Minimum Data Set
©Home Care (MDS-HC)©
Canadian Version

- Unless otherwise noted, score for last 3 days
- Examples of exceptions include IADLs/Continence/ Services/Treatments where status scored over last 7 days

Addressograph

SECTION AA. NAME AND IDENTIFICATION INFORMATION

1	NAME OF CLIENT	a. Last/Family Name b. First Name c. Middle Name/Initial
2	CASE RECORD NO.	
3a	HEALTH CARD NO.	a. Enter the client's health card number, or enter "**0**" if unknown or "**1**" if not applicable.
3b	PROVINCE/ TERRITORY ISSUING HEALTH CARD NO.	b. Enter the Province/Territory code issuing health card number. (See RAI-HC manual for province/territory codes and for missing/not applicable codes)
4	POSTAL CODE OF RESIDENCE	See RAI-HC manual for homeless/missing codes.

SECTION BB. PERSONAL ITEMS

1	SEX	**M.** Male **F.** Female	
2a	BIRTH DATE	Year Month Day	
2b	ESTIMATED BIRTH DATE	Birth date is estimated? **0**. No **1**. Yes	
3	ABORIGINAL IDENTITY	Client identifies self as First Nations, Métis, Inuit **0**. No **1**. Yes	
4	MARITAL STATUS	**1**. Never married **2**. Married **3**. Widowed **4**. Separated **5**. Divorced **6**. Other	
5	LANGUAGE	a. Primary language (See RAI-HC manual for additional codes.) **ENG**. English **FRE**. French b. Interpreter needed **0**. No **1**. Yes	
6	EDUCATION (Highest Level Completed)	**1**. No schooling **2**. 8th grade/less **3**. 9–11 grades **4**. High school **5**. Technical or trade school **6**. Some college/university **7**. Diploma/Bachelor's degree **8**. Graduate degree **9**. Unknown	

7	RESPONSI-BILITY/ ADVANCED DIRECTIVES	***(Code for responsibility/advanced directives)*** **0**. No **1**. Yes a. Client has a legal guardian/substitute decision-maker b. Client has advanced medical directives in place (for example, a do not hospitalize order)	
8	RESPONSI-BILITY FOR PAYMENT	***(Check all codes that apply)*** a. Provincial/territorial government plan b. Other province/territory c. Federal government—Veterans Affairs Canada d. Federal government—First Nations and Inuit Health Branch (FNIHB) e. Federal government—other (RCMP, Canadian Forces, federal penitentiary inmate, refugee) f. Worker's Compensation Board (WCB/WSIB) g. Canadian resident—private insurance pay h. Canadian resident—public trustee pay i. Canadian resident—self pay j. Other country resident—self pay k. Responsibility for payment unknown/unavailable	a. b. c. d. e. f. g. h. i. j. k.

SECTION CC. REFERRAL ITEMS *(Complete at Intake Only)*

1	DATE CASE OPENED/ REOPENED	Year Month Day	
2	REASON FOR REFERRAL	**1**. Post hospital care **2**. Community chronic care **3**. Home placement screen **4**. Eligibility for home care **5**. Day care **6**. Other	
3	UNDER-STANDING OF GOALS OF CARE	***(Code for client/family understanding of goals of care)*** **0**. No **1**. Yes a. Skilled nursing treatments b. Monitoring to avoid clinical complications c. Rehabilitation d. Client/family education e. Family respite f. Palliative care	

