SECTION 3: THE FIM™ INSTRUMENT

UNDERLYING PRINCIPLES FOR USE OF THE FIM™ INSTRUMENT

By design, the FIM™ instrument includes only a minimum number of items. It is not intended to incorporate all the activities that could possibly be measured, or that might need to be measured, for clinical purposes. Rather, the FIM instrument is a basic indicator of severity of disability that can be administered comparatively quickly and therefore can be used to generate data on large groups of people. As the severity of disability changes during rehabilitation, the data generated by the FIM instrument can be used to track such changes and analyze the outcomes of rehabilitation.

The FIM instrument includes a seven-level scale that designates major gradations in behavior from dependence to independence. This scale rates patients on their performance of an activity taking into account their need for assistance from another person or a device. If help is needed, the scale quantifies that need. The need for assistance (burden of care) translates to the time/energy that another person must expend to serve the dependent needs of the disabled individual so that the individual can achieve and maintain a certain quality of life.

The FIM instrument is a measure of disability, not impairment. The FIM instrument is intended to measure what the person with the disability actually does, whatever the diagnosis or impairment, not what (s)he ought to be able to do, or might be able to do under different circumstances. As an experienced clinician, you may be well aware that a depressed person could do many things (s)he is not currently doing; nevertheless, the person should be assessed on the basis of what (s)he actually does.

NOTE: There is no provision to consider an item "not applicable." All FIM instrument items (39A - 39R) must be completed.

The FIM instrument was designed to be discipline-free. Any trained clinician, regardless of discipline, can use it to measure disability. Under a particular set of circumstances, however, some clinicians may find it difficult to assess certain activities. In such cases, a more appropriate clinician may participate in the assessment. For example, a given assessment can be completed by a speech pathologist that assesses the communication items, a nurse who is more knowledgeable with respect to bowel and bladder management, a physical therapist who has the expertise to evaluate transfers, and an occupational therapist who scores self-care and social cognition items.

You must read the definitions of the items carefully before beginning to use the FIM instrument, committing to memory what each activity includes. Rate the subject only with respect to the specific item. For example, when rating the subject with regard to bowel and bladder management, do not take into consideration whether (s)he can get to the toilet. That information is measured during assessments of Walk/Wheelchair and Transfers: Toilet.

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To be categorized at any given level, the patient must complete either all of the tasks included in the definition or only one of several tasks. If all must be completed, the series of tasks will be connected in the text of the definition by the word "and." If only one must be completed, the series of tasks will be connected by the word "or." For example, Grooming includes oral care, hair grooming, washing the hands, washing the face, and either shaving or applying make-up. Communication includes clear comprehension of either auditory or visual communication.

Implicit in all of the definitions, and stated in many of them, is a concern that the individual perform these activities with reasonable safety. With respect to level 6, you must ask yourself whether the patient is at risk of injury while performing the task. As with all human endeavors, your judgment should take into account a balance between an individual's risk of participating in some activities and a corresponding, although different risk if (s)he does not.

Because the data set is still being refined, your opinions and suggestions are considered very important. We are also interested in any problems you encounter in collecting and recording data.

The FIM instrument may be added to information that has already been gathered by a facility. This information may include items such as independent living skills, ability to take medications, to use community transportation, to direct care provided by an aide, or to write or use the telephone, and other characteristics such as mobility outdoors, impairments such as blindness and deafness, and pre-morbid status.

Do not modify the FIM instrument itself.

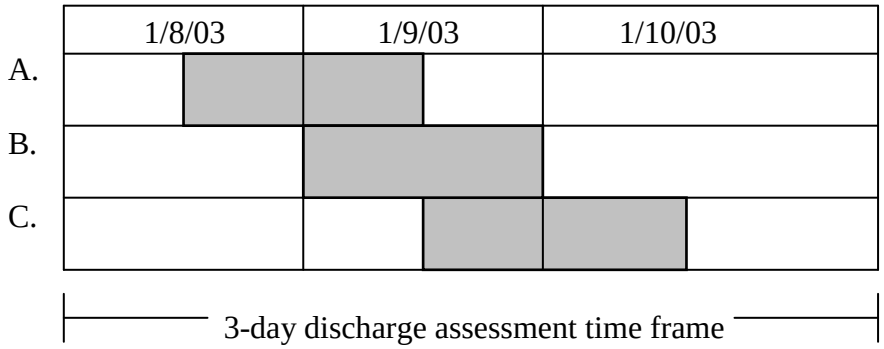
PROCEDURES FOR SCORING THE FIM™ INSTRUMENT AND FUNCTION MODIFIERS

Each of the 18 items comprising the FIM™ instrument has a maximum score of seven (7), which indicates complete independence. A score of one (1) indicates total assistance. A code of zero (0) may be used for some items to indicate that the activity does not occur. Use only whole numbers. For the Function Modifiers, the score range is a minimum of 1 and a maximum of 7, except for Items 35 and 36, where the maximum score is three (3), and for some Function Modifiers a code of 0 may be used. The following rules will help guide you in your administration of the FIM instrument.

1. Admission FIM scores must be collected during the first 3 calendar days of the patient's current rehabilitation hospitalization that is covered by Medicare. These scores must be based upon activities performed during the **entire** 3-calendar-day admission time frame. The FIM rating should reflect the lowest functional score from treating disciplines during the assessment timeframe.

2. The discharge assessment time frame encompasses the day of discharge and the two calendar days prior to the day of discharge. Completion of the FIM items at discharge, with the exception of items reflecting bowel and bladder function, should reflect the lowest functional score within any 24-hour period within the three calendar days comprising the discharge assessment. At discharge, all FIM items except bowel and bladder should be assessed within the same 24-hour period. The diagram below depicts three possible scenarios meeting this definition:

   Assume the patient's discharge date is 1/10/03. The 3-day discharge assessment time frame would be 1/8, 1/9 and 1/10/03.



   In scenario A, the FIM items would be scored in a 24-hour period between 1/8 and 1/9/03. In scenario B, the FIM items would be scored in a 24-hour period, all on 1/9/03. In scenario C, the FIM items would be scored in a 24-hour period beginning on 1/9 and ending on 1/10/03. Note that in each of these examples, all FIM items (with an exception for bladder and bowel as listed below) were scored within the same 24-hour period, and the lowest level of function was scored for each item. Scoring the lowest level of function provides a way to measure the amount of assistance (burden of care) the individual requires from another person to carry out daily living activities.

   Exception: Rather than assessing the bladder and bowel function modifiers and associated FIM items within a 24-hour period within the discharge assessment time frame, these items must be scored according to previously established look-back periods. At discharge, function modifiers concerning level of assistance for bladder and bowel (Items 29 and 31) have a look-back period of 3 days (the day of discharge and the two calendar days immediately prior to discharge). Function modifiers concerning frequency of accidents for bladder and bowel (Items 30 and 32) have a look-back period of 7 days (the day of discharge and the six calendar days immediately prior to discharge). The diagram below depicts how these items must be assessed at discharge:

Assume the patient's discharge date is 1/10/03. The 3-day discharge assessment time frame would be 1/8, 1/9 and 1/10/03. The 3-day look-back period for bladder and bowel level of assistance would be 1/8, 1/9 and 1/10/03. The 7-day look-back period for bladder and bowel frequency of accidents would be 1/4, 1/5, 1/6, 1/7, 1/8, 1/9, and 1/10/03.

	01/4/03	01/5/03	01/6/03	01/7/03	01/8/03	01/9/03	01/10/03
Bladder, Bowel Level of Assistance							
Bladder, Bowel Frequency of Accidents							

NOTE: Comorbid conditions recognized or diagnosed on the day of discharge or on the day prior to the day of discharge are not allowed to be entered in item number 24. Therefore, if the 24-hour time period chosen to determine the score of most of the Function Modifiers and the associated elements of the FIM items encompasses the day of discharge or the day prior to the day of discharge then the comorbidities that are first recognized or diagnosed during such a 24-hour time period can't be recorded in item 24.

3. At admission, most **FIM items** use an assessment time period of 3 calendar days. For the **Function Modifiers** Bladder Frequency of Accidents and Bowel Frequency of Accidents (Items 30 and 32), a 7-day assessment time period is needed. The admission assessment for bladder and bowel accidents would include the 4 calendar days prior to the rehabilitation admission, as well as the first 3 calendar days in the rehabilitation facility.

   In the event that information about bladder and/or bowel accidents prior to the rehabilitation admission is unavailable, record scores for items 30 and 32 that are based upon the number of accidents **since** the rehabilitation admission.

4. The **FIM scores** and **Function Modifier scores** should reflect the patient's actual performance of the activity, not what the patient should be able to do, not a simulation of the activity, or not what they are expected to do in a different environment (e.g., home).

5. If differences in function occur in different environments or at different times of the day, record the *lowest* (most dependent) score. In such cases, the patient usually has

not mastered the function across a 24-hour period, is too tired, or is not motivated enough to perform the activity out of the therapy setting. There may be a need to resolve the question of what is the most dependent level by discussion among team members.

NOTE: The patient's score on measures of function should not reflect arbitrary limitations or circumstances imposed by the facility. For example, a patient who can routinely ambulate more than 150 feet throughout the day with supervision (score of 5 for FIM Locomotion: Walk/Wheelchair item), but who is observed to ambulate only 20 feet at night to use the toilet because that is the distance from his/her bed, should receive a Walk score of 5 rather than a lower score.

6. The **FIM scores** and **Function Modifier scores** should be based on the best available information. Direct observation of the patient's performance is preferred; however, credible reports of performance may be gathered from the medical record, the patient, other staff members, family, and friends. The medical record may also provide additional information about bladder and bowel accidents and inappropriate behaviors.

7. Record a **Function Modifier score** for EITHER Tub Transfer (Item 33) OR Shower Transfer (Item 34), but not both. Leave the other transfer item blank. Please note that the mode for this item does not need to be the same at admission and discharge.

8. Record the **FIM score** that best describes the patient's level of function for *every* FIM item (Items 39A through 39R). No FIM item should be left blank. The patient's medical chart must substantiate each FIM rating.

9. For some **FIM items** (e.g., Walk/Wheelchair (39L), Comprehension (39N), and Expression (39O)) there are boxes next to the functional score box that are to be used to indicate the more frequent mode used by the patient for that item. To indicate the more frequent mode, place the appropriate letter in each box (i.e., W for Walk, C for Wheelchair, or B for Both for Item 39L (Walk/Wheelchair); A for Auditory, V for Visual, or B for Both for Item 39N (Comprehension); and V for Vocal, N for Nonvocal, and B for Both for Item 39O (Expression)).

   NOTE: For items 39N (Comprehension) and 39O (Expression) the mode at admission does not have to match the mode at discharge.

10. The mode of locomotion for the **FIM item** Walk/Wheelchair (39L) must be the same on admission and discharge. Some patients may change the mode of locomotion from admission to discharge, usually wheelchair to walking. In such cases, you should code the admission mode and score based on the *more frequent mode of locomotion at discharge*. If, at discharge, the patient uses both modes (walk, wheelchair) equally, score Item 39L using the Walk scores from Item 37 for both admission and

discharge.[1]

11. When the assistance of two helpers is required for the patient to perform the tasks described in an item, score level 1 - Total Assistance.

12. A code of 0 may be used for some **FIM items** and some **Function Modifiers** to indicate that the activity does not occur at any time during the assessment period. (For a summary of the scoring rules concerning the use of the 0 code, see the table labeled "Overview for Use of Code 0 – Activity Does Not Occur for FIM Instrument and Function Modifier Items on the IRF-PAI" at the end of this section). A code of 0 means that the patient does not perform the activity and a helper does not perform the activity for the patient, at any time during the assessment period. Use of this code should be rare for most items, and justification for the use of 0 should be documented in the medical record. Possible reasons why the patient does not perform the activity may include the following:
    - The patient does not attempt the activity because the clinician determines that it is unsafe for the patient to perform the activity (e.g., going up and down stairs for patient with lower extremity paralysis).
    - The patient cannot perform the activity because of a medical condition or medical treatment (e.g., walking for the patient who is unable to bear weight on lower extremities).
    - The patient refuses to perform an activity (e.g., the patient refuses to dress in clothing other than a hospital gown or the patient refuses to be dressed by a helper).

13. For certain **FIM items**, a code of 0 may be used on **admission** but not at **discharge**. However, code 0 may NOT be used for Bladder Management (Items 29, 30 and 39G), Bowel Management (Items 31, 32 and 39H), or the cognitive items (Items 39N through 39R) at either admission or discharge.

14. If a **FIM activity** does not occur at the time of **discharge** record a score of 1 – Total Assistance. If a patient expires while in the rehabilitation facility, record a score of Level 1 for all discharge FIM items.

15. For the **Function Modifiers Items 33 through 38**, a code of 0 may be used on admission and discharge.

16. Prior to recording a code of 0, the clinician completing the assessment must consult with other clinicians, the patient's medical record, the patient, and the patient's family members to determine whether the patient did perform or was observed performing the activity. Do not use code "0" to indicate that the clinician **did not observe** the patient performing the activity; use the code only when the activity did not occur.

SECTION 3: THE FIM™ INSTRUMENT

Overview for Use of Code 0 - Activity Does Not Occur for FIM Instrument and Function Modifier Items on the IRF-PAI

IRF-PAI Item	Can code "0-Activity does not occur", be used during the Admission Assessment?	Can code "0-Activity does not occur", be used during the Discharge Assessment?
Function Modifiers		
29 Bladder Level of Assistance	No	No
30 Bladder Frequency of Accidents	No	No
31 Bowel Level of Assistance	No	No
32 Bowel Frequency of Accidents	No	No
33 Tub Transfer	Yes	Yes
34 Shower Transfer	Yes	No
35 Distance Walked	Yes	Yes
36 Distance Traveled in Wheelchair	Yes	Yes
37 Walk	Yes	Yes
38 Wheelchair	Yes	Yes
FIM Items*		
39A Eating	Yes	No
39B Grooming	Yes	No
39C Bathing	Yes	No
39D Dressing-Upper	Yes	No
39E Dressing-Lower	Yes	No
39F Toileting	Yes	No
39G Bladder	No	No
39H Bowel	No	No
39I Transfers: Bed, Chair, Wheelchair	Yes	No
39J Transfers: Toilet	Yes	No
39K Transfers: Tub, Shower	Yes	No
39L Walk/Wheelchair	Yes	No
39M Stairs	Yes	No
39N Comprehension	No	No
39O Expression	No	No
39P Social Interaction	No	No
39Q Problem Solving	No	No
39R Memory	No	No

*If activity does not occur at discharge, code FIM items using "1"

SECTION 3: THE FIM™ INSTRUMENT

DESCRIPTION OF THE LEVELS OF FUNCTION AND THEIR SCORES

INDEPENDENT - Another person is not required for the activity (NO HELPER).

7 Complete Independence—The patient safely performs all the tasks described as making up the activity within a reasonable amount of time, and does so without modification, assistive devices, or aids.

6 Modified Independence—One or more of the following may be true: the activity requires an assistive device or aid, the activity takes more than reasonable time, or the activity involves safety (risk) considerations.

DEPENDENT - Patient requires another person for either supervision or physical assistance in order to perform the activity, or it is not performed (REQUIRES HELPER).

Modified Dependence: The patient expends half (50%) or more of the effort. The levels of assistance required are defined below.

5 Supervision or Setup—The patient requires no more help than standby, cuing, or coaxing, without physical contact; alternately, the helper sets up needed items or applies orthoses or assistive/adaptive devices.

4 Minimal Contact Assistance—The patient requires no more help than touching, and expends 75% or more of the effort.

3 Moderate Assistance—The patient requires more help than touching, or expends between 50 and 74% of the effort.

Complete Dependence: The patient expends less than half (less than 50%) of the effort. Maximal or total assistance is required. The levels of assistance required are defined below.

2 Maximal Assistance—The patient expends between 25 to 49% of the effort.

1 Total Assistance—The patient expends less than 25% of the effort.

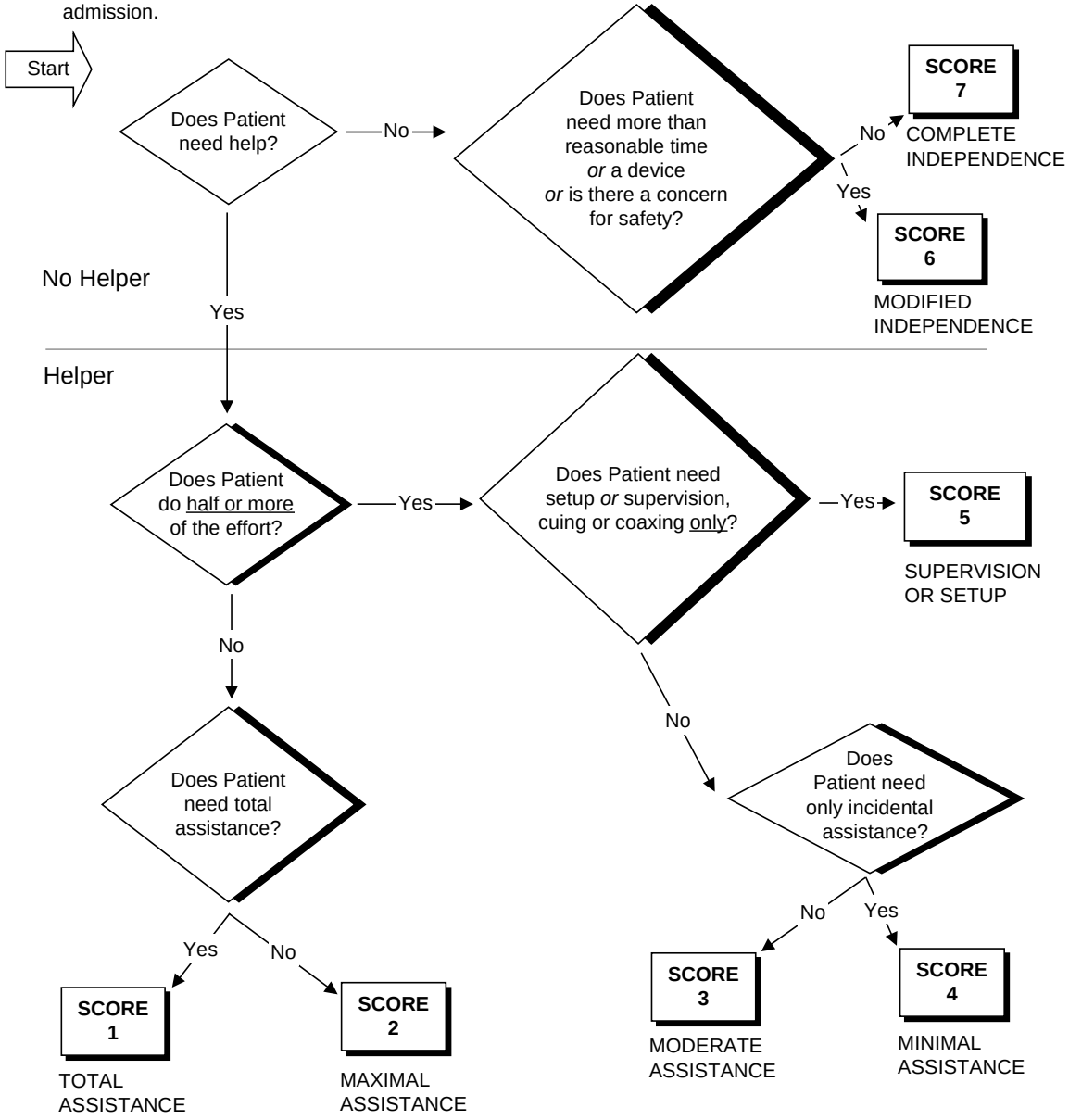
0 Activity Does Not Occur – The patient does not perform the activity, and a helper does not perform the activity for the patient during the entire assessment time frame. **NOTE**: Do *not* use this code only because you did not observe the patient perform the activity. In such cases, consult other clinicians, the patient's medical record, the patient, and the patient's family members to discover whether others observed the patient perform the activity.

