.4	Rationale for Change
36.	**Discharge**	**M0300B1** **M0300B2** **M0300B3** **M0300B4**	**M0300B. 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. **M0300B1.** Enter **total** number of pressure ulcers currently at **Stage 2. (If patient has no Stage 2 pressure ulcers at discharge, skip to Item M0300C1.)** **M0300B2.** Of **these Stage 2** pressure ulcers present at discharge, enter the number that were: (a) present on admission, **and** (b) remained at Stage 2 at discharge**.** **M0300B3.** Of **these Stage 2** pressure ulcers present at discharge, enter the number that were: (a) present on admission as an **unstageable pressure ulcer** due to the presence of a **non-removable device and** (b) when it became stageable, the pressure ulcer was staged as a Stage 2, **and** (c) it remained at Stage 2 at the time of discharge. **M0300B4.** Of **these Stage 2** pressure ulcers present at discharge, enter the number that were: (a) not present on admission; **or** (b) were at a lesser stage at admission and worsened to a Stage 2 during the IRF stay	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage** **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 these Stage 2 pressure ulcers that were present upon admission -** enter how many were noted at the time of admission	To align language and formatting with the Draft LTCH Care Data Set Corrected V.3.00, item M0300B3 was deleted. Item M0300B4 was deleted and replaced with M0800A (see below).
37.	**Discharge**	**M0300C1** **M0300C2** **M0300C3** **M0300C4**	**M0300C. 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. **M0300C1.** Enter **total** number of pressure ulcers currently at **Stage 3**. **(If patient has no Stage 3 pressure ulcers at discharge, skip to Item M0300D1.** **M0300C2.** Of **these Stage 3** pressure ulcers present at discharge, enter the number that were: (a) present on admission, **and** (b) remained at Stage 3 at discharge.	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage** **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 these Stage 3 pressure ulcers that were present upon admission -** enter how many were noted at the time of admission	To align language and formatting with the Draft LTCH Care Data Set Corrected V.3.00, items M0300C3 was deleted. Item M0300C4 was deleted and replaced with M0800B (see below).

#	Admission or Discharge Assessment	Item / Text Affected	IRF-PAI Version 1.3	IRF-PAI Corrected Version 1.4	Rationale for Change
			M0300C3. Of **these Stage 3** pressure ulcers present at discharge, enter the number that were: (a) present on admission as an **unstageable pressure ulcer**, **and** (b) when it became stageable, it was staged as a **Stage 3**; **and** (c) it remained at **Stage 3** at the time of discharge. **M0300C4.** Of **these Stage 3** pressure ulcers present at discharge, enter the number that were: (a) not present on admission; **or** (b) were at a lesser stage at admission and worsened to a Stage 3 during the IRF stay; **or** (c) were unstageable due to a non-removeable device at admission, initially became stageable at a lesser stage, , but then progressed to a Stage 3 by the time of discharge.		
38.	**Discharge**	**M0300D1** **M0300D2** **M0300D3** **M0300D4**	**M0300D. 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. **M0300D1.** Enter **total** number of pressure ulcers currently at **Stage 4**. **(If patient has no Stage 4 pressure ulcers at discharge, skip to Item M0300E1.)** **M0300D2**. Of **these Stage 4** pressure ulcers present at discharge, enter number that were: (a) present on admission at Stage 4 , **and** (b) remained at Stage 4 at discharge. **M0300D3.** Of **these Stage 4** pressure ulcers present at discharge, enter the number that were: (a) present on admission as an **unstageable pressure ulcer**, **and** (b) when it became stageable, it was staged as a **Stage 4**, **and** (c) it remained at **Stage 4** at the time of discharge. **M0300D4.** Of **these Stage 4** pressure ulcers present at discharge, enter the number that were: (a) not present on admission); **or** (b) were at a lesser stage at admission and worsened to a Stage 4 by discharge; **or** (c) were unstageable on admission, initially became stageable at a	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage** **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* **2. Number of these Stage 4 pressure ulcers that were present upon admission -** enter how many were noted at the time of admission	To align language and formatting with the Draft LTCH Care Data Set Corrected V.3.00, items M0300D3 was deleted. Item M0300D4 was deleted and replaced with M0800C (see below).

