

interRAI Home Care®
 [CODE FOR LAST 3 DAYS, UNLESS OTHERWISE SPECIFIED]

SECTION A. IDENTIFICATION INFORMATION

1. NAME

a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)

2. GENDER 1. Male 2. Female

3. BIRTHDATE — —

4. MARITAL STATUS

1. Never married
 2. Married
 3. Partner/Significant other
 4. Widowed
 5. Separated
 6. Divorced

5. NATIONAL NUMERIC IDENTIFIER [EXAMPLE - USA]

a. Social Security Number
 — —

b. Medicare number (or comparable railroad insurance number)

c. Medicaid Number ["+" if pending, "N" if not a Medicaid recipient]

6. FACILITY/AGENCY PROVIDER NUMBER

7. CURRENT PAYMENT SOURCES FOR HOME CARE SERVICES [EXAMPLE - USA]

0. No 1. Yes

a. Medicaid

b. Medicare

c. Self or family pays for full cost

d. Medicaid or Medicare co-payment

e. Private insurance

8. REASON FOR ASSESSMENT

1. First assessment
 2. Routine reassessment
 3. Significant change in status reassessment (e.g., return from hospital)
 4. Discharge assessment, covers last 3 days of service
 5. Discharge tracking only
 6. Other (e.g., research)

9. ASSESSMENT REFERENCE DATE

— —

10. POSTAL/ZIP CODE OF USUAL LIVING ARRANGEMENT

11. RESIDENTIAL/LIVING STATUS

1. Private home/apartment/rented room—one floor
 2. Private home/apartment/rented room—bedroom on separate floor
 3. Board and care/assisted living/group home/mental health residence
 4. Facility for persons with developmental disability
 5. Psychiatric hospital or unit
 6. Homeless (with or without shelter)
 7. Long-term care facility (nursing home)
 8. Rehabilitation hospital/unit
 9. Hospice facility/palliative care unit
 10. Acute care hospital
 11. Correctional facility
 12. Other

a. Admitted from

b. Usual residential status

12. LIVING ARRANGEMENT

a. Lives

1. Alone
 2. With spouse/partner only
 3. With spouse/partner and other(s)
 4. With child (not spouse)
 5. With other relatives (not spouse or children)
 6. With non-relative(s)

b. As compared to 90 DAYS AGO (or since last assessment), person now lives with someone new— e.g., moved in with another person, other moved in

0. No 1. Yes

c. Person or caregiver feels that the person would be better off living elsewhere

0. No 1. Yes

13. TIME SINCE LAST HOSPITAL STAY
 (Code for most recent instance in LAST 90 DAYS)

0. No hospitalization within 90 days
 1. More than 30 days ago
 2. 15 to 30 days
 3. 8 to 14 days
 4. Last week
 5. Now in hospital

SECTION B. INTAKE/INITIAL HISTORY

Fill in at Admission/First Assessment only

1. PERSON'S EXPRESSED GOALS OF CARE

2. DATE CASE OPENED

— —

3. ETHNICITY/RACE [EXAMPLE - USA]

0. No 1. Yes

ETHNICITY

a. Hispanic or Latino

RACE

b. American Indian/Alaskan Native

c. Asian

d. Black or African American

e. Native Hawaiian or other Pacific Islander

f. White

4. PRIMARY LANGUAGE [EXAMPLE - USA]

1. English
 2. Spanish
 3. French
 4. Other

5. RESIDENTIAL HISTORY OVER LAST 5 YEARS
 (Code for all settings person lived in during 5 years prior to date case opened [B2])

0. No 1. Yes

a. Long-term care facility (e.g., nursing home)

b. Board and care home, assisted living, group home

c. Mental health/psychiatric hospital or unit

d. Setting for persons with developmental disability

SECTION C. COGNITION

1. COGNITIVE SKILLS FOR DAILY DECISION MAKING

Making decisions regarding tasks of daily life (e.g., when to get up or have meals, which clothes to wear or activities to do)

0. **Independent** — Decisions consistent/ reasonable/safe

1. **Modified independence** — Some difficulty in new situations only

2. **Minimally impaired** — In specific situations, decisions become poor or unsafe; cues/supervision necessary at those times

3. **Moderately impaired** — Decisions consistently poor or unsafe, cues/supervision required at all times

4. **Severely impaired** — Never/rarely makes decisions

5. **No discernable consciousness** [SKIP TO SECTION G]

