CARE-C
Discharge
Assessment

I. Administrative Information

FOR OFFICE USE ONLY

Office Staff: Please complete this information before providing this questionnaire to the patient or to whomever is helping them.

A.1 Current Date |__|__| / |__|__| / |__|__|__|__|
MM DD YYYY

A.2 Names and National Provider Identification Codes (NPI) for therapists billing separately

Please enter the names and NPIs of therapists treating this patient in this clinic who bill Medicare separately. Each therapist who bills Medicare separately must complete their own separate "Provider Information" sections.

	Therapist Name		Therapist NPI
A.2.a	_____	A.3.a	|__|__|__|__|__|__|__|__|__|__|
A.2.b	_____	A.3.b	|__|__|__|__|__|__|__|__|__|__|
A.2.c	_____	A.3.c	|__|__|__|__|__|__|__|__|__|__|
A.2.d	_____	A.3.d	|__|__|__|__|__|__|__|__|__|__|

A.4 Patient's Medicare Health Insurance Claim Number |__|__|__|__|__|__|__|__|__|__|__|__|

A.5 Does the patient need someone to assist them to complete the form, or answer for them?

There are several items in this questionnaire intended to be reported by patients. However, some patients may need assistance to fill out the form, and others may need someone to fill the form out for them.

A.5a Based on your knowledge of the patient or conversations you have had with him or her, please indicate whether the patient may need assistance completing the form or needs to have someone else complete the form for them. Please check all that apply.

¨ 1. The patient cannot read English or Spanish.
¨ 2. The patient has low vision or blindness.
¨ 3. The patient cannot write their own responses on the form (e.g., upper limb impairment).
¨ 4. The patent has difficulty understanding instructions.
¨ 5. The patient cannot concentrate for 15 minutes.
¨ 6. The patient cannot give correct/accurate answers to questions about their health.
¨ 7. Another reason: _____
¨ 8. The patient does not need any assistance and can complete the questionnaire themself.

If a patient meets any of the above conditions, please choose an assistant or proxy to help the patient answer the questionnaire from the following list:

1. Family member or friend who came to the appointment with the patient
2. Treating therapist
3. Other office staff (**ONLY** if the patient appears to need an assistant to write down answers on the form, NOT if they appear to need a proxy to answer for them)

Please go in order down the list to choose an assistant or proxy. For example, if someone who came with the patient cannot help, please have the treating therapist help the patient with the questionnaire.

A.5b Who completed this form?

¨ Patient
Proxy/Assistant: ¨ Family Member ¨ Companion Not Family ¨ Therapist ¨ Other Office/Practice Staff

II. Patient Information

Patients: Please complete this form before meeting with your therapist.

B.1a First Name	B.1b Middle Initial	B.1c Last Name

B.2 Gender ¨ Male ¨ Female

B.3 Birth Date |___|___| / |___|___| / |___|___|___|___|
MM DD YYYY

D Global Ratings of Change
Think of the condition for which you are receiving therapy. Has there been any change in this condition since you began therapy? Please indicate the change in your condition by checking the box next to the appropriate category.

D.1 Please check the box that best describes the health condition for which you are seeing a therapist today.

¨ Worse ¨ About the same ¨ Better

D.1a If you indicated that your condition is **WORSE** than when you began therapy, please see the list below. Check the box next to the statement that best describes how much worse your condition is.	D.1b If you indicated that your condition is **BETTER** than when you received therapy, please see the list below. Check the box next to the statement that best describes how much better your condition is.
¨ Almost the same, hardly any WORSE at all	¨ Almost the same, hardly any BETTER at all
¨ A little WORSE	¨ A little BETTER
¨ Somewhat WORSE	¨ Somewhat BETTER
¨ Moderately WORSE	¨ Moderately BETTER
¨ A good deal WORSE	¨ A good deal BETTER
¨ A great deal WORSE	¨ A great deal BETTER
¨ A very great deal WORSE	¨ A very great deal BETTER

II. Patient Information (cont.)

E. Pain or Hurting

E.1 **Pain Presence or Hurting** Have you had pain or hurting at any time during the last 7 days? **If "no," please skip to the next page.**	Yes	No	Don't know
	¨	¨	¨

E.2 Pain or Hurting Severity (Check one box.)
Please rate your worst pain during the last 7 days from 0 to 10, with 0 being no pain and 10 being the worst pain you can imagine.