SECTION 3: THE FIM™ INSTRUMENT

INSTRUCTIONS FOR THE USE OF THE FIM™ DECISION TREES

General Description of FIM Instrument
Levels of Function and Their Scores

To use the FIM™ Decision Tree, begin in the upper left hand corner. Answer the questions and follow the branches to the correct score. You will notice that behaviors and scores above the line indicate that NO HELPER is needed, while behaviors and scores below the bottom line indicate that a HELPER is needed. If an activity does not occur for self care, transfer or locomotion items on admission, enter code "0" on admission.



SECTION 3: THE FIM™ INSTRUMENT

EATING: *Eating* includes the ability to use suitable utensils to bring food to the mouth, as well as the ability to chew and swallow the food once the meal is presented in the customary manner on a table or tray. The patient performs this activity safely.

NO HELPER

7 Complete Independence—The patient eats from a dish while managing a variety of food consistencies, and drinks from a cup or glass with the meal presented in the customary manner on a table or tray. The subject opens containers, butters bread, cuts meat, pours liquids, and uses a spoon or fork to bring food to the mouth, where it is chewed and swallowed. The patient performs this activity safely.

6 Modified Independence—Performance of the activity involves safety considerations, or the patient requires an adaptive or assistive device such as a long straw, spork, or rocking knife; requires more than a reasonable time to eat; or requires modified food consistency or blenderized food. If the patient relies on other means of alimentation, such as parenteral or gastrostomy feedings, then (s)he self-administers the feedings.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (application of orthoses or assistive/adaptive devices), or another person is required to open containers, butter bread, cut meat, or pour liquids.

4 Minimal Contact Assistance—The patient performs 75% or more of eating tasks.

3 Moderate Assistance—The patient performs 50% to 74% of eating tasks.

2 Maximal Assistance—The patient performs 25% to 49% of eating tasks.

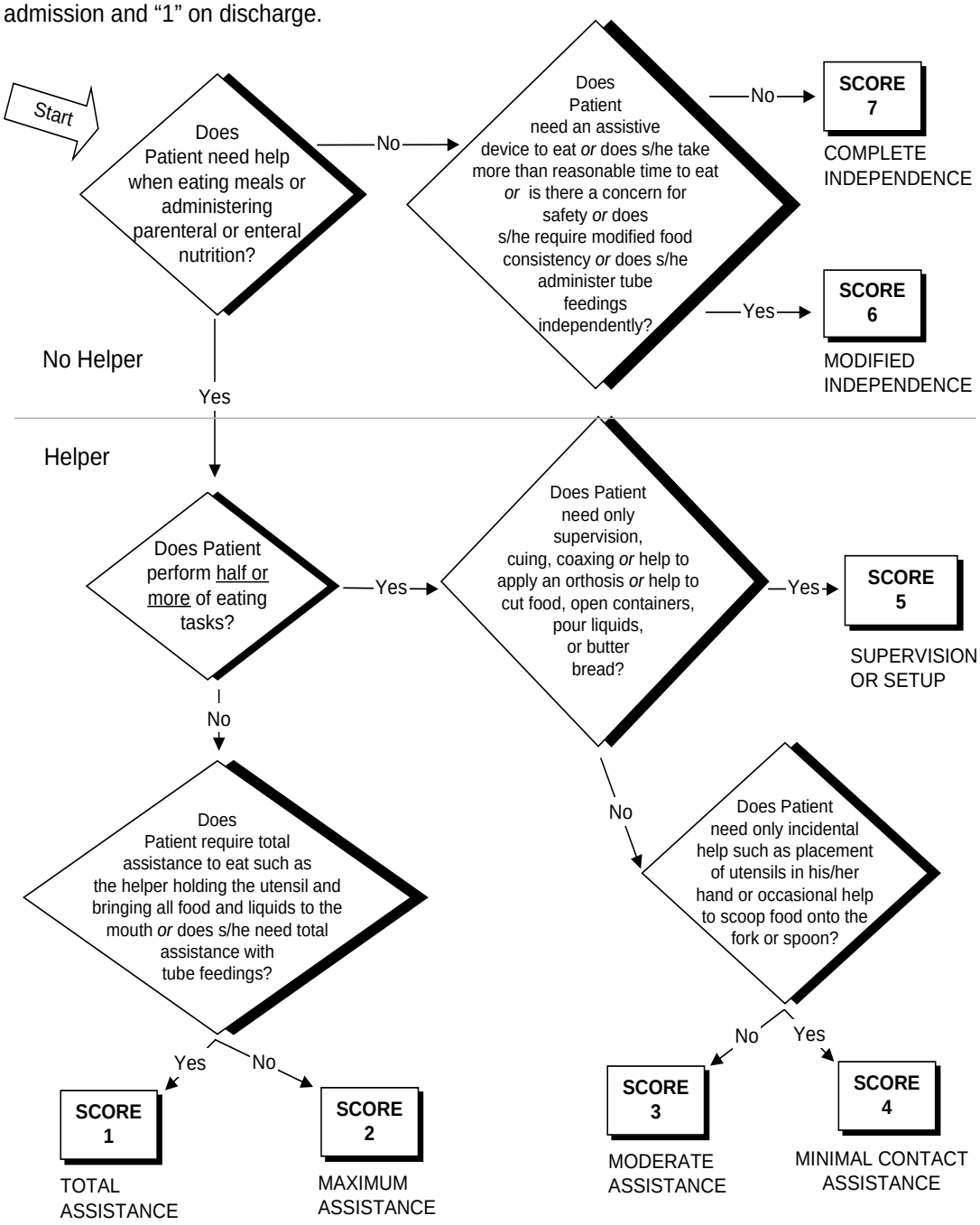
1 Total Assistance—The patient performs less than 25% of eating tasks, or the patient relies on parenteral or gastrostomy feedings (either wholly or partially) and does not self-administer the feedings.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not eat *and* does not receive any parenteral/enteral nutrition during the entire assessment time frame. Use of this code should be rare.

SECTION 3: THE FIM™ INSTRUMENT

EATING

Eating includes the use of suitable utensils to bring food to the mouth, chewing and swallowing, once the meal is presented in the customary manner on a table or tray. At level 7 the patient eats from a dish while managing all consistencies of food, and drinks from a cup or glass with the meal presented in the customary manner on a table or tray. The patient uses suitable utensils to bring food to the mouth; food is chewed and swallowed. Performs independently and safely. If activity does not occur, code "0" on admission and "1" on discharge.



SECTION 3: THE FIM™ INSTRUMENT

GROOMING: *Grooming* includes oral care, hair grooming (combing or brushing hair), washing the hands*, washing the face*, and either shaving the face or applying make-up. If the subject neither shaves nor applies make-up, Grooming includes only the first four tasks. The patient performs this activity safely. This item includes obtaining articles necessary for grooming.

NO HELPER

7 Complete Independence—The patient cleans teeth or dentures, combs or brushes hair, washes the hands*, washes the face*, and either shaves the face or applies make-up, including all preparations. The patient performs this activity safely.

6 Modified Independence—The patient requires specialized equipment (including prosthesis or orthosis) to perform grooming activities, or takes more than a reasonable time, or there are safety considerations.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (application of orthoses or adapted/assistive devices, setting out grooming equipment, or initial preparation such as applying toothpaste to toothbrush or opening make-up containers).

4 Minimal Contact Assistance—The patient performs 75% or more of grooming tasks.

3 Moderate Assistance—The patient performs 50% to 74% of grooming tasks.

2 Maximal Assistance—The patient performs 25% to 49% of grooming tasks.

1 Total Assistance—The patient performs less than 25% of grooming tasks.

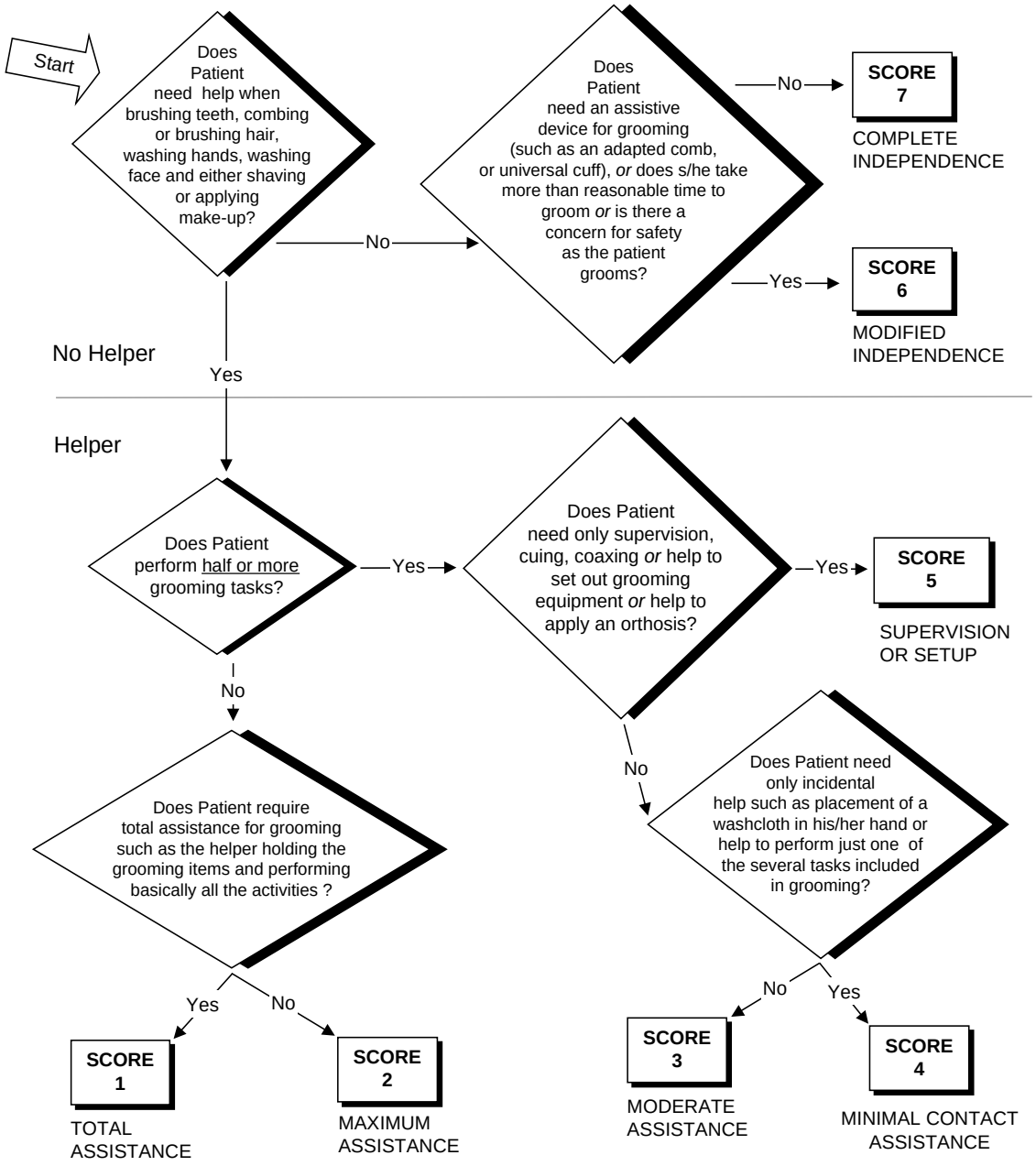
0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not perform any grooming activities (oral care, hair grooming, washing the hands, washing the face, and either shaving the face or applying make-up), and is not groomed by a helper during the entire assessment time frame. Use of this code should be rare.

NOTE: Assess only the activities listed in the definition. Grooming does not include flossing teeth, shampooing hair, applying deodorant, or shaving legs. If the subject is bald or chooses not to shave or apply make-up, do not assess those activities.

*including rinsing and drying.

GROOMING

Grooming includes oral care, hair grooming (combing and brushing hair), washing the hands and washing the face, and either shaving the face or applying make-up. If the patient neither shaves nor applies makeup, Grooming includes only the first four tasks. At level 7 the patient cleans his/her teeth or dentures, combs or brushes his/her hair, washes his/her hands and face, and may shave or apply make-up, including all preparations. Performs independently and safely. If activity does not occur, score "0" on admission and "1" on discharge.



SECTION 3: THE FIM™ INSTRUMENT

BATHING: *Bathing* includes washing, rinsing, and drying the body from the neck down (excluding the back) in either a tub, shower, or sponge/bed bath. The patient performs the activity safely.

NO HELPER

7 Complete Independence—The patient safely bathes (washes, rinses and dries) the body.

6 Modified Independence—The patient requires specialized equipment (including prosthesis or orthosis) to bathe, or takes more than a reasonable amount of time, or there are safety considerations.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing or coaxing) or setup (application of assistive/adaptive devices, setting out bathing equipment, or initial preparation such as preparing the water or washing materials).

4 Minimal Contact Assistance—The patient performs 75% or more of bathing tasks.

3 Moderate Assistance—The patient performs 50% to 74% of bathing tasks.

2 Maximal Assistance—The patient performs 25% to 49% of bathing tasks.

1 Total Assistance—The patient performs less than 25% of bathing tasks.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not bathe self, and is not bathed by a helper. Use of this code should be rare.

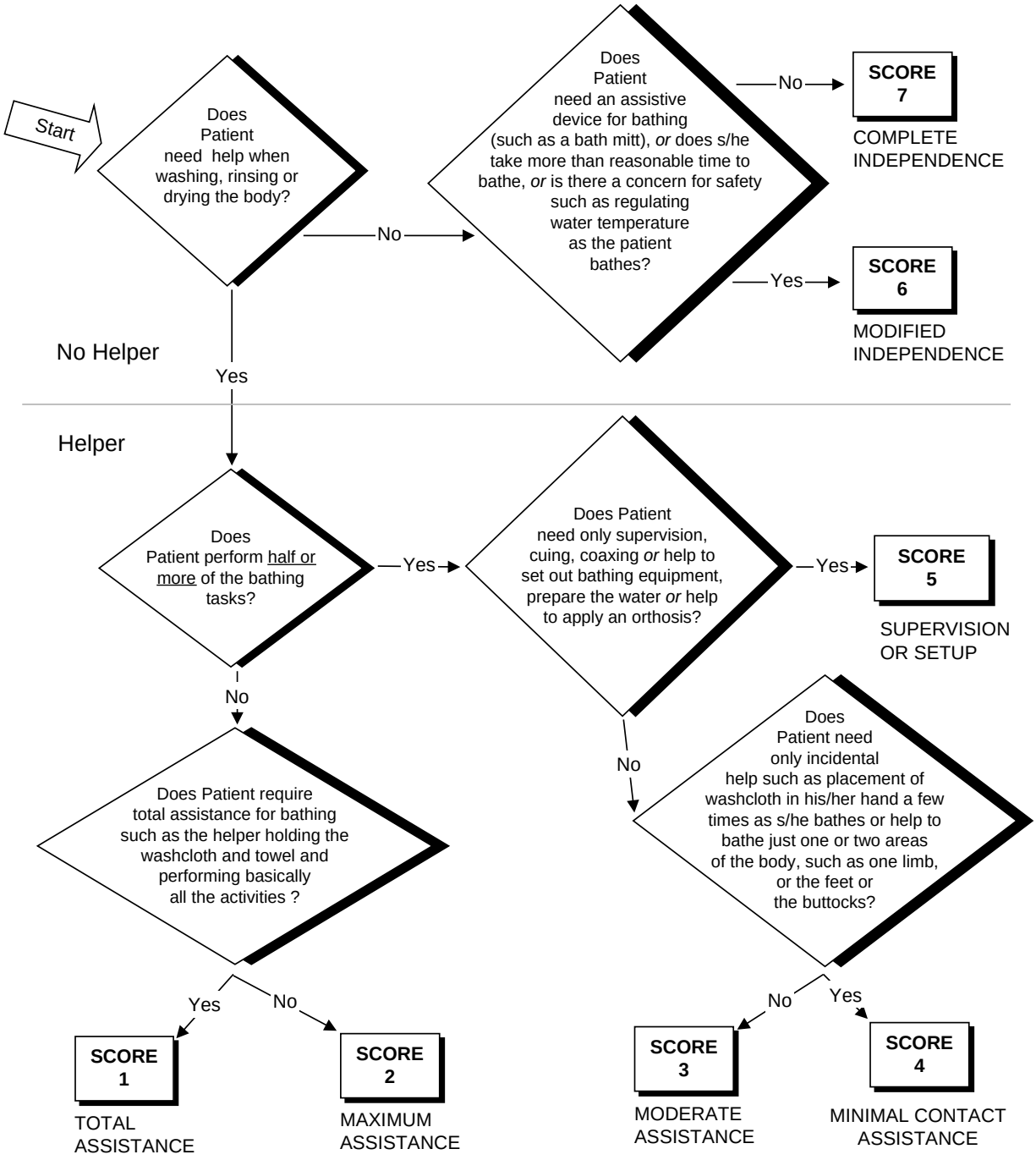
When scoring this item, consider the body as divided up into ten areas or parts. Evaluate how the patient bathes each of the ten areas or parts, with each accounting for 10% of the total:

Chest	buttocks
left arm	left upper leg
right arm	right upper leg
abdomen	left lower leg, including foot
perineal area	right lower leg, including foot

SECTION 3: THE FIM™ INSTRUMENT

BATHING

Bathing includes bathing (washing, rinsing and drying) the body from the neck down (excluding the back); may be either tub, shower or sponge/bed bath. At level 7 the patient bathes (washes, rinses and dries) the body, excluding the back. Performs independently and safely. If activity does not occur, code "0" on admission and "1" on discharge.



SECTION 3: THE FIM™ INSTRUMENT

DRESSING - UPPER BODY: *Dressing – Upper Body* includes dressing and undressing above the waist, as well as applying and removing a prosthesis or orthosis when applicable. The patient performs this activity safely.

NO HELPER

7 Complete Independence—The patient dresses and undresses self. This includes obtaining clothes from their customary places (such as drawers and closets), and may include managing a bra, pullover garment, front-opening garment, zippers, buttons, or snaps, as well as the application and removal of a prosthesis or orthosis (which is not used as an assistive device for upper body dressing) when applicable. The patient performs this activity safely.

6 Modified Independence—The patient requires special adaptive closure such as a Velcro® Fastener, or an assistive device (including a prosthesis or orthosis) to dress, or takes more than a reasonable amount of time.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (application of an upper body or limb orthosis/prosthesis, application of an assistive/adaptive device, or setting out clothes or dressing equipment).

