

# DRAFT Inpatient Psychiatric Facility - Patient Assessment Instrument (IPF-PAI) Version 1.0 - Admission

Admission assessment period is the first three (3) days of the IPF stay (includes day of admission and two days after)

## Section A Identification Information

### A0050. Type of Record

Enter Code

1. Add new record
2. Modify existing record
3. Inactivate existing record

### A0100. Facility Provider Numbers

(Enter Codes in boxes provided)

#### A. National Provider Identifier (NPI)

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#### B. CMS Certification Number (CCN):

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### A0210. Assessment Reference Date

(At admission, the third calendar of the IPF stay. At discharge, the day of discharge.)

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Month

Day

Year

### A0220. Admission Date

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Month

Day

Year

### A0250. Reason for Assessment

Enter Code

1. Admission
9. Discharge

### A0255. Type of Admission

Enter Code

1. Voluntary
2. Involuntary

### A0500. Legal Name of Patient

(If the patient does not have a middle initial or suffix, or the IPF does not have this information, leave A0500B and/or A0500D blank).

#### A. First name:

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#### B. Middle initial:

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#### C. Last name:

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#### D. Suffix:

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**A0600. Social Security and Medicare Numbers****A. Social Security Number**

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**B. Medicare Number**

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**A0810. Sex**

Enter Code

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1. **Male**
2. **Female**

**A0900. Birth Date**

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Month

Day

Year

**A1405. Payer Information - Primary Payer**

Enter Code

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01. **Medicare - Part A** (traditional fee-for-service)
02. **Medicare - Part C** (Medicare Advantage)
03. **Medicaid fee-for-service**
04. **Medicaid - other** (e.g., managed care)
05. **Workers' compensation**
06. **Title Programs** (e.g., Title III, V, XX)
07. **Other government** (e.g., TRICARE, VA, etc.)
08. **Private insurance - not managed care**
09. **Private insurance - managed care** (e.g., PPO, HMO)
10. **Self-pay**
98. **Other payer**
99. **Unknown**

<b>Section B</b>	<b>Hearing, Speech, and Vision - Admission Only</b>
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**B0200. Hearing**

*(Complete only if A0250 = 1)*

<b>Enter Code</b>  <input style="width: 40px; height: 20px;" type="text"/>	<b>Ability to hear</b> (with hearing aid or hearing appliances if normally used) 0. <b>Adequate</b> —no difficulty in normal conversation, social interaction, listening to TV 1. <b>Minimal difficulty</b> —difficulty in some environments (e.g., when person speaks softly or setting is noisy) 2. <b>Moderate difficulty</b> —speaker has to increase volume and speak distinctly 3. <b>Highly impaired</b> —absence of useful hearing
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**B0600. Speech Clarity**

*(Complete only if A0250 = 1)*

<b>Enter Code</b>  <input style="width: 40px; height: 20px;" type="text"/>	<b>Select best description of speech pattern</b> 0. <b>Clear speech</b> —distinct intelligible words 1. <b>Unclear speech</b> —slurred or mumbled words 2. <b>No speech</b> —absence of spoken words
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**B1000. Vision**

*(Complete only if A0250 = 1)*

<b>Enter Code</b>  <input style="width: 40px; height: 20px;" type="text"/>	<b>Ability to see in adequate light</b> (with glasses or other visual appliances) 0. <b>Adequate</b> —sees fine detail, such as regular print in newspapers/books 1. <b>Impaired</b> —sees large print, but not regular print in newspapers/books 2. <b>Moderately impaired</b> —limited vision, not able to see newspaper headlines but can identify objects 3. <b>Highly impaired</b> —object identification in question, but eyes appear to follow objects 4. <b>Severely impaired</b> —no vision or sees only light, colors, or shapes; eyes do not appear to follow objects
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<b>Section D</b>	<b>Mood</b>
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**D1000. Suicide Screening**