¨	¨	¨	¨	¨	¨	¨	¨	¨	¨	¨
0	1	2	3	4	5	6	7	8	9	10
No Pain					Moderate Pain					Worst Pain

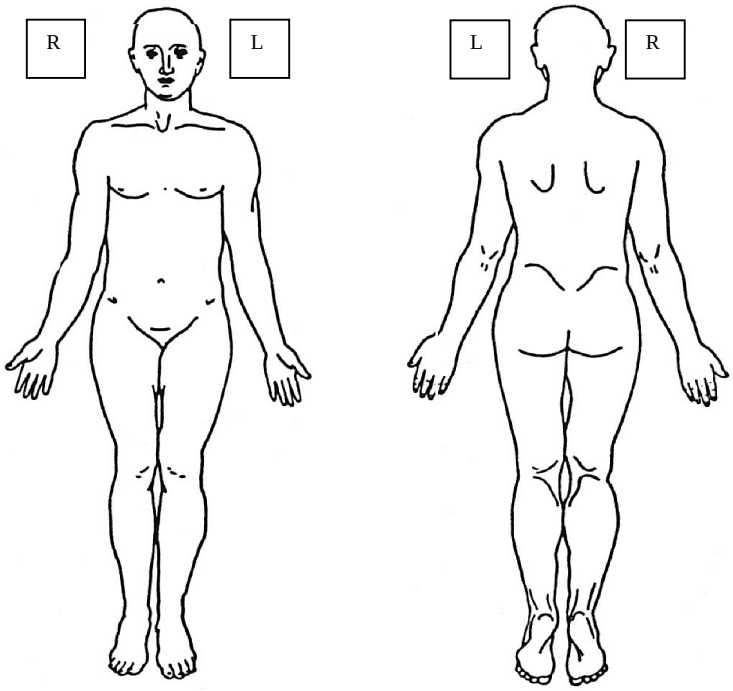
E.3 Please describe your pain or hurting. (Check all that apply.)

Check all that apply.

¨ a. Constant	¨ e. Burning	¨ i. Ache/Throb	¨ m. Tightness
¨ b. Intermittent	¨ f. Pinching	¨ j. Stabbing	¨ n. Stiffness
¨ c. Sharp	¨ g. Numbness	¨ k. Pulling	¨ o. Other: Please write in
¨ d. Dull	¨ h. Tingling	¨ l. Cramping	_____

E.4 Pain/Hurting Location

Please mark with an **X** the area(s) of your body where you have pain or hurting.



E.5 Pain/Hurting Effect on Sleep (Check one box.)
During the past 2 days, has pain made it hard for you to sleep?
¨ No ¨ Yes ¨ Don't know

E.6 Pain/Hurting Effect on Activities (Check one box.)
During the past 2 days, have you limited your activities because of pain?
¨ No ¨ Yes ¨ Don't know

II. Patient Information (cont.)

F.1 Basic Mobility

Do you have difficulty with getting around (mobility), either walking or in a wheelchair?

¨ Yes è If "yes," please answer the rest of the questions on this page.

¨ No è If "no," please skip to the next page.

How much DIFFICULTY do you currently have… (If you have not done an activity recently, how much difficulty do you think you would have if you tried?)	**Unable**	**A Lot**	**A Little**	**None**
a. Moving from sitting at the side of the bed to lying down on your back?	¨	¨	¨	¨
b. Moving up in bed (e.g. reposition self)?	¨	¨	¨	¨
c. Standing for at least one minute?	¨	¨	¨	¨
d. Sitting down in an armless straight chair (e.g., dining room chair)?	¨	¨	¨	¨
e. Getting into and out of a car/taxi (sedan)?	¨	¨	¨	¨
f. Cleaning up spills on the floor (e.g., with a rag or mop)?	¨	¨	¨	¨
g. Walking around one floor of your home, taking into consideration thresholds, doors, furniture, and a variety of floor coverings?	¨	¨	¨	¨
h. Walking on an uneven surface (e.g., grass, dirt road or sidewalk, brick walkways, sidewalks with curb and driveway cuts) using your walking aid?	¨	¨	¨	¨
i. Doing light housework (e.g., dusting, minor sweeping)?	¨	¨	¨	¨
j. Bending over from a standing position to pick up a piece of clothing from the floor without holding onto anything?	¨	¨	¨	¨
k. Standing up from a low, soft couch?	¨	¨	¨	¨
l. Walking several blocks?	¨	¨	¨	¨
m. Going up and down a flight of stairs outside, without using a handrail?	¨	¨	¨	¨
n. Walking up and down steep unpaved inclines (e.g., steep gravel driveway)?	¨	¨	¨	¨
o. Taking a 1-mile brisk walk, without stopping to rest?	¨	¨	¨	¨
p. Carrying something in both arms while climbing a flight of stairs (e.g., laundry basket)?	¨	¨	¨	¨

Do you also use a wheelchair to get around?

¨ Yes è If "yes," please answer the rest of the questions on this page.

¨ No è If "no," please skip to the next page.

