

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	<i>(Code for observed indicators irrespective of the assumed cause)</i>	
	0. Indicator not exhibited in last 3 days 1. Exhibited 1-2 of last 3 days 2. Exhibited on each of last 3 days	
2. MOOD DECLINE	Mood indicators have become worse as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No 1. Yes	
	Instances when client exhibited behavioral symptoms. If EXHIBITED, ease of altering the symptom when it occurred. 0. Did not occur in last 3 days 1. Occurred, easily altered 2. Occurred, not easily altered	
3. BEHAVIORAL SYMPTOMS	a. WANDERING—Moved with no rational purpose, seemingly oblivious to needs or safety	
	b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS—Threatened, screamed at, cursed at others	
4. CHANGES IN BEHAVIOR SYMPTOMS	Behavioral symptoms have become worse or are less well tolerated by family as compared to 90 DAYS AGO (or since last assessment if less than 90 days) 0. No, or no change in behavioral symptoms 1. Yes	

SECTION F. SOCIAL FUNCTIONING

1. INVOLVEMENT	a. At ease interacting with others (e.g., likes to spend time with others) 0. At ease 1. Not at ease b. Openly expresses conflict or anger with family/friends 0. No 1. Yes
2. CHANGE IN SOCIAL ACTIVITIES	As compared to 90 DAYS AGO (or since last assessment if less than 90 days ago), decline in the client's level of participation in social, religious, occupational or other preferred activities. IF THERE WAS A DECLINE, client distressed by this fact 0. No decline 1. Decline, not distressed 2. Decline, distressed
3. ISOLATION	a. Length of time client is alone during the day (morning and afternoon) 0. Never or hardly ever 1. About one hour 2. Long periods of time—e.g., all morning 3. All of the time b. Client says or indicates that he/she feels lonely 0. No 1. Yes

SECTION G. INFORMAL SUPPORT SERVICES

1. TWO KEY INFORMAL HELPERS	NAME OF PRIMARY AND SECONDARY HELPERS	
	a. (Last/Family Name)	b. (First)
Primary (A) and Secondary (B)	c. (Last/Family Name)	d. (First)
e. Lives with client	0. Yes 1. No	2. No such helper [skip other items in the appropriate column]
f. Relationship to client	0. Child or child-in-law 1. Spouse	2. Other Relative 3. Friend/neighbor
g.— Advice or emotional support	Areas of help: 0. Yes 1. No	
h.— IADL care		
i.— ADL care		

1. TWO KEY INFORMAL HELPERS			(A) Prim	(B) Secn
	Primary (A) and Secondary (B) (cont)	If needed, willingness (with ability) to increase help: 0. More than 2 hours 1. 1-2 hours per day 2. No j.— Advice or emotional support k.— IADL care l.— ADL care		
2. CAREGIVER STATUS	(Check all that apply) A caregiver is unable to continue in caring activities—e.g., decline in the health of the caregiver makes it difficult to continue Primary caregiver is not satisfied with support received from family and friends (e.g., other children of client) Primary caregiver expresses feelings of distress, anger or depression NONE OF ABOVE		a.	
			b.	
3. EXTENT OF INFORMAL HELP (HOURS OF CARE, ROUNDED)	For instrumental and personal activities of daily living received over the LAST 7 DAYS, indicate extent of help from family, friends, and neighbors		HOURS	
	a. Sum of time across five weekdays			
	b. Sum of time across two weekend days			

SECTION H. PHYSICAL FUNCTIONING:

- IADL PERFORMANCE IN 7 DAYS
- ADL PERFORMANCE IN 3 DAYS

1. IADL SELF PERFORMANCE—Code for functioning in routine activities around the home or in the community during the LAST 7 DAYS	(A) IADL SELF PERFORMANCE CODE (Code for client's performance during LAST 7 DAYS) 0. INDEPENDENT—did on own 1. SOME HELP—help some of the time 2. FULL HELP—performed with help all of the time 3. BY OTHERS—performed by others 8. ACTIVITY DID NOT OCCUR			
	(B) IADL DIFFICULTY CODE How difficult it is (or would it be) for client to do activity on own 0. NO DIFFICULTY 1. SOME DIFFICULTY—e.g., needs some help, is very slow, or fatigues 2. GREAT DIFFICULTY—e.g., little or no involvement in the activity is possible		(A) Performance	(B) Difficulty
a. MEAL PREPARATION—How meals are prepared (e.g., planning meals, cooking, assembling ingredients, setting out food and utensils)				
b. ORDINARY HOUSEWORK—How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)				
c. MANAGING FINANCE—How bills are paid, checkbook is balanced, household expenses are balanced				
d. MANAGING MEDICATIONS—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)				
e. PHONE USE—How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)				
f. SHOPPING—How shopping is performed for food and household items (e.g., selecting items, managing money)				
g. TRANSPORTATION—How client travels by vehicle (e.g., gets to places beyond walking distance)				
2. ADL SELF-PERFORMANCE—The following address the client's physical functioning in routine personal activities of daily life, for example, dressing, eating, etc. during the LAST 3 DAYS, considering all episodes of these activities. For clients who performed an activity independently, be sure to determine and record whether others encouraged the activity or were present to supervise or oversee the activity [Note—For bathing, code for most dependent single episode in LAST 7 DAYS]	0. INDEPENDENT—No help, setup, or oversight —OR— Help, setup, oversight provided only 1 or 2 times (with any task or subtask)			
	1. SETUP HELP ONLY—Article or device provided within reach of client 3 or more times			
2. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 3 days —OR— Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision)				
3. LIMITED ASSISTANCE—Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times —OR— Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help)				
4. EXTENSIVE ASSISTANCE—Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times: —Weight-bearing support —OR— — Full performance by another during part (but not all) of last 3 days				
5. MAXIMAL ASSISTANCE—Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times				
6. TOTAL DEPENDENCE—Full performance of activity by another				
8. ACTIVITY DID NOT OCCUR (regardless of ability)				

