

ADL SELF-PERFORMANCE (cont)	
EATING—Including taking in food by any method, including tube feedings.	
TOILET USE—Including using the toilet room or commode, bedpan, urinal, transferring /off toilet, cleaning self after toilet use, changing pad, managing any special devices required (ostomy or catheter), and adjusting clothes.	
PERSONAL HYGIENE—Including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands, and perineum (EXCLUDE baths and showers)	
BATHING—How patient takes full-body bath/shower or sponge bath (EXCLUDE washing back and hair). Includes how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area. Code for most dependent episode in LAST 7 DAYS	
PRIMARY MODES OF LOCOMOTION	0. No assistive device 1. Cane 2. Walker/crutch
	3. Scooter (e.g., Amigo) 4. Wheelchair 5. Activity did not occur
	a. Indoors b. Outdoors
STAIR CLIMBING	In the last 3 days, how client went up and down stairs (e.g., single or multiple steps, using handrail as needed). If client did not go up and down stairs, code client's capacity for stair climbing 0. Up and down stairs without help 1. Up and down stairs with help 2. Not go up and down stairs—could do without help 3. Not go up and down stairs—could do with help 4. Not go up and down stairs—no capacity to do it 5. UNKNOWN—did not climb stairs and assessor is unable to judge whether the capacity exists
STAMINA	a. In a typical week, during the LAST 30 DAYS (or since last assessment), code the number of days client usually went out of the house or building in which client lives (no matter how short a time period) 0. Every day 1. 2-6 days a week 2. 1 day a week 3. No days b. Hours of physical activities in the last 3 days (e.g., walking, cleaning house, exercise) 0. Two or more hours 1. Less than two hours
FUNCTIONAL POTENTIAL	Client believes he/she capable of increased functional independence (ADL, IADL, mobility) Caregivers believe client is capable of increased functional independence (ADL, IADL, mobility) Good prospects of recovery from current disease or conditions, improved health status expected NONE OF ABOVE

SECTION I. CONTINENCE IN LAST 7 DAYS

BLADDER CONTINENCE	In LAST 7 DAYS (or since last assessment if less than 7 days) control of urinary bladder function (with appliances such as catheters or incontinence program employed) [Note—if dribbles, volume insufficient to soak through underpants] 0. CONTINENT—Complete control 1. USUALLY CONTINENT—Incontinent episodes once a week or less 2. OCCASIONALLY INCONTINENT—Incontinent episodes 2 or more times a week but not daily 3. FREQUENTLY INCONTINENT—Tends to be incontinent daily, but some control present 4. INCONTINENT—Inadequate control, multiple daily episodes
BLADDER DEVICES	(Check all that apply in LAST 7 DAYS—or since last assessment if less than 7 days) Use of pads or briefs to protect against wetness Use of an indwelling urinary catheter NONE OF ABOVE
BOWEL CONTINENCE	In LAST 7 DAYS (or since last assessment if less than 7 days), control of bowel movement (with appliance or bowel continence program if employed) 0. CONTINENT—Complete control 1. USUALLY CONTINENT—Bowel incontinent episodes less than weekly 2. OCCASIONALLY INCONTINENT—Bowel incontinent episode once a week 3. FREQUENTLY INCONTINENT—Bowel incontinent episodes 2-3 times a week 4. INCONTINENT—Bowel incontinent all (or almost all) of the time

SECTION J. DISEASE DIAGNOSES

Disease/infection that doctor has indicated is present and affects client's status, requires treatment, or symptom management. Also include if disease is monitored by a health professional or is reason for a hospitalization in last 90 days (or since last assessment if less than 90 days)	
blank]. Not present	
1. Present—not subject to focused treatment or monitoring by home care nurse	
2. Present—monitored or treated by home care nurse	
If no disease in list, check J1ac, None of Above]	

1. DISEASES	HEART/CIRCULATION	p. Osteoporosis
	a. Cerebrovascular accident (stroke)	SENSES
	b. Congestive heart failure	q. Cataract
	c. Coronary artery disease	r. Glaucoma
	d. Hypertension	PSYCHIATRIC MOOD
	e. Irregularly irregular pulse	s. Any psychiatric diagnosis
	f. Peripheral vascular disease	INFECTIONS
	NEUROLOGICAL	t. HIV infection
	g. Alzheimer's	u. Pneumonia
	h. Dementia other than Alzheimer's disease	v. Tuberculosis
	i. Head trauma	w. Urinary tract infection (in last 30 days)
	j. Hemiplegia/hemiparesis	OTHER DISEASES
	k. Multiple sclerosis	x. Cancer—(in past 5 years) not including skin cancer
	l. Parkinsonism	y. Diabetes
	MUSCULO-SKELETAL	z. Emphysema/COPD/asthma
	m. Arthritis	aa. Renal Failure
	n. Hip fracture	ab. Thyroid disease (hyper or hypo)
	o. Other fractures (e.g., wrist, vertebral)	ac. NONE OF ABOVE
2. OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES	a. _____	_____
	b. _____	_____
	c. _____	_____
	d. _____	_____