4 Minimal Contact Assistance—The patient performs 75% or more of dressing tasks.

3 Moderate Assistance—The patient performs 50% to 74% of dressing tasks.

2 Maximal Assistance—The patient performs 25% to 49% of dressing tasks.

1 Total Assistance—The patient performs less than 25% of dressing tasks.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not dress and the helper does not dress the patient in clothing that is appropriate to wear in public during the entire assessment time frame. The subject who wears only a hospital gown would be coded "0 – Activity Does Not Occur." Putting on and taking off scrubs may be appropriate for purposes of assessment. Use of this code should be rare.

NOTE: When assessing dressing and undressing, the subject must use clothing that is appropriate to wear in public. If the subject wears only hospital gowns or nightgowns/pajamas, rate this activity as code 0. Starting at the time that the patient is admitted to the IRF and continuing during the admission assessment time period the

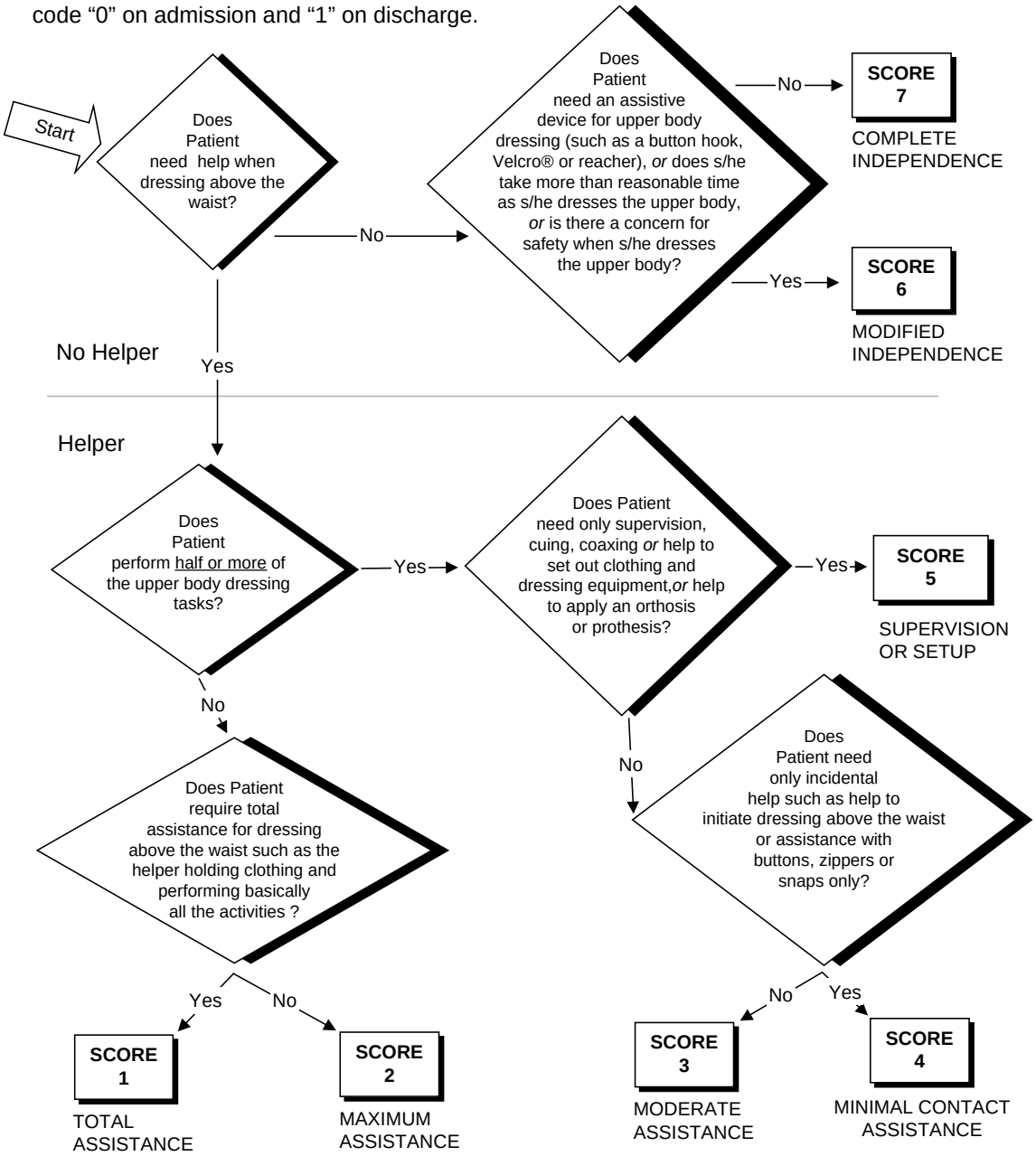
SECTION 3: THE FIM™ INSTRUMENT

IRF's staff must make every attempt to obtain from any source clothing for the patient. For example, if a patient is admitted wearing a hospital gown and without, not possessing, any other items of clothing, then the staff of the IRF should immediately request that the patient's family or friends bring as soon as possible to the patient clothing suitable for the patient to wear which would cover the patient's upper body and lower body including footwear. Once clothing during the admission assessment time period is available, then any previous scoring during the admission assessment time period should be updated to reflect the performance of this task with clothing. The task of dressing should be scored during what is the usual time of the day that the patient is awake and alert. The result would be that the updated score would be more reflective of the patient's actual functional performance which is not the case when a score of "0" is used, because a "0" score only indicates that the activity did not occur during the admission assessment time period.

SECTION 3: THE FIM™ INSTRUMENT

DRESSING - UPPER BODY

Dressing Upper Body includes dressing and undressing above the waist, as well as applying and removing a prosthesis or orthosis when applicable. Note: this item may include assessment of one to several activities, depending on whether the patient chooses to wear one piece of clothing (a sweatshirt for example) or several pieces of clothing (a bra, blouse and sweater). At level 7 the patient dresses and undresses including obtaining clothing from his/her drawers and closets; manages bra, pullover garment; applies and removes orthosis or prosthesis when applicable. Performs independently and safely. If activity does not occur, code "0" on admission and "1" on discharge.



DRESSING - LOWER BODY: *Dressing – Lower Body* includes dressing and undressing from the waist down, as well as applying and removing a prosthesis or orthosis when applicable. The patient performs this activity safely.

NO HELPER

7 Complete Independence—The patient dresses and undresses safely. This includes obtaining clothes from their customary places (such as drawers and closets), and may also include managing underpants, slacks, skirt, belt, stockings, shoes, zippers, buttons, and snaps, as well as the application and removal of a prosthesis or orthosis (which is not used as an assistive device for lower body dressing) when applicable.

6 Modified Independence—The patient requires a special adaptive closure such as a Velcro® fastener, or an assistive device (including a prosthesis or orthosis) to dress, or takes more than a reasonable amount of time.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (application of a lower body or limb orthosis/prosthesis, application of an assistive/adaptive device or setting out clothes or dressing equipment).

4 Minimal Contact Assistance—The patient performs 75% or more of dressing tasks.

3 Moderate Assistance—The patient performs 50% to 74% of dressing tasks.

2 Maximal Assistance—The patient performs 25% to 49% of dressing tasks.

1 Total Assistance—The patient performs less than 25% of dressing tasks.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not dress and the helper does not dress the patient in clothing that is appropriate to wear in public during the entire assessment time frame. For example, the patient who wears only a hospital gown and/or underpants and/or footwear would be coded "0 – Activity Does Not Occur" for this item. Putting on and taking off scrubs may be appropriate for purposes of assessment. Use of this code should be rare.

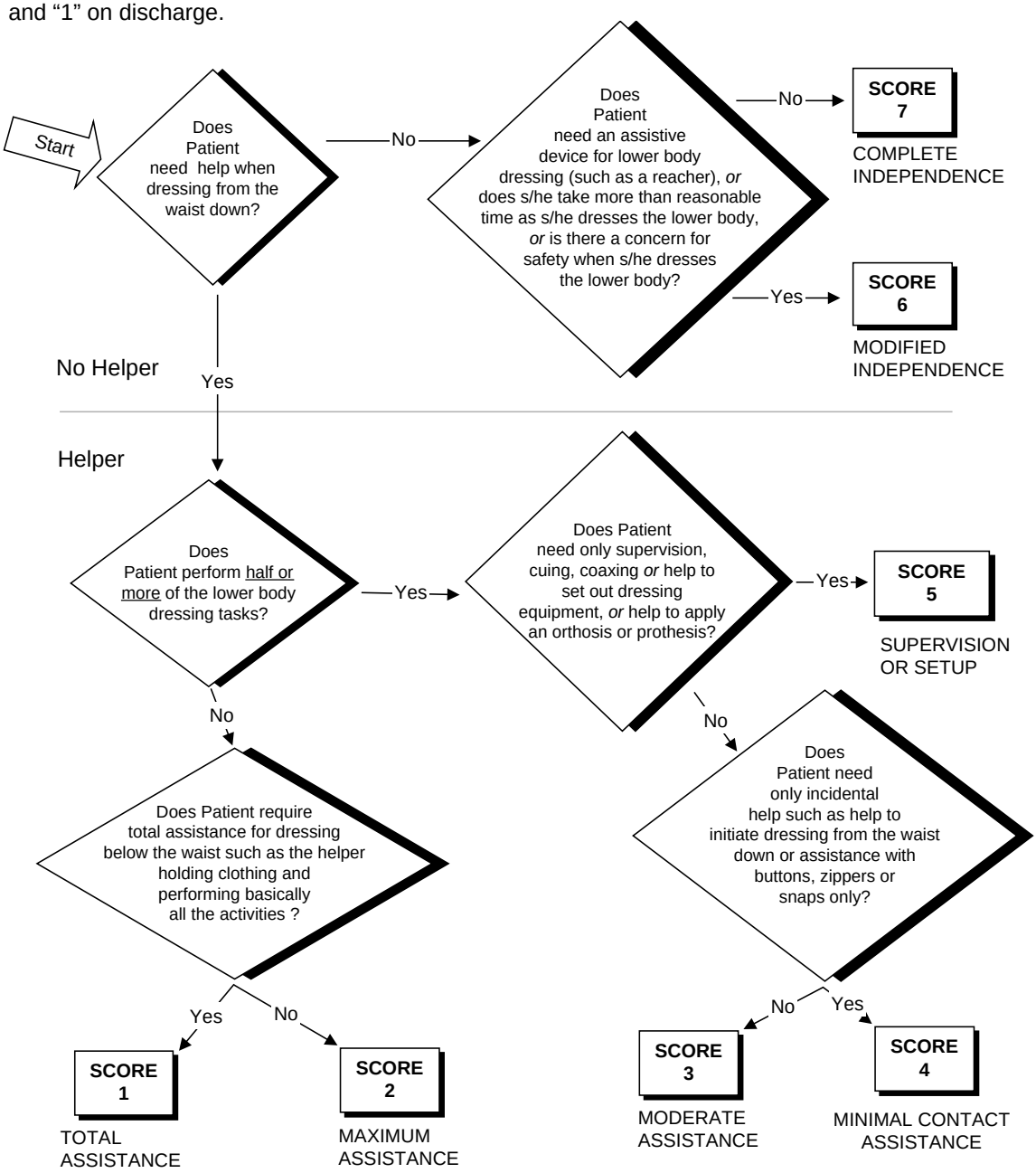
NOTE: When assessing dressing and undressing, the subject must use clothing that is appropriate to wear in public. If the subject wears only hospital gowns or nightgowns/pajamas, rate this activity as code 0. Starting at the time that the patient is

admitted to the IRF and continuing during the admission assessment time period the IRF's staff must make every attempt to obtain from any source clothing for the patient. For example, if a patient is admitted wearing a hospital gown and without, not possessing, any other items of clothing, then the staff of the IRF should immediately request that the patient's family or friends bring as soon as possible to the patient clothing suitable for the patient to wear which would cover the patient's upper body and lower body including footwear. Once clothing during the admission assessment time period is available, then any previous scoring during the admission assessment time period should be updated to reflect the performance of this task with clothing. The task of dressing should be scored during what is the usual time of the day that the patient is awake and alert. The result would be that the updated score would be more reflective of the patient's actual functional performance which is not the case when a score of "0" is used, because a "0" score only indicates that the activity did not occur during the admission assessment time period.

SECTION 3: THE FIM™ INSTRUMENT

DRESSING - LOWER BODY

Dressing Lower Body includes dressing and undressing from the waist down as well as applying and removing a prosthesis or orthosis when applicable. Note: this item typically includes assessment of applying and removing several pieces of clothing. At level 7 the patient dresses and undresses including obtaining clothing from his/her drawers and closets; manages underpants, slacks or skirt, socks, shoes; applies and removes orthosis or prosthesis when applicable. Performs independently and safely. If activity does not occur code "0" on admission and "1" on discharge.



SECTION 3: THE FIM™ INSTRUMENT

TOILETING: *Toileting i*ncludes maintaining perineal hygiene and adjusting clothing before and after using a toilet, commode, bedpan, or urinal. The patient performs this activity safely.

NO HELPER

7 Complete Independence—The patient safely cleanses self after voiding and bowel movements, and safely adjusts clothing before and after using toilet, bedpan, commode or urinal.

6 Modified Independence—The patient requires specialized equipment (including orthosis or prosthesis) during toileting, or takes more than a reasonable amount of time, or there are safety considerations.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (application of adaptive devices or opening packages).

4 Minimal Contact Assistance—The patient performs 75% or more of toileting tasks.

3 Moderate Assistance—The patient performs 50% to 74% of toileting tasks.

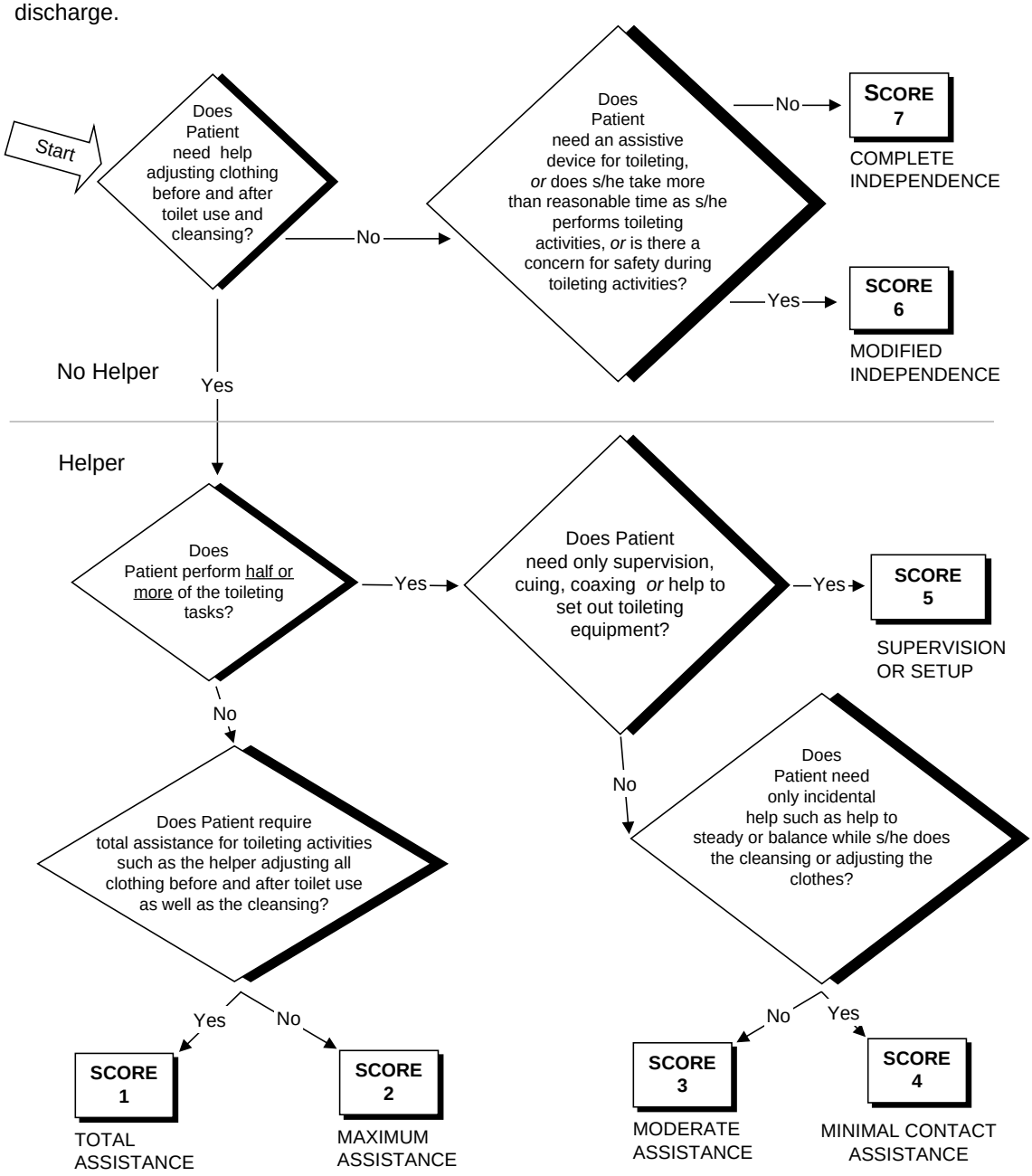
2 Maximal Assistance—The patient performs 25% to 49% of toileting tasks.

1 Total Assistance—The patient performs less than 25% of toileting tasks.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not perform *any* of the toileting tasks (perineal cleansing, clothing adjustment before and after toilet use), and a helper does not perform *any* of these activities for the subject. Use of this code should be rare.

TOILETING

Toileting includes maintaining perineal hygiene and adjusting clothing before and after using toilet or bedpan. If level of assistance for care differs between voiding and bowel movements, record the lower score. At level 7 the patient cleanses self after voiding and bowel movements; adjusts clothing before and after using toilet or bedpan. Performs independently and safely. If activity does not occur, code "0" on admission and "1" on discharge.



BLADDER MANAGEMENT - Level of Assistance: *Bladder Management - Level of Assistance* includes the safe use of equipment or agents for bladder management. (Note: Use these definitions to score the Function Modifier, Item 29; refer to the note below to score Item 39G).

NO HELPER

7 Complete Independence—The patient controls bladder completely and intentionally without equipment or devices, and is *never incontinent* (no accidents).

6 Modified Independence—The patient requires a urinal, bedpan, catheter, bedside commode absorbent pad, diaper, urinary collecting device, or urinary diversion, or uses medication for control. If catheter is used, the patient cleans, sterilizes, and sets up the equipment for irrigation without assistance. If the individual uses a device, (s)he assembles and applies an external catheter with drainage bags or an ileal appliance without assistance of another person; the patient also empties, puts on, removes, and cleans leg bag, or empties and cleans ileal appliance bag.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (placing or emptying) of equipment to maintain either a satisfactory voiding pattern or an external device in the past 3 days.

4 Minimal Contact Assistance—The patient requires minimal contact assistance to maintain an external device, and performs 75% or more of bladder management tasks in the past 3 days.

3 Moderate Assistance—The patient requires moderate assistance to maintain an external device, and performs 50% to 74% of bladder management tasks in the past 3 days.

