PHYSICAL THERAPY DISCHARGE ASSESSMENT

INCLUDING OASIS ELEMENTS FOR DISCHARGE NOT TO AN INPATIENT FACILITY

VISIT MADE DATE:_____

TIME IN:_____ TIME OUT:_____

(–) = Dash is a valid response.
See the OASIS Guidance Manual for specific item.

Follow OASIS items in sequence unless otherwise directed.

Section A Administrative Information

M0080. Discipline of Person Completing Assessment

Enter Code ☐

1. **RN**
2. **PT**
3. **SLP/ST**
4. **OT**

M0090. Date Assessment Completed

☐ Month/Day/Year

Complete M0090 using the date of the day information was last collected.

M0100. This Assessment is Currently Being Completed for the Following Reason

Enter Code ☐

Discharge from Agency – Not to an Inpatient Facility

9. **Discharge from agency**

M0906. Discharge/Transfer/Death Date

Enter the date of the discharge, transfer, or death (at home) of the patient.

☐ Month/Day/Year

SUPPORTIVE ASSISTANCE/CARE PREFERENCES SUMMARY

Primary Caregiver (other than paid home health agency) ❑ **N/A**

Name:_____ Phone Number:_____

Relationship to Patient:_____ Email:_____

❑ Contacted and had a two-way communication regarding discharge plan with:

❑ Patient ❑ Representative ❑ Family Member ❑ Caregiver (other than home health staff)

Reviewed (check all that apply):

❑ Doctor appointment(s) ❑ Follow-up appointment(s) ❑ Referral(s)
❑ Disease management ❑ Medication(s) safe administration ❑ Pain management
❑ Diet ❑ Meal preparation ❑ Wound care
❑ Diabetic foot care ❑ Who to call in case of emergency, includes ED and/or hospitalization usage

If applicable, for the following items, provide any additional information in the post-discharge support plan area. (For example: family will provide transportation as needed or supplies will be delivered by local pharmacy or family paying privately for an aide to help with bathing).

❑ Personal POC for transition ❑ Access to a working phone to make and receive calls ❑ Safety issues
❑ Personal emergency preparedness plan ❑ Transportation for personal or medical care ❑ Treatment(s)
❑ Home and Community Based Services ❑ Infection prevention and/or control ❑ Fall prevention
❑ ADLs completion ❑ IADLs completion ❑ Activity level
❑ Supplies ❑ Device(s) ❑ Equipment

Describe any ongoing risks or limitations noted impacting discharge planning interventions:

Comments:

Patient Name - Last, First, Middle Initial	ID #

Patient Name _____ ID # _____

Section A Administrative Information (Continued)

A1250. Transportation *(NACHC©)*

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

↓ **Check all that apply**

- ☐ A. **Yes, it has kept me from medical appointments or from getting my medications**
- ☐ B. **Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need**
- ☐ C. **No**
- ☐ X. **Patient unable to respond**
- ☐ Y. **Patient declines to respond**

Adapted from: NACHC© 2019. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. PRAPARE and its resources are proprietary information of NACHC and its partners, intended for use by NACHC, its partners, and authorized recipients. Do not publish, copy, or distribute this information in part or whole without written consent from NACHC.

M2301. Emergent Care

At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)?

Enter Code ☐

- 0. **No** → *Skip to M2410, Inpatient Facility*
- 1. **Yes, used hospital emergency department WITHOUT hospital admission**
- 2. **Yes, used hospital emergency department WITH hospital admission**
- UK **Unknown** → *Skip to M2410, Inpatient Facility*

M2310. Reason for Emergent Care

For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)?

↓ **Check all that apply**

- ☐ 1. **Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis**
- ☐ 10. **Hypo/Hyperglycemia, diabetes out of control**
- ☐ 19. **Other than above reasons**
- ☐ UK **Reason unknown**

If response is 19 or UK, explain the reason(s):

M2410. To which **Inpatient Facility** has the patient been admitted?

Enter Code ☐

- 1. **Hospital**
- 2. **Rehabilitation facility**
- 3. **Nursing home**
- 4. **Hospice**
- NA **No inpatient facility admission**

If admitted, name of inpatient facility: _____

M2420. Discharge Disposition

Where is the patient after discharge from your agency? (Choose only one answer.)

Enter Code ☐

- 1. **Patient remained in the community (without formal assistive services)** → *Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge*
- 2. **Patient remained in the community (with formal assistive services)** → Continue to A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
- 3. **Patient transferred to a non-institutional hospice** → Continue to A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
- 4. **Unknown because patient moved to a geographic location not served by this agency** → *Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge*
- UK **Other unknown** → *Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge*

NOTE: Per CMS, "Formal assistance" (in Code 2) is only to be coded when the patient is going to receive care from another certified home health agency.

Patient Name _____ ID # _____

Section A Administrative Information (Continued)

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

At the time of discharge to another provider, did your agency provide the patient's current reconciled medication list to the subsequent provider?

Enter Code ☐

0. **No – Current reconciled medication list not provided to the subsequent provider** → *Skip to B1300, Health Literacy*
1. **Yes – Current reconciled medication list provided to the subsequent provider** → Continue to A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

NOTE: This item is a CMS quality measure ("Transfer of Health Information") and it is imperative to be completed and coded as "Yes".
If coded "No", document reason why here:

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Route of Transmission	↓ Check all that apply ↓
A. Electronic Health Record	☐
B. Health Information Exchange	☐
C. Verbal (e.g., in-person, telephone, video conferencing)	☐
D. Paper-based (e.g., fax, copies, printouts)	☐
E. Other Methods (e.g., texting, email, CDs)	☐

After completing A2122, Skip to B1300, Health Literacy at Discharge

Who provided the medication list: ❑ Assessing clinician ❑ Clinical manager ❑ Administrative staff Date provided:_____

A2123. Provision of Current Reconciled Medication List to Patient at Discharge

At the time of discharge, did your agency provide the patient's current reconciled medication list to the patient, family and/or caregiver?

Enter Code ☐

0. **No – Current reconciled medication list not provided to the patient, family, and/or caregiver** → *Skip to B1300, Health Literacy*
1. **Yes – Current reconciled medication list provided to the patient, family, and/or caregiver** → Continue to A2124, Route of Current Reconciled Medication List Transmission to Patient.

A2124. Route of Current Reconciled Medication List Transmission to Patient

Indicate the route(s) of transmission of the current reconciled medication list to the patient, family, and/or caregiver.

Route of Transmission	↓ Check all that apply ↓
A. Electronic Health Record	☐
B. Health Information Exchange	☐
C. Verbal (e.g., in-person, telephone, video conferencing)	☐
D. Paper-based (e.g., fax, copies, printouts)	☐
E. Other Methods (e.g., texting, email, CDs)	☐

Who provided the medication list: ❑ Assessing clinician ❑ Clinical manager ❑ Administrative staff Date provided:_____

Patient Name _____ ID # _____

Section B Hearing, Speech, and Vision

B1300. Health Literacy *(From Creative Commons©)*

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Enter Code ☐

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Patient declines to respond**
8. **Patient unable to respond**

The Single Item Literacy Screener is licensed under a Creative Commons Attribution Noncommercial 4.0 International License.

LEARNING BARRIER(S)

❑ **No Problem**

❑ Mental Health Disability ❑ Psychosocial ❑ Physical ❑ Functional Cognition

❑ Unable to: ❑ Read ❑ Write

Educational level:_____

LANGUAGE BARRIER(S)

❑ **No Problem**

❑ Needs interpreter Language:_____ ❑ Sign language (type):_____

❑ Aphasic: ❑ Receptive ❑ Expressive

SENSORY REVIEW

❑ **No Problem**

What is the sensory impairment(s) impacting function: ❑ Sight ❑ Hearing ❑ Smell ❑ Taste ❑ Throat

If patient has a sensory impairment(s) impacting function, how does the patient plan to manage their need(s) after discharge? (explain):

ADDITIONAL COMMENTS

Patient Name _____ ID # _____

Section C Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?