SECTION K. HEALTH CONDITIONS AND PREVENTIVE HEALTH MEASURES

1. PREVENTIVE HEALTH (PAST TWO YEARS)	(Check all that apply—in PAST 2 YEARS) Blood pressure measured Received influenza vaccination Test for blood in stool or screening endoscopy IF FEMALE: Received breast examination or mammography NONE OF ABOVE	a. b. c. d. e.
2. PROBLEM CONDITIONS PRESENT ON 2 OR MORE DAYS	(Check all that were present on at least 2 of the last 3 days) Diarrhea Difficulty urinating or urinating 3 or more times at night Fever a. _____ b. _____ c. _____	Loss of appetite Vomiting NONE OF ABOVE d. e. f.
3. PROBLEM CONDITIONS IN LAST WEEK	(Check all present at any point during last 3 days) PHYSICAL HEALTH Chest pain at exertion or chest pain/pressure at rest Constipation on all 3 of last 3 days Dizziness or lightheadedness a. _____ b. _____ c. _____	Edema Shortness of breath MENTAL HEALTH Delusions Hallucinations NONE OF ABOVE d. e. f. g. h.
4. PAIN	a. Frequency with which client complains or shows evidence of pain 0. No pain 1. Less than daily 2. Daily - one period 3. Daily - multiple periods (e.g., morning and evening) b. Intensity of pain 0. No pain 1. Mild 2. Moderate 3. Severe 4. Times when pain is horrible or excruciating c. From client's point of view, pain intensity disrupts usual activities 0. No 1. Yes d. Character of pain 0. No pain 1. Localized - single site 2. Multiple sites e. From client's point of view, medications adequately control pain 0. Yes or no pain 1. Medications do not adequately control pain 2. Pain present, medication not taken	
5. FALLS FREQUENCY	Number of times fell in LAST 180 DAYS (or since last assessment if less than 180 days) If none, code "0"; if more than 9, code "9"	
6. DANGER OF FALL	(Code for danger of falling) 0. No 1. Yes a. Unsteady gait b. Client limits going outdoors due to fear of falling (e.g., stopped using bus, goes out only with others)	

2. SPECIAL TREATMENTS, THERAPIES, PROGRAMS (cont)	SPECIAL PROCEDURES DONE IN HOME		z. Medical alert bracelet or electronic security alert	
	x. Daily nurse monitoring (e.g., EKG, urinary output)		aa. Skin treatment	
	y. Nurse monitoring less than daily		ab. Special diet	
			ac. NONE OF ABOVE	ac.
3. MANAGEMENT OF EQUIPMENT (In Last 3 Days)	Management codes: 0. Not used 1. Managed on own 2. Managed on own if laid out or with verbal reminders 3. Partially performed by others 4. Fully performed by others			
	a. Oxygen		c. Catheter	
	b. IV			
4. VISITS IN LAST 90 DAYS OR SINCE LAST ASSESSMENT	Enter 0 if none, if more than 9, code "9"			
	a. Number of times ADMITTED TO HOSPITAL with an overnight stay			
	b. Number of times VISITED EMERGENCY ROOM without an overnight stay			
	c. EMERGENT CARE—including unscheduled nursing, physician, or therapeutic visits to office or home			
5. TREATMENT GOALS	Any treatment goals that have been met in the LAST 90 DAYS (or since last assessment if less than 90 days)? 0. No 1. Yes			
6. OVERALL CHANGE IN CARE NEEDS	Overall self sufficiency has changed significantly as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports 2. Deteriorated—receives more support			
7. TRADE OFFS	Because of limited funds, during the last month, client made trade-offs among purchasing any of the following: prescribed medications, sufficient home heat, necessary physician care, adequate food, home care 0. No 1. Yes			

SECTION Q. MEDICATIONS

1. NUMBER OF MEDICATIONS	Record the number of different medicines (prescriptions and over the counter), including eye drops, taken regularly or on an occasional basis in the LAST 7 DAYS (or since last assessment) [if none, code "0", if more than 9, code "9"]			
2. RECEIPT OF PSYCHOTROPIC MEDICATION	Psychotropic medications taken in the LAST 7 DAYS (or since last assessment) [Note—Review client's medications with the list that applies to the following categories] 0. No 1. Yes			
	a. Antipsychotic		c. Antidepressant	
	b. Antianxiety		d. Hypnotic	
3. MEDICAL OVERSIGHT	Physician reviewed client's medications as a whole in LAST 180 DAYS (or since last assessment) 0. Discussed with at least one physician (or no medication taken) 1. No single physician reviewed all medications			
4. COMPLIANCE/ADHERENCE WITH MEDICATIONS	Compliant all or most of time with medications prescribed by physician (both during and between therapy visits) 0. Always compliant 1. Compliant 80% of time or more 2. Compliant less than 80% of time, including failure to purchase prescribed medications 3. NO MEDICATIONS PRESCRIBED			
5. LIST OF ALL MEDICATIONS	List prescribed and nonprescribed medications taken in LAST 7 DAYS (or since last assessment) a. Name and Dose—Record the name of the medication and dose ordered. b. Form: Code the route of Administration using the following list: 1=by mouth (PO) 4=intravenous (IV) 7=topical 10=other 2=sub lingual (SL) 5=subcutaneous (SQ) 8=inhalation 3=intramuscular (IM) 6=rectal (R) 9=enteral tube d. Freq: Code the number of times per day, week, or month the medication is administered using the following list: PR=(PRN) as necessary 2D=(BID) two times daily QO=every other day 1H=(QH) every hour (includes every 12 hrs) 4W=4 times each week 2H=(Q2H) every two hours 3D=(TID) three times daily 5W=five times each week 3H=(Q3H) every three hours 4D=(QID) four times daily 6W=six times each week 4H=(Q4H) every four hours 5D=five times daily 1M=(Q month) once every month 6H=(Q6H) every six hours 1W=(Q week) once each wk 2M=twice every month 8H=(Q8H) every eight hours 2W=two times every week C=continuous 1D=(QD or HS) once daily 3W=three times every week O=other			
	a. Name and Dose	b. Form	c. Number Taken	d. Freq.
	a.			
	b.			
	c.			
	d.			
	e.			
	f.			
	g.			
	h.			
	i.			
	j.			
k.				

⁹ Country specific