2 Maximal Assistance—Patient performs 25-49% of bladder management tasks in the past 3 days.

1 Total Assistance—Patient performs less than 25% of bladder management tasks in the past 3 days.

Do not use code "0" for Bladder Management – Level of Assistance.

NOTE: The functional goal of bladder management is to open the urinary sphincter only when needed and to keep it closed the rest of the time. This may require devices, medications (agents), or assistance for some individuals. This item deals with the level of assistance required to complete bladder management tasks. If the subject does not void (e.g., subject has renal failure and is on hemodialysis or peritoneal dialysis), then code level 7 - Complete Independence.

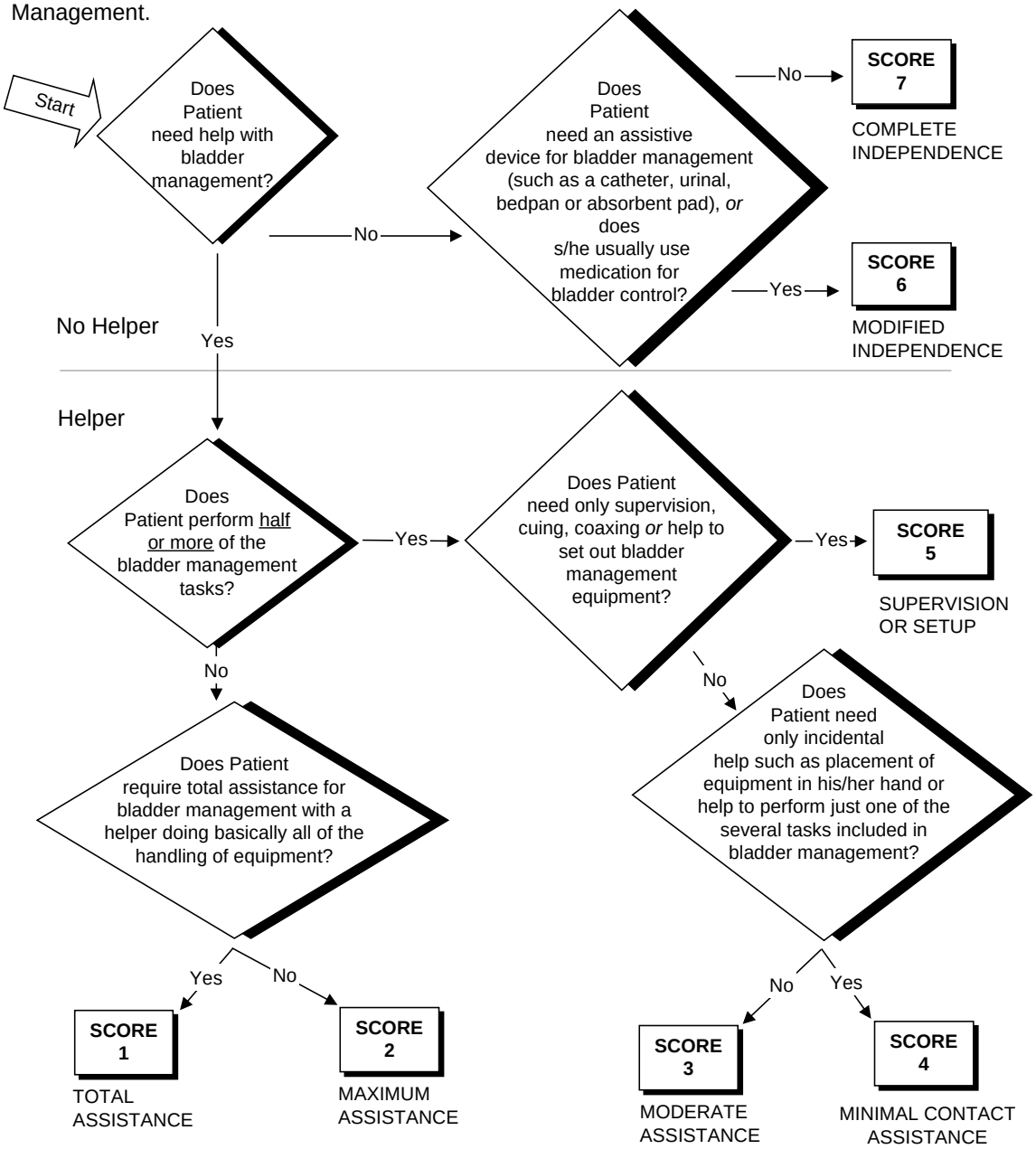
A separate Function Modifier, *Bladder Management—Frequency of Accidents* (Item 30), deals with the success of the bladder management program.

Scoring Item 39G (Bladder): Enter into Item 39G (Bladder) the lower score from the two Function Modifiers (Items 29 and 30).

SECTION 3: THE FIM™ INSTRUMENT

BLADDER MANAGEMENT - LEVEL OF ASSISTANCE

Bladder Management includes complete and intentional control of the urinary bladder and, if necessary, use of equipment or agents for bladder control. At level 7 the patient controls bladder completely and intentionally and is never incontinent. No equipment or agents are required. Bladder Management, with two function modifiers, level of assistance for bladder management and frequency of accidents. Score the function modifiers separately. Then, record the **lower** score on the FIM™ instrument. Do not use code "0" for Bladder Management.



SECTION 3: THE FIM™ INSTRUMENT

BLADDER MANAGEMENT - Frequency of Accidents: *Bladder Management: Frequency of Accidents* includes complete intentional control of urinary bladder and, if necessary, use of equipment or agents for bladder control. (Note: Use these definitions to score the Function Modifier, Item 30; refer to the note below to score Item 39G).

Definition of Bladder Accidents – Bladder accidents refers to the act of wetting linen or clothing with urine, and includes bedpan and urinal spills. If the helper spills the container, it is not counted as a patient accident.

NO HELPER

7 No Accidents—The patient controls bladder completely and intentionally, and does not have any accidents.

6 No Accidents; uses device such as catheter—The patient requires a urinal, bedpan, catheter, beside commode, absorbent pad, diaper, urinary collecting device, or urinary diversion, or uses medication for control. *The patient has no accidents*.

HELPER

5 One (1) bladder accident, including bedpan and urinal spills, in the past 7 days.

4 Two (2) accidents, including bedpan and urinal spills, in the past 7 days.

3 Three (3) accidents, including bedpan and urinal spills, in the past 7 days.

2 Four (4) accidents, including bedpan and urinal spills, in the past 7 days.

1 Five (5) or more accidents, including bedpan and urinal spills, in the past 7 days.

Do not use code "0" for Bladder Management – Frequency of Accidents.

If the subject does not void (e.g., subject has renal failure and is on hemodialysis or peritoneal dialysis), then code level 7 - Complete Independence.

NOTE: The functional goal of bladder management is to open the urinary sphincter only when needed and to keep it closed the rest of the time. This item deals with the frequency of accidents required to complete bladder management tasks.

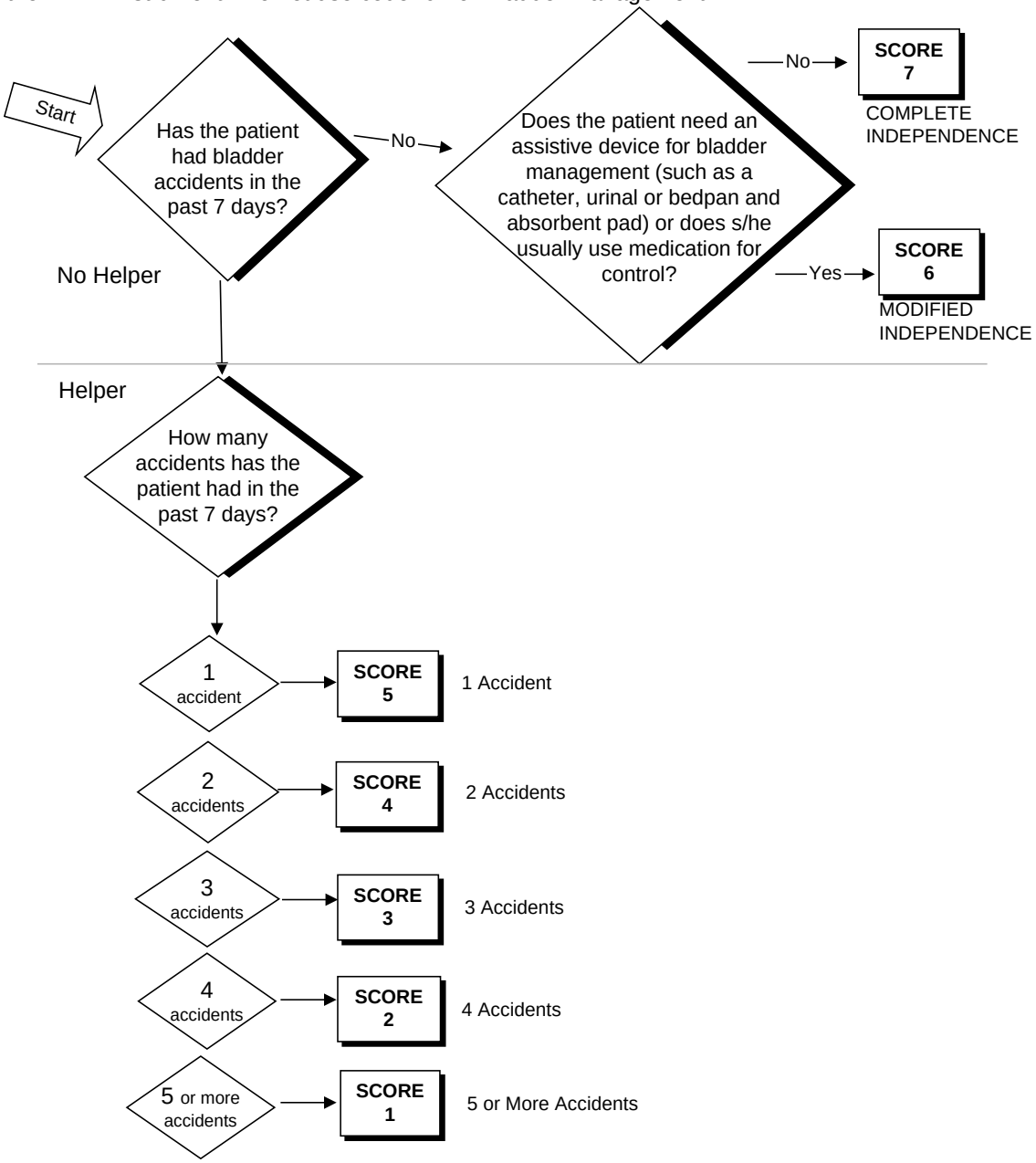
A separate Function Modifier, *Bladder Management—Level of Assistance* (Item 29), deals with assistance with bladder management.

Scoring Item 39G (Bladder): Enter into Item 39G (Bladder) the lower score from the two Function Modifiers (Items 29 and 30).

SECTION 3: THE FIM™ INSTRUMENT

BLADDER MANAGEMENT - PART 2 FREQUENCY OF ACCIDENTS

Bladder Management includes complete and intentional control of the urinary bladder and, if necessary, use of equipment or agents for bladder control. At level 7 the subject controls bladder completely and intentionally and is never incontinent. No equipment or agents are required. Note: this item deals with two function modifiers, level of assistance for bladder management and frequency of accidents. Score the function modifiers separately. Then, record the **lower** score on the FIM™ instrument. Do not use code "0" for Bladder Management.



BOWEL MANAGEMENT - Level of Assistance: *Bowel Management - Level of Assistance* includes use of equipment or agents for bowel management. (Note: Use these definitions to score the Function Modifier, Item 31; refer to the note below to score Item 39H).

NO HELPER

7 Complete Independence—The patient controls bowels completely and intentionally without equipment or devices, and does not have any bowel accidents.

6 Modified Independence—The patient requires a bedpan, beside commode, digital stimulation or stool softeners, suppositories, laxatives (other than natural laxatives like prunes), or enemas on a regular basis; alternately, the patient uses other medications for control. If the individual has a colostomy, (s)he maintains it.

HELPER

5 Supervision or Setup—The patient has required supervision (e.g., standing by, cuing, or coaxing) or setup of equipment necessary for the individual to maintain either a satisfactory excretory pattern or an ostomy device at any time during the past 3 days.

4 Minimal Contact Assistance—Patient requires minimal contact assistance to maintain a satisfactory excretory pattern by using suppositories, enemas, or an external device. Patient performs 75% or more of bowel management tasks in the past 3 days.

3 Moderate Assistance—The patient requires moderate assistance to maintain a satisfactory excretory pattern by using suppositories, enemas, or an external device. The patient performs 50 to 74% of bowel management tasks in the past 3 days.

2 Maximal Assistance—Patient performs 25-49% of bowel management tasks in the past 3 days.

1 Total Assistance—Patient performs less than 25% of bowel management tasks in the past 3 days.

Do not use code "0" for Bowel Management – Level of Assistance.

NOTE: The functional goal of bowel management is to open the anal sphincter only when needed and to keep it closed the rest of the time. This may require devices, medications (agents), or assistance in some individuals. This item deals with the level of assistance required to complete bowel management tasks.

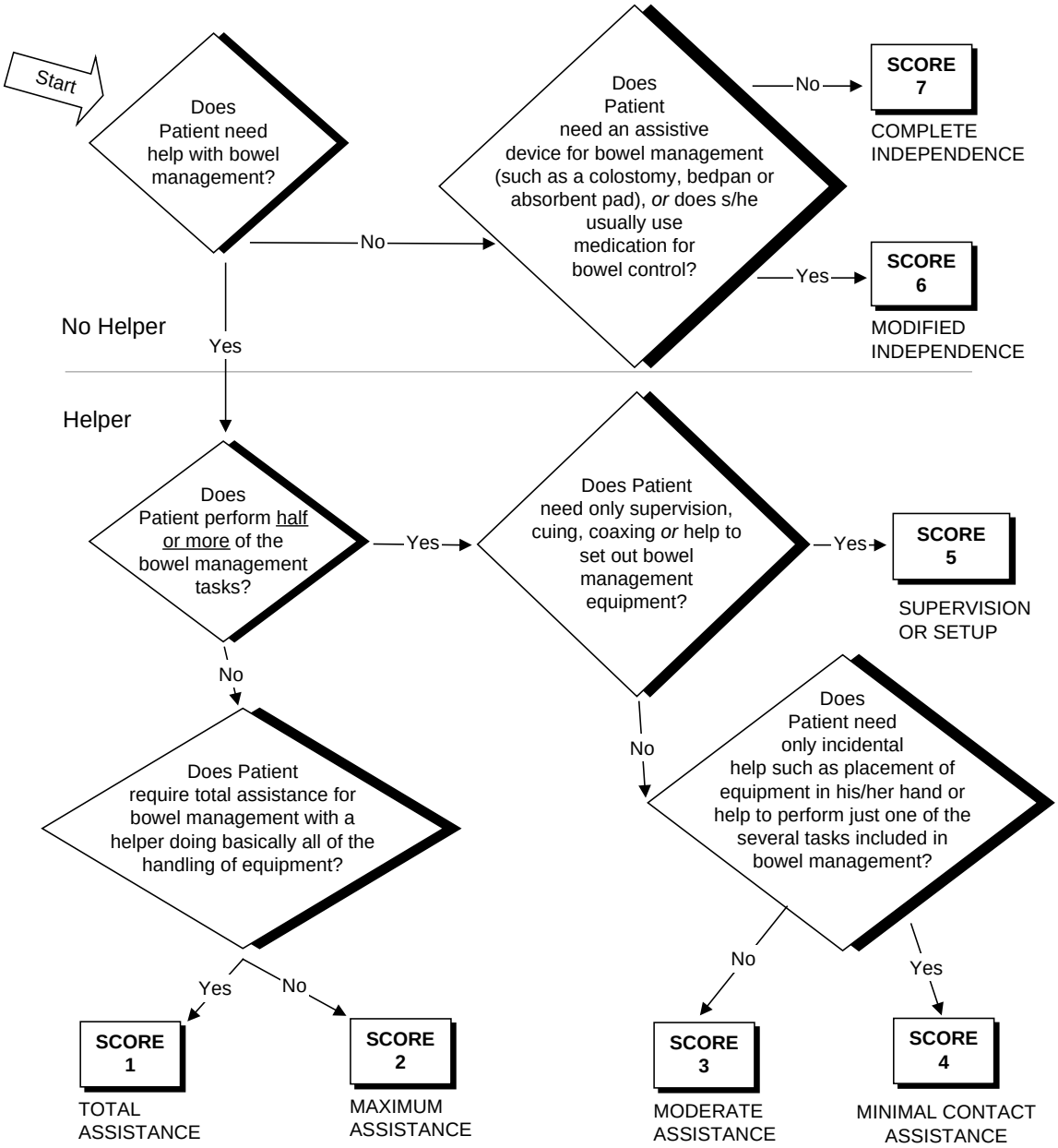
A separate Function Modifier, *Bowel Management—Frequency of Accidents* (Item 32), deals with frequency of bowel accidents.

Scoring Item 39H (Bowel): Enter into Item 39H (Bowel) the lower score from the two Function Modifiers (Items 31 and 32).

SECTION 3: THE FIM™ INSTRUMENT

Bowel Management - Level of Assistance

Bowel Management includes complete and intentional control of bowel movements and, if necessary, use of equipment or agents for bowel control. At level 7 the subject controls bowel completely and intentionally and is never incontinent. No equipment or agents are required. Note: this item deals with two variables, level of assistance for bowel management and frequency of accidents. Score the function modifiers separately. Then, record the **lower** score on the FIM™ instrument. Do not use code "0" for Bowel Management.



BOWEL MANAGEMENT - Frequency of Accidents: *Bowel Management - Frequency of Accidents* includes complete intentional control of bowel movements and (if necessary) use of equipment/agents for bowel control. (Note: Use these definitions to score the Function Modifier, Item 32; refer to the note below to score Item 39H).

Definition of Bowel Accidents - Bowel accidents refer to the act of soiling linen or clothing with stool, and includes bedpan spills. If the helper spills the container, it is not counted as a patient accident.

NO HELPER

7 No Accidents—The patient controls bowels completely and intentionally without equipment or devices, and is *never incontinent* (no accidents).

6 No Accidents; uses device such as ostomy—The patient requires a bedpan, digital stimulation or stool softeners, suppositories, laxatives (other than natural laxatives like prunes), or enemas on a regular basis; alternately, the patient uses other medications for control. *The patient has no accidents*.

HELPER

5 One (1) accident in the past 7 days.

4 Two (2) accidents in the past 7 days.

3 Three (3) accidents in the past 7 days.

2 Four (4) accidents in the past 7 days.

1 Five (5) or more accidents in the past 7 days.

Do not use code "0" for Bowel Management – Frequency of Accidents.

NOTE: The functional goal of bowel management is to open the anal sphincter only when needed and to keep it closed the rest of the time. This item deals with the frequency of accidents required to complete bowel management tasks.