Attempt to conduct interview with all patients.

Enter Code

0. **No** (patient is rarely/never understood) → *Skip to C1310, Signs and Symptoms of Delirium (from CAM©)*
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 after first attempt

0. **None**
1. **One**
2. **Two**
3. **Three**

After the patient's first attempt, repeat the words using cues *("sock, something to wear; blue, a color; bed, a piece of furniture").* You may repeat the words up to two more times.

C0300. Temporal Orientation (Orientation to year, month, and day)

Enter Code

Ask patient: *"Please tell me what year it is right now."*

A. **Able to report correct year**
   0. **Missed by > 5 years** or no answer
   1. **Missed by 2-5 years**
   2. **Missed by 1 year**
   3. **Correct**

Enter Code

Ask patient: *"What month are we in right now?"*

B. **Able to report correct month**
   0. **Missed by > 1 month** or no answer
   1. **Missed by 6 days to 1 month**
   2. **Accurate within 5 days**

Enter Code

Ask patient: *"What day of the week is today?"*

C. **Able to report correct day of the week**
   0. **Incorrect** or no answer
   1. **Correct**

C0400. Recall

Enter Code

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

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

Enter Code

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

Enter Code

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

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

Patient Name _____ ID # _____

Section C Cognitive Patterns (Continued)

C1310. Signs and Symptoms of Delirium (from CAM©)

Code **after completing** Brief Interview for Mental Status and reviewing medical record.

A. **Acute Onset of Mental Status Change**

Enter Code ☐

Is there evidence of an acute change in mental status from the patient's baseline?

0. **No**
1. **Yes**

Coding:

0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

↓ **Enter Codes in Boxes**

☐ B. **Inattention** – Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?

☐ C. **Disorganized thinking** – Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

☐ D. **Altered level of consciousness** – Did the patient have altered level of consciousness, as indicated by any of the following criteria?

- **vigilant** – startled easily to any sound or touch
- **lethargic** – repeatedly dozed off when being asked questions, but responded to voice or touch
- **stuporous** – very difficult to arouse and keep aroused for the interview
- **comatose** – could not be aroused

Adapted from: Inouye SK, et al. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment Method. Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.

M1700. Cognitive Functioning

Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

Enter Code ☐

0. **Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.**
1. **Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.**
2. **Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.**
3. **Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.**
4. **Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.**

M1710. When Confused

(Reported or Observed Within the Last 14 Days):

Enter Code ☐

0. **Never**
1. **In new or complex situations only**
2. **On awakening or at night only**
3. **During the day and evening, but not constantly**
4. **Constantly**

NA **Patient nonresponsive**

M1720. When Anxious

(Reported or Observed Within the Last 14 Days):

Enter Code ☐

0. **None of the time**
1. **Less often than daily**
2. **Daily, but not constantly**
3. **All of the time**

NA **Patient nonresponsive**

Patient Name _____ ID # _____

Section D Mood

D0150. Patient Mood Interview (PHQ-2 to 9)

Say to patient: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the patient: "About how often have you been bothered by this?"
Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

	1. Symptom Presence 0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) 9. **No response** (leave column 2 blank) 2. Symptom Frequency 0. **Never or 1 day** 1. **2-6 days** (several days) 2. **7-11 days** (half or more of the days) 3. **12-14 days** (nearly every day)	1. Symptom Presence	2. Symptom Frequency
		↓ Enter Scores in ↓ Boxes	
A.	***Little interest or pleasure in doing things***	☐	☐
B.	***Feeling down, depressed, or hopeless***	☐	☐
	If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.		
C.	***Trouble falling or staying asleep, or sleeping too much***	☐	☐
D.	***Feeling tired or having little energy***	☐	☐
E.	***Poor appetite or overeating***	☐	☐
F.	***Feeling bad about yourself – or that you are a failure or have let yourself or your family down***	☐	☐
G.	***Trouble concentrating on things, such as reading the newspaper or watching television***	☐	☐
H.	***Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual***	☐	☐
I.	***Thoughts that you would be better off dead, or of hurting yourself in some way***	☐	☐

D0160. Total Severity Score

Enter Score ☐

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)

D0700. Social Isolation

How often do you feel lonely or isolated from those around you?

Enter Code ☐

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Patient declines to respond**
8. **Patient unable to respond**

Section E Behavior

M1740. Cognitive, Behavioral, and Psychiatric Symptoms that are demonstrated at least once a week (Reported or Observed):

↓ **Check all that apply**

☐	1. **Memory deficit:** failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
☐	2. **Impaired decision-making:** failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
☐	3. **Verbal disruption:** yelling, threatening, excessive profanity, sexual references, etc.
☐	4. **Physical aggression:** aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
☐	5. **Disruptive, infantile, or socially inappropriate behavior** (excludes verbal actions)
☐	6. **Delusional, hallucinatory, or paranoid behavior**
☐	7. **None of the above behaviors demonstrated**

Patient Name _____ ID # _____

Section E Behavior (Continued)

M1745. Frequency of Disruptive Behavior Symptoms (Reported or Observed):
Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

Enter Code ☐

0. **Never**
1. **Less than once a month**
2. **Once a month**
3. **Several times each month**
4. **Several times a week**
5. **At least daily**

COGNITIVE/MOOD/BEHAVIOR REVIEW

Is there any cognitive/mood/behavior issue(s) that may impact need for support post-discharge? ❍ No ❍ Yes If yes, what is the plan for support:

Section F Preferences for Customary Routine Activities

M2102. Types and Sources of Assistance
Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.

Enter Code ☐

a. **ADL assistance** (for example, transfer/ambulation, bathing, dressing, toileting, eating/feeding)
0. **No assistance needed – patient is independent or does not have needs in this area**
1. **Non-agency caregiver(s) currently provide assistance**
2. **Non-agency caregiver(s) need training/supportive services to provide assistance**
3. **Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance**
4. **Assistance needed, but no non-agency caregiver(s) available**

Enter Code ☐

c. **Medication administration** (for example, oral, inhaled, or injectable)
0. **No assistance needed – patient is independent or does not have needs in this area**
1. **Non-agency caregiver(s) currently provide assistance**
2. **Non-agency caregiver(s) need training/supportive services to provide assistance**
3. **Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance**
4. **Assistance needed, but no non-agency caregiver(s) available**

Enter Code ☐

d. **Medical procedures/treatments** (for example, changing wound dressing, home exercise program)
0. **No assistance needed – patient is independent or does not have needs in this area**
1. **Non-agency caregiver(s) currently provide assistance**
2. **Non-agency caregiver(s) need training/supportive services to provide assistance**
3. **Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance**
4. **Assistance needed, but no non-agency caregiver(s) available**

Enter Code ☐

f. **Supervision and safety** (due to cognitive impairment)
0. **No assistance needed – patient is independent or does not have needs in this area**
1. **Non-agency caregiver(s) currently provide assistance**
2. **Non-agency caregiver(s) need training/supportive services to provide assistance**
3. **Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance**
4. **Assistance needed, but no non-agency caregiver(s) available**

Patient Name _____ ID # _____

Section G Functional Status

M1800. Grooming
Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).

Enter Code ☐

0. **Able to groom self unaided, with or without the use of assistive devices or adapted methods.**
1. **Grooming utensils must be placed within reach before able to complete grooming activities.**
2. **Someone must assist the patient to groom self.**
3. **Patient depends entirely upon someone else for grooming needs.**

M1810. Current Ability to Dress Upper Body safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps.

Enter Code ☐

0. **Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.**
1. **Able to dress upper body without assistance if clothing is laid out or handed to the patient.**
2. **Someone must help the patient put on upper body clothing.**
3. **Patient depends entirely upon another person to dress the upper body.**

M1820. Current Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes.

