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*This statement applies to the 2015 release of the IRF-PAI (version 1.3) and not to any additional burden related to the addition of new data elements added for the purpose of informating CMS' newly proposed measures, including those quality measures related to the IMPACT Act of 2014.

Identification Information*

1. Facility Information

   A. Facility Name

_____

_____

_____

_____

_____

   B. Facility Medicare Provider Number _____

2. Patient Medicare Number _____

3. Patient Medicaid Number _____

4. Patient First Name _____

5A. Patient Last Name _____

5B. Patient Identification Number _____

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

7. Social Security Number _____

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

9. Race/Ethnicity (*Check all that apply*)

   American Indian or Alaska Native A. _____

   Asian B. _____

   Black or African American C. _____

   Hispanic or Latino D. _____

   Native Hawaiian or Other Pacific Islander E. _____

   White F. _____

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

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

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

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

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

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

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

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

18. DELETED

19. DELETED

Payer Information*

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

   A. Primary Source _____

   B. Secondary Source _____

Medical Information*

21. Impairment Group _____ _____
Admission Discharge

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

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

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

24. Comorbid Conditions

Use ICD codes to enter comorbid medical conditions

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

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

25. DELETED

26. DELETED

Height and Weight

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

25A. Height on admission (in inches) _____

26A. Weight on admission (in pounds) _____
Measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, with shoes off, etc.)

27. Swallowing Status _____ _____
Admission Discharge

3- *Regular Food*: solids and liquids swallowed safely without supervision or modified food consistency

2- *Modified Food Consistency/Supervision:* subject requires modified food consistency and/or needs supervision for safety

1- *Tube/Parenteral Feeding:* tube/parenteral feeding used wholly or partially as a means of sustenance

28. DELETED

Function Modifiers*

Complete the following specific functional items prior to scoring the FIM™ Instrument:

		Admission	Discharge
29.	Bladder Level of Assistance (Score using FIM Levels 1 - 7)	☐	☐
30.	Bladder Frequency of Accidents (Score as below)	☐	☐

7 - No accidents
6 - No accidents; uses device such as a catheter
5 - One accident in the past 7 days
4 - Two accidents in the past 7 days
3 - Three accidents in the past 7 days
2 - Four accidents in the past 7 days
1 - Five or more accidents in the past 7 days

Enter in Item 39G (Bladder) the lower *(more dependent) score from Items 29 and 30 above*

		Admission	Discharge
31.	Bowel Level of Assistance (Score using FIM Levels 1 - 7)	☐	☐
32.	Bowel Frequency of Accidents (Score as below)	☐	☐

7 - No accidents
6 - No accidents; uses device such as a ostomy
5 - One accident in the past 7 days
4 - Two accidents in the past 7 days
3 - Three accidents in the past 7 days
2 - Four accidents in the past 7 days
1 - Five or more accidents in the past 7 days

Enter in Item 39H (Bowel) the lower (more dependent) score of Items 31and 32 above.

		Admission	Discharge
33.	Tub Transfer	☐	☐
34.	Shower Transfer	☐	☐

(Score Items 33 and 34 using FIM Levels 1 - 7; use 0 if activity does not occur) *See training manual for scoring of Item 39K (Tub/Shower Transfer)*

		Admission	Discharge
35.	Distance Walked	☐	☐
36.	Distance Traveled in Wheelchair	☐	☐

(Code items 35 and 36 using: 3 - 150 feet; 2 - 50 to 149 feet; 1 - Less than 50 feet; 0 – activity does not occur)

		Admission	Discharge
37.	Walk	☐	☐
38.	Wheelchair	☐	☐

(Score Items 37 and 38 using FIM Levels 1 - 7; 0 if activity does not occur) See training manual for scoring of Item 39L (Walk/Wheelchair)