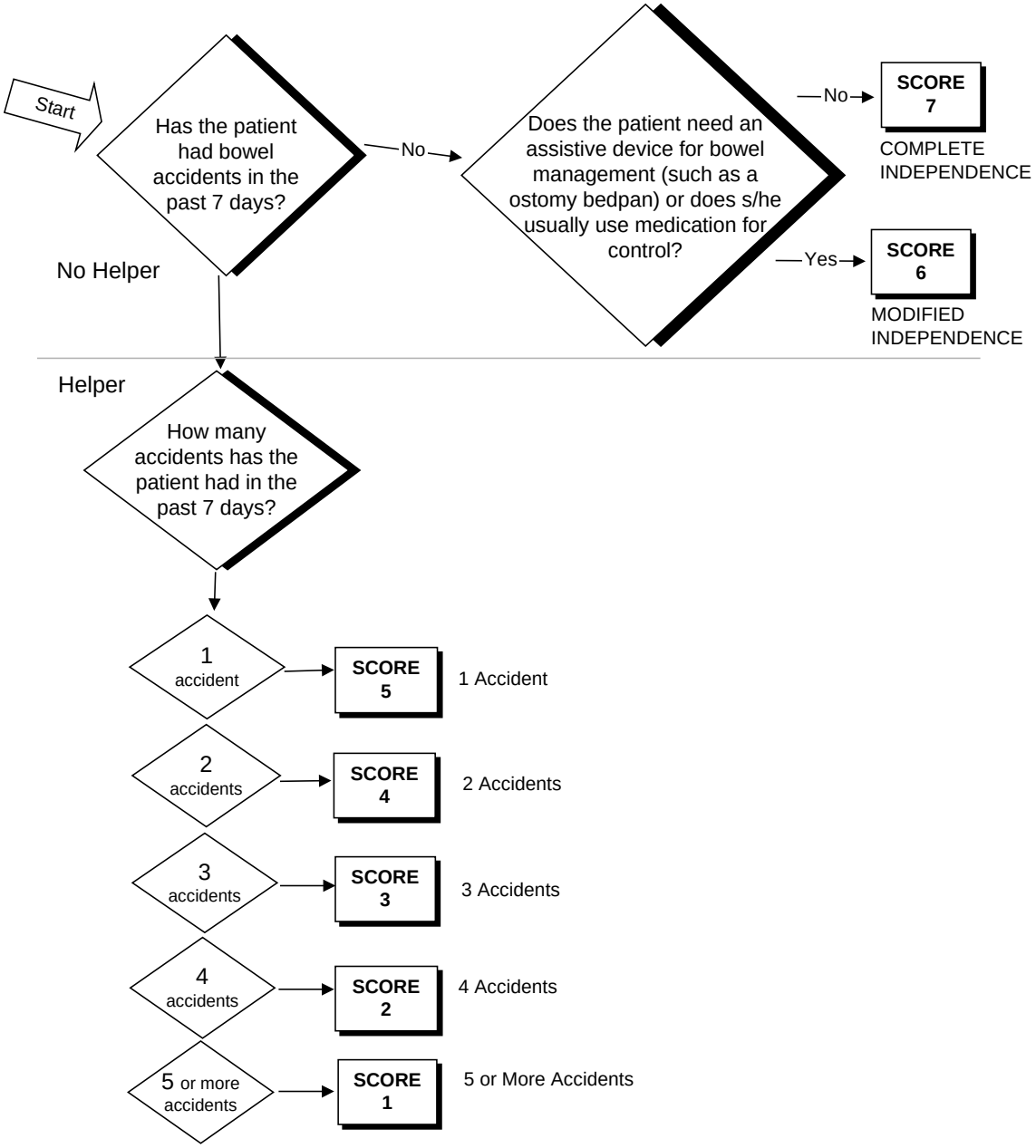
A separate Function Modifier, *Bowel Management—Level of Assistance* (Item 31), deals with level of assistance associated with bowel management.

Scoring Item 39H (Bowel): Enter into Item 39H (Bowel) the lower score from the two Function Modifiers (Items 31 and 32).

SECTION 3: THE FIM™ INSTRUMENT

BOWEL MANAGEMENT - FREQUENCY OF ACCIDENTS

Bowel Management includes complete and intentional control of the bowels and, if necessary, use of equipment or agents for bowel control. At level 7 the subject controls bowels completely and intentionally and has no accidents. No equipment or agents are required. Note: this item deals with two function modifiers, level of assistance for bowel management and frequency of accidents. Score the function modifiers separately. Then, record the **lower** score on the FIM™ instrument. Do not use code "0" for Bowel Management.



SECTION 3: THE FIM™ INSTRUMENT

TRANSFERS: BED, CHAIR, WHEELCHAIR: *Transfers: Bed, Chair, Wheelchair* includes all aspects of transferring from a bed to a chair and back, or from a bed to a wheelchair and back, or coming to a standing position if walking is the typical mode of locomotion. The patient performs the activity safely.

NO HELPER

7 Complete Independence:

If walking, patient safely approaches, sits down on a regular chair, and gets up to a standing position from a regular chair. Patient also safely transfers from bed to chair.

If in a wheelchair, patient approaches a bed or chair, locks brakes, lifts foot rests, removes arm rest if necessary, and performs either a standing pivot or sliding transfer (without a board) and returns. The patient performs this activity safely.

6 Modified Independence—The patient requires an adaptive or assistive device such as a sliding board, a lift, grab bars, or a special seat/chair/brace/crutches; or the activity takes more than a reasonable amount of time; or there are safety considerations. In this case, a prosthesis or orthosis is considered an assistive device if used for the transfer.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (positioning sliding board, moving foot rests, etc.).

4 Minimal Contact Assistance—The patient requires no more help than touching and performs 75% or more of transferring tasks.

3 Moderate Assistance—The patient requires more help than touching or performs 50 to 74% of transferring tasks.

2 Maximal Assistance—The patient performs 25 to 49% of transferring tasks.

1 Total Assistance—The patient performs less than 25% of transferring tasks.

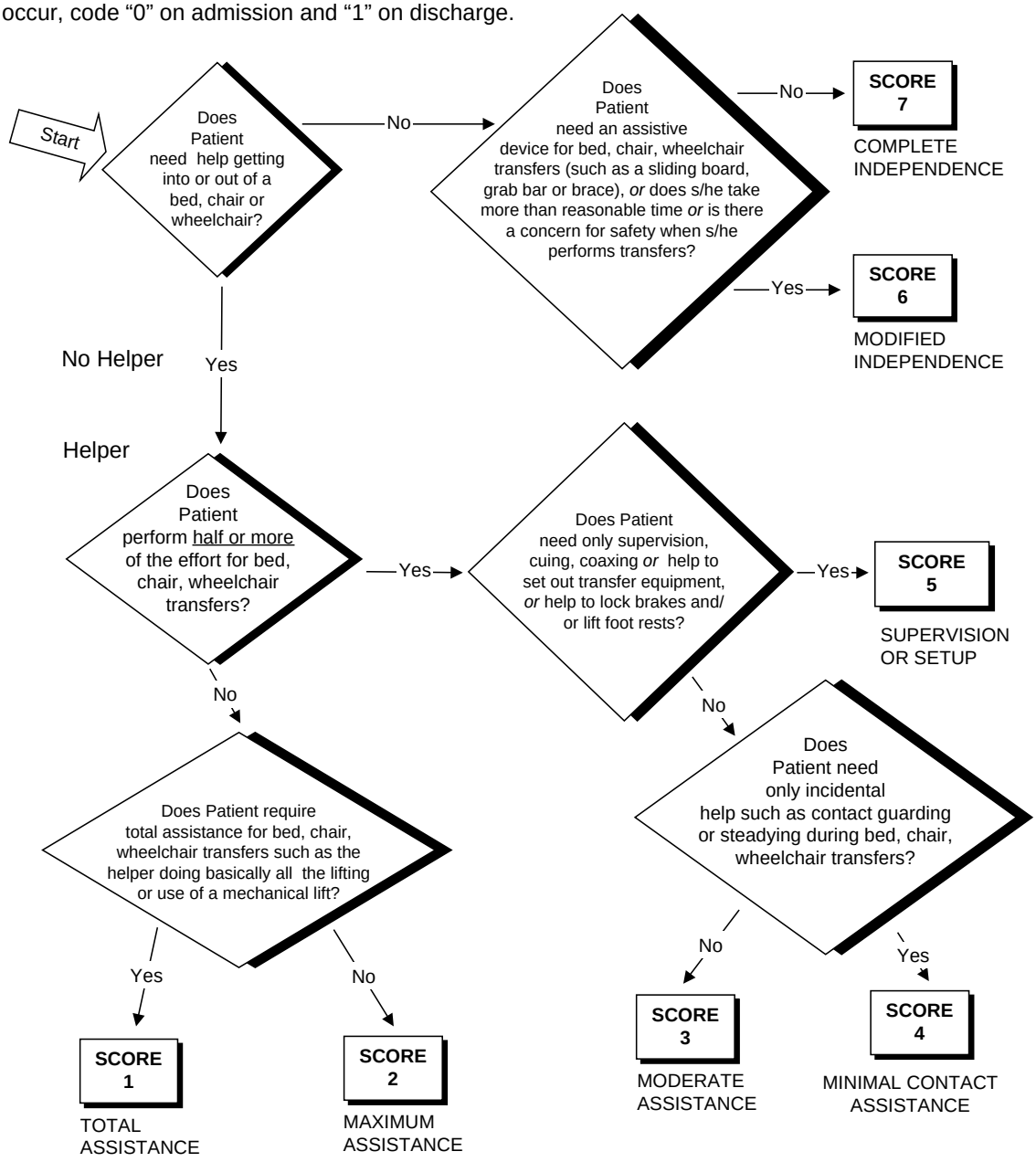
0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not transfer to or from the bed or a chair, and is not transferred to or from the bed or a chair by a helper or lifting device. Use of this code should be rare.

NOTE*:* During the bed-to-chair transfer, the subject begins and ends in the supine position.

SECTION 3: THE FIM™ INSTRUMENT

TRANSFERS: BED, CHAIR, WHEELCHAIR

Transfers: Bed, Chair, Wheelchair includes all aspects of transferring from bed to a chair, or wheelchair, or coming to a standing position, if walking is the typical mode of locomotion. At level 7 the subject approaches, sits down on and gets up to a standing position from a regular chair; transfers from bed to chair. Performs independently and safely. *If in a wheelchair*, approaches a bed or chair, locks brakes, lifts foot rests, removes arm rests if necessary, performs either a standing pivot or sliding transfer (without a board) and returns. Performs independently and safely. If activity does not occur, code "0" on admission and "1" on discharge.



TRANSFERS: TOILET: *Transfers: Toilet* includes safely getting on and off a standard toilet.

NO HELPER

7 Complete Independence

If walking, patient approaches, sits down on a standard toilet, and gets up from a standard toilet. The patient performs the activity safely.

If in a wheelchair, patient approaches toilet, locks brakes, lifts foot rests, removes arm rests if necessary, and does either a standing pivot or sliding transfer (without a board) and returns. The patient performs the activity safely.

6 Modified Independence—The patient requires an adaptive or assistive device such as a sliding board, a lift, grab bars, bedside commode, or special seat; or takes more than a reasonable amount of time to complete the activity; or there are safety considerations. In this case, a prosthesis or orthosis is considered an assistive device if used for the transfer.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (positioning sliding board, moving foot rests, etc.).

4 Minimal Contact Assistance—The patient requires no more help than touching and performs 75% or more of transferring tasks.

3 Moderate Assistance—The patient requires more help than touching or performs 50 to 74% of transferring tasks.

2 Maximal Assistance—The patient performs 25 to 49% of transferring tasks.

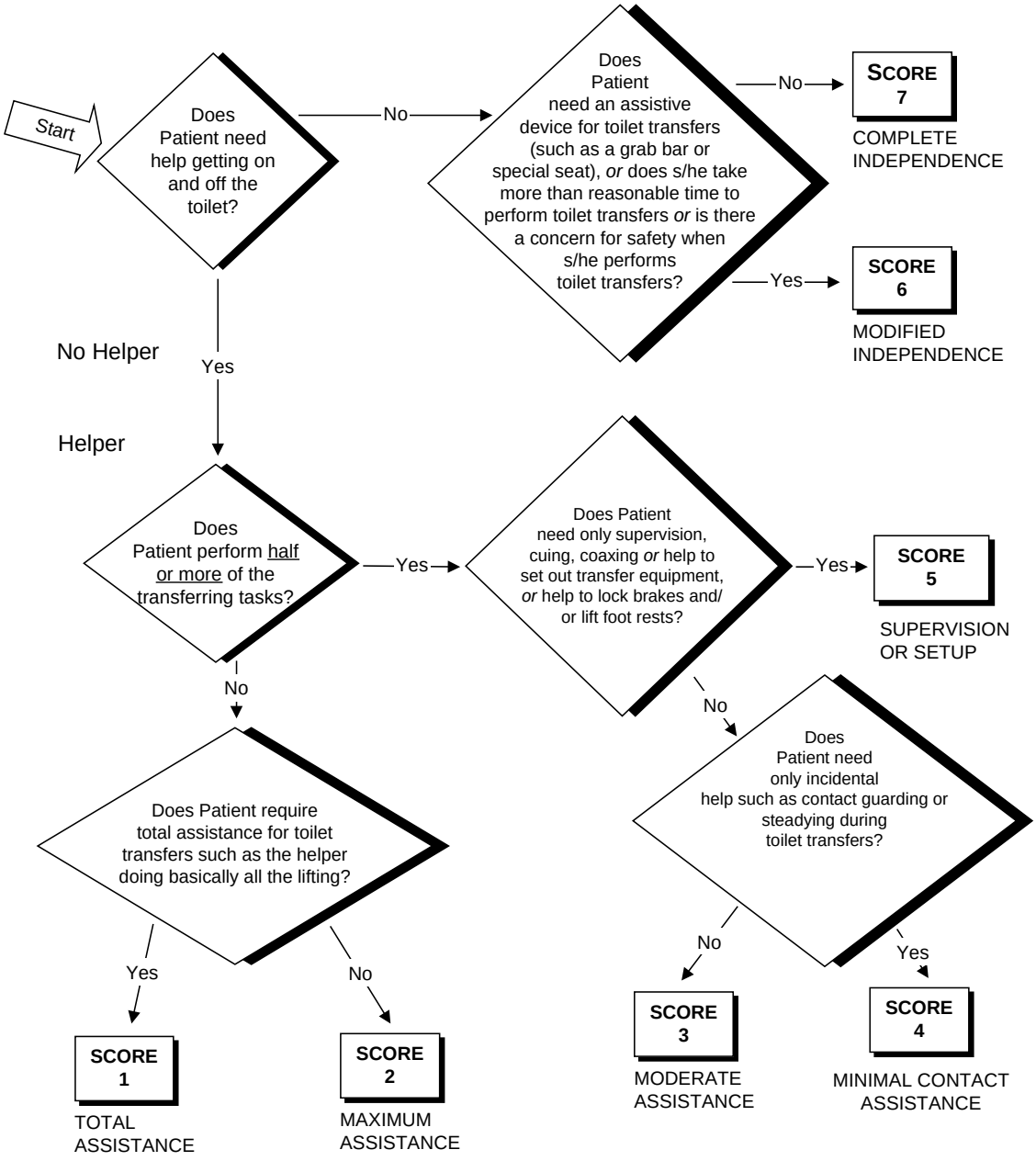
1 Total Assistance—The patient performs less than 25% of transferring tasks.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not transfer on or off the toilet/commode, and is not transferred on or off the toilet/commode by a helper or lifting device. For example, the patient uses only a bedpan and/or urinal. Use of this code should be rare.

SECTION 3: THE FIM™ INSTRUMENT

TRANSFERS: TOILET

Transfers: Toilet includes getting on and off a toilet. At level 7 the subject approaches, sits down on and gets up from a standard toilet. Performs independently and safely. *If in a wheelchair*, approaches toilet, locks brakes, lifts foot rests, removes arm rests if necessary, performs either a standing pivot or sliding transfer (without a board) and returns. Performs independently and safely. If activity does not occur, code "0" on admission and "1" on discharge.



TRANSFERS: TUB: *Transfers: Tub* includes getting into and out of a tub. The patient performs the activity safely. (Note: Use these definitions to score the Function Modifier, Item 33; refer to the note below to score Item 39K). Tub transfer is assessed before and after an actual (wet) bathing episode in a tub, not during a simulated episode.

NO HELPER

7 Complete Independence

If walking, the patient approaches a tub, and gets into and out of it. The patient performs the activity safely.

If in a wheelchair, the patient approaches a tub, locks brakes, lifts foot rests, removes arm rests if necessary, and does either a standing pivot or sliding transfer (without a board) and returns. The patient performs the activity safely.

6 Modified Independence—The patient requires an adaptive or assistive device (including a prosthesis or orthosis) such as a sliding board, a lift, grab bars, or special seat; or takes more than a reasonable amount of time to complete the activity; or there are safety considerations.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (positioning sliding board, moving foot rests, etc.).

4 Minimal Contact Assistance—The patient requires no more help than touching, and performs 75% or more of transferring tasks.

3 Moderate Assistance—The patient requires more help than touching or performs 50 to 74% of transferring tasks.

2 Maximal Assistance—The patient performs 25 to 49% of transferring tasks.

1 Total Assistance—The patient performs less than 25% of transferring tasks.

If the patient does NOT transfer into and out of a tub OR shower, code Transfers: Tub as “0,” and leave Transfers: Shower blank. Code "0" may be used for Transfers: Tub on admission and discharge.

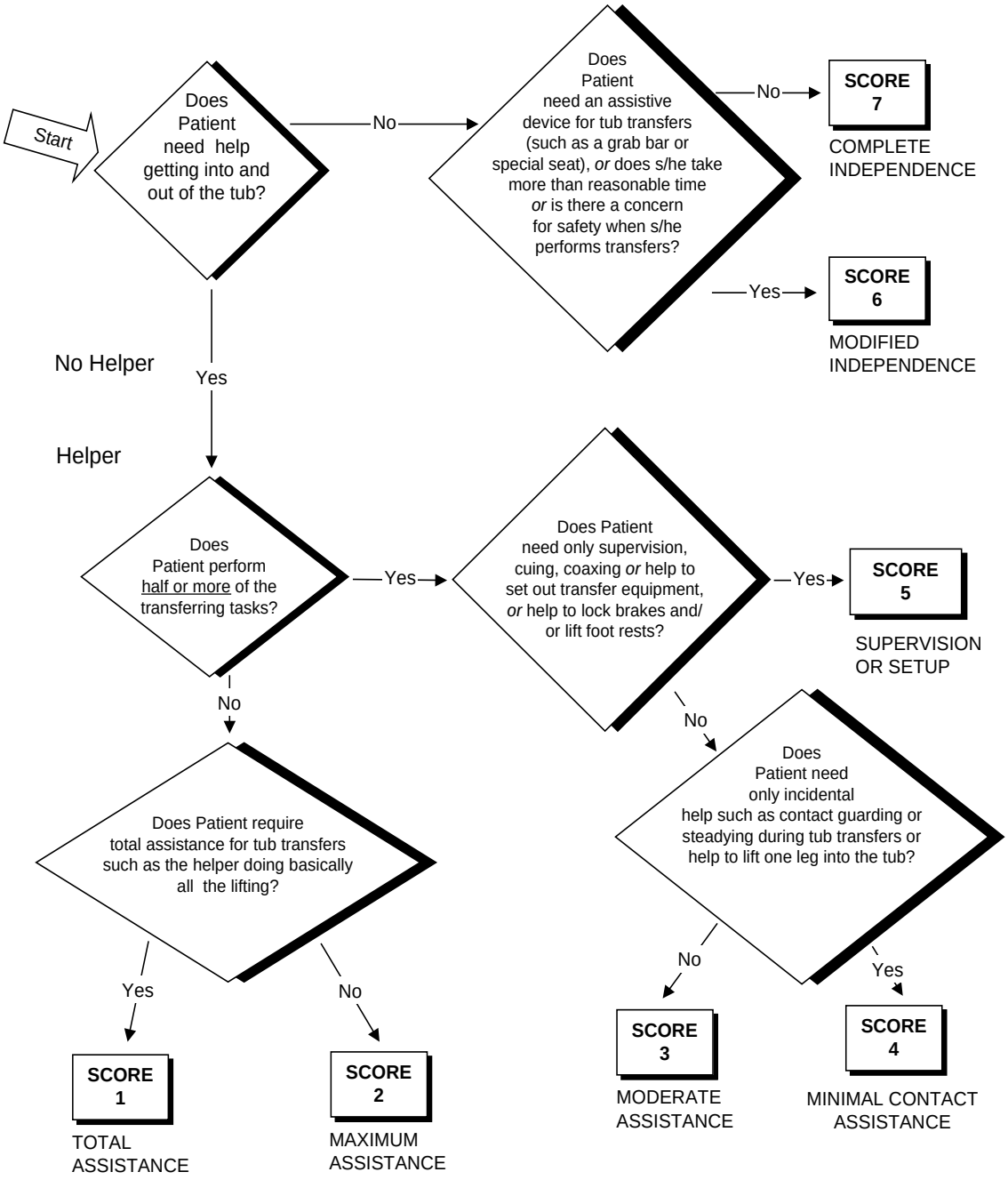
NOTE: There is a separate Function Modifier that addresses transfers into a shower stall. Code only Tub (Item 33) or Shower Transfers (Item 34) but not **both**. That is, if a score is recorded in Item 33, leave Item 34 blank. If the patient transfers into a tub and shower, record the score for the more frequent type of transfer.