Enter Code ☐

0. **Able to obtain, put on, and remove clothing and shoes without assistance.**
1. **Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.**
2. **Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.**
3. **Patient depends entirely upon another person to dress lower body.**

M1830. Bathing
Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair).

Enter Code ☐

0. **Able to bathe self in shower or tub independently, including getting in and out of tub/shower.**
1. **With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.**
2. **Able to bathe in shower or tub with the intermittent assistance of another person:**
   a. **for intermittent supervision or encouragement or reminders, OR**
   b. **to get in and out of the shower or tub, OR**
   c. **for washing difficult to reach areas.**
3. **Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.**
4. **Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.**
5. **Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.**
6. **Unable to participate effectively in bathing and is bathed totally by another person.**

ADDITIONAL COMMENTS

Patient Name _____ ID # _____

Section G Functional Status (Continued)

M1840. Toilet Transferring

Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

Enter Code ☐

0. **Able to get to and from the toilet and transfer independently with or without a device.**
1. **When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.**
2. **Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).**
3. **Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.**
4. **Is totally dependent in toileting.**

M1845. Toileting Hygiene

Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

Enter Code ☐

0. **Able to manage toileting hygiene and clothing management without assistance.**
1. **Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.**
2. **Someone must help the patient to maintain toileting hygiene and/or adjust clothing.**
3. **Patient depends entirely upon another person to maintain toileting hygiene.**

M1850. Transferring

Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

Enter Code ☐

0. **Able to independently transfer.**
1. **Able to transfer with minimal human assistance or with use of an assistive device.**
2. **Able to bear weight and pivot during the transfer process but unable to transfer self.**
3. **Unable to transfer self and is unable to bear weight or pivot when transferred by another person.**
4. **Bedfast, unable to transfer but is able to turn and position self in bed.**
5. **Bedfast, unable to transfer and is unable to turn and position self.**

M1860. Ambulation/Locomotion

Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Enter Code ☐

0. **Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).**
1. **With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.**
2. **Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.**
3. **Able to walk only with the supervision or assistance of another person at all times.**
4. **Chairfast, unable to ambulate but is able to wheel self independently.**
5. **Chairfast, unable to ambulate and is unable to wheel self.**
6. **Bedfast, unable to ambulate or be up in a chair.**

ADDITIONAL COMMENTS

Patient Name _____ ID # _____

Section G Functional Status (Continued)

FALL RISK ASSESSMENT

MAHC 10 - FALL RISK ASSESSMENT TOOL

REQUIRED CORE ELEMENTS – Assess one point for each core element "yes". *Information may be gathered from medical record, assessment and if applicable, the patient/caregiver. Beyond protocols listed below, scoring should be based on your clinical judgment.*	**POINTS**
Age 65+	
Diagnosis (3 or more co-existing) Includes only documented medical diagnosis.	
Prior history of falls within 3 months An unintentional change in position resulting in coming to rest on the ground or at a lower level.	
Incontinence Inability to make it to the bathroom or commode in timely manner. Includes frequency, urgency, and/or nocturia.	
Visual impairment Includes but not limited to, macular degeneration, diabetic retinopathies, visual field loss, age related changes, decline in visual acuity, accommodation, glare tolerance, depth perception, and night vision or not wearing prescribed glasses or having the correct prescription.	
Impaired functional mobility May include patients who need help with IADLs or ADLs or have gait or transfer problems, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination or improper use of assistive devices.	
Environmental hazards May include but not limited to, poor illumination, equipment tubing, inappropriate footwear, pets, hard to reach items, floor surfaces that are uneven or cluttered, or outdoor entry and exits.	
Poly Pharmacy (4 or more prescriptions – any type) All PRESCRIPTIONS including prescriptions for OTC meds. Drugs highly associated with fall risk include but not limited to, sedatives, anti-depressants, tranquilizers, narcotics, antihypertensives, cardiac meds, corticosteroids, anti-anxiety drugs, anticholinergic drugs, and hypoglycemic drugs.	
Pain affecting level of function Pain often affects an individual's desire or ability to move or pain can be a factor in depression or compliance with safety recommendations.	
Cognitive impairment Could include patients with dementia, Alzheimer's or stroke patients or patients who are confused, use poor judgment, have decreased comprehension, impulsivity, memory deficits. Consider patient's ability to adhere to the plan of care.	
A score of 4 or more is considered at risk for falling **TOTAL**	

MAHC 10 reprinted with permission from ***Missouri Alliance for* HOME CARE**

Plan/Comments re: ADLs and fall risk:

CURRENT FINDINGS/GAIT EVALUATION

Muscle Tone: _____

Posture: _____

Endurance: _____

Gait Assessment:	**Level** Surfaces	**Uneven** Surfaces	Other
Distance			
Distance limited due to:			
Assistance			
Assistive Device			
Quality/Deviations:			

Weight Bearing Status (specify extremities):

❑ FWB ❑ WBAT ❑ PWB ❑ TDWB ❑ NWB

Assistive Device(s):

❑ Cane ❑ Quad Cane ❑ Hemi Walker
❑ Walker ❑ Wheeled Walker
❑ Other: _____

Comments:

Patient Name _____ ID # _____

Section G Functional Status (Continued)

ADL/IADLs (Cont'd)

MUSCLE STRENGTH/ROM EVAL

	AREA	STRENGTH Right	STRENGTH Left	ACTION	ROM Right Active	ROM Right Passive	ROM Left Active	ROM Left Passive
UPPER EXTREMITY	Shoulder			Flex/Extend				
				Abd./Add.				
				Int. Rot./Ext. Rot.				
	Elbow			Flex/Extend				
	Forearm			Sup./Pron.				
	Wrist			Flex/Extend				
	Fingers			Flex/Extend				
LOWER EXTREMITY	Hip			Flex/Extend				
				Abd./Add.				
				Int. Rot./Ext. Rot.				
	Knee			Flex/Extend				
	Ankle			Plant./Dors.				
	Foot			Inver./Ever.				

SPINE	AREA	STRENGTH	ACTION	ROM

MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

GRADE	DESCRIPTION
5	Normal functional strength - against gravity - full resistance
4	Good strength - against gravity with some resistance
3	Fair strength - against gravity - no resistance - safety compromise
2	Poor strength - unable to move against gravity
1	Trace strength - slight muscle contraction - no motion
0	Zero - no active muscle contraction

FUNCTIONAL INDEPENDENCE/BALANCE EVAL

	TASKS	ASSIST SCORE	ASSISTIVE DEVICES/COMMENTS
BED MOBILITY	Roll/Turn		
	Sit/Supine		
	Scoot/Bridge		
TRANSFERS	Sit/Stand		
	Bed/Wheelchair		
	Toilet		
	Floor		
	Auto		
STAIRS	Indoors		Railings: ❑ Left ❑ Right
	Quantity:		
	Outdoors		Railings: ❑ Left ❑ Right
	Quantity:		
W/C SKILLS	Propulsion		
	Pressure Relief		
	Foot Rests		
	Locks		

FUNCTIONAL INDEPENDENCE SCALE (bed mobility, transfers, balance, W/C skills)

GRADE	DESCRIPTION
5	Independent - physically able and independent
4	Verbal cue (VC) only needed
3	Stand-by assist (SBA) - 100% patient/client effort
2	Minimum assist (Min A) - 75% patient/client effort
1	Maximum assist (Max A) - 25% - 50% patient/client effort
0	Totally dependent - total care/support

Discharge Summary of Physical and Functional Findings

❑ 5x Sit to Stand Test score: _____ What score implies:

❑ 30 Second Chair Stand Test score: _____ What score implies:

❑ MMT as noted above, significant deficits in the following muscle groups:

❑ ROM as noted above, significant deficits in the following joints:

❑ PASS Assessment Test score: _____ What score implies:

❑ RPE Test score: _____ What score implies:_____

❑ 2MST score: _____ What score implies:_____

❑ 6MST score: _____ What score implies:_____

❑ Tinetti score: _____ What score implies:_____

❑ TUG Test score: _____ What score implies:_____

❑ Berg Test score: _____ What score implies:_____

❑ Functional Reach Test score: _____
What score implies:_____

❑ Activities Specific Balance Confidence Test score: _____
What score implies:

Other Tests Used for Assessment:_____
Test scores: _____ What score implies:

Based on the above objective Tests and Measures, the patient has demonstrated improvement, and is now able to (be specific with current functional abilities):

See Briggs Test Key at the back of this form

Patient Name _____ ID # _____

Section GG Functional Abilities and Goals

NOTE: Code the GG tasks based on the amount of assistance needed by a helper to complete the task safely, based on the patient's innate ability and environment – NOT based on preferences or current caregiver circumstance.