39. FIM™ Instrument*

		Admission	Discharge	Goal
SELF-CARE				
A.	Eating	☐	☐	☐
B.	Grooming	☐	☐	☐
C.	Bathing	☐	☐	☐
D.	Dressing - Upper	☐	☐	☐
E.	Dressing - Lower	☐	☐	☐
F.	Toileting	☐	☐	☐
SPHINCTER CONTROL				
G.	Bladder	☐	☐	☐
H.	Bowel	☐	☐	☐
TRANSFERS				
I.	Bed, Chair, Wheelchair	☐	☐	☐
J.	Toilet	☐	☐	☐
K.	Tub, Shower	☐	☐	☐
LOCOMOTION	(W - Walk, C - Wheelchair, B - Both)			
L.	Walk/Wheelchair	☐☐	☐☐	☐
M.	Stairs	☐	☐	☐
COMMUNICATION	(A - Auditory, V - Visual, B - Both)			
N.	Comprehension	☐☐	☐☐	☐
O.	Expression	☐☐	☐☐	☐
	(V - Vocal, N - Nonvocal, B - Both)			
SOCIAL COGNITION				
P.	Social Interaction	☐	☐	☐
Q.	Problem Solving	☐	☐	☐
R.	Memory	☐	☐	☐

FIM LEVELS

No Helper

7 Complete Independence (Timely, Safely)
6 Modified Independence (Device)

Helper - Modified Dependence

5 Supervision (Subject = 100%)
4 Minimal Assistance (Subject = 75% or more)
3 Moderate Assistance (Subject = 50% or more)

Helper - Complete Dependence

2 Maximal Assistance (Subject = 25% or more)
1 Total Assistance (Subject less than 25%)

0 Activity does not occur; Use this code only at admission

Discharge Information*

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

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

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

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

A. 1st Interruption Date
MM / DD / YYYY

B. 1st Return Date
MM / DD / YYYY

C. 2nd Interruption Date
MM / DD / YYYY

D. 2nd Return Date
MM / DD / YYYY

E. 3rd Interruption Date
MM / DD / YYYY

F. 3rd Return Date
MM / DD / YYYY

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

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

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

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

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

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

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

* The FIM data set, measurement scale and impairment codes incorporated or referenced herein are the property of U B Foundation Activities, Inc. © 1993, 2001 U B Foundation Activities, Inc. The FIM mark is owned by UBFA, Inc.

Therapy Information

O0401. Week 1: Total Number of Minutes Provided

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

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

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

O0402. Week 2: Total Number of Minutes Provided

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

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

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

Patient _____ Identifier _____ Date _____

QUALITY INDICATORS

ADMISSION

Section B Hearing, Speech, and Vision

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

Enter Code ☐

Expression of Ideas and Wants (consider both verbal and non-verbal expression and excluding language barriers)
4. Expresses complex messages **without difficulty** and with speech that is clear and easy to understand
3. Exhibits some **difficulty** with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear
2. **Frequently** exhibits difficulty with expressing needs and ideas
1. **Rarely/Never** expresses self or speech is very difficult to understand

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

Enter Code ☐

Understanding Verbal Content (with hearing aid or device, if used and excluding language barriers)
4. **Understands:** Clear comprehension without cues or repetitions
3. **Usually Understands:** Understands most conversations, but misses some part/intent of message. Requires cues at times to understand
2. **Sometimes Understands:** Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand
1. **Rarely/Never Understands**

Section C Cognitive Patterns

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

Enter Code ☐

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

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code ☐

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

Number of words repeated by patient after first attempt:
3. **Three**
2. **Two**
1. **One**
0. **None**

After the patient's first attempt say: *"I will repeat each of the three words with a cue and ask you about them later: sock, something to wear; blue, a color; bed, a piece of furniture."* You may repeat the words up to two more times.