Without help from another person, when you are using your wheelchair, how much difficulty do you currently have… (If you have not done an activity recently, how much help do you think you would need if you tried?)	**Unable**	**A Lot**	**A Little**	**None**
a. Moving around within one room, including making turns in a wheelchair?	¨	¨	¨	¨
b. Reaching for a high object, using a wheelchair?	¨	¨	¨	¨
c. Opening a door away from a wheelchair?	¨	¨	¨	¨
d. Opening a door toward a wheelchair?	¨	¨	¨	¨
e. Transferring between a wheelchair and other seating surfaces, such as a chair or bed?	¨	¨	¨	¨
f. Propelling/driving a wheelchair several blocks?	¨	¨	¨	¨

II. Patient Information (cont.)

F.2 Everyday Activities

Do you have difficulty with engaging in everday activities?

¨ Yes è If "yes," please answer the rest of the questions on this page.

¨ No è If "no," please skip to the next page.

How much DIFFICULTY do you currently have… (If you have not done an activity recently, how much difficulty do you think you would have if you tried?)	**Unable**	**A Lot**	**A Little**	**None**
a. Picking up thin, flat objects from a table (e.g., coins, post card, envelope)?	¨	¨	¨	¨
b. Putting on and taking off a shirt or blouse?	¨	¨	¨	¨
c. Putting on and taking off socks?	¨	¨	¨	¨
d. Removing stiff plastic packaging using hands and scissors?	¨	¨	¨	¨
e. Tying shoes?	¨	¨	¨	¨
f. Replacing or tightening small parts using only your hands (e.g., screws)?	¨	¨	¨	¨
g. Holding a screw and screwing it tight with a manual screwdriver?	¨	¨	¨	¨
h. Unscrewing the lid off a previously unopened jar without using devices?	¨	¨	¨	¨
i. Washing indoor windows?	¨	¨	¨	¨
j. Hanging wash on a line at eye level or above?	¨	¨	¨	¨
k. Pounding a nail in straight with a hammer to hang a picture?	¨	¨	¨	¨
l. Sewing on a button?	¨	¨	¨	¨
m. Fastening clothing behind your back?	¨	¨	¨	¨
n. Lifting 25 pounds from the ground to a table?	¨	¨	¨	¨
o. Moving a sofa to clean under it?	¨	¨	¨	¨
p. Cutting your toenails?	¨	¨	¨	¨

II. Patient Information (cont.)

F.3 Life Skills

Do you have difficulty with communicating, remembering, organizing, or planning in your daily life?

¨ Yes è If "yes," please answer the rest of the questions on this page.
¨ No è If "no," please go to the next page.

How much DIFFICULTY do you currently have… (If you have not done an activity recently, how much difficulty do you think you would have if you tried?)	**Unable**	**A Lot**	**A Little**	**None**
a. Understanding familiar people during ordinary conversations?	¨	¨	¨	¨
b. Understanding instructions involving several steps (e.g., how to prepare a meal or following directions)?	¨	¨	¨	¨
c. Following/understanding a 10- to 15-minute speech or presentation (e.g., lesson at a place of worship, guest lecture).	¨	¨	¨	¨
d. Answering yes/no questions about basic needs (e.g., "Do you need to use the restroom?" "Are you in pain?")	¨	¨	¨	¨
e. Making yourself understood to other people during ordinary conversations?	¨	¨	¨	¨
f. Telling someone important information about yourself in case of emergency?	¨	¨	¨	¨
g. Explaining how to do something involving several steps to another person?	¨	¨	¨	¨
h. Reading and following complex instructions (e.g., directions to operate a new appliance or for a new medication)?	¨	¨	¨	¨
i. Telling others your basic needs (e.g., need to use the restroom, have a drink of water or request help)?	¨	¨	¨	¨
j. Planning for and keeping appointments that are not part of your weekly routine (e.g., a therapy or doctor appointment, or a social gathering with friends and family)?	¨	¨	¨	¨
k. Reading simple material (e.g., a menu or the TV or radio guide)?	¨	¨	¨	¨
l. Filling out a long form (e.g., insurance form or an application for services)?	¨	¨	¨	¨
m. Writing down a short message or note?	¨	¨	¨	¨
n. Getting to know new people?	¨	¨	¨	¨
o. Remembering where things were placed or put away (e.g., keys)?	¨	¨	¨	¨
p. Remembering personal information (e.g., medical history, important events)?	¨	¨	¨	¨
q. Keeping track of time (e.g., using a clock)?	¨	¨	¨	¨
r. Putting together a shopping list of 10 to 15 items?	¨	¨	¨	¨
s. Remembering a list of 4 or 5 errands without writing it down?	¨	¨	¨	¨
t. Taking care of complicated tasks like managing a checking account or getting appliances fixed?	¨	¨	¨	¨
u. Keeping important personal papers such as bills, insurance documents, and tax forms organized?	¨	¨	¨	¨

II. Patient Information (cont.)

G. **Additional Questions**

G.3 Feeling Sad?

During the past 2 weeks, how often would you say, “I feel sad?”