Score 06-01 whenever it is possible for the task to be completed, even if the helper must complete the entire task, which would be coded as a "01". When a task can not be completed, even with the assistance of a helper, such as walking or steps, then utilize one of the "activity not attempted codes".

GG0130. Self-Care

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 themself 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, 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** – 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**

3. Discharge Performance	
Enter Codes in Boxes ↓	
☐	A. **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
☐	B. **Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from mouth, and manage denture soaking and rinsing with use of equipment.
☐	C. **Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐	E. **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐	F. **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, 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; including fasteners, if applicable.

Patient Name _____ ID # _____

Section GG Functional Abilities and Goals (Continued)

GG0170. Mobility

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 themself 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, 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** - 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**

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 on the bed.
☐	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 move from lying on the back to sitting on the side of the bed with no back support.
☐	D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐	F. **Toilet transfer:** The ability to 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.
☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If Discharge performance is coded 07, 09, 10, or 88, → Skip to GG0170M, 1 step (curb).*
☐	J. **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐	K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
☐	L. **Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐	M. **1 step (curb):** The ability to go up and down a curb or up and down one step. *If Discharge performance is coded 07, 09, 10, or 88, → Skip to GG0170P, Picking up object.*
☐	N. **4 steps:** The ability to go up and down four steps with or without a rail. *If Discharge performance is coded 07, 09, 10, or 88, → Skip to GG0170P, Picking up object.*
☐	O. **12 steps:** The ability to go up and down 12 steps with or without a rail.

Patient Name _____ ID # _____

Section GG Functional Abilities and Goals (Continued)

GG0170. Mobility – Continued

3. Discharge Performance	
Enter Codes in Boxes ↓	
☐	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.
☐	Q. **Does patient use wheelchair and/or scooter?** 0. **No** → *Skip to M1600, Urinary Tract Infection* 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 or 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 or scooter used.** 1. **Manual** 2. **Motorized**

FUNCTIONAL/MOBILITY/ADL REVIEW

Does the patient continue to have functional limitations/risks that impacted discharge planning? ❍ No ❍ Yes If yes, what is the plan for support for these needs at discharge:

Section H Bladder and Bowel

M1600. Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?

Enter Code ☐

0. **No**
1. **Yes**
NA **Patient on prophylactic treatment**

M1620. Bowel Incontinence Frequency

Enter Code ☐

0. **Very rarely or never has bowel incontinence**
1. **Less than once weekly**
2. **One to three times weekly**
3. **Four to six times weekly**
4. **On a daily basis**
5. **More often than once daily**
NA **Patient has ostomy for bowel elimination**

ADDITIONAL COMMENTS

Patient Name _____ ID # _____

Section J Health Conditions

PAIN

Is patient experiencing pain? ❍ No ❍ Yes ❍ Unable to communicate

Non-verbals demonstrated: ❑ Diaphoresis ❑ Grimacing ❑ Moaning ❑ Crying ❑ Guarding ❑ Irritability ❑ Anger ❑ Tense ❑ Restlessness ❑ Change in vital signs ❑ Other: _____

❑ Self-assessment ❑ Implications: _____

If applicable (with or without pain medication) what level of discomfort/pain did the patient report is tolerable?

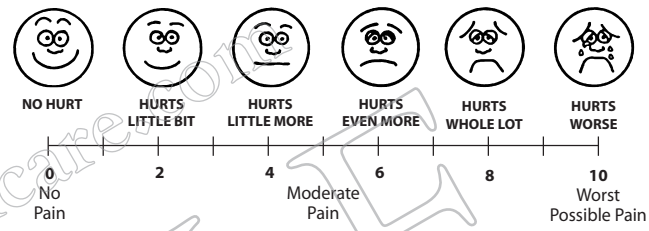
Score: _____ Assessment used: _____

Check box to indicate which pain assessment was used: ❍ **Wong-Baker** ❍ **PAINAD**

Pain Assessment	Site 1	Site 2	Site 3
Location			
Present level (0-10)			
Worst pain gets (0-10)			
Best pain gets (0-10)			
Pain description (aching, radiating, throbbing, etc.)			

Intensity: (using scales below)

Wong-Baker FACES® Pain Rating Scale**



Collected using: ❍ **FACES® Scale** ❍ **0-10 Scale (subjective reporting)**

**From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

Pain Assessment IN Advanced Dementia - PAINAD*

ITEMS	0	1	2	SCORE
Breathing Independent of Vocalization	Normal	Occasional labored breathing or short periods of hyperventilation	Noisy labored breathing, long period of hyperventilation or Cheyne-Stokes respirations	
Negative Vocalization	None	Occasional moan/groan or low level speech with a negative quality	Repeated troubled calling out, loud moaning/groaning/crying	
Facial Expression	Smiling or inexpressive	Sad/frightened/frown	Facial grimacing	
Body Language	Relaxed	Tense, distressed pacing/fidgeting	Rigid, fists clenched, knees pulled up; pulling/pushing away/striking out	
Consolability	No need to console	Distracted or reassured by voice/touch	Unable to console, distract or reassure	
****Total scores range from 0 to 10 (based on a scale of 0 to 2 for five items), with a higher score indicating more severe pain 0 = "no pain" to 10 = "severe pain").**			**TOTAL****	

Instructions: Observe the older person both at rest and during activity/with movement. For each of the items included in the PAINAD, select the score (0, 1, or 2) that reflects the current state of the person's behavior. Add the score for each item to achieve a total score. Monitor changes in the total score over time and in response to treatment to determine changes in pain. Higher scores suggest greater pain severity.

Note: Behavior observation scores should be considered in conjunction with knowledge of existing painful conditions and report from an individual knowledgeable of the person and their pain behaviors. Remember that some individuals may not demonstrate obvious pain behaviors or cues.

***Reference:** Warden, V, Hurley AC, Volicer, V. (2003). Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale. *J Am Med Dir Assoc*, 4:9-15. Developed at the New England Geriatric Research Education & Clinical Center, Bedford VAMC, MA.; Document updated 1.10.2013.

J0510. Pain Effect on Sleep

Enter Code ☐

Ask patient: *"Over the past 5 days,* ***how much of the time has pain made it hard for you to sleep at night"***

0. **Does not apply – I have not had any pain or hurting in the past 5 days** → *Skip to J1800, Any Falls Since SOC/ROC*
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

Patient Name _____ ID # _____

Section J Health Conditions (Continued)

J0520. Pain Interference with Therapy Activities

Enter Code ☐

Ask patient: *"Over the past 5 days,* ***how often have you limited your participation in rehabilitation therapy sessions due to pain?"***

0. **Does not apply – I have not received rehabilitation therapy in the past 5 days**
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

J0530. Pain Interference with Day-to-Day Activities

Enter Code ☐

Ask patient: *"Over the past 5 days,* ***how often you have limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"***

1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

PAIN REVIEW

How does patient plan to manage pain after discharge (explain): ☐ **N/A**

J1800. Any Falls Since SOC/ROC, whichever is more recent

Enter Code ☐

Has the patient **had any falls since SOC/ROC,** whichever is more recent?