Patient _____ Identifier _____ Date _____

Section C Cognitive Patterns

Brief Interview for Mental Status (BIMS) - Continued

C0300. Temporal Orientation: Year, Month, Day

Enter Code ☐

A. Ask patient: *"Please tell me what year it is right now."*
Patient's answer is:
3. **Correct**
2. **Missed by 1 year**
1. **Missed by 2 to 5 years**
0. **Missed by more than 5 years or no answer**

Enter Code ☐

B. Ask patient: *"What month are we in right now?"*
Patient's answer is:
2. **Accurate within 5 days**
1. **Missed by 6 days to 1 month**
0. **Missed by more than 1 month or no answer**

Enter Code ☐

C. Ask patient: *"What day of the week is today?"*
Patient's answer is:
1. **Correct**
0. **Incorrect or no answer**

C0400. Recall

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

Enter Code ☐

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

Enter Code ☐

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

Enter Code ☐

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

C0500. BIMS Summary Score

Enter Score ☐☐

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

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

Enter Code ☐

0. **No** (patient was able to complete Brief Interview for Mental Status) → *Skip to GG0100. Prior Functioning: Everyday Activities*
1. **Yes** (patient was unable to complete Brief Interview for Mental Status) → *Continue to C0900. Memory/Recall Ability*

Staff Assessment for Mental Status

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

C0900. Memory/Recall Ability

Check all that the patient was normally able to recall

☐ **A. Current season**

☐ **B. Location of own room**

☐ **C. Staff names and faces**

☐ **E. That he or she is in a hospital/hospital unit**

☐ **Z. None of the above** were recalled

Patient _____ Identifier _____ Date _____

Section GG Functional Abilities and Goals

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

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

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

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

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

Patient _____ Identifier _____ Date _____

Section GG Functional Abilities and Goals

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

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale.

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

Activities may be completed with or without assistive devices.

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

If activity was not attempted, code reason:
07. **Patient refused**
09. **Not applicable**
88. Not attempted due to **medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
☐☐	☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
☐☐	☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	☐☐	**E. Shower/bathe self:** The ability to bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower.
☐☐	☐☐	**F. Upper body dressing:** The ability to put on and remove shirt or pajama top; includes buttoning, if applicable.
☐☐	☐☐	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	☐☐	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility.

Patient _____ Identifier _____ Date _____

Section GG Functional Abilities and Goals

GG0170. Mobility (3-day assessment period)

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale.

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

Activities may be completed with or without assistive devices.

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

If activity was not attempted, code reason:
07. **Patient refused**
09. **Not applicable**
88. Not attempted due to **medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back.
☐☐	☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	**C. Lying to sitting on side of bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	☐☐	**D. Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
☐☐	☐☐	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.
☐☐	☐☐	**G. Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
	☐	**H1. Does the patient walk?** 0. **No,** and walking goal **is not** clinically indicated → *Skip to GG0170Q1. Does the patient use a wheelchair/scooter?* 1. **No,** and walking goal **is** clinically indicated → *Code the patient's discharge goal(s) for items GG0170I, J, K, L, M, N, O, and P. For admission performance, skip to GG0170Q1. Does the patient use a wheelchair/scooter?* 2. **Yes** → *Continue to GG0170I. Walk 10 feet*
☐☐	☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor or similar space.
☐☐	☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Patient _____ Identifier _____ Date _____

Section GG Functional Abilities and Goals

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

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale.

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

Activities may be completed with or without assistive devices.

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

If activity was not attempted, code the reason:
07. **Patient refused**
09. **Not applicable**
88. Not attempted due to **medical condition or safety concerns**

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

Patient _____ Identifier _____ Date _____

Section H Bladder and Bowel

H0350. Bladder Continence (3-day assessment period)

Enter Code ☐

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

H0400. Bowel Continence (3-day assessment period)

Enter Code ☐

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

Section I Active Diagnoses

Comorbidities and Co-existing Conditions

↓ **Check all that apply**

☐ **I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**

☐ **I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)

☐ **I7900. None of the above**

Section J Health Conditions

J1750. History of Falls

Enter Code ☐

Has the patient had two or more falls in the past year or any fall with injury in the past year?
0. **No**
1. **Yes**
8. **Unknown**

J2000. Prior Surgery

Enter Code ☐

Did the patient have major surgery during the 100 days prior to admission?
0. **No**
1. **Yes**
8. **Unknown**

Section K Swallowing/Nutritional Status

K0110. Swallowing/Nutritional Status (3-day assessment period) Indicate the patient's usual ability to swallow.