2. MEMORY/RECALL ABILITY

CODE for recall of what was learned or known

- 0. Yes, memory ok
- 1. Memory problem
- a. **Short-term memory OK**—Seems/appears to recall after 5 minutes
- b. **Procedural memory OK**—Can perform all or almost all steps in a multitask sequence without cues for initiation
- c. **Situational memory OK**—Both: recognizes caregivers' names/faces frequently encountered AND knows location of places regularly visited (bedroom, dining room, activity room, therapy room)

3. PERIODIC DISORDERED THINKING/AWARENESS

[Note: Accurate assessment requires conversations with staff, family, or others who have direct knowledge of the person's behavior over this time]

- 0. Behavior not present
- 1. Behavior present, consistent with usual functioning
- 2. Behavior present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)
- a. **Easily distracted**—e.g., episodes of difficulty paying attention; gets sidetracked
- b. **Episodes of disorganized speech**—e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought
- c. **Mental function varies over the course of the day**—e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not
- d. **Acute change in mental status from person's baseline**—e.g., restlessness, lethargy, difficult to arouse, altered environmental perception
- 4. **NOW MORE IMPAIRED IN DECISION MAKING THAN 90 DAYS AGO (OR SINCE LAST ASSESSMENT)**
- 0. No 1. Yes, more impaired today 8. Uncertain

SECTION D. COMMUNICATION/HEARING

- 1. **MAKING SELF UNDERSTOOD (Expression)**
Expressing information content—both verbal and nonverbal
 - 0. **Understood**—Expresses ideas without difficulty
 - 1. **Usually understood**—Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required
 - 2. **Often understood**—Difficulty finding words or finishing thoughts AND prompting usually required
 - 3. **Sometimes understood**—Ability is limited to concrete requests
 - 4. **Rarely/never understood**
- 2. **ABILITY TO UNDERSTAND OTHERS (Comprehension)**
Understanding verbal information content (however able; with hearing appliance, if used)
 - 0. **Understands**—Clear comprehension
 - 1. **Usually understands**—Misses some part/intent of message BUT comprehends most conversation
 - 2. **Often understands**—Misses some part/intent of message BUT with repetition or explanation can often comprehend conversation
 - 3. **Sometimes understands**—Responds adequately to simple, direct communication only
 - 4. **Rarely/never understands**
- 3. **HEARING**—Ability to hear (with hearing appliance normally used)
 - 0. **Hears adequately**—No difficulty in normal conversation, social interaction, TV, phone
 - 1. **Minimal difficulty**—Requires quiet setting to hear well
 - 2. **Hears in special situations only**—Speaker has to increase volume and speak distinctly
 - 3. **Highly impaired**—Absence of useful hearing

4. VISION—Ability to see in adequate light (with glasses or with other visual appliance normally used)

- 0. **Adequate**—sees fine detail, including regular print in newspapers/books
- 1. **Impaired**—sees large print, but not regular print in newspapers/books
- 2. **Moderately impaired**—limited vision; not able to see newspaper headlines, but can identify objects
- 3. **Highly impaired**—object identification in question, but eyes appear to follow objects
- 4. **Severely impaired**—no vision; OR sees only light, colors, or shapes; OR eyes do not appear to follow objects