<b>Enter Code</b>  <input style="width: 40px; height: 20px;" type="text"/>	<b>Has the patient been screened for suicide risk?</b> 1. <b>Yes</b> —using a standardized tool 2. <b>Yes</b> —through clinical assessment 9. <b>No</b> —Patient declined to respond or patient unable to be assessed.
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Section GG	Functional Abilities
<b>GG0170. Mobility</b>	
(Complete only if A0250 = 1 or A0260 = 1, 2, or 3.)	
<b>Admission:</b> For the activity, code the patient's performance using the 6-point scale. If the activity was not attempted, code the reason.	
<b>Coding:</b>  <b>Safety and Quality of Performance</b> —If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.  <i>Activities may be completed with or without assistive devices.</i>	
06. <b>Independent</b> —Patient completes the activity by themselves with no assistance from a helper.  05. <b>Setup or clean-up assistance</b> —Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.  04. <b>Supervision or touching assistance</b> —Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.  03. <b>Partial/moderate assistance</b> —Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs and provides more than half the effort.  02. <b>Substantial/maximal assistance</b> —Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.  01. <b>Dependent</b> —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.	
<b>If activity was not attempted, code reason:</b>  07. <b>Patient refused</b>  09. <b>Not applicable</b> —Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury.  10. <b>Not attempted due to environmental limitations</b> (e.g., lack of equipment, weather constraints)  88. <b>Not attempted due to medical condition or safety concerns</b>	
<b>1. Admission Performance</b> <b>Enter Codes in Boxes ↓</b>	
<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto; display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 15px; height: 15px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 15px; height: 15px;"></div> </div>	<b>E. Chair/bed-to-chair transfer:</b> The ability to transfer to and from a bed to a chair (or wheelchair).

Section I	Active Diagnoses
<b>I0060. Indicate the patient's primary medical condition category</b>	
<b>Enter Code</b> <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto; display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 15px; height: 15px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 15px; height: 15px;"></div> </div>	<b>Indicate the patient's primary medical condition category that best describes the primary reason for admission.</b>  01. <b>Anxiety disorders</b> 02. <b>Delirium, dementia, and amnestic and other cognitive disorders</b> 03. <b>Eating disorders</b> 04. <b>Mood disorders</b> 05. <b>Schizophrenia and other psychotic disorders</b> 06. <b>Substance-related disorders including alcohol-related disorders</b> 09. <b>Other diagnosis—not included in one of the above categories</b>

Section O Special Services, Treatments, and Interventions	
<b>O0115. Special Services, Treatments, and Interventions in the Inpatient Psychiatric Setting</b>	
<b>Admission:</b> Indicate all of the following services, treatments, and interventions received in <i>the first 3-days of the IPF stay</i> (includes day of admission and two days after).	
	<b>a. Admission</b>
<b>Psychiatric Treatments</b>	
A1. Medications	<input type="checkbox"/>
B1. Brain Stimulation	<input type="checkbox"/>
B2. Electroconvulsive Therapy (ECT)	<input type="checkbox"/>
B3. Transcranial Magnetic Stimulation (rTMS)	<input type="checkbox"/>
B4. Other	<input type="checkbox"/>
C1. Non-Pharmacological Treatment (Other than Brain Stimulation)	<input type="checkbox"/>
C2. Therapy (Individual or Group)	<input type="checkbox"/>
C3. Therapeutic Activities	<input type="checkbox"/>
C4. Other	<input type="checkbox"/>
<b>Restrictive Interventions</b>	
D1. Seclusion	<input type="checkbox"/>
E1. Restraint	<input type="checkbox"/>
E2. Chemical Restraints	<input type="checkbox"/>
E3. Physical Restraints	<input type="checkbox"/>
E4. Other	<input type="checkbox"/>
F1. Other Restrictive Interventions	<input type="checkbox"/>
F2. Unit Restrictions	<input type="checkbox"/>
F3. Line of Sight Supervision	<input type="checkbox"/>
F4. 1:1 Observation	<input type="checkbox"/>
F5. Other	<input type="checkbox"/>
<b>None of the Above</b>	
Z1. None of the Above	<input type="checkbox"/>

<b>Section Z</b>		<b>Record Administration</b>									
<b>Z0510. IPF-PAI Completion Date</b>											
This date represents completion of the IPF-PAI for this patient record.											
		<b>B. Date</b>									
		<input type="text"/>		<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>
		Month			Day			Year			