↓ **Check all that apply**

☐ **A. Regular food -** Solids and liquids swallowed safely without supervision or modified food or liquid consistency.

☐ **B. Modified food consistency/supervision -** Patient requires modified food or liquid consistency and/or needs supervision during eating for safety.

☐ **C. Tube/parenteral feeding -** Tube/parenteral feeding used wholly or partially as a means of sustenance.

Patient _____ Identifier _____ Date _____

Section M Skin Conditions

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

M0210. Unhealed Pressure Ulcer(s)

Enter Code ☐

Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher?

0. **No** → *Skip to O0100. Special Treatments, Procedures, and Programs*
1. **Yes** → *Continue to M0300. Current Number of Unhealed Pressure Ulcers at Each Stage*

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

Enter Number ☐

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

Number of Stage 1 pressure ulcers

Enter Number ☐

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

1. Number of Stage 2 pressure ulcers

Enter Number ☐

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

1. Number of Stage 3 pressure ulcers

Enter Number ☐

D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

1. Number of Stage 4 pressure ulcers

Enter Number ☐

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

1. Number of unstageable pressure ulcers due to non-removable dressing/device

Enter Number ☐

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

1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar

Enter Number ☐

G. Unstageable - Deep tissue injury: Suspected deep tissue injury in evolution

1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution

Section O Special Treatments, Procedures, and Programs

O0100. Special Treatments, Procedures, and Programs

Check if treatment applies at admission

☐ **N. Total Parenteral Nutrition**

Patient _____ Identifier _____ Date _____

DISCHARGE

Section GG Functional Abilities and Goals

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

Code the patient's usual performance at discharge for each activity using the 6-point scale. If activity was not attempted at discharge, code the reason.

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

Activities may be completed with or without assistive devices.

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

If activity was not attempted, code the reason:
07. **Patient refused**
09. **Not applicable**
88. Not attempted due to **medical condition or safety concerns**

3. Discharge Performance **Enter Codes in Boxes ↓**	
☐☐	**A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	**E. Shower/bathe self:** The ability to bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower.
☐☐	**F. Upper body dressing:** The ability to put on and remove shirt or pajama top; includes buttoning, if applicable.
☐☐	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility.

Patient _____ Identifier _____ Date _____

Section GG Functional Abilities and Goals

GG0170. Mobility (3-day assessment period)

Code the patient's usual performance at discharge for each activity using the 6-point scale. If activity was not attempted at discharge, code the reason.

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

Activities may be completed with or without assistive devices.

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

If activity was not attempted, code the reason:
07. **Patient refused**
09. **Not applicable**
88. Not attempted due to **medical condition or safety concerns**

3. Discharge Performance **Enter Codes in Boxes ↓**	
☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back.
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to sitting on side of bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	**D. Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
☐☐	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.
☐☐	**G. Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
	☐ **H3. Does the patient walk?** 0. **No** → *Skip to GG0170Q3. Does the patient use a wheelchair/scooter?* 2. **Yes** → *Continue to GG0170I. Walk 10 feet*
☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor or similar space
☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns
☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space

Patient _____ Identifier _____ Date _____

Section GG Functional Abilities and Goals

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

Code the patient's usual performance at discharge for each activity using the 6-point scale. If activity was not attempted at discharge, code the reason.

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

Activities may be completed with or without assistive devices.