SECTION E. MOOD AND BEHAVIOR

- 1. **INDICATORS OF POSSIBLE DEPRESSION, ANXIETY, SAD MOOD**
(CODE for indicators observed in last 3 days, irrespective of the assumed cause)
 - 0. Not Present
 - 1. Present but not exhibited in last 3 days
 - 2. Exhibited on 1-2 of last 3 days
 - 3. Exhibited daily in last 3 days
 - a. **Made negative statements**—e.g., "Nothing matters; Would rather be dead; What's the use; Regret having lived so long; Let me die"
 - b. **Persistent anger with self or others**—e.g., easily annoyed, anger at care received
 - c. **Expressions (including non-verbal) of what appear to be unrealistic fears**—e.g., fear of being abandoned, being left alone, being with others; intense fear of specific objects or situations
 - d. **Repetitive health complaints**—e.g., persistently seeks medical attention, incessant concern with body functions
 - e. **Repetitive anxious complaints/concerns (non-health related)**—e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationships
 - f. **Sad, pained, worried facial expressions**—e.g., furrowed brow
 - g. **Crying, tearfulness**
 - h. **Repetitive verbalizations**—e.g., calling out for help ("God help me")
 - i. **Recurrent statements that something terrible is about to happen**—e.g., believes he or she is about to die, have a heart attack
 - j. **Withdrawal from activities of interest**—e.g., no interest in long standing activities or being with family/friends
 - k. **Reduced social interaction**
 - l. **Expressions (including non-verbal) of a lack of pleasure in life**—e.g., "I don't enjoy anything anymore," anhedonia
- 2. **SELF-REPORTED MOOD ITEMS**
 - 0. Not in the last 3 days
 - 1. Not in the last 3 days, but often feel that way
 - 2. In 1-2 of last 3 days
 - 3. Daily in the last 3 days
 - 8. **PERSON COULD NOT (WOULD NOT) RESPOND**
(In the last 3 days, how often have you felt...)
 - a. **Little interest or pleasure in things you normally enjoy**
 - b. **Anxious, restless or uneasy**
 - c. **Sad, depressed or hopeless**
- 3. **BEHAVIOR SYMPTOMS**
(CODE for indicators observed in last 3 days, irrespective of the assumed cause)
 - 0. Not Present
 - 1. Present but not exhibited in last 3 days
 - 2. Exhibited on 1-2 of last 3 days
 - 3. Exhibited daily in last 3 days
 - a. **Wandering**—moved with no rational purpose, seemingly oblivious to needs or safety
 - b. **Verbal abuse**—e.g., others were threatened, screamed at, cursed at
 - c. **Physical abuse**—e.g., others were hit, shoved, scratched, sexually abused
 - d. **Socially inappropriate or disruptive behavior**—e.g., made disruptive sounds, noisiness, screaming, smeared/ threw food/feces, hoarding, rummaged through others' belongings
 - e. **Resists care**—e.g., taking medications/ injections, ADL assistance, or eating
- 4. **MAJOR LIFE EVENTS IN LAST 90 DAYS** (e.g., death or severe illness of close family member/friend, loss of home; major loss of income/assets; victim of a crime such as robbery/assault; loss of driving license/car)
 - 0. No 1. Yes

SECTION F. PSYCHOSOCIAL WELL-BEING

- 1. SOCIAL RELATIONSHIPS**
(Ask person, direct care staff present, and family, if present)
- 0. Never
 - 1. More than one month ago
 - 2. Within last month
 - 3. Within last week
 - 4. Within last 3 days
- a. Participation in social activities of long-standing interest
 - b. Visit by a long-standing social relation/family member
 - c. Telephone or e-mail contact with long-standing social relation/family member
 - d. Says or indicates that he/she feels lonely
 - e. Openly expresses conflict or anger with family/friends
 - f. Fearful of a family member or caregiver
 - g. Neglected, abused, or mistreated
- 2. CHANGE IN SOCIAL ACTIVITIES**
 As compared to 90 DAYS AGO (or since last assessment if less than 90 days ago), decline in level of participation in social, religious, occupational or other preferred activities. IF THERE WAS A DECLINE, distressed by this fact
- 0. No decline
 - 1. Decline, not distressed
 - 2. Decline, distressed
- 3. ISOLATION** Length of time alone during the day (morning and afternoon)
- 0. Less than 1 hour
 - 1. 1 - 2 hours
 - 2. More than 2 hours but less than 8 hours
 - 3. 8 hours or more

SECTION G. PHYSICAL FUNCTIONING

- 1. IADL SELF PERFORMANCE and CAPACITY**
CODE for Performance in routine activities around the home or in the community during the LAST 3 DAYS.
CODE for Capacity based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.
- | | PERFORMANCE | CAPACITY |
|---|--------------------------|--------------------------|
| 0. Independent – No help, setup, or supervision | | |
| 1. Setup help only | | |
| 2. Supervision – Oversight/cuing | | |
| 3. Limited assistance – Help on some occasions | | |
| 4. Extensive assistance – Help throughout task, but performs 50% or more of tasks on own | | |
| 5. Maximal assistance – Help throughout task but performs less than 50% of tasks on own | | |
| 6. Total dependence – Full performance by others during entire period | | |
| 8. Activity did not occur – During entire period
[DO NOT USE THIS CODE IN SCORING CAPACITY] | | |
| a. Meal preparation —How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Ordinary housework —How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Managing finance —How bills are paid, checkbook is balanced, household expenses are balanced, credit card account is monitored - EXCLUDE TRANSPORTATION | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Managing medications —How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments) | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Phone use —How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed) | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Stairs --How manages full flight of stairs (i.e., 12-14 stairs) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Shopping —How shopping is performed for food and household items (e.g., selecting items, paying money) - EXCLUDE TRANSPORTATION | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Transportation —How travels by public transportation (navigating system, paying fare), or arranges other transport, or drives self (including getting out of house, into/out of vehicles) | <input type="checkbox"/> | <input type="checkbox"/> |