¨ Never ¨ Rarely ¨ Sometimes ¨ Often ¨ Always ¨ Don’t know

G.4 Confidence

Thinking about all the activities you like to do, how much confidence do you feel today about your overall ability in doing them?

¨ None ¨ Some ¨ A lot ¨ Complete ¨ Don’t know

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE!

III. Provider Information

Providers, please complete by the end of your therapy session.

A. Primary Reason for Therapy

Please indicate the primary body function(s), body structure(s), and activity & participation reason(s) for which you are treating this patient using the categories below. **Check all primary reasons for therapy that apply.**

A.1 Body Functions (Check at least one)

- ¨ a. Global Mental Functions (consciousness, orientation, intellectual function, energy & drive, sleep, temperament, personality)
- ¨ b. Specific Mental Functions (attention, memory, psychomotor, emotional, perceptual, higher level cognition, sequencing of complex tasks, calculation, mental functions of language)
- ¨ c. Seeing & Related Functions
- ¨ d. Hearing & Related Vestibular Functions
- ¨ e. Other Sensory Functions (taste, smell, proprioceptive, touch)
- ¨ f. Pain
- ¨ g. Voice & Speech Functions (articulation, speech, fluency & rhythm, alternative vocalization)
- ¨ h. Functions of the Cardiovascular System
- ¨ i. Functions of the Immunological & Hematological Systems
- ¨ j. Functions of the Respiratory System
- ¨ k. Functions of the Digestive System
- ¨ l. Functions Related to Metabolism & Endocrine System
- ¨ m. Urinary Functions
- ¨ n. Genital & Reproductive Functions
- ¨ o. Functions of the Joints & Bones
- ¨ p. Muscle Functions (muscle power, tone, endurance)
- ¨ q. Movement Functions (motor reflexes, involuntary movements, control of movements, gait patterns, neuromuscular functions)
- ¨ r. Functions of the Skin
- ¨ s. Functions of the Hair & Nails

A.2 Body Structures (Check at least one)

Structures Related to Movement

- ¨ a. General/No Specific Body Location
- ¨ b. Head
- ¨ c. Cervical Spine
- ¨ d. Thoracic Spine
- ¨ e. Lumbar Spine
- ¨ f. Pelvic Girdle

U: Unilateral; B: Bilateral

U	B	
¨	¨	g. Hip
¨	¨	h. Thigh
¨	¨	i. Knee
¨	¨	j. Calf
¨	¨	k. Foot/Ankle
¨	¨	l. Toes
¨	¨	m. Shoulder
¨	¨	n. Arm
¨	¨	o. Elbow
¨	¨	p. Wrist
¨	¨	q. Hand
¨	¨	r. Fingers

Structures Involved in Voice & Speech

- ¨ s. Nose
- ¨ t. Mouth
- ¨ u. Tongue
- ¨ v. Pharynx
- ¨ w. Larynx

Other Structures

- ¨ x. Eye & Related Structures
- ¨ y. Ear & Related Structures
- ¨ z. Structures of the Nervous System
- ¨ aa. Structures of the Cardiovascular, Immunological, & Respiratory Systems
- ¨ bb. Structures Related to the Digestive, Metabolic, & Endocrine Systems
- ¨ cc. Structures Related to the Genitourinary & Reproductive Systems
- ¨ dd. Skin & Related Structures

A.3 Activities and Participation (Check at least one)

- ¨ a. Purposeful Sensory Experiences (watching, listening)
- ¨ b. Basic Learning (copying, rehearsing, learning to read, write, acquiring skills)
- ¨ c. Applying Knowledge (focusing attention, thinking, reading, writing, calculating, solving problems, making decisions)
- ¨ d. General Tasks & Demands (simple and multiple tasks, carrying out daily routine, handling stress)
- ¨ e. Communication: Receiving (spoken, non verbal, sign language, written)
- ¨ f. Communication: Producing (speaking, nonverbal, sign language, writing)
- ¨ g. Conversation & Use of Communication Devices (conversation, discussion, using devices and techniques)
- ¨ h. Changing & Maintaining Body Position
- ¨ i. Carrying, Moving, & Handling Objects
- ¨ j. Walking & Moving
- ¨ k. Moving Around Using Transportation
- ¨ l. Self Care (washing oneself, toileting, dressing, eating, drinking)
- ¨ m. Acquisition of Necessities (a place to live, goods and services)
- ¨ n. Household Tasks (preparing meals, doing housework)
- ¨ o. Caring for Household Objects & Assisting Others
- ¨ p. General Interpersonal Interactions
- ¨ q. Particular Interpersonal Interactions (relating with strangers, formal and informal relationships, family and intimate relationships)
- ¨ r. Education
- ¨ s. Work & Employment
- ¨ t. Economic Life
- ¨ u. Community, Social, & Civic Life
- ¨ v. Ribs/Collar Bone

III. Current Medical Information (cont.)

Providers, please complete by the end of your therapy session.