0. **No** → *Skip to M1400, Short of Breath*
1. **Yes** → Continue to J1900, Number of Falls Since SOC/ROC

J1900. Number of Falls Since SOC/ROC, whichever is more recent

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

ADDITIONAL COMMENTS

Patient Name _____ ID # _____

Section J Health Conditions (Continued)

M1400. When is the patient dyspneic or noticeably **Short of Breath?**

Enter Code ☐

0. **Patient is not short of breath**
1. **When walking more than 20 feet, climbing stairs**
2. **With moderate exertion** (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)
3. **With minimal exertion** (for example, while eating, talking, or performing other ADLs) or with agitation
4. **At rest** (during day or night)

CARDIOPULMONARY

❑ **No problem with heart/respiratory system**

Breath Sounds: (e.g., clear, crackles/rales, wheezes/rhonchi, diminished, absent)

Anterior: Right_____ Left_____

Posterior: Right Upper_____ Left Upper_____ Right Lower_____ Left Lower_____

❑ Labored breathing

❍ Non-smoker Has patient ever smoked in the past? ❍ No ❍ Yes If yes, date last smoked:_____

❍ Smoker - frequency: ❍ Daily ❍ Occasional ❍ Very Occasional

If daily, (include all types of products that are smoked or vaporized) how often:_____

❑ Positive airway pressure therapy: ❑ continuous ❑ bi-level O_2 @ _____LPM via ❑ cannula ❑ mask ❑ trach O_2 saturation _____%

Trach size/type_____ Who manages? ❑ Patient ❑ Nurse ❑ Caregiver ❑ Family_____

Heart Sounds: ❍ Regular ❍ Irregular ❑ Pacemaker: Date:_____ Last date checked:_____

Color of nail beds:_____

Circulation	N/A	Non-Pitting	Pitting	Capillary Refill
Edema Pedal Right	❍	❍	❍ +1 ❍ +2 ❍ +3 ❍ +4	❍ <3 sec ❍ >3 sec
Edema Pedal Left	❍	❍	❍ +1 ❍ +2 ❍ +3 ❍ +4	❍ <3 sec ❍ >3 sec
	❍	❍	❍ +1 ❍ +2 ❍ +3 ❍ +4	❍ <3 sec ❍ >3 sec
	❍	❍	❍ +1 ❍ +2 ❍ +3 ❍ +4	❍ <3 sec ❍ >3 sec
	❍	❍	❍ +1 ❍ +2 ❍ +3 ❍ +4	❍ <3 sec ❍ >3 sec

❑ Extremity Cramp(s) (location):_____

❑ Pain at rest:_____

❑ Dependent:_____

Discharge instructions/plans for cardiopulmonary management: ❑ **N/A**

VITAL SIGNS

Temperature:_____ F ❍ Oral ❍ Temporal/Forehead ❍ Rectal ❍ Axillary ❍ Tympanic

Pulse: ❑ Apical_____ ❑ Brachial_____ ❍ Regular ❍ Irregular ❑ Radial_____ ❑ Carotid_____

Respirations:_____ ❍ Regular ❍ Irregular

❑ Apnea periods _____ sec. ❍ Observed ❍ Reported

Blood Pressure:	Left	Right	Sitting/Lying	Standing
At rest				
With activity				
Post activity				

ENDOCRINE MANAGEMENT

❑ **No Problem**

Weight:_____ ❍ reported ❍ actual A1C _____% ❑ Patient reported ❑ Lab slip Date:_____ (if known)

BS _____mg/dL Date:_____ Time:_____ ❑ FBS ❑ Before meal ❑ After meal ❑ Random ❑ HS

❑ Blood sugar ranges:_____ Reported by: ❑ Patient ❑ Caregiver ❑ Family

Monitored by: ❑ Patient ❑ Caregiver ❑ Family ❑ Nurse ❑ Other:_____

❑ Discharge instructions/plans for endocrine/diabetic management: ❑ **N/A**

Patient Name _____ ID # _____

Section K Swallowing/Nutritional Status

K0520. Nutritional Approaches

	4. Last 7 days	5. At discharge
4. **Last 7 days** Check all of the nutritional approaches that were received in the last 7 days 5. **At discharge** Check all of the nutritional approaches that were being received at discharge	↓ Check all that apply ↓	
A. **Parenteral/IV feeding**	☐	☐
B. **Feeding tube** (e.g., nasogastric or abdominal (PEG))	☐	☐
C. **Mechanically altered diet** – require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐	☐
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	☐	☐
Z. **None of the above**	☐	☐

M1870. Feeding or Eating

Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

Enter Code ☐

0. **Able to independently feed self.**
1. **Able to feed self independently but requires:**
   a. **meal set-up; OR**
   b. **intermittent assistance or supervision from another person; OR**
   c. **a liquid, pureed, or ground meat diet.**
2. **Unable to feed self and must be assisted or supervised throughout the meal/snack.**
3. **Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.**
4. **Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.**
5. **Unable to take in nutrients orally or by tube feeding.**

NUTRITIONAL REVIEW

❑ **No Problem**

Diet type:_____

❍ Increase fluids:_____amt. ❍ Restrict fluids:_____amt.

Appetite: ❍ Good ❍ Fair ❍ Poor

Alcohol Use: ❍ No ❍ Yes If yes, frequency: ❍ Daily ❍ Occasional ❍ Very Occasional If daily, amount per day:_____

Allergies: List any environmental or food allergies: ❑ **N/A**

If the patient has a problem ❑ preparing meals and/or ❑ feeding self, what is the plan for support post-discharge:

Patient Name ______________________________ ID # ______________

Section M Skin Conditions

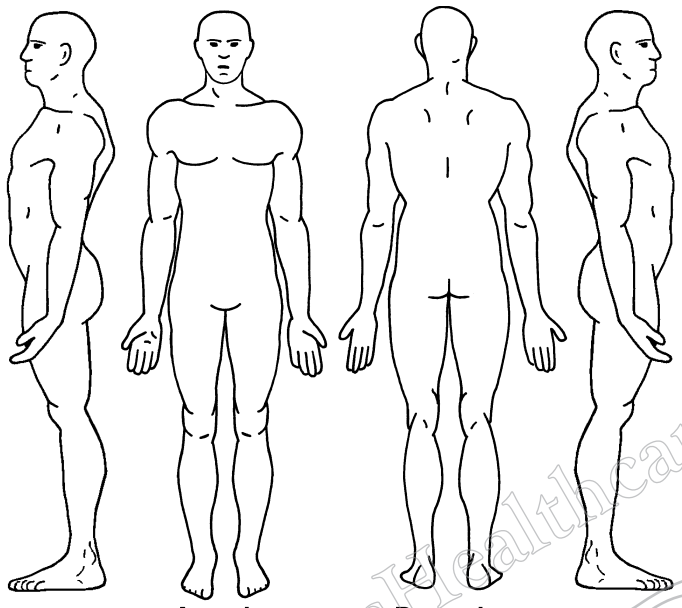
INTEGUMENTARY STATUS					
WOUND/LESION ASSESSMENT					
WOUND/LESION **Date Originally Reported ➤**	**#1** __________	**#2** __________	**#3** __________	**#4** __________	**#5** __________
Location					
Type *Include depth of infected surgical wound(s) in **Size** category below ➤	❍ Arterial ❍ Diabetic foot ulcer ❍ Malignancy ❍ Mechanical/Trauma ❍ Pressure ulcer ❍ Surgical* ❍ Dialysis access ❍ Venous stasis ulcer ❍ IV ❍ Other: __________	❍ Arterial ❍ Diabetic foot ulcer ❍ Malignancy ❍ Mechanical/Trauma ❍ Pressure ulcer ❍ Surgical* ❍ Dialysis access ❍ Venous stasis ulcer ❍ IV ❍ Other: __________	❍ Arterial ❍ Diabetic foot ulcer ❍ Malignancy ❍ Mechanical/Trauma ❍ Pressure ulcer ❍ Surgical* ❍ Dialysis access ❍ Venous stasis ulcer ❍ IV ❍ Other: __________	❍ Arterial ❍ Diabetic foot ulcer ❍ Malignancy ❍ Mechanical/Trauma ❍ Pressure ulcer ❍ Surgical* ❍ Dialysis access ❍ Venous stasis ulcer ❍ IV ❍ Other: __________	❍ Arterial ❍ Diabetic foot ulcer ❍ Malignancy ❍ Mechanical/Trauma ❍ Pressure ulcer ❍ Surgical* ❍ Dialysis access ❍ Venous stasis ulcer ❍ IV ❍ Other: __________
Size (cm) (LxWxD)					
Tunneling/Sinus Tract	length ______cm @ ______o'clock	length ______cm @ ______o'clock	length ______cm @ ______o'clock	length ______cm @ ______o'clock	length ______cm @ ______o'clock
Undermining (cm)	______cm, from ______ to ______ o'clock	______cm, from ______ to ______ o'clock	______cm, from ______ to ______ o'clock	______cm, from ______ to ______ o'clock	______cm, from ______ to ______ o'clock
Stage **(pressure ulcers only)**	Stage: ______ ❍ Unstageable ❍ Unobservable ❍ DTI	Stage: ______ ❍ Unstageable ❍ Unobservable ❍ DTI	Stage: ______ ❍ Unstageable ❍ Unobservable ❍ DTI	Stage: ______ ❍ Unstageable ❍ Unobservable ❍ DTI	Stage: ______ ❍ Unstageable ❍ Unobservable ❍ DTI
Severity of Ulcer (exclude pressure ulcers)	❑ Skin only ❑ Fatty tissue ❑ Muscle ❑ Bone ❑ Muscle necrosis ❑ Bone necrosis ❑ Other:__________	❑ Skin only ❑ Fatty tissue ❑ Muscle ❑ Bone ❑ Muscle necrosis ❑ Bone necrosis ❑ Other:__________	❑ Skin only ❑ Fatty tissue ❑ Muscle ❑ Bone ❑ Muscle necrosis ❑ Bone necrosis ❑ Other:__________	❑ Skin only ❑ Fatty tissue ❑ Muscle ❑ Bone ❑ Muscle necrosis ❑ Bone necrosis ❑ Other:__________	❑ Skin only ❑ Fatty tissue ❑ Muscle ❑ Bone ❑ Muscle necrosis ❑ Bone necrosis ❑ Other:__________
Odor	❍ No ❍ Yes	❍ No ❍ Yes	❍ No ❍ Yes	❍ No ❍ Yes	❍ No ❍ Yes
Surrounding Skin	❑ Erythema ❑ Induration ❑ Maceration ❑ Normal ❑ Other:__________	❑ Erythema ❑ Induration ❑ Maceration ❑ Normal ❑ Other:__________	❑ Erythema ❑ Induration ❑ Maceration ❑ Normal ❑ Other:__________	❑ Erythema ❑ Induration ❑ Maceration ❑ Normal ❑ Other:__________	❑ Erythema ❑ Induration ❑ Maceration ❑ Normal ❑ Other:__________
Edema					
Appearance of the Wound Bed	❑ Slough ________% ❑ Eschar ________% ❑ Granulation ________%	❑ Slough ________% ❑ Eschar ________% ❑ Granulation ________%	❑ Slough ________% ❑ Eschar ________% ❑ Granulation ________%	❑ Slough ________% ❑ Eschar ________% ❑ Granulation ________%	❑ Slough ________% ❑ Eschar ________% ❑ Granulation ________%
Drainage/Amount	❍ None ❍ Small ❍ Moderate ❍ Large	❍ None ❍ Small ❍ Moderate ❍ Large	❍ None ❍ Small ❍ Moderate ❍ Large	❍ None ❍ Small ❍ Moderate ❍ Large	❍ None ❍ Small ❍ Moderate ❍ Large
Color	❍ Clear ❍ Tan ❍ Serosanguineous ❍ Other	❍ Clear ❍ Tan ❍ Serosanguineous ❍ Other	❍ Clear ❍ Tan ❍ Serosanguineous ❍ Other	❍ Clear ❍ Tan ❍ Serosanguineous ❍ Other	❍ Clear ❍ Tan ❍ Serosanguineous ❍ Other
Consistency	❍ Thin ❍ Thick	❍ Thin ❍ Thick	❍ Thin ❍ Thick	❍ Thin ❍ Thick	❍ Thin ❍ Thick
Incision Status	❍ Well Approximated ❍ Incisional separation ❍ Planned secondary Intention	❍ Well Approximated ❍ Incisional separation ❍ Planned secondary Intention	❍ Well Approximated ❍ Incisional separation ❍ Planned secondary Intention	❍ Well Approximated ❍ Incisional separation ❍ Planned secondary Intention	❍ Well Approximated ❍ Incisional separation ❍ Planned secondary Intention
Dialysis Access	❍ PD ❍ AV Graft ❍ AV Fistula Site:__________	❍ PD ❍ AV Graft ❍ AV Fistula Site:__________	❍ PD ❍ AV Graft ❍ AV Fistula Site:__________	❍ PD ❍ AV Graft ❍ AV Fistula Site:__________	❍ PD ❍ AV Graft ❍ AV Fistula Site:__________
IV	❍ Peripheral ❍ PICC ❍ Central:__________ # of lumens__________	❍ Peripheral ❍ PICC ❍ Central:__________ # of lumens__________	❍ Peripheral ❍ PICC ❍ Central:__________ # of lumens__________	❍ Peripheral ❍ PICC ❍ Central:__________ # of lumens__________	❍ Peripheral ❍ PICC ❍ Central:__________ # of lumens__________
Date Healed					

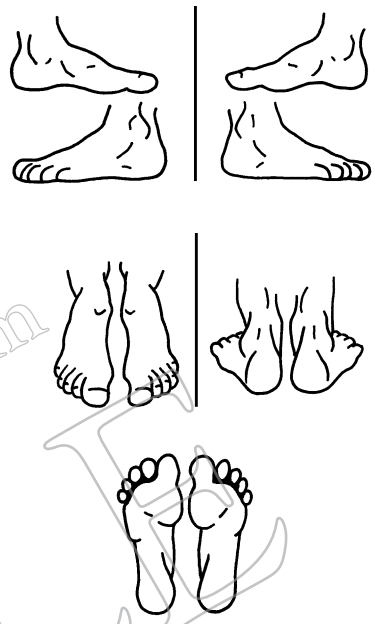
Comments:

Patient Name _____ ID # _____

Section M Skin Conditions (Continued)

INTEGUMENTARY STATUS (Continued)





WOUND CARE: (Check all that apply) ❑ **N/A**

❑ Patient ❑ Caregiver able to perform wound care independently post-discharge.