2. ADL SELF-PERFORMANCE

- (CODE for Performance over full 24 hour periods, considering all occurrences of the activity IN LAST 3 DAYS)*
(NOTE – for ALL ADLs, if less than 3 episodes over the three-day time frame, code based on most dependent episode)
- 0. **Independent** – No help—OR—Help, setup, or supervision provided 1-2 times
 - 1. **Setup help only**— Article or device provided or placed within reach 3+ times
 - 2. **Supervision** -- Oversight/cuing 3+ times – OR – Oversight/cuing 1+ time and physical assistance 1-2 times
 - 3. **Limited assistance** – Guided maneuvering of limbs 3+ times – OR – Combination of guided maneuvering and more help 1-2 times
 - 4. **Extensive assistance** – Weight-bearing support 3+ times by one helper where person still performs 50% or more of tasks
 - 5. **Maximal assistance** – Weight-bearing support 3+ times by 2+ helpers - OR - Weight-bearing support for more than 50% of subtasks
 - 6. **Total dependence** – Full performance by others during entire period
 - 8. **Activity did not occur** – During entire period
- a. **Bathing**—How takes full-body bath/shower (EXCLUDE WASHING OF BACK AND HAIR). Includes how transfers in/out of tub/shower AND how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area.
 - b. **Personal hygiene**— How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing/drying face and hands - EXCLUDE BATHS AND SHOWERS
 - c. **Dressing upper body**—How dresses and undresses (street clothes, underwear) above the waist, includes prostheses, orthotics, fasteners, pullovers, etc.
 - d. **Dressing lower body**—How dresses and undresses (street clothes, underwear) from the waist down, includes prostheses orthotics, belts, pants, skirts, shoes, and fasteners
 - e. **Walking**—How walks between locations on same floor indoors
 - f. **Locomotion outside of home**—[Note—If in wheelchair, self sufficiency once in chair]
 - g. **Transfer toilet**—How moves on and off toilet or commode
 - h. **Toilet use**—How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON/OFF TOILET
 - i. **Bed mobility**—How moves to and from lying position, turns side to side, and positions body while in bed
 - j. **Eating**—How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)
- 3. WHEELING**
Furthest distance wheeled at one time in the last 3 days (includes independent use of motorized wheelchair)
- 0. **Did not use wheelchair**
 - 1. **Independent over long distances (300+feet/ 100+ meters)**
 - 2. **Independent over intermediate distance (150-299 feet/50-90 meters)**
 - 3. **No physical assistance over short distances (less than 50 meters)**
 - 4. **Limited physical assistance over short distances**
 - 5. **Wheeled by others**
- 4. PRIMARY MODE OF LOCOMOTION INDOORS**
- 1. Walking, no assistive device
 - 2. Walking, uses assistive device (e.g., cane, walker, crutch, wheelchair)
 - 3. Wheelchair, scooter
 - 4. Bedbound
- 5. ACTIVITY LEVEL**
- a. **Hours of exercise/physical activity in last 3 days** (e.g., walking)
 - 0. More than 2 hours
 - 1. 1-2 hours
 - 2. Less than 1 hour
 - 3. None
 - b. **In the last 3 days, number of days went out of the house or building in which he/she lives** (no matter how short the period)
 - 0. 3 days
 - 1. 1-2 days
 - 2. Did not go out in last 3 days, but usually goes out over a 3-day period
 - 3. No days out

6. PHYSICAL REHABILITATION POTENTIAL

0. No 1. Yes

- a. Person believes he/she is capable of improved performance in physical function
- b. Care professional believes person is capable of improved performance in physical function

7. ADL STATUS IS WORSE THAN 90 DAYS AGO, OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO

0. No 1. Yes, more impaired today

8. DRIVING

0. No 1. Yes

- a. Person reports driving a car (vehicle) in the last 90 days (e.g., to a store, to visit, to a medical appointment)
 - b. If drives, someone has suggested that person limits OR stops driving in the last 90 days
0. No, or does not drive 1. Yes

SECTION H. CONTINENCE

1. BLADDER CONTINENCE

- 0. *Continent* —Complete control; DOES NOT USE any type of catheter or other urinary collection device
- 1. *Control with any catheter or ostomy* for all hours over the last 3 days
- 2. *Infrequent incontinence* —Not incontinent over last 3 days, but does have incontinent episodes
- 3. *Episode(s) of incontinence*—On one day
- 4. *Occasionally incontinent*—On two days
- 5. *Frequently incontinent*—Incontinent daily, but some control present
- 6. *Incontinent*—Has inadequate control of bladder, multiple daily episodes all or almost all of time
- 8. *Did not occur* —No urine output from bladder