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

If activity was not attempted, code the reason:
07. **Patient refused**
09. **Not applicable**
88. Not attempted due to **medical condition or safety concerns**

3. Discharge Performance **Enter Codes in Boxes ↓**	
☐☐	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces, such as grass or gravel.
☐☐	**M. 1 step (curb):** The ability to step over a curb or up and down one step.
☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail.
☐☐	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	☐ **Q3. Does the patient use a wheelchair/scooter?** 0. **No** → *Skip to J1800. Any Falls Since Admission* 1. **Yes** → *Continue to GG0170R. Wheel 50 feet with two turns*
☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	☐ **RR3. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**
☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	☐ **SS3. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**

Patient _____ Identifier _____ Date _____

Section J Health Conditions

J1800. Any Falls Since Admission

Enter Code ☐

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

0. **No** → *Skip to M0210. Unhealed Pressure Ulcer(s)*
1. **Yes** → *Continue to J1900. Number of Falls Since Admission*

J1900. Number of Falls Since Admission

CODING:

0. None
1. One
2. Two or more

↓ **Enter Codes in Boxes**

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

Section M Skin Conditions

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

M0210. Unhealed Pressure Ulcer(s)

Enter Code ☐

Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher?

0. **No** → *Skip to M0900A. Healed Pressure Ulcer(s)*
1. **Yes** → *Continue to M0300. Current Number of Unhealed Pressure Ulcers at Each Stage*

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

Enter Number ☐

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

Number of Stage 1 pressure ulcers

Enter Number ☐

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

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

Enter Number ☐

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

Enter Number ☐

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

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

Enter Number ☐

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

Patient _____ Identifier _____ Date _____

Section M Skin Conditions

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

Enter Number ☐

D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

1. **Number of Stage 4 pressure ulcers**
   If 0 → Skip to M0300E. Unstageable - Non-removable dressing
2. **Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

Enter Number ☐

Enter Number ☐

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

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

Enter Number ☐

Enter Number ☐

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

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

Enter Number ☐

Enter Number ☐

G. Unstageable - Deep tissue injury: Suspected deep tissue injury in evolution

1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution**
   If 0 → Skip to M0800. Worsening in Pressure Ulcer Status Since Admission
2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

M0800. Worsening in Pressure Ulcer Status Since Admission

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on admission.
If no current pressure ulcer at a given stage, enter 0.

Enter Number	
☐	**A. Stage 2**
☐	**B. Stage 3**
☐	**C. Stage 4**
☐	**D. Unstageable - Non-removable dressing**
☐	**E. Unstageable - Slough and/or eschar**
☐	**F. Unstageable - Deep tissue injury**

Patient _____ Identifier _____ Date _____

Section M Skin Conditions

M0900. Healed Pressure Ulcer(s)

Indicate the number of pressure ulcers that were: (a) present on **Admission**; **and** (b) have completely closed (resurfaced with epithelium) upon **Discharge.** If there are no healed pressure ulcers noted at a given stage, enter 0.

Enter Number	
☐	**A. Stage 1**
☐	**B. Stage 2**
☐	**C. Stage 3**
☐	**D. Stage 4**

Section O Special Treatments, Procedures, and Programs

O0250. Influenza Vaccine - Refer to current version of IRF-PAI Training Manual for current influenza vaccination season and reporting period.

Enter Code ☐

A. Did the **patient receive the influenza vaccine *in this facility*** for this year's influenza *vaccination* season?

0. **No** → *Skip to O0250C. If influenza vaccine not received, state reason*
1. **Yes** → *Continue to O0250B. Date influenza vaccine received*

B. Date influenza vaccine received → Complete date and skip to Z0400A. Signature of Persons Completing the Assessment

☐☐ ☐☐ ☐☐☐☐
M M D D Y Y Y Y

Enter Code ☐

C. If influenza vaccine not received, state reason:

1. **Patient not in this facility** during this year's influenza vaccination season
2. **Received outside of this facility**
3. **Not eligible -** medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain influenza vaccine** due to a declared shortage
9. **None of the above**

Item Z0400A. Signature of Persons Completing the Assessment*			
I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that patients receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information.			
Signature	**Title**	**Date Information is Provided**	**Time**
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			