B. Primary and Secondary Medical Diagnoses

Based on available medical information, please indicate the patient's primary (1ary) and secondary (2ary) medical conditions. The primary diagnosis should be related to the reason for therapy. **Please check all that apply.**

B.1 Musculoskeletal

1ary 2ary
- ¨ ¨ a. Pain Syndrome (fibromyalgia, polymyalgia, etc.)
- ¨ ¨ b. Pain, Not Pain Syndrome
- ¨ ¨ c. Osteoarthritis
- ¨ ¨ d. Rheumatoid Arthritis
- ¨ ¨ e. TMJ Disorder
- ¨ ¨ f. Fracture
- ¨ ¨ g. Sprain/Strain
- ¨ ¨ h. Osteoporosis
- ¨ ¨ i. Herniated Disc
- ¨ ¨ j. Spinal Stenosis
- ¨ ¨ k. Scoliosis
- ¨ ¨ l. Torticolis
- ¨ ¨ m. Contusion
- ¨ ¨ n. Joint Replacement
- ¨ ¨ o. Amputation
- ¨ ¨ p. Bursitis
- ¨ ¨ q. Tendonitis
- ¨ ¨ r. Internal Derangement of Joint
- ¨ ¨ s. Tendon Rupture
- ¨ ¨ t. Nerve Entrapment
- ¨ ¨ u. Contracture
- ¨ ¨ v. Other _____

B.2 Circulatory

1ary 2ary
- ¨ ¨ a. TIA
- ¨ ¨ b. Stroke
- ¨ ¨ c. Atrial Fibrillation & Other Dysrhythmia (bradycardia, tachydardia)
- ¨ ¨ d. Coronary Artery Disease (angina, myocardial infarction)
- ¨ ¨ e. Deep Vein Thrombosis (DVT)
- ¨ ¨ f. Heart Failure (including pulmonary edema)
- ¨ ¨ g. Hypertension
- ¨ ¨ h. Peripheral Vascular Disease/Peripheral Arterial Disease
- ¨ ¨ i. Other _____

B.3 Lymphatic System

1ary 2ary
- ¨ ¨ a. Lymphedema
- ¨ ¨ b. Other _____

B.4 Pulmonary/Respiratory System

1ary 2ary
- ¨ ¨ a. Pneumonia
- ¨ ¨ b. Chronic Obstructive Pulmonary Disease (COPD)
- ¨ ¨ c. Cystic Fibrosis
- ¨ ¨ d. Other _____

B.5 Integumentary System

1ary 2ary
- ¨ ¨ a. Skin Ulcer/Wound
- ¨ ¨ b. Burn
- ¨ ¨ c. Other _____

B.6 Genitourinary System

1ary 2ary
- ¨ ¨ a. End Stage Renal Disease (ESRD)
- ¨ ¨ b. Incontinence
- ¨ ¨ c. Pelvic Pain
- ¨ ¨ d. Other _____

B.7 Mental Health

1ary 2ary
- ¨ ¨ a. Anxiety Disorder
- ¨ ¨ b. Depression
- ¨ ¨ c. Bipolar Disease
- ¨ ¨ d. Attention Disorder
- ¨ ¨ e. Schizophrenia
- ¨ ¨ f. Alzheimer's Disease
- ¨ ¨ g. Other _____

B.8 Cancer/Other Neoplasms

1ary 2ary
- ¨ ¨ a. Please Specify

B.9 Metabolic System

1ary 2ary
- ¨ ¨ a. Diabetes Mellitus
- ¨ ¨ b. Obesity
- ¨ ¨ c. Other _____

B.10 Generalized Weakness

1ary 2ary
- ¨ ¨ a. Generalized Weakness

B.11 Infectious Diseases

1ary 2ary
- ¨ ¨ a. Please Specify

B.12 HIV

1ary 2ary
- ¨ ¨ a. HIV

B.13 Gastrointestinal Disorders

1ary 2ary
- ¨ ¨ a. Please Specify

B.14 Immune Disorders

1ary 2ary
- ¨ ¨ a. Immune Disorders

B.15 Anemias/Other Hematological Disorders

1ary 2ary
- ¨ ¨ a. Anemia
- ¨ ¨ b. Other _____

B.16 Congenital Abnormalities

1ary 2ary
- ¨ ¨ a. Musculoskeletal Congenital Deformities/ Anomalies
- ¨ ¨ b. Neurological Congenital/Developmental Anomalies
- ¨ ¨ c. Other _____