4	TIME SINCE LAST HOSPITAL STAY	Time since discharge from last inpatient setting ***(Code for most recent instance in LAST 180 DAYS)***	
		0. Presently in hospital **1**. No hospitalization within 180 days **2**. Within last week **3**. Within 8 to 14 days **4**. Within 15 to 30 days **5**. More than 30 days ago	☐
5	WHERE LIVED AT TIME OF REFERRAL	**1**. Private home/apt. with no home care services **2**. Private home/apt. with home care services **3**. Board and care/assisted living/group home **4**. Residential care facility **5**. Other	☐
6	WHO LIVED WITH AT REFERRAL	**1**. Lived alone **2**. Lived with spouse only **3**. Lived with spouse and other(s) **4**. Lived with child (not spouse) **5**. Lived with other(s) (not spouse or children) **6**. Lived in group setting with non-relative(s)	☐
7	PRIOR RESIDENTIAL CARE FACILITY PLACEMENT	Resided in a residential care facility at anytime during **5 YEARS** prior to case opening **0**. No **1**. Yes	☐
8	RESIDENTIAL HISTORY	Moved to current residence within last two years. **0**. No **1**. Yes	☐

SECTION A. ASSESSMENT INFORMATION

1	ASSESSMENT REFERENCE DATE	***Date of assessment*** ☐☐☐☐ Year ☐☐ Month ☐☐ Day	
2	REASON FOR ASSESSMENT	***Type of assessment*** **1**. Initial assessment **2**. Follow-up assessment **3**. Routine assessment at fixed intervals **4**. Review within 30-day period prior to discharge from the program **5**. Review at return from hospital **6**. Change in status **7**. Other	☐

SECTION X. ASSESSMENT LOCATION

70	LOCATION OF ASSESSMENT	***Type of location*** **1**. Private home, condominium, apartment, assisted living settings **2**. Hospital **3**. Residential care facility **4**. Other	☐
71	FACILITY ADMISSION DATE	***Date of admission to facility*** ***(Leave blank if X70 is coded 1)*** ☐☐☐☐ Year ☐☐ Month ☐☐ Day	

SECTION B. COGNITIVE PATTERNS

1	MEMORY RECALL ABILITY	***(Code for recall of what was learned or known)*** **0**. 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	☐
2	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	a. How well client made decisions about organizing the day (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 and 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 made decisions	☐
		b. Worsening of decision making as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) **0**. No **1**. Yes	☐
3	INDICATORS OF DELIRIUM	a. Sudden or new onset/change in mental function over **LAST 7 DAYS** (including ability to pay attention, awareness of surroundings, being coherent, unpredictable variation over course of day) **0**. No **1**. Yes	☐
		b. In the **LAST 90 DAYS** (or since last assessment if less than 90 days), client has become agitated or disoriented such that his or her safety is endangered or client requires protection by others **0**. No **1**. Yes	☐

SECTION C. COMMUNICATION/HEARING PATTERNS

1	HEARING	***(With hearing appliance if used)*** **0**. *HEARS ADEQUATELY*—Normal talk, TV, phone, doorbell **1**. *MINIMAL DIFFICULTY*—When not in quiet setting **2**. *HEARS IN SPECIAL SITUATIONS ONLY*—Speaker has to adjust tonal quality and speak distinctly **3**. *HIGHLY IMPAIRED*—Absence of useful hearing	☐
2	MAKING SELF UNDER-STOOD (Expression)	***(Expressing information content—however able)*** **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, prompting usually required **3**. *SOMETIMES UNDERSTOOD*—Ability is limited to making concrete requests **4**. *RARELY/NEVER UNDERSTOOD*	☐
3	ABILITY TO UNDER-STAND OTHERS (Compre-hension)	***(Understands verbal information—however able)*** **0**. *UNDERSTANDS*—Clear comprehension **1**. *USUALLY UNDERSTANDS*—Misses some part/intent of message, BUT comprehends most conversation with little or no prompting **2**. *OFTEN UNDERSTANDS*—Misses some part/intent of message; with prompting can often comprehend conversation **3**. *SOMETIMES UNDERSTANDS*—Responds adequately to simple, direct communication **4**. *RARELY/NEVER UNDERSTANDS*	☐

4	COMMUNI-CATION DECLINE	Worsening in communication (making self understood or understanding others) as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) **0**. No **1**. Yes	☐