#	Admission or Discharge Assessment	Item / Text Affected	IRF-PAI Version 1.3	IRF-PAI Corrected Version 1.4	Rationale for Change
			lesser stage, and then progressed to a Stage 4 by the time of discharge.		
39.	**Discharge**	**M0300E1** **M0300E2** **M0300E3**	**M0300E. Unstageable Pressure Ulcers due to a non-removable dressing or device:** pressure ulcers that are known but not stageable due to the presence of a non-removable dressing or device. **M0300E1**. Enter **total** number of pressure ulcers currently **Unstageable** due to a **Non-removable dressing or device**. **(If patient has no pressure ulcers Unstageable due to Non-Removable Device at discharge, skip to Item M0300F1.)** **M0300E2**. Of **these Unstageable** pressure ulcers due to a **non-removable dressing or device** present at discharge, enter number that were:(a) present on admission as an unstageable pressure ulcer due to **non-removable dressing or device**; **and** (b) remained unstageable due to **non-removable dressing or device** until discharge. **M0300E3**. Of **these Unstageable** pressure ulcers due to **non-removable dressing or device** present at discharge, enter number that were (a) present on admission as a stageable pressure ulcer **and** became **unstageable due to non-removable dressing or device** during the IRF stay; and (b) remained unstageable due to a **non-removable dressing or device** until discharge.	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage** **E. Unstageable - Non-removable dressing**: Known but not stageable due to non-removable dressing/device **1. Number of unstageable pressure ulcers due to non-removable dressing/device** *If 0 → Skip to M0300F. Unstageable - Slough and/or eschar.* 2. **Number of these unstageable pressure ulcers that were present upon admission** - enter how many were noted at the time of admission	To align language and formatting with the Draft LTCH Care Data Set Corrected V.3.00, item M0300E3 was deleted, and replaced with M0800D (see below).

#	Admission or Discharge Assessment	Item / Text Affected	IRF-PAI Version 1.3	IRF-PAI Corrected Version 1.4	Rationale for Change
40.	**Discharge**	**M0300F1** **M0300F2** **M0300F3**	**M0300F. Unstageable Pressure Ulcers due to slough or eschar:** pressure ulcers that are known but not stageable due to coverage of wound bed by slough and/or eschar. **M0300F1**. Enter **total** number of pressure ulcers currently **Unstageable** due to **a Slough and/or Eschar**. (**If patient has no pressure ulcers Unstageable due to Slough and/or Eschar at discharge, skip to Item M0300G1**.) **M0300F2**. Of **these Unstageable** pressure ulcers due **to slough and/or eschar** present at discharge, enter number that were: (a) present on admission as an unstageable pressure ulcer due to **slough and/or eschar**; **and** (b) remained unstageable due to **slough and/or eschar** until discharge. **M0300F3**. Of **these Unstageable** pressure ulcers due to **slough or eschar** present at discharge, enter number that were: (a) present on admission as a stageable pressure ulcer **and** became unstageable due to **slough and/or eschar**, during the IRF stay; **and** (b) remained unstageable due to **slough and/or eschar** until discharge.	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage** **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 these unstageable pressure ulcers that were present upon admission -** enter how many were noted at the time of admission	To align language and formatting with the Draft LTCH Care Data Set Corrected V.3.00, item M0300F3 was deleted, and replaced with M0800E (see below).
41.	**Discharge**	**M0300G1** **M0300G2**	**M0300G. Unstageable Pressure Ulcers with Suspected Deep Tissue Injury (DTI) in evolution:** suspected deep tissue injury in evolution. **M0300G1.** Enter **total** number of **unstageable pressure ulcers with Suspected Deep Tissue Injury**. **(If patient has no Unstageable pressure ulcers with Suspected Deep Tissue Injury at discharge, skip to Item M0900A.)** **M0300G2**. Of **these unstageable pressure ulcers with Suspected DTI** present at discharge, enter number that were:(a) present on admission as an unstageable pressure ulcer due to a **suspected deep tissue injury; and** (b) remained unstageable due to a **suspected DTI** until discharge.	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage** **G. Unstageable - Deep tissue injury:** Suspected deep tissue injury in evolution **1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** *If 0 → Skip to M0800. Worsening in Pressure Ulcer Status Since Admission* **2. Number of these unstageable pressure ulcers that were present upon admission -** enter how many were noted at the time of admission	Revised to align language and formatting with the Draft LTCH Care Data Set Corrected V.3.00.