B.17 Neurological Conditions

1ary 2ary
- ¨ ¨ a. Specific Diseases of Central Nervous System (CNS)
- ¨ ¨ b. Cranial Neuralgia
- ¨ ¨ c. Cranial Nerve Injury
- ¨ ¨ d. Seizure Disorder
- ¨ ¨ e. Paralysis
- ¨ ¨ f. Peripheral Nervous System Disorder (including neuropathy)
- ¨ ¨ g. Complex Regional Syndrome
- ¨ ¨ h. Vertigo
- ¨ ¨ i. Multiple Sclerosis
- ¨ ¨ j. Parkinson's
- ¨ ¨ k. Huntington's Disease
- ¨ ¨ l. Head Injury
- ¨ ¨ m. Traumatic Brain Injury
- ¨ ¨ n. Non-Traumatic Brain Injury
- ¨ ¨ o. Encephalopathy
- ¨ ¨ p. Retinopathy
- ¨ ¨ q. Guillain-Barré Syndrome
- ¨ ¨ r. Other _____

B.18 Cognition/Judgement

1ary 2ary
- ¨ ¨ a. Executive Function Disorder
- ¨ ¨ b. Memory Impairment
- ¨ ¨ c. Pragmatics Disorder
- ¨ ¨ d. Dementia
- ¨ ¨ e. Other _____

B.19 Communication, Voice, or Speech Disorder

1ary 2ary
- ¨ ¨ a. Aphasia
- ¨ ¨ b. Apraxia of Speech
- ¨ ¨ c. Reading or Writing Dysfunction
- ¨ ¨ d. Voice Disorder (Dysphonia)
- ¨ ¨ e. Speech Disorder
- ¨ ¨ f. Cognitive-Communication Disorder
- ¨ ¨ g. Other _____

B.20 Swallowing Disorder

1ary 2ary
- ¨ ¨ a. Dysphagia

B.21 Sensory Disorders/Gait or Balance Disorder

1ary 2ary
- ¨ ¨ a. Hearing Impairment
- ¨ ¨ b. Vision Impairment
- ¨ ¨ c. Gait or Balance Disorder
- ¨ ¨ d. Other _____

B.22 Other Condition

1ary 2ary
- ¨ ¨ a. Please Specify _____

III. Provider Information (cont.)

C. Supplemental Conditions/Impairments

	Yes	No	Don't Know	If "Yes," complete…
C.1a Does the patient have any vision impairments?	..	..	..	C.1b on page 10
C.2a Does the patient have any hearing impairments?	..	..	..	C.2b on page 10
C.3a Does the patient have any signs or symptoms of a possible swallowing disorder?	..	..	..	C.3b on page 10
C.4a Does the patient have any problems with memory, attention, problem solving, planning, organizing or judgment?	..	..	..	C.4b & C.4c on page 11
C.5a Does the patient have any signs or symptoms of a possible communication impairment?	..	..	..	C.5b–C.5d on page 11
C.6a Does this patient have one or more unhealed pressure ulcers at stage 2 or higher or unstageable?	..	..	..	C.6b on page 12
C.7a Does the patient have any impairments with bladder or bowel management (e.g., use of a device or incontinence)?	..	..	..	C.7b–C.7d on page 12

If you answered "No" or "Don't Know" to all of items C.1a–C.7a above, you are done with this assessment instrument and may skip all remaining items.

C.1 Vision

Answer **only** if you answered "Yes" to C.1a (Does the patient have any vision impairments?)

C.1b Describe the patient's ability to see in adequate light (with glasses or other visual appliances)

.. **Adequate:** Sees fine detail, including regular print in newspapers/books

.. **Mild to Moderately Impaired:** Can identify objects; may see large print

.. **Severely Impaired:** No vision or object identification questionable

C.2 Hearing

Answer **only** if you answered "Yes" to C.2a (Does the patient have any hearing impairments?)

C.2b Describe the patient's ability to hear (with hearing aid or hearing appliance, if normally used)

.. **Adequate:** Hears normal conversation and TV without difficulty

.. **Mild to Moderately Impaired:** Difficulty hearing in some environments or speaker may need to increase volume or speak distinctly

.. **Severely Impaired:** Absence of useful hearing

C.3 Swallowing

Answer **only** if you answered "Yes" to C.3a (Does the patient have any signs or symptoms of a possible swallowing disorder?)

C.3b What signs and symptoms of a swallowing disorder does the patient have?

Check all that apply.

.. 1. History of dysphagia/aspiration pneumonia

.. 2. Complaints of difficulty or pain with swallowing

.. 3. Coughing or choking during meals or when swallowing medications

.. 4. Holding food in mouth/cheeks or residual food in mouth after meals

.. 5. Loss of liquids/solids from mouth when eating or drinking

.. 6. NPO: intake not by mouth

.. 7. Other (specify) _____

III. Provider Information (cont.)

C.4 Cognitive Status

Answer **only** if you answered "Yes" to C.4a (Does the patient have any problems with memory, attention, problem solving, planning, organizing or judgment?)

