

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

Discharge assessment period is the last seven (7) days of the IPF stay (includes day of discharge and six days prior) - unless otherwise noted.

Section A		Identification Information																										
A0050. Type of Record																												
Enter Code	<input type="checkbox"/>	<ol style="list-style-type: none">1. Add new record2. Modify existing record3. Inactivate existing record																										
A0100. Facility Provider Numbers (Enter Codes in boxes provided)																												
		<p>A. National Provider Identifier (NPI)</p> <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> <p>B. CMS Certification Number (CCN):</p> <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																										
A0210. Assessment Reference Date (At admission, the third calendar of the IPF stay. At discharge, the day of discharge.)																												
		<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> <p>Month Day Year</p>																										
A0220. Admission Date																												
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A0250. Reason for Assessment																												
Enter Code	<input type="checkbox"/>	<ol style="list-style-type: none">1. Admission9. Discharge																										
A0260. Type of Discharge (An Unplanned discharge [A0260 = 4] includes discharges due to medical emergencies.)																												
Enter Code	<input type="checkbox"/>	<ol style="list-style-type: none">1. Planned - Following court order2. Planned - Not following court order3. Against medical advice (AMA)4. Unplanned5. Expired																										
A0270. Discharge Date																												
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(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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[illegible]

1. Male
2. Female

		—			—				
Month			Day			Year			

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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 |

Section D	Mood
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D1000. Suicide Screening	
Discharge: Assessment period is the entire IPF stay, excluding the first three days of admission.	
Enter Code <div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div>	Has the patient been screened for suicide risk? 1. Yes —using a standardized tool 2. Yes —through clinical assessment 9. No —Patient declined to respond or patient unable to be assessed.

Section GG	Functional Abilities
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GG0170. Mobility	
<i>(Complete only if A0250 = 1 or A0260 =1, 2, or 3.)</i>	
Discharge: For the activity, code the patient's performance using the 6-point scale. If the activity was not attempted, code the reason.	
Coding: Safety and Quality of Performance —If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. <i>Activities may be completed with or without assistive devices.</i> 06. Independent —Patient completes the activity by themselves with no assistance from a helper. 05. Setup or clean-up assistance —Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity. 04. Supervision or touching assistance —Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 03. Partial/moderate assistance —Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs and provides more than half the effort. 02. Substantial/maximal assistance —Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. Dependent —Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity. If activity was not attempted, code reason: 07. Patient refused 09. Not applicable —Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury. 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints) 88. Not attempted due to medical condition or safety concerns	
1. Discharge Performance Enter Codes in Boxes ↓	
<div style="display: inline-block; border: 1px solid black; width: 30px; height: 30px; margin: 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 30px; height: 30px; margin: 5px; margin-left: 10px;"></div>	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).

Section I	Active Diagnoses
I0060. Indicate the patient's primary medical condition category	
Enter Code <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px auto;"></div>	Indicate the patient's primary medical condition category at discharge. 01. Anxiety disorders 02. Delirium, dementia, and amnestic and other cognitive disorders 03. Eating disorders 04. Mood disorders 05. Schizophrenia and other psychotic disorders 06. Substance-related disorders including alcohol-related disorders 09. Other diagnosis—not included in one of the above categories

Section O	Special Services, Treatments, and Interventions
O0115. Special Services, Treatments, and Interventions in the Inpatient Psychiatric Setting	
Discharge: Indicate all of the following services, treatments, and interventions received during the entire IPF stay, excluding <i>the first 3-days of admission</i> .	
	a. Admission
Psychiatric Treatments	
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"/>
Restrictive Interventions	
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"/>
None of the Above	
Z1. None of the Above	<input type="checkbox"/>

Section Z	Record Administration
Z0510. IPF-PAI Completion Date	
This date represents completion of the IPF-PAI for this patient record.	
	<div>B. Date</div> <div><div><div></div><div></div></div><div>—</div><div><div></div><div></div></div><div>—</div><div><div></div><div></div><div></div><div></div></div></div> <div>MonthDayYear</div>