2. ADL SELF-PERFORMANCE (cont)	
a. MOBILITY IN BED —Including moving to and from lying position, turning side to side, and positioning body while in bed.	
b. TRANSFER —Including moving to and between surfaces—to/from bed, chair, wheelchair, standing position. [Note—Excludes to/from bath/toilet]	
c. LOCOMOTION IN HOME —[Note—If in wheelchair, self-sufficiency once in chair]	
d. LOCOMOTION OUTSIDE OF HOME —[Note—If in wheelchair, self-sufficiency once in chair]	
e. DRESSING UPPER BODY —How client dresses and undresses (street clothes, underwear) above the waist, includes prostheses, orthotics, fasteners, pullovers, etc.	
f. DRESSING LOWER BODY —How client dresses and undresses (street clothes, underwear) from the waist down, includes prostheses, orthotics, belts, pants, skirts, shoes, and fasteners	
g. EATING —Including taking in food by any method, including tube feedings.	
h. TOILET USE —Including using the toilet room or commode, bedpan, urinal, transferring on/off toilet, cleaning self after toilet use or incontinent episode, changing pad, managing any special devices required (ostomy or catheter), and adjusting clothes.	
i. PERSONAL HYGIENE —Including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (EXCLUDE baths and showers)	
j. BATHING —How client takes full-body bath/shower or sponge bath (EXCLUDE washing of 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	
3. ADL DECLINE	ADL status has become worse (i.e., now more impaired in self performance) as compared to status 90 days ago (or since last assessment if less than 90 days) 0. No 1. Yes
4. PRIMARY MODES OF LOCOMOTION	0. No assistive device 3. Scooter (e.g., Amigo) 1. Cane 4. Wheelchair 2. Walker/crutch 8. ACTIVITY DID NOT OCCUR a. Indoors b. Outdoors
5. STAIR CLIMBING	In the last 3 days , how client went up and down stairs (e.g., single or multiple steps, using handrail as needed) 0. Up and down stairs without help 1. Up and down stairs with help 2. Not go up and down stairs
6. 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 2. 1 day a week 1. 2-6 days 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
7. 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

1. BLADDER CONTINENCE	a. In LAST 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; DOES NOT USE any type of catheter or other urinary collection device 1. CONTINENT WITH CATHETER —Complete control with use of any type of catheter or urinary collection device that does not leak urine 2. USUALLY CONTINENT —Incontinent episodes once a week or less 3. OCCASIONALLY INCONTINENT —Incontinent episodes 2 or more times a week but not daily 4. FREQUENTLY INCONTINENT —Tends to be incontinent daily, but some control present 5. INCONTINENT —Inadequate control, multiple daily episodes 8. DID NOT OCCUR —No urine output from bladder b. Worsening of bladder incontinence as compared to status 90 DAYS AGO (or since last assessment if less than 90 days) 0. No 1. Yes
2. BLADDER DEVICES	(Check all that apply in LAST 7 DAYS) Use of pads or briefs to protect against wetness Use of an indwelling urinary catheter NONE OF ABOVE

3. BOWEL CONTINENCE	In LAST 7 DAYS , control of bowel movement (with appliance or bowel continence program if employed) 0. CONTINENT —Complete control; DOES NOT USE ostomy device 1. CONTINENT WITH OSTOMY —Complete control with use of ostomy device that does not leak stool 2. USUALLY CONTINENT —Bowel incontinent episodes less than weekly 3. OCCASIONALLY INCONTINENT —Bowel incontinent episode once a week 4. FREQUENTLY INCONTINENT —Bowel incontinent episodes 2-3 times a week 5. INCONTINENT —Bowel incontinent all (or almost all) of the time 8. DID NOT OCCUR —No bowel movement during entire 7 day assessment period
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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 home care professional or is the 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 professional
2. Present—monitored or treated by home care professional
[If no disease in list, check **J1ac**, *None of Above*]