SECTION D. VISION PATTERNS

1	VISION	***(Ability to see in adequate light and glasses if used)*** **0**. *ADEQUATE*—Sees fine detail, including regular print in newspapers/books **1**. *IMPAIRED*—Sees large print, but no 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, colours, or shapes; eyes do not appear to follow objects	☐
2	VISUAL LIMITATION/ DIFFICULTIES	Saw halos or rings around lights, curtains over eyes, or flashes of lights **0**. No **1**. Yes	☐
3	VISION DECLINE	Worsening of vision as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) **0**. No **1**. Yes	☐

SECTION E. MOOD AND BEHAVIOUR PATTERNS

1	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	***(Code for observed indicators irrespective of the assumed cause)*** **0**. Indicator not exhibited in last 3 days **1**. Exhibited 1–2 of last 3 days **2**. Exhibited on each of last 3 days	
		a. **A FEELING OF SADNESS OR BEING DEPRESSED**, that life is not worth living, that nothing matters, that he or she is of no use to anyone or would rather be dead	☐
		b. **PERSISTENT ANGER WITH SELF OR OTHERS**—e.g. easily annoyed, anger at care received	☐
		c. **EXPRESSIONS OF WHAT APPEAR TO BE UNREALISTIC FEARS**—e.g. fear of being abandoned, left alone, being with others	☐
		d. **REPETITIVE HEALTH COMPLAINTS**—e.g. persistently seeks medical attention, obsessive concern with body functions	☐
		e. **REPETITIVE ANXIOUS COMPLAINTS, CONCERNS**—e.g. persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues	☐
		f. **SAD, PAINED, WORRIED FACIAL EXPRESSIONS**—e.g. furrowed brows	☐
		g. **RECURRENT CRYING, TEARFULNESS**	☐
		h. **WITHDRAWAL FROM ACTIVITIES OF INTEREST**—e.g. no interest in long standing activities or being with family/friends	☐
		i. **REDUCED SOCIAL INTERACTION**	☐
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	☐

3	BEHAVIOURAL SYMPTOMS	Instances when client exhibited behavioural 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	
		a. **WANDERING**—Moved with no rational purpose, seemingly oblivious to needs or safety	☐
		b. **VERBALLY ABUSIVE BEHAVIOURAL SYMPTOMS**—Threatened, screamed at, cursed at others	☐
		c. **PHYSICALLY ABUSIVE BEHAVIOURAL SYMPTOMS**—Hit, shoved, scratched, sexually abused others	☐
		d. **SOCIALLY INAPPROPRIATE/ DISRUPTIVE BEHAVIOURAL SYMPTOMS**—Disruptive sounds, noisiness, screaming, self-abusive acts, sexual behaviour or disrobing in public, smears/ throws food/feces, rummaging, repetitive behaviour, rises early and causes disruption	☐
		e. **RESISTS CARE**—Resisted taking medications/ injections, ADL assistance, eating, or changes in position	☐
4	CHANGES IN BEHAVIOUR SYMPTOMS	Behavioural 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 behavioural symptoms or acceptance by family **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	☐

Name of Client _____ Case Record # _____

SECTION G. INFORMAL SUPPORT SERVICES

1 TWO KEY INFORMAL HELPERS Primary (A) and Secondary (B)

NAME OF PRIMARY AND SECONDARY HELPERS

a. (Last/Family Name) b. (First Name)

c. (Last/Family Name) d. (First Name)

	(A) Pri	(B) Sec
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/neighbour	☐	☐
Areas of help: **0**. Yes **1**. No		
g. Advice or emotional support	☐	☐
h. IADL care	☐	☐
i. ADL care	☐	☐
If needed, willingness (with ability) to increase help: **0**. More than 2 hours per day **1**. 1–2 hours per day **2**. No		
j. 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	a. ☐
Primary caregiver is not satisfied with support received from family and friends (e.g. other children of client)	b. ☐
Primary caregiver expresses feelings of distress, anger or depression	c. ☐
NONE OF ABOVE	d. ☐

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 neighbours

	HOURS
a. Sum of time across five weekdays	☐☐☐
b. Sum of time across two weekend days	☐☐☐