2. URINARY COLLECTION DEVICE

- 0. None
- 1. Condom catheter
- 2. Indwelling catheter
- 3. Cystostomy, ureterostomy

3. BOWEL CONTINENCE

- 0. *Continent* —Complete control; Does not use any type of ostomy device
- 1. *Control with ostomy* —Control with ostomy device for all hours over last 3 days
- 2. *Infrequent incontinence* —Not incontinent over last 3 days, but does have incontinent episodes
- 3. *Episode(s) of incontinence* —On one day
- 4. *Occasionally incontinent* —On two days
- 5. *Frequently incontinent* —Incontinent daily, but some control present (e.g., during part of day)
- 6. *Incontinent* —All days
- 8. *Did not occur* —No bowel movement during the period

4. PADS, BRIEFS WORN

0. No 1. Yes

SECTION I. DISEASE DIAGNOSES

1. DISEASES

Diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)
Disease Code

- 1. Primary diagnosis/diagnoses for current stay
- 2. Diagnosis present, receiving active treatment
- 3. Diagnosis present, monitored but no active treatment

Diagnosis	Disease Code	ICD code
a. _____	<input type="checkbox"/>	
b. _____	<input type="checkbox"/>	
c. _____	<input type="checkbox"/>	
d. _____	<input type="checkbox"/>	
e. _____	<input type="checkbox"/>	
f. _____	<input type="checkbox"/>	

[Add additional lines as necessary for other disease diagnoses]

SECTION J. HEALTH CONDITIONS

1. FALLS

- 0. No fall in last 90 days
- 1. No fall in last 30 days, but fell 31-90 days ago
- 2. One fall in last 30 days
- 3. Two or more falls in last 30 days

2. PROBLEM PRESENCE (Code for last 3 days unless otherwise specified)

0. No 1. Yes

BALANCE/BODY CONTROL

- a. Difficult/unable to stand unassisted
- b. Hip fracture during past 30 days (or since last assessment)
- c. Dizziness/vertigo/lightheadedness
- d. Unsteady gait

INFECTION

- e. Urinary tract infection in last 30 days
- f. Septicemia

PNEUMONIA

PSYCHIATRIC

- g. Depression
- h. Schizophrenia
- i. Abnormal thought process (e.g., lessening of associations, blocking, flight of ideas, tangentiality, circumstantiality)
- j. Delusion (fixed false beliefs)
- k. Hallucinations (false sensory perceptions)

NEUROLOGICAL

- m. Aphasia
- n. Alzheimer's Disease
- o. Dementia other than Alzheimer's Disease

OTHER

- p. Diabetes Mellitus
- q. GI/GU Bleeding
- r. Other fracture during last 30 days (or since last assessment)
- s. Hemiplegia/hemiparesis
- t. Quadriplegia/paraplegia

3. PROBLEM FREQUENCY

- 0. Not present
- 1. Present but not exhibited in last 3 days
- 2. Exhibited on 1-2 of last 3 days
- 3. Exhibited daily in last 3 days

CARDIAC/PULMONARY

- a. Shortness of breath with exertion
- b. Inability to lie flat due to shortness of breath
- c. Tires easily, poor task endurance
- d. Difficulty coughing or clearing airway secretions

GI STATUS

- e. Constipation (no bowel movement in 3 days or difficult passage of stool)
- f. Fecal Impaction
- g. Diarrhea
- h. Vomiting

SLEEP PROBLEMS

- i. Difficulty falling asleep, staying asleep, waking up too early, restlessness, non-restful sleep

OTHER

- j. Edema
- k. Hygiene - Unusually poor hygiene, unkempt, disheveled

4. PAIN SYMPTOMS

[Note - person must be asked about frequency and intensity]

a. Frequency with which person complains or shows evidence of pain (including grimacing, teeth clenching, moaning, withdrawal when touched, or other non-verbal signs suggesting pain)

- 0. No pain
- 1. Present but not exhibited in last 3 days
- 2. Exhibited on 1-2 of last 3 days
- 3. Exhibited daily in last 3 days

b. Intensity of pain (CODE for the highest level present)