The score for Item 39K should match the score for either Item 33 or 34 (i.e., whichever type of transfer was performed).

SECTION 3: THE FIM™ INSTRUMENT

TRANSFERS: TUB

Transfers: Tub includes getting into and out of a tub. At level 7 the subject approaches, gets in and out of a tub. Performs independently and safely. *If in a wheelchair*, approaches tub or shower, locks brakes, lifts foot rests, removes arm rests if necessary, performs either a standing pivot or sliding transfer (without a board) and returns. Performs independently and safely. If activity does not occur, code "0" on admission and "1" on discharge. COMMENT: There is a separate function modifier that addresses transfers into a shower stall. Score the function modifiers separately. If the patient uses only one mode, record this score on the FIM™ instrument. If the patient transfers into the tub and shower, record the lower score.



TRANSFERS: SHOWER: *Transfers: Shower* includes getting into and out of a shower. The patient performs the activity safely. (Note: Use these definitions to score the Function Modifier, Item 34; refer to the note below to score Item 39K). Shower transfer is assessed before and after an actual (wet) bathing episode in a shower, not during a simulated episode.

NO HELPER

7 Complete Independence

If walking, the patient approaches a shower stall, and gets into and out of it. The patient performs the activity safely.

If in a wheelchair, the patient approaches a shower stall, locks brakes, lifts foot rests, removes arm rests if necessary, and does either a standing pivot or sliding transfer (without a board) and returns. The patient performs the activity safely.

6 Modified Independence—The patient requires an adaptive or assistive device (including a prosthesis or orthosis) such as a sliding board, a lift, grab bars, or special seat; or takes more than a reasonable amount of time to complete the activity; or there are safety considerations.

HELPER

5 Supervision or Setup—The patient requires supervision (e.g., standing by, cuing, or coaxing) or setup (positioning sliding board, moving foot rests, etc.).

4 Minimal Contact Assistance—The patient requires no more help than touching and performs 75% or more of transferring tasks.

3 Moderate Assistance—The patient requires more help than touching or performs 50 to 74% of transferring tasks.

2 Maximal Assistance—The patient requires more help than touching or performs 25 to 49% of transferring tasks.

1 Total Assistance—The patient performs less than 25% of transferring tasks.

If the patient does NOT transfer into and out of a tub OR shower, code Tub Transfer as “0,” and leave Shower Transfer blank. Do not use code "0" for Shower Transfer.

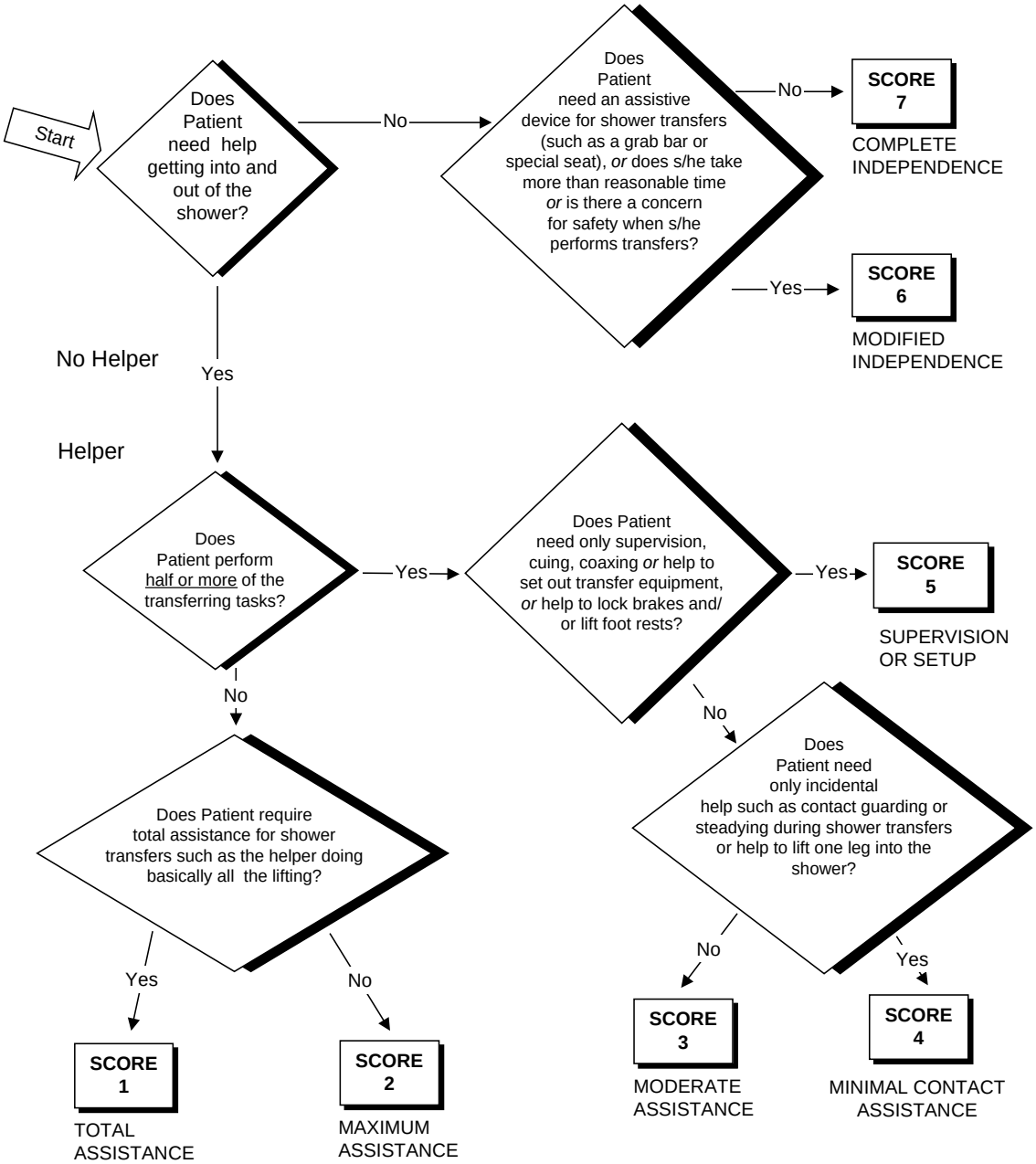
NOTE: There is a separate Function Modifier that addresses transfers into a tub. Code only Tub (Item 33) or Shower Transfers (Item 34) but not **both**. That is, if a score is recorded in Item 34, leave Item 33 blank. If the patient transfers into a tub and shower, record the score for the more frequent type of transfer.

The score for Item 39K should match the score for either Item 33 or 34 (i.e., whichever type of transfer was performed).

SECTION 3: THE FIM™ INSTRUMENT

TRANSFERS: SHOWER

Transfers: Shower includes getting into and out of a shower stall. At level 7 the subject approaches, gets in and out of a shower stall. Performs independently and safely. *If in a wheelchair*, approaches shower, locks brakes, lifts foot rests, removes arm rests if necessary, performs either a standing pivot or sliding transfer (without a board) and returns. Performs independently and safely. Do not use code "0" for Transfers: Shower. COMMENT: There is a separate function modifier that addresses transfers into a tub. Score the function modifiers separately. If the patient uses only one mode, record this score on the FIM™ instrument. If the patient transfers into the tub and shower, record the lower score.



LOCOMOTION: WALK: *Locomotion: Walk* includes walking on a level surface once in a standing position. The patient performs the activity safely. This is the first of two locomotion function modifiers.

NO HELPER

7 Complete Independence—The patient walks a minimum of 150 feet (50 meters) without assistive devices. The patient performs the activity safely.

6 Modified Independence—The patient walks a minimum of 150 feet (50 meters), but uses a brace (orthosis) or prosthesis on leg, special adaptive shoes, cane, crutches, or walkerette; or takes more than a reasonable amount of time to complete the activity; or there are safety considerations.

5 Exception (Household Locomotion)—The patient walks only short distances (a minimum of 50 feet or 15 meters) *independently* with or without a device. The activity takes more than a reasonable amount of time, or there are safety considerations.

HELPER

5 Supervision—The patient requires standby supervision, cuing, or coaxing to go a minimum of 150 feet (50 meters).

4 Minimal Contact Assistance—The patient performs 75% or more of walking effort to go a minimum of 150 feet (50 meters).

3 Moderate Assistance—The patient performs 50 to 74% of walking effort to go a minimum of 150 feet (50 meters).

2 Maximal Assistance—The patient performs 25 to 49% of walking effort to go a minimum of 50 feet (15 meters), and requires the assistance of one person only.

1 Total Assistance—The patient performs less than 25% of effort, or requires the assistance of two people, or walks to less than 50 feet (15 meters).

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not walk. For example, use 0 if the patient uses only a wheelchair for locomotion or the patient is on bed rest.

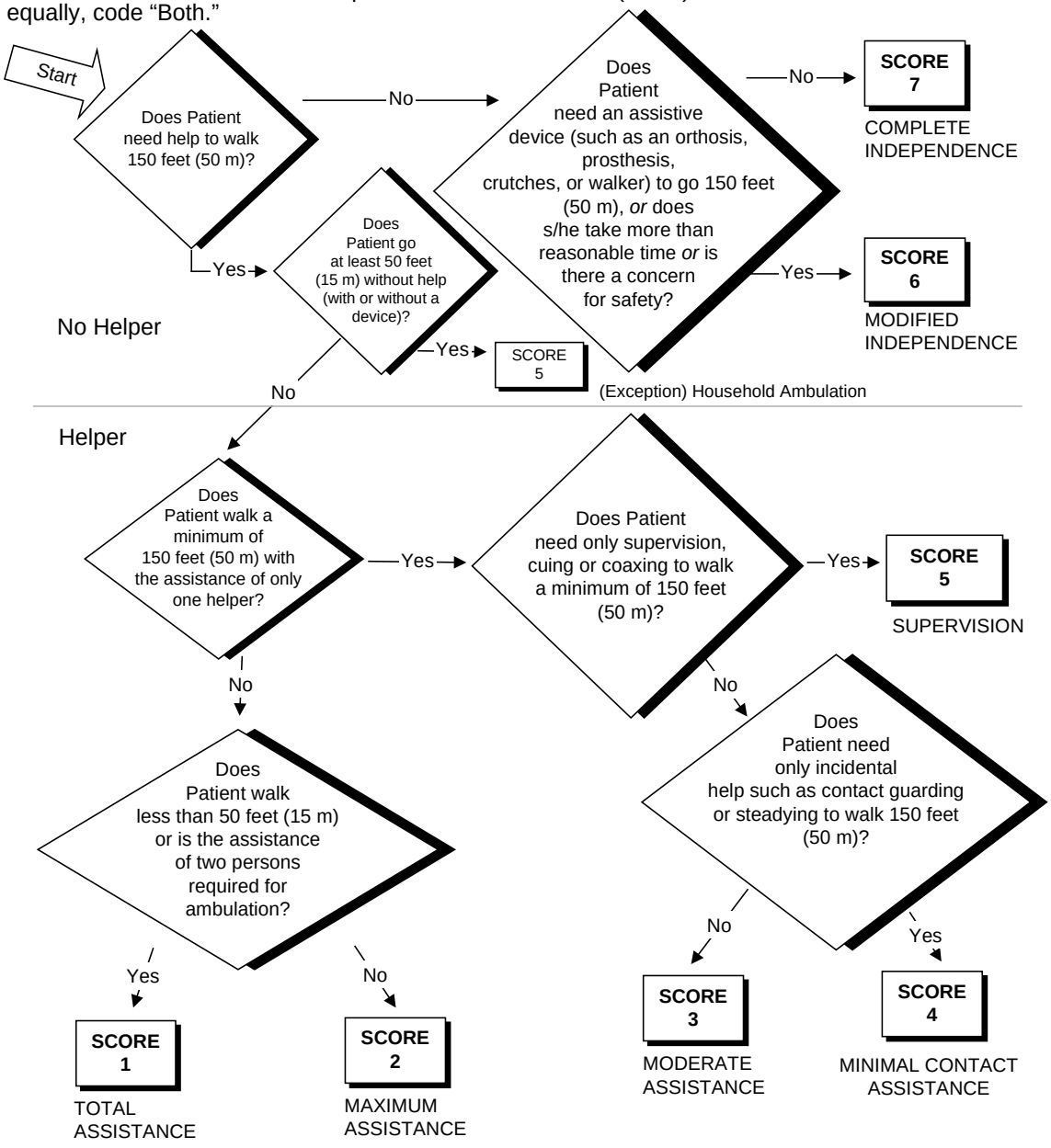
NOTE: If the patient requires an assistive device for locomotion (prosthesis, walker, cane, AFO, adapted shoe, etc.), then the Locomotion: Walk score can never be higher than level 6.

There are two locomotion function modifiers. Score both function modifiers on admission and discharge. On the FIM™ instrument item 39L, the mode of locomotion (Walk or Wheelchair) must be the same on admission and discharge. If the patient changes the mode of locomotion between admission and discharge (usually wheelchair to walking), record the admission mode and scores based on the *more frequent mode of locomotion at discharge* on the FIM™ instrument.[1] Indicate the most frequent mode of locomotion (Walk or Wheelchair). If both are used about equally, code "Both."

SECTION 3: THE FIM™ INSTRUMENT

LOCOMOTION: WALK

Walk includes walking, once in a standing position, on a level surface. At level 7 the patient walks a minimum of 150 feet (50 meters), in a reasonable time, without assistive devices. Performs independently and safely. There are two function modifiers. Score both function modifiers on admission and discharge. On the FIM™ instrument, the mode of locomotion (Walk) must be the same on admission and discharge. If the patient changes the mode of locomotion between admission and discharge (usually wheelchair to walking), record the admission mode and scores based on the *more frequent mode of locomotion at discharge* on the FIM™ instrument. Indicate the most frequent mode of locomotion (Walk). If both are used about equally, code "Both."



SECTION 3: THE FIM™ INSTRUMENT

LOCOMOTION: WHEELCHAIR: *Locomotion: Wheelchair* includes using a wheelchair on a level surface once in a seated position. The patient performs the activity safely. This is the second function modifier.

NO HELPER

7 This score is not to be used if the patient uses a wheelchair for Locomotion.

6 Modified Independence—The patient operates a manual or motorized wheelchair independently for a minimum of 150 feet (50 meters); turns around; maneuvers the chair to a table, bed, toilet; negotiates at least a 3 percent grade; and maneuvers on rugs and over door sills.

5 Exception (Household Locomotion)—The patient operates a manual or motorized wheelchair *independently* only short distances (a minimum of 50 feet or 15 meters).

HELPER

5 Supervision—The patient requires standby supervision, cuing, or coaxing to go a minimum of 150 feet (50 meters) in a wheelchair.

4 Minimal Contact Assistance—The patient performs 75% or more of locomotion effort to go a minimum of 150 feet (50 meters).

3 Moderate Assistance—The patient performs 50 to 74% of locomotion effort to go a minimum of 150 feet (50 meters).

2 Maximal Assistance—The patient performs 25 to 49% of locomotion effort to go a minimum of 50 feet (15 meters), and requires the assistance of one person only.

1 Total Assistance—The patient performs less than 25% of effort, or requires the assistance of two people, or wheels less than 50 feet (15 meters).

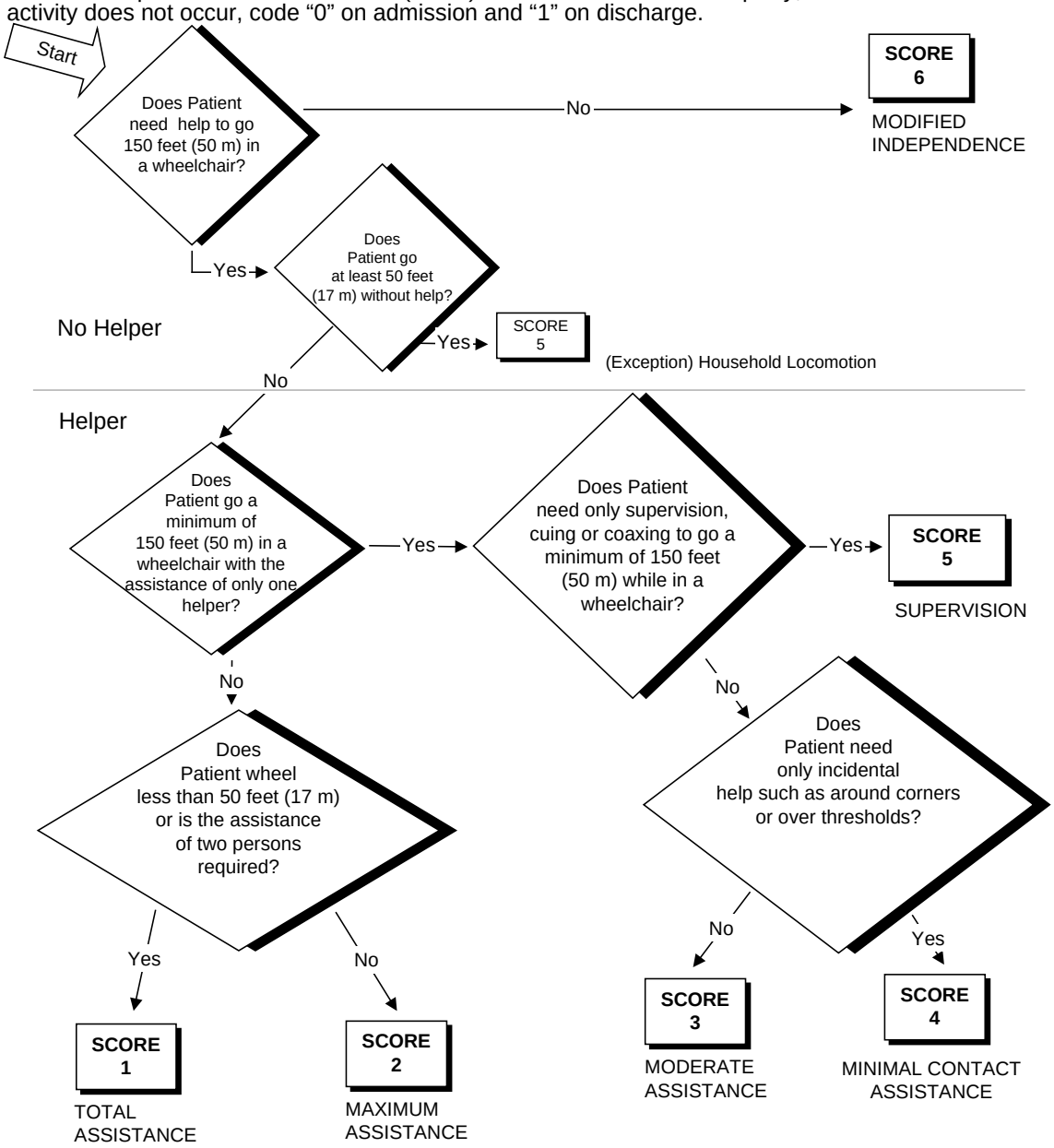
0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The patient does not use a wheelchair, and is not pushed in a wheelchair by a helper.