1. DISEASES	HEART/CIRCULATION a. Cerebrovascular accident (stroke) b. Congestive heart failure c. Coronary artery disease d. Hypertension e. Irregularly irregular pulse f. Peripheral vascular disease NEUROLOGICAL g. Alzheimer's h. Dementia other than Alzheimer's disease i. Head trauma j. Hemiplegia/hemiparesis k. Multiple sclerosis l. Parkinsonism MUSCULO-SKELETAL m. Arthritis n. Hip fracture o. Other fractures (e.g., wrist, vertebral)	p. Osteoporosis SENSES q. Cataract r. Glaucoma PSYCHIATRIC/MOOD s. Any psychiatric diagnosis INFECTIONS t. HIV infection u. Pneumonia v. Tuberculosis w. Urinary tract infection (in LAST 30 DAYS) OTHER DISEASES x. Cancer—(in past 5 years) not including skin cancer y. Diabetes z. Emphysema/COPD/asthma aa. Renal Failure ab. Thyroid disease (hyper or hypo) 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 Loss of appetite Vomiting NONE OF ABOVE	a. b. c. d. e. f.
3. PROBLEM CONDITIONS	(Check all present at any point during last 3 days) PHYSICAL HEALTH Shortness of breath MENTAL HEALTH Chest pain/pressure at rest or on exertion No bowel movement in 3 days Dizziness or lightheadedness Edema Delusions Hallucinations NONE OF ABOVE	a. b. c. d. e. f. g. h.

2.	SPECIAL TREATMENTS, THERAPIES, PROGRAMS	Special treatments, therapies, and programs received or scheduled during the LAST 7 DAYS (or since last assessment if less than 7 days) and adherence to the required schedule. Includes services received in the home or on an outpatient basis.	
		[Blank]. Not applicable 1. Scheduled, full adherence as prescribed 2. Scheduled, partial adherence 3. Scheduled, not received [If no treatments provided, check NONE OF ABOVE P2aa]	
	RESPIRATORY TREATMENTS	<input type="checkbox"/>	o. Occupational therapy
	a. Oxygen	<input type="checkbox"/>	p. Physical therapy
	b. Respirator for assistive breathing	<input type="checkbox"/>	PROGRAMS
	c. All other respiratory treatments	<input type="checkbox"/>	q. Day center
	OTHER TREATMENTS	<input type="checkbox"/>	r. Day hospital
	d. Alcohol/drug treatment program	<input type="checkbox"/>	s. Hospice care
	e. Blood transfusion(s)	<input type="checkbox"/>	t. Physician or clinic visit
	f. Chemotherapy	<input type="checkbox"/>	u. Respite care
	g. Dialysis	<input type="checkbox"/>	SPECIAL PROCEDURES DONE IN HOME
	h. IV infusion - central	<input type="checkbox"/>	v. Daily nurse monitoring (e.g., EKG, urinary output)
	i. IV infusion - peripheral	<input type="checkbox"/>	w. Nurse monitoring less than daily
	j. Medication by injection	<input type="checkbox"/>	x. Medical alert bracelet or electronic security alert
	k. Ostomy care	<input type="checkbox"/>	y. Skin treatment
	l. Radiation	<input type="checkbox"/>	z. Special diet
	m. Tracheostomy care	<input type="checkbox"/>	aa. <i>NONE OF ABOVE</i>
	THERAPIES	<input type="checkbox"/>	aa.
	n. Exercise therapy	<input type="checkbox"/>	
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	d. Ostomy	
4.	VISITS IN LAST 90 DAYS OR SINCE LAST ASSESSMENT	<i>Enter 0 if none, if more than 9, code "9"</i>	
		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/neuroleptic	c. Antidepressant
	b. Anxiolytic	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) in LAST 7 DAYS 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	

= When box blank, must enter number or letter a. = When letter in box, check if condition applies

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)	5. Subcutaneous (SQ)	9. Enteral tube	
		2. Sub lingual (SL)	6. Rectal (R)	10. Other	
		3. Intramuscular (IM)	7. Topical		
		4. Intravenous (IV)	8. Inhalation		
		c. Number taken —Record the amount of medication administered each time the medication is given			
		d. Freq: Code the number of times per day, week, or month the medication is administered using the following list:			
		PRN. As necessary	5D. Five times daily		
		QH. Every hour	QOD. Every other day		
		Q2H. Every two hours	QW. Once each wk		
		Q3H. Every three hours	2W. Two times every week		
		Q4H. Every four hours	3W. Three times every week		
		Q6H. Every six hours	4W. Four times each week		
		Q8H. Every eight hours	5W. Five times each week		
		QD. Once daily	6W. Six times each week		
		BID. Two times daily (includes every 12 hrs)	1M. Once every month		
		TID. Three times daily	2M. Twice every month		
		QID. Four times daily	C. Continuous		
			O. Other		
	a. Name and Dose	b. Form	c. Number Taken	d. Freq.	
	a. _____				
	b. _____				
	c. _____				
	d. _____				
	e. _____				
	f. _____				
	g. _____				
	h. _____				
	i. _____				
	j. _____				
	k. _____				

SECTION R. ASSESSMENT INFORMATION

1. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:			
a. Signature of Assessment Coordinator			
b. Title of Assessment Coordinator			
c. Date Assessment Coordinator signed as complete		<input type="text"/>	<input type="text"/>
	Month	Day	Year
d. Other Signatures	Title	Sections	Date
e.			Date
f.			Date
g.			Date
h.			Date
i.			Date