Post-discharge the patient has a follow-up appointment with the ❑ Physician ❑ Wound Clinic ❑ Other:_____

Discharge instructions/plans for wound care:

M1306. Does this patient have at least one **Unhealed Pressure Ulcer/Injury at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure injuries and all healed pressure ulcers/injuries)

Enter Code ☐

0. **No** → *Skip to M1324, Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable*
1. **Yes**

M1307. The Oldest Stage 2 Pressure Ulcer that is present at discharge: (Excludes healed Stage 2 pressure ulcers)

Enter Code ☐

1. **Was present at the most recent SOC/ROC assessment**
2. **Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified:**

☐
Month/Day/Year

NA **No Stage 2 pressure ulcers are present at discharge**

Patient Name _____ ID # _____

Section M Skin Conditions (Continued)

M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Enter Number	A1. **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. **Number of Stage 2 pressure ulcers** – If 0 → *Skip to M1311B1, Stage 3*
Enter Number	A2. **Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC
Enter Number	B1. **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. **Number of Stage 3 pressure ulcers** – If 0 → *Skip to M1311C1, Stage 4*
Enter Number	B2. **Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC
Enter Number	C1. **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. **Number of Stage 4 pressure ulcers** – If 0 → *Skip to M1311D1, Unstageable: Non-removable dressing/device*
Enter Number	C2. **Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC
Enter Number	D1. **Unstageable: Non-removable dressing/device:** Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** – If 0 → *Skip to M1311E1, Unstageable: Slough and/or eschar*
Enter Number	D2. **Number of these unstageable pressure ulcers/injuries that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC
Enter Number	E1. **Unstageable: Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** – If 0 → *Skip to M1311F1, Unstageable: Deep tissue injury*
Enter Number	E2. **Number of these unstageable pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC
Enter Number	F1. **Unstageable: Deep tissue injury** **Number of unstageable pressure injuries presenting as deep tissue injury** – If 0 → *Skip to M1324, Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable*
Enter Number	F2. **Number of these unstageable pressure injuries that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC

M1324. Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable

Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.

Enter Code

1. **Stage 1**
2. **Stage 2**
3. **Stage 3**
4. **Stage 4**

NA **Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries**

ADDITIONAL COMMENTS

Patient Name _____ ID # _____

Section M Skin Conditions (Continued)

M1330. Does this patient have a **Stasis Ulcer?**

Enter Code ☐

0. **No** → *Skip to M1340, Surgical Wound*
1. **Yes, patient has BOTH observable and unobservable stasis ulcers**
2. **Yes, patient has observable stasis ulcers ONLY**
3. **Yes, patient has unobservable stasis ulcers ONLY** (known but not observable due to non-removable dressing/device) → *Skip to M1340, Surgical Wound*

M1334. Status of Most Problematic Stasis Ulcer that is Observable

Enter Code ☐

1. **Fully granulating**
2. **Early/partial granulation**
3. **Not healing**

M1340. Does this patient have a **Surgical Wound?**

Enter Code ☐

0. **No** → *Skip to N0415, High-Risk Drug Classes: Use and Indication*
1. **Yes, patient has at least one observable surgical wound**
2. **Surgical wound known but not observable due to non-removable dressing/device** → *Skip N0415, High-Risk Drug Classes: Use and Indication*

M1342. Status of Most Problematic Surgical Wound that is Observable

Enter Code ☐

0. **Newly epithelialized**
1. **Fully granulating**
2. **Early/partial granulation**
3. **Not healing**

SKIN CONDITION REVIEW

Is there any skin condition issue(s) that may impact need for support post-discharge: ❍ No ❍ Yes If yes, what is the plan for support:

Section N Medications

MEDICATION

❑ Drug Regimen Review completed. Date:_____

Check if any of the following were identified: ❑ Potential adverse effects ❑ Drug reactions ❑ Ineffective drug therapy ❑ Significant side effects ❑ Significant drug interactions ❑ Duplicate drug therapy ❑ Non-compliance with drug therapy ❑ High-risk drugs

Comments:

MEDICATION ALLERGIES

❑ No known medication allergies ❑ Aspirin ❑ Penicillin ❑ Sulfa ❑ Other(s):

ADDITIONAL COMMENTS

Patient Name _____ ID # _____

Section N Medications (Continued)

N0415. High-Risk Drug Classes: Use and Indication

1. **Is taking**
   Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes

2. **Indication noted**
   If Column 1 is checked, check if there is an indication noted for all medications in the drug class

	1. Is Taking	2. Indication Noted
	↓ Check all that apply ↓	
A. **Antipsychotic**	☐	☐
E. **Anticoagulant**	☐	☐
F. **Antibiotic**	☐	☐
H. **Opioid**	☐	☐
I. **Antiplatelet**	☐	☐
J. **Hypoglycemic** (including insulin)	☐	☐
Z. **None of the above**	☐	

M2005. Medication Intervention

Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?

Enter Code ☐

0. **No**
1. **Yes**
9. **NA** – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

M2020. Management of Oral Medications

Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)

Enter Code ☐

0. **Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.**
1. **Able to take medication(s) at the correct times if:**
   a. **individual dosages are prepared in advance by another person; OR**
   b. **another person develops a drug diary or chart.**
2. **Able to take medication(s) at the correct times if given reminders by another person at the appropriate times**
3. **Unable to take medication unless administered by another person.**

NA **No oral medications prescribed.**

MEDICATION REVIEW

Is there any medication issue(s) that may impact need for support post-discharge? ❍ No ❍ Yes If yes, what is the plan for support:

Were medication goals met? ❍ Yes ❍ No If no, what is the plan for support post-discharge (include all administration routes):

Patient Name _____ ID # _____

Section O Special Treatment, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs (M) Check all of the following treatments, procedures, and programs that apply at discharge.	c. At Discharge Check all that apply ↓
Cancer Treatments	
A1. Chemotherapy	☐
A2. IV	☐
A3. Oral	☐
A10. Other	☐
B1. Radiation	☐
Respiratory Therapies	
C1. Oxygen Therapy	☐
C2. Continuous	☐
C3. Intermittent	☐
C4. High-concentration	☐
D1. Suctioning	☐
D2. Scheduled	☐
D3. As Needed	☐
E1. Tracheostomy care	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐
G1. Non-invasive Mechanical Ventilator	☐
G2. BiPAP	☐
G3. CPAP	☐
Other	
H1. IV Medications	☐
H2. Vasoactive medications	☐
H3. Antibiotics	☐
H4. Anticoagulation	☐
H10. Other	☐
I1. Transfusions	☐
J1. Dialysis	☐
J2. Hemodialysis	☐
J3. Peritoneal dialysis	☐
O1. IV Access	☐
O2. Peripheral	☐
O3. Mid-line	☐
O4. Central (e.g., PICC, tunneled, port)	☐
None of the Above	
Z1. None of the Above	☐

SPECIAL TREATMENT REVIEW

Is there any special treatment issue(s) that may impact need for support post-discharge? ❍ No ❍ Yes If yes, what is the plan for support:

Patient Name _____ ID # _____

Section O Special Treatment, Procedures, and Programs (Continued)

M1041. Influenza Vaccine Data Collection Period

Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?

Enter Code ☐

0. **No** → *Skip to M2401, Intervention Synopsis*
1. **Yes** → Continue to M1046, Influenza Vaccine Received

M1046. Influenza Vaccine Received

Did the patient receive the influenza vaccine for this year's flu season?

Enter Code ☐

1. **Yes;** received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)
2. **Yes;** received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)
3. **Yes;** received from another health care provider (for example, physician, pharmacist)
4. **No;** patient offered and declined
5. **No;** patient assessed and determined to have medical contraindication(s)
6. **No;** not indicated – patient does not meet age/condition guidelines for influenza vaccine
7. **No;** inability to obtain vaccine due to declared shortage
8. **No;** patient did not receive the vaccine due to reasons other than those listed in responses 4-7.

If answer is 8, if known, specify reason:

Section Q Participation in Assessment and Goal Setting

M2401. Intervention Synopsis

At the time of or at any time since the most recent SOC/ROC assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented? (Mark only one box in each row.)