C.4b	**Please indicate all of the following that the patient is able to recall:**	**Check all that apply.** .. 1. Current season .. 2. Location of own room (nursing home only) .. 3. Staff names and faces .. 4. That s/he is in a hospital, nursing home, clinic, office, or home .. 5. None of the above
C.4c	**Please describe the patient's problems with memory, attention, problem solving, planning, organizing or judgment.**	.. **Mildly impaired:** Demonstrates some difficulty with some or all of these cognitive abilities. .. **Moderately impaired:** Demonstrates marked difficulty with with some or all of these cognitive abilities .. **Severely impaired:** Demonstrates extreme difficulty with some or all of these cognitive abilities.

C.5 Communication

Answer **only** if you answered "Yes" to C.5a (Does the patient have any signs or symptoms of a possible communication impairment?)

C.5b	**Please describe the patient's problems with communication.**	.. **Mildly impaired:** Demonstrates some difficulty with comprehension and/or expression but is able to functionally communicate most of the time. .. **Moderately impaired:** Demonstrates marked difficulty with comprehension and/or expression that noticeably interferes with functional communication. .. **Severely impaired:** Demonstrates extreme difficulty with comprehension and/or expression with little-to-no functional communication.
C.5c	**Please describe the patient's ability to understanding verbal content** (excluding language barriers).	.. **Understands:** Clear comprehension without cues or repetitions. .. **Usually Understands:** Understands most conversations, but misses some part/intent of message. Requires cues at times to understand. .. **Sometimes Understands:** Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand. .. **Rarely/Never Understands.**
C.5d	**Please describe the patient's ability to express ideas and wants.**	.. Expresses complex messages **without difficulty** and with speech that is clear and easy to understand. .. Exhibits some **difficulty** with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear. .. **Frequently** exhibits difficulty with expressing needs and ideas. .. **Rarely/Never** expresses self or speech is very difficult to understand.

III. Provider Information (cont.)

C.6 Pressure Ulcers

Answer **only** if you answered "Yes" to C.6a (Does this patient have one or more unhealed pressure ulcers at stage 2 or higher, or unstageable?)

C.6b Do these pressure ulcers interfere with your therapy treatments?	.. Yes	.. No	.. Don't Know

C.7 Incontinence

Answer **only** if you answered "Yes" to C.7a (Does the patient have any impairments with bladder or bowel management [e.g., use of a device or incontinence]?)

C.7b Does the incontinence interfere with your therapy treatments?	.. Yes	.. No	.. Don't Know

	C.7c Bladder	C.7d Bowel	
C.7c&d Please Indicate the frequency of the patient's bladder and bowel incontinence	..	..	Stress Incontinence Only
	..	..	Incontinent Less Than Daily
	..	..	Incontinent Daily
	..	..	Always Incontinent
	..	..	No Urine/Bowel Output
	..	..	Not Applicable

III. Provider Information (cont.)

D. Supplemental Swallowing, Cognition & Communication Function

Are you treating or evaluating this patient for any of the following reasons?

	Yes	No	If "Yes," complete…
D.1a Signs or symptoms of a possible swallowing disorder?	··	··	D.2 on page 13
D.1b Difficulty with communicating in daily life?	··	··	D.3–D.6 on pages 13 & 14
D.1c Difficulty with remembering, organizing, or attending in daily life?	··	··	D.7–D.9 on page 15

If you answered "No" to all of items D.1a–D.1c above, you are done with this assessment instrument and may skip all remaining items.

D.2 Swallowing Function

Answer **only** if you answered "Yes" to D.1a (Signs or symptoms of a possible swallowing disorder?)

For safety and maximal nutritional intake, the patient requires:

Liquid Diet Modification: Thickened liquids (e.g., consistency of syrup, honey, or pudding)

Solid Diet Modification: Cooked until soft; chopped, ground, mashed; or pureed

Maximal Cueing: Multiple cues that are obvious to nonclinicians, including any combination of auditory, visual, pictorial, tactile, or written cues

Minimal Cueing: Subtle and only one type of cueing

	D.2a Diet Modification		**D.2b Level of Cueing or Assistance**
··	Both Liquids & Solids	··	Maximal
··	Either Liquids or Solids	··	Minimal
··	None	··	None

D.3–D.6 Communication Function

Answer **only** if you answered "Yes" to D.1b (Difficulty with communicating in daily life?)