#	Admission or Discharge Assessment	Item / Text Affected	IRF-PAI Version 1.3	IRF-PAI Corrected Version 1.4	Rationale for Change
42.	**Discharge**	**M0800A** **M0800B** **M0800C** **M0800D** **M0800E** **M0800F**	N/A – New item	**M0800. Worsening in Pressure Ulcer Status Since Admission** Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on admission. If no current pressure ulcer at a given stage, enter 0. **A. Stage 2** **B. Stage 3** **C. Stage 4** **D. Unstageable - Non-removable dressing** **E. Unstageable - Slough and/or eschar** **F. Unstageable - Deep tissue injury**	To align language and formatting with the Draft LTCH Care Data Set Corrected V.3.00, items M0800A, M0800B, M0800C, M0800D, M0800E, and M0800F were added.
43.	**Discharge**	**M0900A** **M0900B** **M0900C** **M0900D**	**M0900. Healed Pressure Ulcers- Discharge** Indicate the number of pressure ulcers that were: (a) present on **Admission**; **and** (b) have completely closed (resurfaced with epithelium) upon **Discharge.** If there are no healed pressure ulcers noted at a given stage, enter 0. **M0900A.** Stage 1 **M0900B.** Stage 2 **M0900C.** Stage 3 **M0900D.** Stage 4	**M0900. Healed Pressure Ulcer(s)** Indicate the number of pressure ulcers that were: (a) present on **Admission**; **and** (b) have completely closed (resurfaced with epithelium) upon **Discharge**. If there are no healed pressure ulcers noted at a given stage, enter 0. **A. Stage 1** **B. Stage 2** **C. Stage 3** **D. Stage 4**	Revised to align language and formatting with the Draft LTCH Care Data Set Corrected V.3.00.
44.	**Discharge**	**O0250A** **O0250B** **O0250C**	**O0250. Influenza Vaccine – Discharge - Refer to current version of IRF-PAI Training Manual for current influenza vaccination season and reporting period.** **O0250A.** Did the **patient receive the influenza vaccine *in this facility*** for this year's influenza *vaccination* season? **0. No** → Skip to O0250C, If influenza vaccine not received, state reason **1. Yes** → Continue to O0250B, Date influenza vaccine received	**Section O Special Treatments, Procedures, and Programs** **O0250. Influenza Vaccine - Refer to current version of IRF-PAI Training Manual for current influenza vaccination season and reporting period.** **A.** Did the **patient receive the influenza vaccine *in this facility*** for this year's influenza *vaccination* season? 0. **No** → *Skip to O0250C. If influenza vaccine not received, state reason* 1. **Yes** → *Continue to O0250B. Date influenza vaccine received*	Revised to align language and formatting with the Draft LTCH Care Data Set Corrected V.3.00.

Change Table: Inpatient Rehabilitation Facility–Patient Assessment Instrument (IRF-PAI) Version 1.3 to DRAFT Corrected Version 1.4

#	Admission or Discharge Assessment	Item / Text Affected	IRF-PAI Version 1.3	IRF-PAI Corrected Version 1.4	Rationale for Change
			O0250B. Date influenza vaccine received → Complete date and skip to Z0400A, Signature of Persons Completing the Assessment **O0250C. If influenza vaccine not received, state reason:** **1. Patient not in this facility** during this year's influenza vaccination season **2. Received outside of this facility** **3. Not eligible -** medical contraindication **4. Offered and declined** **5. Not offered** **6. Inability to obtain influenza vaccine** due to a declared shortage. **9. None of the above**	**B.** Date influenza vaccine received → Complete date and skip to Z0400A. Signature and Persons Completing the Assessment. **C. If influenza vaccine not received, state reason:** 1. **Patient not in this facility** during this year's influenza vaccination season 2. **Received outside of this facility** 3. **Not eligible** - medical contraindication 4. **Offered and declined** 5. **Not offered** 6. **Inability to obtain influenza vaccine** due to a declared shortage 9. **None of the above**	