- 0. No pain
- 1. Mild
- 2. Moderate
- 3. Severe
- 4. Times when pain is horrible or excruciating

c. Consistency of pain

- 0. No pain
- 1. Single episode during last 3 days
- 2. Intermittent
- 3. Constant

d. Pain control

Ability of current therapeutic regime to control pain adequately (from person's point of view)

- 0. No issue of pain
- 1. Controlled adequately by therapeutic regime
- 2. Controlled when therapeutic regime followed, but not always followed as ordered
- 3. Therapeutic regime followed, but pain control not adequate
- 4. No therapeutic regime being followed for pain, pain not adequately controlled

5. INSTABILITY OF CONDITIONS

- 0. No
- 1. Yes
- a. Feels he/she has poor health (when asked)
- b. Experiencing an acute episode or a flare-up of a recurrent or chronic problem
- c. End-stage disease; 6 or fewer months to live

6. LIFESTYLE

a. Smokes tobacco daily

- 0. No
- 1. Not in last 3 days, but is usually a daily smoker
- 2. Yes

b. Alcohol -- Highest number of drinks in any "single sitting" in last 14 days

- 0. None
- 1. 1
- 2. 2 - 4
- 3. 5 or more

SECTION K. ORAL/NUTRITIONAL STATUS

1. HEIGHT AND WEIGHT [INCHES AND POUNDS-- COUNTRY SPECIFIC]

Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in last 30 days

a. HT (in.) b. WT (lb.)

2. NUTRITIONAL ISSUES

- 0. No
- 1. Yes
- a. Weight loss of 5% or more in last 30 days, or 10% or more in last 180 days
- b. Fluid intake less than 1,000cc per day (less than four 8oz cups/day)
- c. Dehydrated; output exceeds input; or BUN/Creat ratio > 25
- d. In at least 2 of last 3 days, ate one or fewer meals a day
- e. In last 3 days, noticeable decrease in the amount of food usually eaten or fluids usually consumed

3. MODE OF NUTRITIONAL INTAKE

- 0. Normal—swallows all diet consistencies
- 1. Modified independent—e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
- 2. Requires diet modifications to swallow solid food--mechanical diet (e.g., puree, minced) or only able to ingest specific food
- 3. Requires modification to swallow liquids--e.g., thickened liquids
- 4. Can swallow only pureed solids AND thickened liquids
- 5. Combined oral and parenteral/tube feeding
- 6. Nasogastric tube feeding only
- 7. PEG
- 8. Parenteral feeding only--includes all types of parental feedings, such as total parenteral nutrition (TPN)

4. DENTAL

- 0. No
- 1. Yes
- a. Wears a denture (removable prosthesis)
- b. Has broken, fragmented, loose, or otherwise non-intact natural teeth
- c. Reports difficulty chewing
- d. Reports having dry mouth

SECTION L. SKIN CONDITION

1. MOST SEVERE PRESSURE ULCER

- 0. No pressure ulcer
- 1. Any area of persistent skin redness
- 2. Partial loss of skin layers
- 3. Deep craters in the skin
- 4. Breaks in skin exposing muscle or bone
- 5. Not codeable, e.g., necrotic eschar predominant

2. PRIOR PRESSURE ULCER

- 0. No
- 1. Yes

3. STASIS ULCER -- open lesion caused by poor circulation in the lower limbs

- 0. No
- 1. Yes

4. MAJOR SKIN PROBLEMS -- e.g., lesions, 2nd or 3rd degree burns, healing surgical wounds

- 0. No
- 1. Yes

5. SKIN TEARS OR CUTS -- other than surgery

- 0. No
- 1. Yes

6. OTHER SKIN CONDITIONS OR CHANGES IN SKIN CONDITION--e.g., bruises, rashes, itching, mottling, herpes zoster, intertrigo, eczema

- 0. No
- 1. Yes

7. FOOT PROBLEMS -- e.g., bunions, hammertoes, overlapping toes, structural problems, infections, ulcers

- 0. No foot problems
- 1. Foot problems, no limitation walking
- 2. Foot problems limit walking
- 3. Foot problems prevent walking
- 4. Foot problems, doesn't walk for other reasons

SECTION M. MEDICATIONS

1. LIST OF ALL MEDICATIONS

List prescribed and nonprescribed medications scheduled in LAST 3 DAYS [NOTE: Where possible, use computerized records -- (e.g., for prescribed medications); hand enter only where absolutely necessary; a computerized system is recommended]

a. Name: Record the name of the medication

For each drug record both:

b. Dose (a positive number e.g., 150, 300, etc.) Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg).