In Questions K.3 through K.6, please use the following definitions for the frequency with which the patient can perform the indicated activity and for level of assistance:

Frequency Performing Activity	**Never:**	Unable
	Rarely:	Less than 20% of the time
	Sometimes:	Between 20% and 49% of the time
	Usually or Always:	At least 50% of the time
Level of Assistance	**Without Assistance:**	Patient performance **without** cueing, external guidance, assistive device, or other compensatory augmentative intervention
	With Assistance:	Patient performance **with** cueing, external guidance, assistive device, or other compensatory augmentative intervention

D.3 Language Comprehension

The patient comprehends:

Basic Information: Simple directions; simple yes/no questions; simple words or phrases

Complex Information: Complex sentences/directions/messages; conversations about routine daily activities

	Basic Information		**Complex Information**	
	D.3a Without Assistance	**D.3b With Assistance**	**D.3c Without Assistance**	**D.3d With Assistance**
Never	··	··	··	··
Rarely	··	··	··	··
Sometimes	··	··	··	··
Usually or Always	··	··	··	··

III. Provider Information (cont.)

D.4 Language Expression

The patient conveys:

Basic Information: Simple directions; simple yes/no questions; simple words or phrases

Complex Information: Complex sentences/directions/messages; conversations about routine daily activities

	Basic Information		Complex Information	
	D.4a Without Assistance	D.4b With Assistance	D.4c Without Assistance	D.4d With Assistance
Never	..	..	..	..
Rarely	..	..	..	..
Sometimes	..	..	..	..
Usually or Always	..	..	..	..

D.5 Motor Speech Production

The patient's speech is:

Intelligible in Short Utterances: Short consonant-vowel combinations; automatic words; simple words or predictable phrases

Intelligible in Conversation: Long utterances; low predictability sentences; communication in vocational, avocational, and social activities

	Intelligible in Short Utterances		Intelligible in Conversation	
	D.5a Without Assistance	D.5b With Assistance	D.5c Without Assistance	D.5d With Assistance
Never	..	..	..	..
Rarely	..	..	..	..
Sometimes	..	..	..	..
Usually or Always	..	..	..	..

D.6 Voice

The patient's voice is functional in the following types of activities:

Low Vocal Demand: Speaking softly; speaking in quiet environments; talking for short periods of time

High Vocal Demand: Speaking loudly; speaking in noisy environments; talking for extended periods of time

	Low Vocal Demand		High Vocal Demand	
	D.6a Without Assistance	D.6b With Assistance	D.6c Without Assistance	D.6d With Assistance
Never	..	..	..	..
Rarely	..	..	..	..
Sometimes	..	..	..	..
Usually or Always	..	..	..	..

III. Provider Information (cont.)

D.7–D.9 Cognitive Function

Answer **only** if you answered "Yes" to D.1c (Difficulty with remembering, organizing, or attending in daily life?)

In Questions D.7 through D.9, please use the following definitions for the frequency with which the patient can perform the indicated activity and for level of assistance:

Frequency Performing Activity	**Never:**	Unable
	Rarely:	Less than 20% of the time
	Sometimes:	Between 20% and 49% of the time
	Usually or Always:	At least 50% of the time
Level of Assistance	**Without Assistance:**	Patient performance **without** cueing, external guidance, assistive device, or other compensatory augmentative intervention
	With Assistance:	Patient performance **with** cueing, external guidance, assistive device, or other compensatory augmentative intervention

D.7 Problem Solving

The patient solves:

Simple Problems: Following schedules; requesting assistance; using a call bell; identifying basic wants/needs; preparing a simple cold meal

Complex problems: Working on a computer; managing personal, medical, and financial affairs; preparing a complex hot meal; grocery shopping; route finding and map reading

	Simple Problems		Complex Problems	
	D.7a Without Assistance	**D.7b With Assistance**	**D.7c Without Assistance**	**D.7d With Assistance**
Never	··	··	··	··
Rarely	··	··	··	··
Sometimes	··	··	··	··
Usually or Always	··	··	··	··

D.8 Memory

The patient recalls:

Basic Information: Personal information (e.g., family members, biographical information, physical location); schedules; names of familiar staff; location of therapy area

Complex Information: Complex and novel information (e.g., carry out multiple-step activities, follow a plan); anticipate future events (e.g., keeping appointments)

	Basic Information		Complex Information	
	D.8a Without Assistance	**D.8b With Assistance**	**D.8c Without Assistance**	**D.8d With Assistance**
Never	··	··	··	··
Rarely	··	··	··	··
Sometimes	··	··	··	··
Usually or Always	··	··	··	··

D.9 Attention

The patient maintains attention for:

Simple Activities: Following simple directions; reading environmental signs; eating a meal; completing personal hygiene; dressing

Complex Activities: Watching a news program; reading a book; planning and preparing a meal; managing one's own medical, financial, and personal affairs

	Simple Activities		Complex Activities	
	D.9a Without Assistance	**D.9b With Assistance**	**D.9c Without Assistance**	**D.9d With Assistance**
Never	··	··	··	··
Rarely	··	··	··	··
Sometimes	··	··	··	··
Usually or Always	··	··	··	··

IV. Other Useful Information

A. Is there other useful information about this patient that you want to add?

V. Feedback

A. Notes

Thank you for your participation in this important project. So that we may improve the form for future use, please comment on any areas of concern or things you would change about the form.