NOTE: There are two Locomotion function modifiers (Items 37 and 38). Score both function modifiers on admission and discharge. On the FIM™ instrument, the mode of locomotion (Walk or Wheelchair) must be the same on admission and discharge. If the patient changes the mode of locomotion between admission and discharge (usually wheelchair to walking), record the admission mode and scores based on the *more frequent mode of locomotion at discharge* on the FIM™ instrument.[1] Indicate the more frequent mode of locomotion (Walk or Wheelchair). If both are used about equally, code "Both." If both are used about equally at discharge, use the score for Walk (Item 37) to complete both the admission and discharge portions of Item 39L.

SECTION 3: THE FIM™ INSTRUMENT

LOCOMOTION: WHEELCHAIR

Wheelchair includes, once in a seated position, on a level surface. At level 6 the subject wheels a minimum of 150 feet (50 meters), in a reasonable time, without assistive devices. Performs independently and safely. There are two function modifiers. Score both function modifiers on admission and discharge. On the FIM™ instrument, the mode of locomotion (Walk) must be the same on admission and discharge. If the patient changes the mode of locomotion between admission and discharge (usually wheelchair to walking), record the admission mode and scores based on the *more frequent mode of locomotion at discharge* on the FIM™ instrument. Indicate the most frequent mode of locomotion (Walk). If both are used about equally, code "Both." If activity does not occur, code "0" on admission and "1" on discharge.



SECTION 3: THE FIM™ INSTRUMENT

LOCOMOTION: STAIRS: *Locomotion: Stairs* includes going up and down 12 to 14 stairs (one flight) indoors in a safe manner.

NO HELPER

7 Complete Independence—The patient safely goes up and down at least one flight of stairs without depending on any type of handrail or support.

6 Modified Independence—The patient goes up and down at least one flight of stairs but requires a side support, handrail, cane, or portable supports; or the activity takes more than a reasonable amount of time; or there are safety considerations.

5 Exception (Household Ambulation)—The patient goes up and down 4 to 6 stairs *independently*, with or without a device. The activity takes more than a reasonable amount of time, or there are safety considerations.

HELPER

5 Supervision—The patient requires supervision (e.g., standing by, cuing, or coaxing) to go up and down one flight of stairs.

4 Minimal Contact Assistance—The patient performs 75% or more of the effort to go up and down one flight of stairs.

3 Moderate Assistance—The patient performs 50 to 74% of the effort to go up and down one flight of stairs.

2 Maximal Assistance—The patient performs 25 to 49% of the effort to go up and down 4 to 6 stairs, and requires the assistance of one person only.

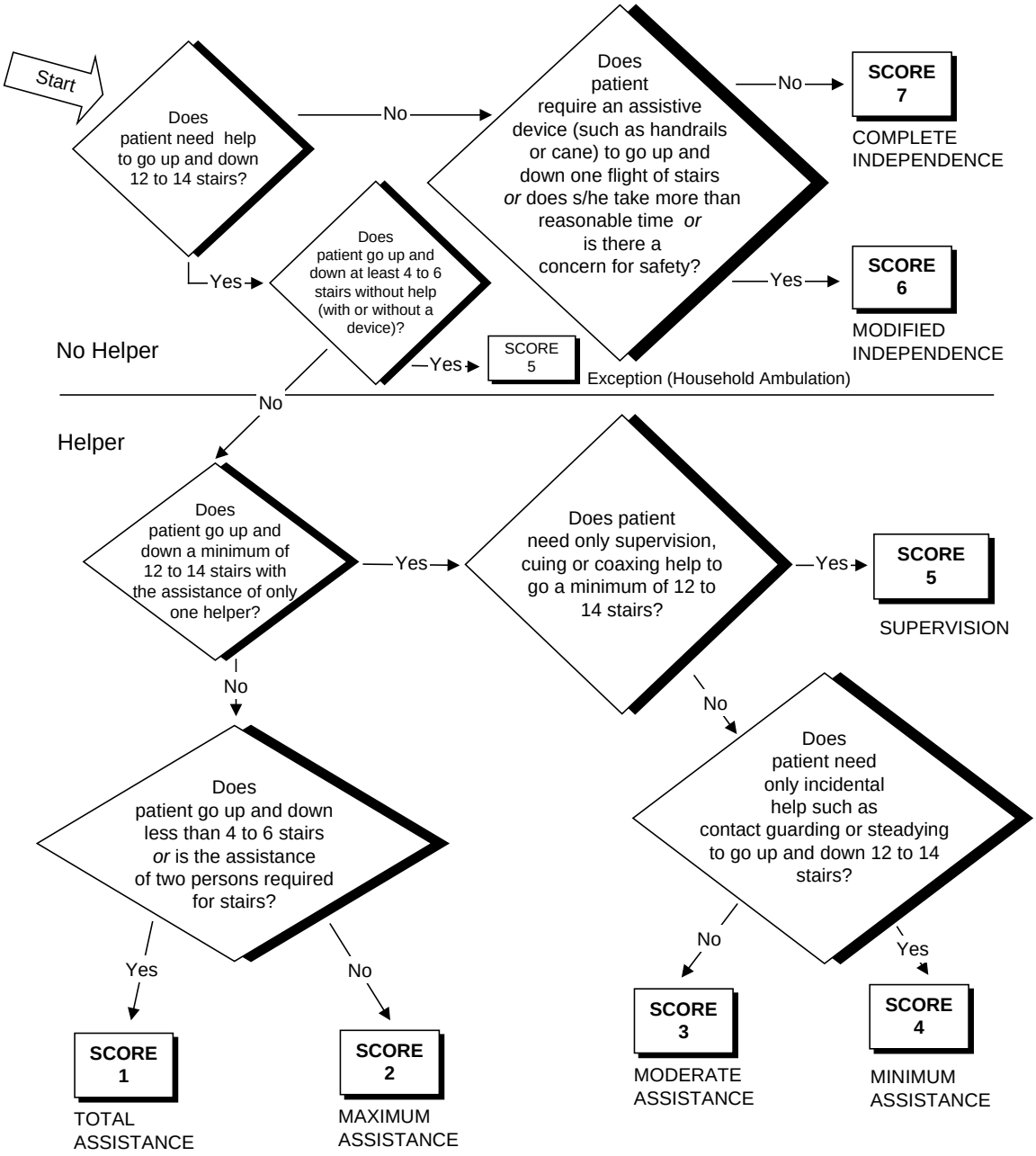
1 Total Assistance—The patient performs less than 25% of the effort, or requires the assistance of two people, or goes up and down fewer than 4 stairs.

0 Activity Does Not Occur—Enter code 0 only for the admission assessment. The subject does not go up or down stairs, and a helper does not carry the subject up or down stairs.

SECTION 3: THE FIM™ INSTRUMENT

LOCOMOTION: STAIRS

Stairs includes going up and down 12 to 14 stairs (one flight). At level 7 the patient goes up and down one flight of stairs without any type of handrail or support. Performs independently and safely. If activity does not occur code "0" on admission and "1" on discharge.



SECTION 3: THE FIM™ INSTRUMENT

COMPREHENSION: ***Comprehension*** includes understanding of either auditory or visual communication (e.g., writing, sign language, gestures). Evaluate and indicate the more usual mode of comprehension ("Auditory" or "Visual"). If both are used about equally, code "Both."

NO HELPER

7 Complete Independence—The patient understands *complex or abstract directions and conversation*, and understands either spoken or written language (not necessarily English).

6 Modified Independence—In most situations, the patient understands readily or with only mild difficulty *complex or abstract directions and conversation.* The patient does not require prompting, though (s)he may require a hearing or visual aid, other assistive device, or extra time to understand the information.

HELPER

5 Standby Prompting—The patient understands *directions and conversation about basic daily needs* more than 90% of the time. The patient requires prompting (slowed speech rate, use of repetition, stressing particular words or phrases, pauses, visual or gestural cues) less than 10% of the time.

4 Minimal Prompting—The patient understands *directions and conversation about basic daily needs* 75 to 90% of the time.

3 Moderate Prompting—The patient understands *directions and conversation about basic daily needs* 50 to 74% of the time.

2 Maximal Prompting—The patient understands *directions and conversation about basic daily needs* 25 to 49% of the time. Understands only *simple, commonly used spoken expressions* (e.g., *hello, how are you*) or gestures (e.g., waving good-bye, thank you). Requires prompting more than half the time.

1 Total Assistance—The patient understands *directions and conversation about basic daily needs* less than 25% of the time, or does not understand *simple, commonly used spoken expressions* (e.g., *hello, how are you*) or gestures (e.g., waving good-bye, thank you), or does not respond appropriately or consistently despite prompting.

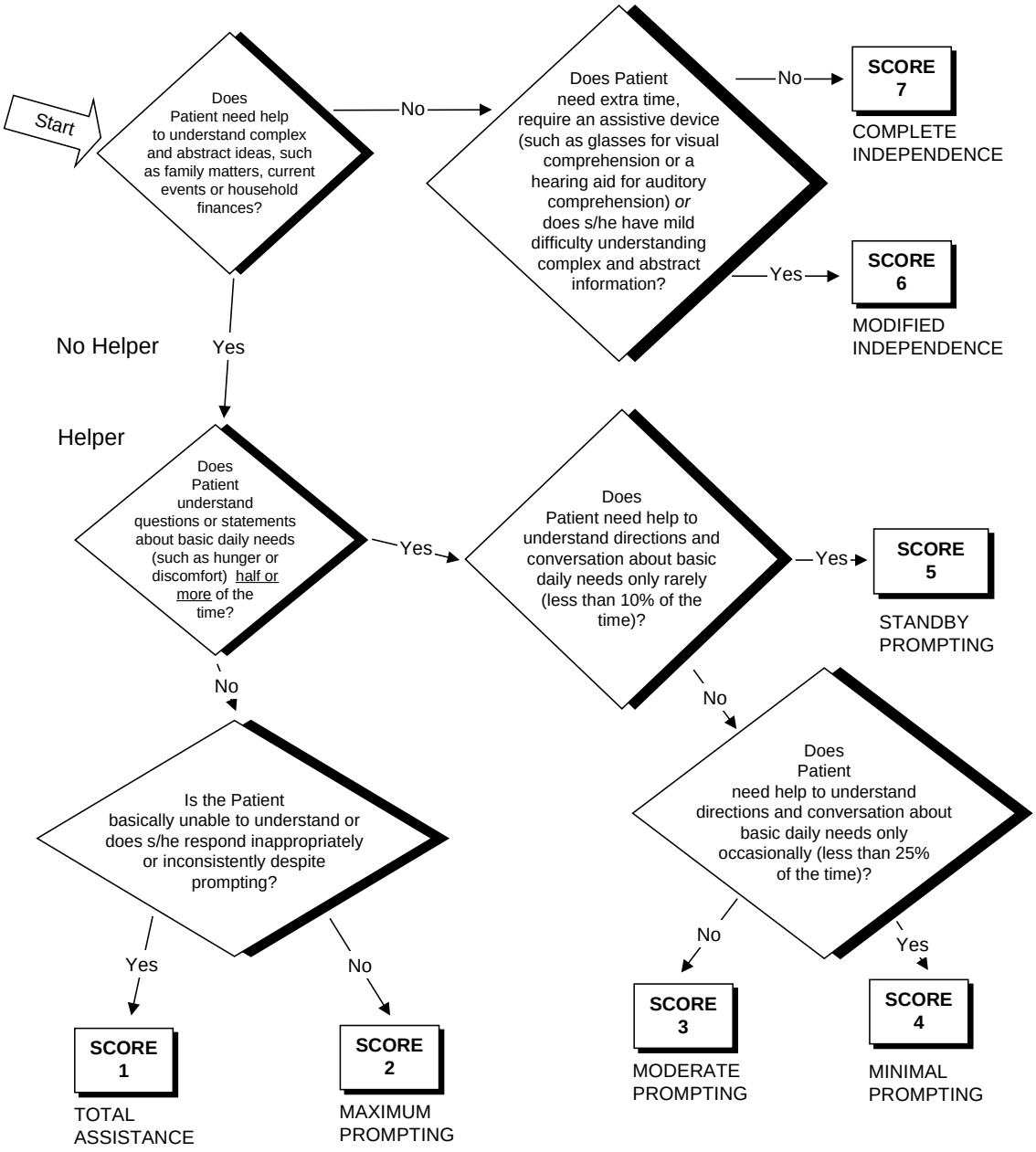
Do not use code "0" for Comprehension.

NOTE: *Comprehension* of complex or abstract information includes (but is not limited to) understanding current events appearing in television programs or newspaper articles, or abstract information on subjects such as religion, humor, math, or finances used in daily living. Comprehension of *complex or abstract information* may also include understanding information given during a group conversation. Information about *basic daily needs* refers to conversation, directions, and questions or statements related to the patient's need for nutrition, fluids, elimination, hygiene or sleep (physiological needs).

SECTION 3: THE FIM™ INSTRUMENT

COMPREHENSION

Comprehension includes understanding of either auditory or visual communication (e.g., writing, sign language, gestures). At level 7 the subject understands directions and conversation that are complex or abstract; understands either spoken or written language, not necessarily English. Evaluate and indicate the more usual mode of comprehension ("Auditory" or "Visual"). If both are used about equally, code "Both." Do not use Code “0” for Comprehension.



EXPRESSION: *Expression* includes clear vocal or nonvocal expression of language. This item includes either intelligible speech or clear expression of language using writing or a communication device. Evaluate and indicate the more usual mode of expression ("Vocal" or "Nonvocal"). If both are used about equally, code "Both".

NO HELPER

7 Complete Independence—The patient expresses *complex or abstract ideas* clearly and fluently (not necessarily in English).

6 Modified Independence—In most situations, the patient expresses *complex or abstract ideas* relatively clearly or with only mild difficulty. The patient does not need any prompting, but (s)he may require an augmentative communication device or system.

HELPER

5 Standby Prompting—The patient expresses *basic daily needs and ideas* more than 90% of the time. Requires prompting (e.g., frequent repetition) less than 10% of the time to be understood.

4 Minimal Prompting—The patient expresses *basic daily needs and ideas* 75 to 90% of the time.

3 Moderate Prompting—The patient expresses *basic daily needs and ideas* 50 to 74% of the time.

2 Maximal Prompting—The patient expresses *basic daily needs and ideas* 25 to 49% of the time. The patient uses only single words or gestures, and (s)he needs prompting more than half the time.

1 Total Assistance—The patient expresses *basic daily needs and ideas* less than 25% of the time, or does not express basic needs appropriately or consistently despite prompting.

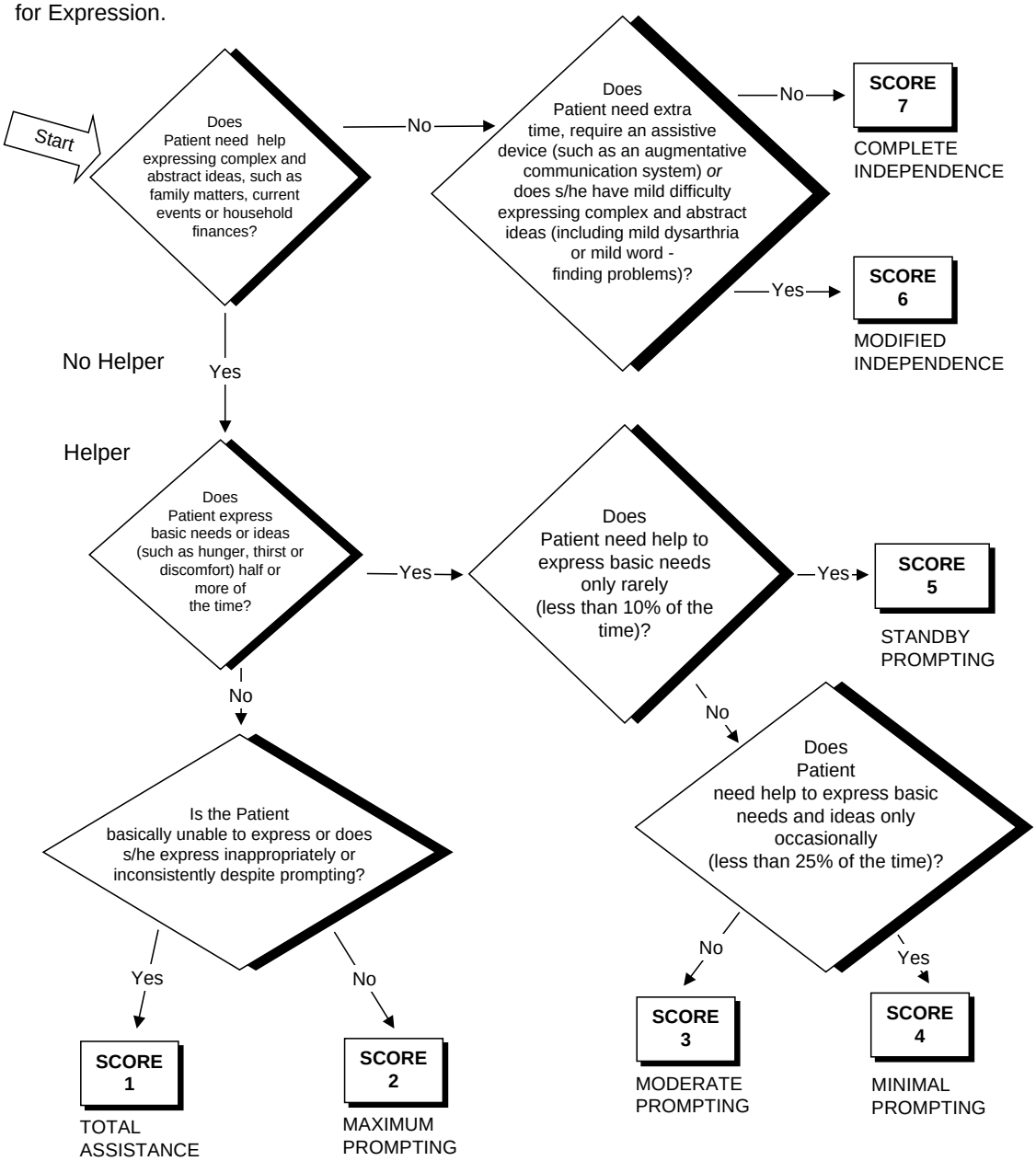
Do not use code "0" for Expression.