c. Unit Code using the following list:

gts (Drops)	mEq (Milliequivalent)	Puffs
gm (Gram)	mg (Milligram)	% (Percentage)
L (Liter)	ml (Milliliter)	Units
mcg (Microgram)	oz (Ounce)	OTH (Other) Specify:

d. Form: Code the route of administration using the following list:

PO (By mouth (oral))	Sub-Q (Subcutaneous)	NAS (Nasal)
SL (Sublingual)	REC (Rectal)	ET (Enteral Tube)
IM (Intramuscular)	TOP (Topical)	TD (Transdermal)
IV (Intravenous)	IH (Inhalation)	OTH (Other) Specify:

e. Freq: Code the number of times per day, week, or month the medication is administered using the following:

- | | |
|-------------------------|-------------------------|
| Q1H (Every hour) | Q2D (Every other day) |
| Q2H (Every 2 hours) | Q3D (Every 3 days) |
| Q3H (Every 3 hours) | Weekly |
| Q4H (Every 4 hours) | 2W (2 times weekly) |
| Q6H (Every 6 hours) | 3W (3 times weekly) |
| Q8H (Every 8 hours) | 4W (4 times weekly) |
| Daily | 5W (5 times weekly) |
| BID (2 times daily) | 6W (6 times weekly) |
| (includes every 12 hrs) | 1 M (Monthly) |
| TID (3 times daily) | 2 M (Twice every month) |
| QID (4 times daily) | OTH (Other) |
| 5D (5 times daily) | Specify: _____ |

f. PRN 0. No 1. Yes ATC or NDC code

a. Name	b. Dose	c. Unit	d. Form	e. Freq.	f. PRN	g. code
1.						
2.						
3.						
4.						
5.						

[Add additional lines as necessary, for other drugs taken]
[For Unit, Form, Frequency, abbreviations are Country Specific]

2. ALLERGY TO DRUGS

0. No 1. Yes

3. ADHERENT ALL OR MOST OF TIME WITH MEDICATIONS PRESCRIBED BY PHYSICIAN

0. Always adherent
 1. Adherent 80% of time or more
 2. Adherent less than 80% of time, including failure to purchase prescribed medications
 8. NO MEDICATIONS PRESCRIBED

SECTION N. TREATMENTS AND PROCEDURES

1. PREVENTION

0. No 1. Yes
- a. Influenza vaccination in last year
- b. Pneumovax vaccine in last 5 years
- c. Mammogram or breast exam in last two years (for women)
- d. Blood pressure measured in last year
- e. Dental exam in last year
- f. Eye exam in last year
- g. Tested for blood in stool in last year or colonoscopy

2. TREATMENTS AND PROGRAMS RECEIVED OR SCHEDULED IN THE LAST 3 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 3 DAYS)

0. Did not occur, not ordered
 1. Ordered, not yet implemented
 2. 1 - 2 of last 3 days
 3. Daily in last 3 days
- a. Complimentary non-medication pain therapies (e.g., massage, music)
- b. Chemotherapy
- c. Dialysis
- d. Dietitian
- e. Hospice
- f. IV infusion
- g. Palliative care program
- h. Monitoring of acute medical condition
- i. Radiation therapy
- j. Respirator for assistive breathing
- k. Respite care
- l. Skin treatment
- m. Tracheostomy care
- n. Transfusion
- o. Wound care

3. FORMAL CARE (Days(A) and Total minutes(B) in last week)

Extent of care/treatment in LAST 7 DAYS (or since last assessment or admission if less than 7 days) involving:

	(A) # of Days	(B) Total Minutes in last week
a. Home health aides		
b. Home nurse		
c. Homemaking services		
d. Meals		
e. Physical therapy		
f. Occupational therapy		
g. Speech-language pathology and audiology services		
h. Psychological therapies (by any licensed mental health professional)		

4. PHYSICALLY RESTRAINED (e.g., limbs restrained, used bed rails, constrained to chair when sitting)

0. No 1. Yes

5. HOSPITAL USE, EMERGENCY ROOM USE, PHYSICIAN VISIT

Code for number of times during the last 90 days (or since last assessment if within 90 days)

- a. Inpatient acute hospital with overnight stay
- b. Emergency room visit (not counting overnight hospital stay)
- c. Physician visit (or authorized assistant or practitioner)

SECTION O. RESPONSIBILITY/DIRECTIVES

1. LEGAL GUARDIAN [EXAMPLE-USA]

0. No 1. Yes

SECTION P. DISCHARGE POTENTIAL AND OVERALL STATUS

1. ONE OR MORE CARE GOALS MET IN THE LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS)

0. No 1. Yes

2. OVERALL SELF-SUFFICIENCY HAS CHANGED SIGNIFICANTLY AS COMPARED TO STATUS OF 90 DAYS AGO (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS)