Plan/Intervention	No	Yes	Not Applicable	
	↓ Check only one box in each row ↓			
b. Falls prevention interventions	☐ 0	☐ 1	☐ NA	Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐ 0	☐ 1	☐ NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d. Intervention(s) to monitor and mitigate pain	☐ 0	☐ 1	☐ NA	Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	☐ 0	☐ 1	☐ NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	☐ 0	☐ 1	☐ NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

Patient Name _____ ID # _____

DISCHARGE REVIEW/CHECKLIST

❑ Patient ❑ Caregiver ❑ Representative ❑ Family were notified beforehand of pending discharge: ❍ No ❍ Yes Date notified:_____

❑ HHABN ❑ HHCCN given to ❑ Patient ❑ Caregiver ❑ Representative ❑ Family: ❍ N/A ❍ Yes - Date given:_____

❑ Medication reconciliation was completed per agency policy.

Pertinent findings reviewed with the ❑ Patient ❑ Caregiver ❑ Representative ❑ Family ❍ Yes ❍ No (explain):

❑ All patient education and/or instructions were provided for continued health needs post-discharge, per agency policy.

❑ Patient ❑ Caregiver ❑ Representative ❑ Family instructed to call physician for follow-up appointment(s), as appropriate, for follow-up care, treatments, or services: ❍ Yes ❍ No

❑ Patient ❑ Caregiver ❑ Representative ❑ Family participated with discharge planning: ❍ Yes ❍ No

❑ Patient ❑ Caregiver ❑ Representative ❑ Family verbalized awareness and independence with:

❑ Medication(s) management ❑ Medication safety ❑ Home exercise program ❑ Diet requirements ❑ Nutritional requirements

❑ Treatment(s) ❑ Safety measures ❑ Equipment

❑ Other:

❑ Patient ❑ Caregiver ❑ Representative ❑ Family verbalized understanding of discharge instructions: ❍ Yes ❍ No (explain):

Reviewed: ❑ Home safety ❑ Fall precautions ❑ Patient ❑ Caregiver ❑ Representative ❑ Family instructed: ❑ When to contact physician

❑ Standard precautions ❑ Other (describe):_____

Was a referral made to MSW for assistance with: ❑ Community resources ❑ Living will ❑ Counseling needs ❑ Unsafe environment

❑ Other_____ Date:_____ ❍ Yes ❍ No ❍ Refused ❍ N/A

Comments:

Community referrals made to:

Was the patient's discharge: ❍ Expected/planned ❍ Not planned/unexpected

Was the post-discharge primary care practitioner notified of the discharge date prior to the day of discharge? ❍ Yes ❍ No

Did the ❑ Patient ❑ Representative communicate specific preferences related to the discharge? ❍ Yes ❍ No

If yes, explain:

If no, explain:

Was the ❑ Patient ❑ Representative given contact information for agencies or providers that will continue to provide services, to the patient, post-discharge? ❍ Yes ❍ No

If no, explain:

❑ Post-Discharge referrals or continuation of services (example: Meals on Wheels, Home and Community Based Waiver Services (HCBS), Senior Center, laboratory and/or outpatient therapy etc.)

Patient Name _____ ID # _____

PHYSICIAN DISCHARGE SUMMARY (Include skilled care provided this visit and analysis of findings)

Physician Name:_____

Address:_____ City:_____ State:_____ ZIP:_____

Email:_____ Phone:_____ Fax:_____

This Discharge Summary is for your records.

Thank you for allowing us to care for your patient.

DISCIPLINES NOTIFIED OF DISCHARGE:

❑ PT ❑ OT ❑ SLP ❑ MSW ❑ Aide ❑ Other (specify):_____

Describe the skilled care and discharge plan/teaching provided this visit, along with a summary of all care, and the patient's response during this admission:

Complete this Section for Discharge Purposes (Unless Summary is written elsewhere)

Patient Name: (Last, first, middle initial)_____

Reason for initial referral/diagnosis:_____

Certification period:_____ to_____

SOC date:_____ Discharge date:_____

Insurance:_____

Last primary physician visit date:_____

Discipline discharging: ❑ PT

If applicable, services that will continue or start:_____

Emergency contact name:_____ Relationship:_____ Phone:_____

Was the discharge planned? ❍ Yes ❍ No

If not, explain:_____

If Discharge assessment completed based on prior visits – list dates here:_____

Reason for Discharge:

Copy of summary and current medication list: ❑ mailed ❑ emailed ❑ faxed within 5 days of discharge

To: ❑ Certifying Physician:_____ Date:_____

❑ Secondary Physician:_____ Date:_____

❑ Primary Care Provider Post-transfer/DAH:_____ Date:_____

❑ Representative (if any):_____ Date:_____

SIGNATURES/DATES

X _____ _____ _____

Patient/Family Member/Caregiver/Representative (if applicable) *Date* *Time*

X _____ _____ _____

Person Completing This Form (signature/title) *Date* *Time*

BRIGGS TEST KEY

ADLs

1. **Barthel Index:** 100 point test
2. **Katz:** score of 6 = Independent; score 0 = Very Dependent
3. **Lawton IADL Scale:** 8 item report

AEROBIC CAPACITY

a. **Borg RPE:** CR10 scale (0-10). Subjective report of effort
Mid-range = 3-6

b. **SOB:** 0-10 scale. Subjective report of shortness of breath
Mid-range = 3-5

c. **2MST:** Age related norms:

AGE	MEN	WOMEN
60-64	87-115	75-107
65-69	86-116	73-107
70-74	80-100	68-101
75-79	73-109	68-100
80-84	71-103	60-91
85-89	59-91	55-85
90-94	52-86	44-72

AMBULATION

a. **4 meter** (13 ft 2 in) velocity:
<1.97 ft/sec = non-functional ambulation/falls risk;
1.98-3.3 ft/sec = functional household ambulation/no falls risk; > 3.3 ft/sec = community ambulator

b. **Dynamic Gait Index:** qualitative. Goal is to reduce/eliminate deviations in gait cycle

c. **Tinetti test:** ≥ 8/12 gait = no falls risk

BALANCE

a. **TUG test:**
> 14 seconds = + falls risk
14-20 sec: mostly independent mobility;
21-29 sec: moderately impaired mobility;
>30 sec: ADL dysfunction (severely impaired mobility)

b. **Tinetti test:** ≥ 12/16 balance = no falls risk

c. **Berg:**
<36: 100% risk of falls;
37-44: impaired balance with falls risk;
≥ 45: impaired balance, no falls risk
Clinically significant for goals: 6 point change

d. **FIST – Function in Sitting Test**
56 possible points <42: rehab continued need
Clinically significant for goals: 5 point change

e. **Functional Reach:**
<6 inches = significant increased falls risk;
6-10 inches = impaired balance;
≥ 10 inches = normal reach

f. **One Leg Stance Test:**
<5 seconds = high risk of injurious falls;
<30 sec = history of falls

Tinetti (total):
<19/28 = high falls risk;
19-24 = medium falls risk;
≥ 25 = low falls risk

CAREGIVER STRAIN INDEX

≥ 7 positive items = greater level of strain. Interventions needed

COGNITION

a. **MMSE:** score:
11-17/30 = moderate to severe cognitive impairment: instruct CG;
18-23 = mild cognitive impairment: clinical judgment to instruct CG or client;
≥ 24 = WFL for age

b. **MOCA:** score: ≥ 26 = WFL for age

CONFIDENCE:

To determine client confidence in task performance

a. **ABC:** <80% confidence = increased falls risk

CVA:

a. **PASS test:** 12 item assessment of physical ability

STRENGTH:

Besides MMT, functional assessment of strength of large LE muscle groups:

a. **30 second Chair Stand Test:** findings correlate to mobility loss

AGE	MEN	WOMEN
60-64	14-19	12-17
65-69	12-18	11-16
70-74	12-17	10-15
75-79	11-17	10-15
80-84	10-15	9-14
85-89	8-14	8-13
90-94	7-12	4-11

b. **5x Sit to Stand:** document speed and assist level
Increased risk for debility:
age 60-69: >11.4 sec
70-79: >12.6 sec
80-89: >14.8 sec