NOTE: Examples of *complex or abstract ideas* include (but are not limited to) discussing current events, religion, or relationships with others. Expression of *basic needs and ideas* refers to the patient's ability to communicate about necessary daily activities such as nutrition, fluids, elimination, hygiene, and sleep (physiological needs).

SECTION 3: THE FIM™ INSTRUMENT

EXPRESSION

Expression includes clear vocal or nonvocal expression of language. This item includes either intelligible speech or clear expression of language using writing or a communication device. At level 7 the subject expresses complex or abstract ideas clearly and fluently. Evaluate and indicate the more usual mode of expression ("Vocal" or "Nonvocal"). If both are used about equally, code "Both". Code “0” is not available for Expression.



SOCIAL INTERACTION: *Social Interaction* includes skills related to getting along and participating with others in therapeutic and social situations. It represents how one deals with one's own needs *together with* the needs of others.

NO HELPER

7 Complete Independence—The patient interacts appropriately with staff, other patients, and family members (e.g., controls temper, accepts criticism, is aware that words and actions have an impact on others), and does not require medication for control.

6 Modified Independence—The patient interacts appropriately with staff, other patients, and family members in most situations, and only occasionally loses control. The patient does not require supervision, but may require more than a reasonable amount of time to adjust to social situations, or may require medication for control.

HELPER

5 Supervision—The patient requires supervision (e.g., monitoring, verbal control, cuing, or coaxing) only under stressful or unfamiliar conditions, but less than 10% of the time. The patient may require encouragement to initiate participation.

4 Minimal Direction—The patient interacts appropriately 75 to 90% of the time.

3 Moderate Direction—The patient interacts appropriately 50 to 74% of the time.

2 Maximal Direction—The patient interacts appropriately 25 to 49% of the time, but may need restraint due to socially inappropriate behaviors.

1 Total Assistance—The patient interacts appropriately less than 25% of the time, or not at all, and may need restraint due to socially inappropriate behaviors.

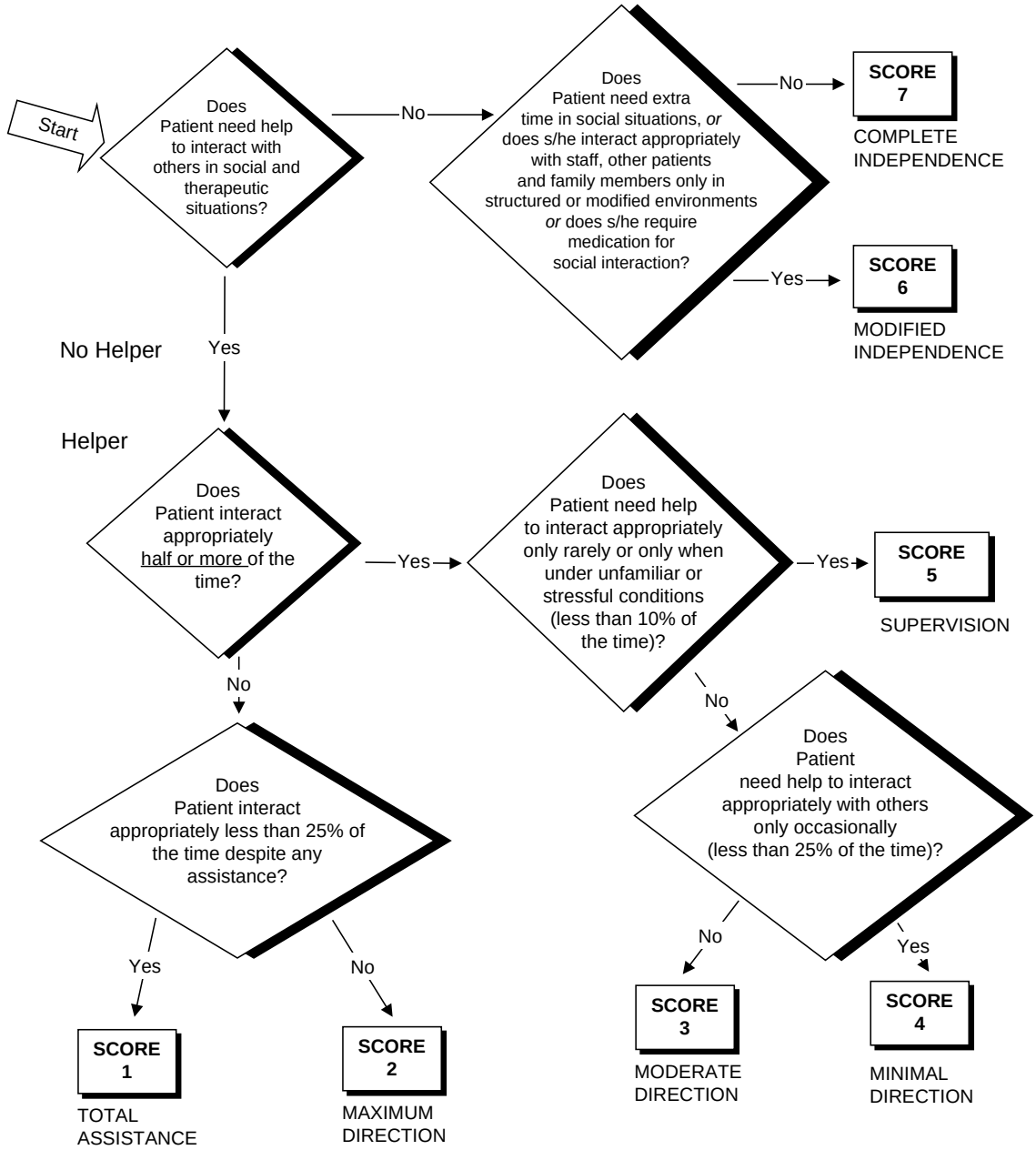
Do not use code "0" for Social Interaction

NOTE: Examples of socially inappropriate behaviors include temper tantrums; loud, foul, or abusive language; excessive laughing or crying; physical attack; or very withdrawn or non-interactive behavior.

SECTION 3: THE FIM™ INSTRUMENT

SOCIAL INTERACTION

Social interaction includes skills related to getting along and participating with others in therapeutic and social situations. It represents how one deals with one's own needs *together with* the needs of others. At level 7 the subject interacts appropriately with staff, other patients, and family members (e.g., controls temper, accepts criticism, is aware that words and actions have an impact on others.) Subject does not require medication for control. Code "0" is not available for Social Interaction.



SECTION 3: THE FIM™ INSTRUMENT

PROBLEM SOLVING: *Problem Solving* includes skills related to solving problems of daily living. This means making reasonable, safe, and timely decisions regarding financial, social, and personal affairs, as well as the initiation, sequencing, and self-correcting of tasks and activities to solve problems.

NO HELPER

7 Complete Independence—The patient consistently recognizes problems when present, makes appropriate decisions, initiates and carries out a sequence of steps to solve *complex problems* until the task is completed, and self-corrects if errors are made.

6 Modified Independence—In most situations, the patient recognizes a present problem, and with only mild difficulty makes appropriate decisions, initiates and carries out a sequence of steps to solve *complex problems*, or requires more than a reasonable time to make appropriate decisions or solve complex problems.

HELPER

5 Supervision—The patient requires supervision (e.g., cuing or coaxing) to solve *routine problems* only under stressful or unfamiliar conditions, but no more than 10% of the time.

4 Minimal Direction—The patient solves *routine problems* 75 to 90% of the time.

3 Moderate Direction—The patient solves *routine problems* 50 to 74% of the time.

2 Maximal Direction—The patient solves *routine problems* 25 to 49% of the time. The patient needs direction more than half the time to initiate, plan, or complete simple daily activities, and may need restraint for safety.

1 Total Assistance—The patient solves *routine problems* less than 25% of the time. The patient needs direction nearly all the time, or does not effectively solve problems, and may require constant one-to-one direction to complete simple daily activities. The patient may need a restraint for safety.

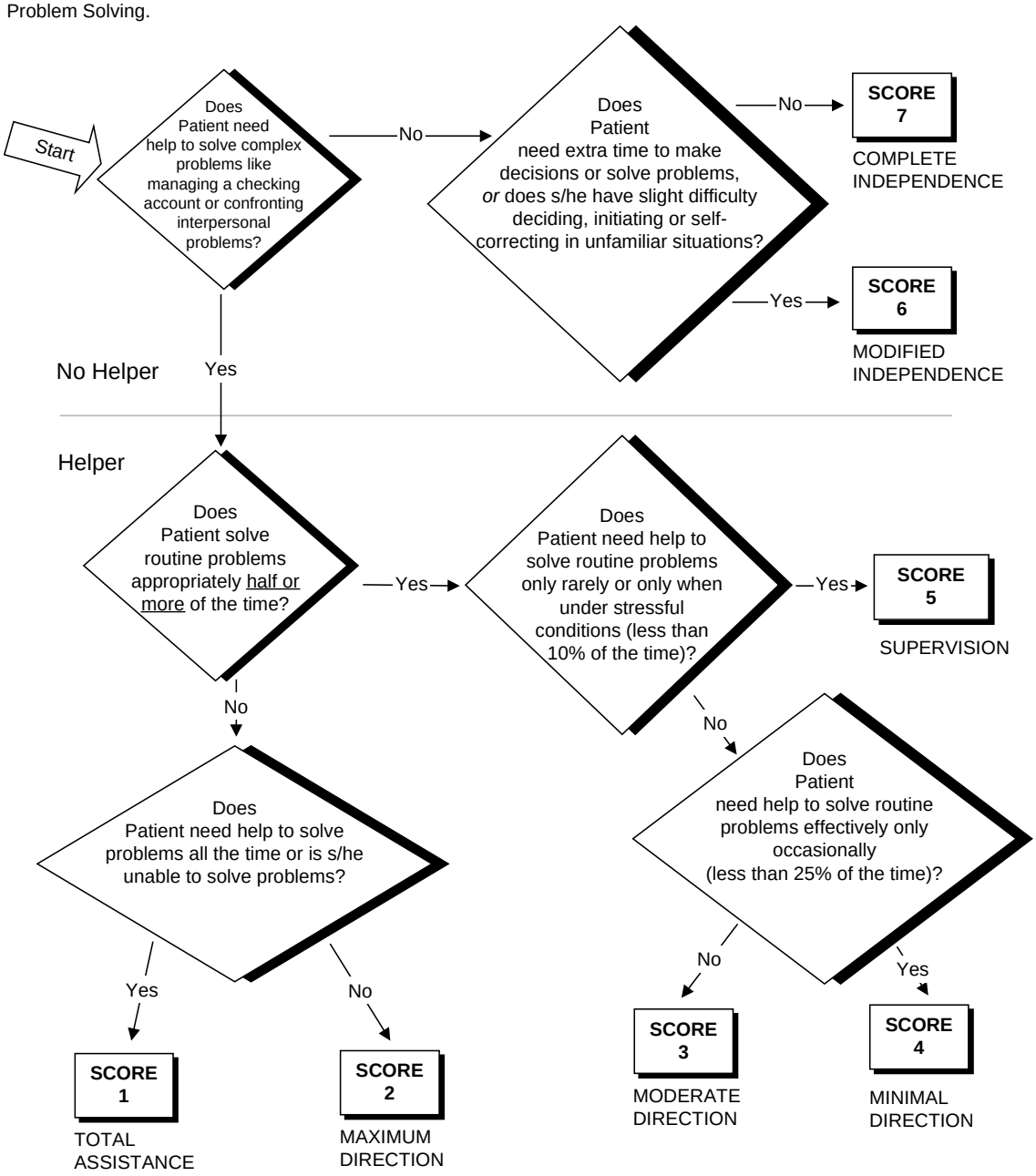
Do not use code "0" for Problem Solving.

NOTE: Examples of *complex problem-solving* includes activities such as managing a checking account, participating in discharge plans, self-administering medications, confronting interpersonal problems, and making employment decisions. *Routine problem-solving* includes successfully completing daily tasks or dealing with unplanned events or hazards that occur during daily activities. More specific examples of routine problems include asking for assistance appropriately during transfer, asking for a new milk carton if milk is sour or missing, unbuttoning a shirt before trying to put it on, and asking for utensils missing from a meal tray.

SECTION 3: THE FIM™ INSTRUMENT

PROBLEM SOLVING

Problem Solving includes skills related to solving problems of daily living. This means making reasonable, safe, and timely decisions regarding financial, social and personal affairs, and initiating, sequencing and self-correcting tasks and activities to solve problems. At level 7 the subject consistently recognizes if there is a problem, makes appropriate decisions, initiates and carries out a sequence of steps to solve complex problems until the task is completed, and self-corrects if errors are made. Code "0" is not available for Problem Solving.



SECTION 3: THE FIM™ INSTRUMENT

MEMORY: *Memory* includes skills related to recognizing and remembering while performing daily activities in an institutional or community setting. Memory in this context includes the ability to store and retrieve information, particularly verbal and visual. The functional evidence of memory includes recognizing people frequently encountered, remembering daily routines, and executing requests without being reminded. A deficit in memory impairs learning as well as performance of tasks.

NO HELPER

7 Complete Independence—The patient recognizes people frequently encountered, remembers daily routines, and executes requests of others without need for repetition.

6 Modified Independence—The patient appears to have only mild difficulty recognizing people frequently encountered, remembering daily routines, and responding to requests of others. The patient may use self-initiated or environmental cues, prompts, or aids.

HELPER

5 Supervision—The patient requires prompting (e.g., cuing, repetition, reminders) only under stressful or unfamiliar conditions, but no more than 10% of the time.

4 Minimal Prompting—The patient recognizes and remembers 75 to 90% of the time.

3 Moderate Prompting—The patient recognizes and remembers 50 to 74% of the time.

2 Maximal Prompting—The patient recognizes and remembers 25 to 49% of the time, and needs prompting more than half the time.

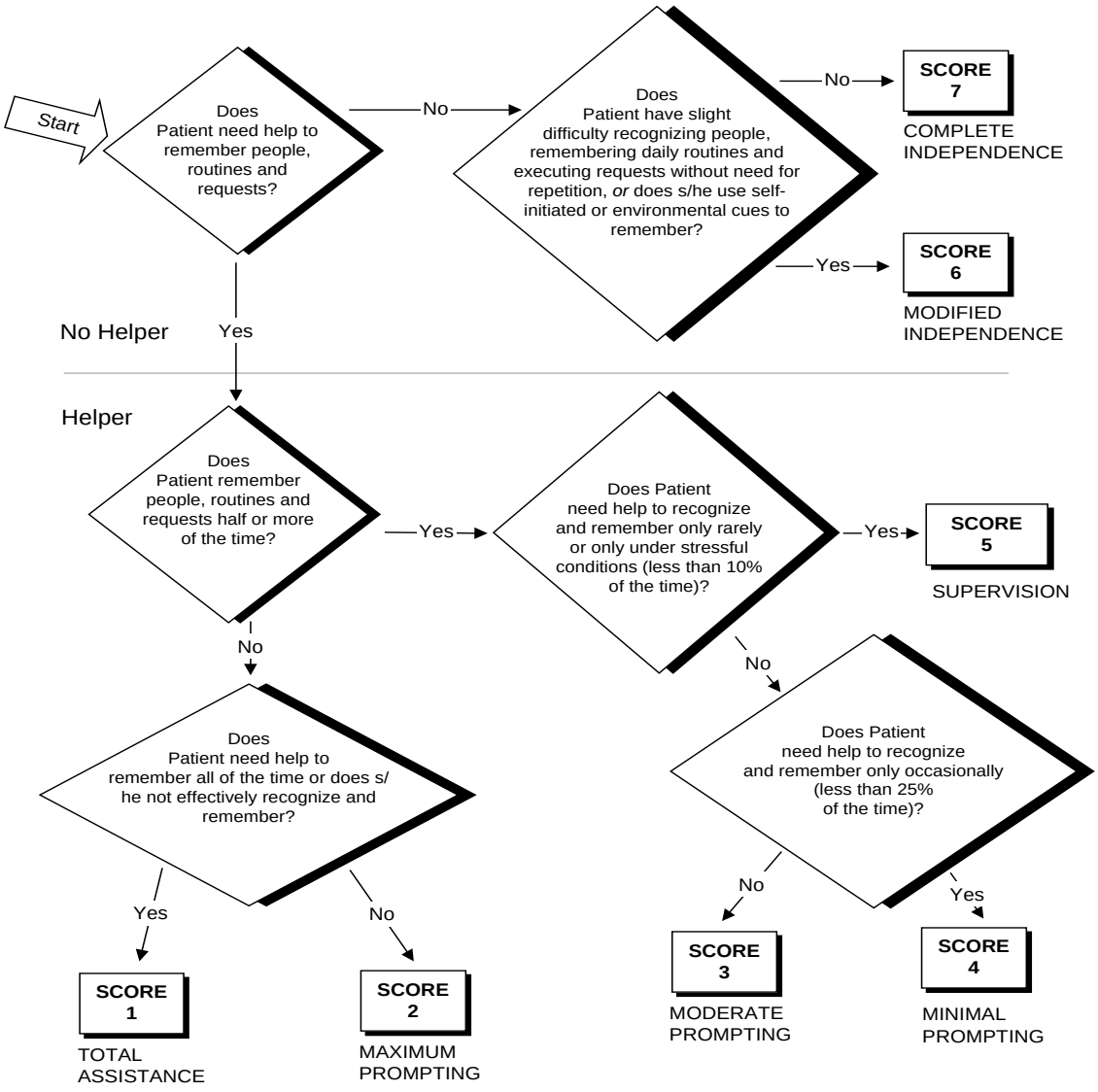
1 Total Assistance—The patient recognizes and remembers less than 25% of the time, or does not effectively recognize and remember.

Do not use code “0” for Memory.

SECTION 3: THE FIM™ INSTRUMENT

MEMORY

Memory includes skills related to recognizing and remembering while performing daily activities in an institutional or community setting. Memory in this context includes the ability to store and retrieve information, particularly verbal and visual. The functional evidence of memory includes recognizing people frequently encountered, remembering daily routines and executing requests without being reminded. A deficit in memory impairs learning as well as performance of tasks. At level 7 the subject recognizes people frequently encountered, remembers daily routines, and executes requests of others without need for repetition. Code "0" is not available for Memory



[1] This method of scoring the Walk/Wheelchair item is in accordance with section 412.610 "Assessment schedule" of the Final Rule (pages 41389-41930) that allows exceptions to the general rules for the admission and discharge assessments to be specified in this manual.