0. Improved—receives fewer supports
 1. No change
 2. Deteriorated—receives more support

CODE FOLLOWING THREE ITEMS IF "DETERIORATED" IN LAST 90 DAYS - OTHERWISE SKIP TO SECTION Q

3. TIME OF ONSET OF THE PRECIPITATING EVENT/PROBLEM

0. Within last week
 1. Within last 8 to 14 days
 2. 15 to 30 days ago
 3. 31 to 60 days
 4. More than 60 days ago

4. NUMBER OF ADL AREAS (FROM "G2" ABOVE) IN WHICH PERSON WAS INDEPENDENT PRIOR TO PRECIPITATING EVENT

5. NUMBER OF IADL AREAS (FROM "G1") IN WHICH PERSON WAS INDEPENDENT PRIOR TO PRECIPITATING EVENT

SECTION Q. SOCIAL RELATIONSHIPS & SUPPORTS

1. TWO KEY INFORMAL HELPERS

a. Relationship to person

- 1. Child or child-in-law
- 2. Spouse
- 3. Partner/significant other
- 4. Parent
- 5. Other relative
- 6. Friend or neighbor
- 8. No helper

Helper
1 2

b. Lives with person

- 0. Yes, more than 6 months
- 1. Yes, 6 months or less
- 2. No
- 8. No helper

Helper
1 2

AREAS OF HELP DURING LAST 3 DAYS:

- 0. No
- 1. Yes
- 8. No Helper

Helper
1 2

c. IADL care

d. ADL care

2. EXTENT OF INFORMAL HELP

- 0. No
- 1. Yes
- a. Strong and supportive relationship with family
- b. Helper(s) is unable to continue in caring activities -- e.g., decline in health of helper makes it difficult to continue
- c. Primary helper expresses feelings of distress, anger or depression
- d. Family/close friends report feeling overwhelmed by person's illness

3. HOURS OF INFORMAL CARE AND ACTIVE MONITORING

For instrumental and personal activities of daily living in the LAST 3 DAYS, indicate the total number of hours of help received from all family, friends, and neighbors

SECTION R. ENVIRONMENTAL ASSESSMENT

1. HOME ENVIRONMENT

Code for any of following that make home environment hazardous or uninhabitable (if temporarily in institution, base assessment on home visit)

- 0. No
- 1. Yes

- a. **Disrepair of the home** -- e.g., hazardous clutter; inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors; holes in floor; leaking pipes
- b. **Squalid Condition** -- e.g. extremely dirty, infestation by rats or bugs
- c. **Heating or cooling** -- e.g., too hot in summer, too cold in winter, wood stove in a home with an asthmatic
- d. **Personal safety** -- e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street
- e. **Access to home or rooms in house** -- e.g., difficulty entering/leaving home, unable to climb stairs, difficulty maneuvering within rooms, no rails though needed

2. OUTSIDE ENVIRONMENT

- 0. No
- 1. Yes

- a. **Access to emergency assistance (e.g., telephone, alarm response system)**
- b. **Access to grocery store without assistance**
- c. **Access to home delivery of groceries**

3. FINANCES

Because of limited funds, during the last 30 days made trade offs among purchasing any of the following: prescribed medications, sufficient home heat, necessary health care, adequate food, home care

- 0. No
- 1. Yes

SECTION S. DISCHARGE [CODE ONLY AT DISCHARGE]

1. LAST DAY OF STAY

2 0 — —
Year Month Day

2. DISCHARGED TO

- 1. Private home/apartment/rented room -- one floor
- 2. Private home/apartment/rented room -- bedroom on separate floor
- 3. Board and care/assisted living/group home/mental health residence
- 4. Facility for persons with developmental disability
- 5. Psychiatric hospital or unit
- 6. Homeless (with or without shelter)
- 7. Long-term care facility (nursing home)
- 8. Rehabilitation on hospital/unit
- 9. Hospice facility/Palliative care unit
- 10. Acute care hospital
- 11. Correctional facility
- 12. Other
- 13. Deceased

SECTION T. ASSESSMENT INFORMATION

SIGNATURE OF PERSON COORDINATING/COMPLETING THE ASSESSMENT:

a. Signature (sign on above line)

b. Date assessment signed as complete

2 0 — —
Year Month Day