SECTION H. PHYSICAL FUNCTIONING:
- **IADL PERFORMANCE IN LAST 7 DAYS**
- **ADL PERFORMANCE IN LAST 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. *INDE*PENDENT—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. ACTIV*ITY 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 FINANCES**—How bills are paid, chequebook is balanced, household expenses are budgeted, credit card account is monitored	☐	☐
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 manoeuvring 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)

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**—How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition.		☐
	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 LOCOMO-TION	**0**. No assistive device **1**. Cane **2**. Walker/crutch **3**. Scooter (e.g. Amigo) **4**. Wheelchair **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	***(Check all that apply)***	
		Client believes he/she capable of increased functional independence (ADL, IADL, mobility)	a. ☐
		Caregivers believe client is capable of increased functional independence (ADL, IADL, mobility)	b. ☐
		Good prospects of recovery from current disease or conditions, improved health status expected	c. ☐
		NONE OF ABOVE	d. ☐

SECTION I. CONTINENCE IN LAST 7 DAYS

1	BLADDER CONTINENCE	a. 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) **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**—or since last assessment if less than 7 days)	
		Use of pads or briefs to protect against wetness	a. ☐
		Use of an indwelling urinary catheter	b. ☐
		NONE OF ABOVE	c. ☐
3	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; 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 episodes 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	☐

SECTION J. DISEASE DIAGNOSES

1	DISEASES	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 health care professional **2**. Present—monitored or treated by health care professional (If no disease in list, check **J1ac**, *None of Above*)

Name of Client _____ Case Record # _____

		HEART/CIRCULATION		**SENSES**	
		a. Cerebrovascular accident (stroke)	☐	q. Cataract	☐
		b. Congestive heart failure	☐	r. Glaucoma	☐
		c. Coronary artery disease	☐	**PSYCHIATRIC/MOOD**	
		d. Hypertension	☐	s. Any psychiatric diagnosis	☐
		e. Irregularly Irregular pulse	☐	**INFECTIONS**	
		f. Peripheral vascular disease	☐	t. HIV infection	☐
				u. Pneumonia	☐
		NEUROLOGICAL			
		g. Alzheimer's	☐	v. Tuberculosis	☐
		h. Dementia other than Alzheimer's disease	☐	w. Urinary tract infection (**in LAST 30 DAYS**)	☐
		i. Head trauma	☐	**OTHER DISEASES**	
		j. Hemiplegia/ hemiparesis	☐	x. Cancer (in past 5 years) not including skin cancer	☐
		k. Multiple sclerosis	☐	y. Diabetes	☐
		l. Parkinsonism	☐	z. Emphysema/ COPD/ asthma	☐
				aa. Renal Failure	☐
		MUSCULO-SKELETAL			
		m. Arthritis	☐	ab. Thyroid disease (hyper or hypo)	☐
		n. Hip fracture	☐		
		o. Other fractures (e.g. wrist, vertebral)	☐	ac. *NONE OF ABOVE*	☐
		p. Osteoporosis	☐		
2	OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-10-CA 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	a. ☐	IF FEMALE: Received breast examination or mammography	d. ☐
		Received influenza vaccination	b. ☐		
		Test for blood in stool or screening endoscopy	c. ☐	*NONE OF ABOVE*	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	a. ☐	Loss of appetite	d. ☐
		Difficulty urinating or urinating 3 or more times at night	b. ☐	Vomiting	e. ☐
				NONE OF ABOVE	f. ☐
		Fever	c. ☐		

3	PROBLEM CONDITIONS	**(Check all present at any point during last 3 days)**			
		PHYSICAL HEALTH		**MENTAL HEALTH**	
		Chest pain/pressure at rest or on exertion	a. ☐	Delusions	f. ☐
				Hallucinations	g. ☐
		No bowel movement in 3 days	b. ☐	*NONE OF ABOVE*	h. ☐
		Dizziness or lightheadedness	c. ☐		
		Edema	d. ☐		
		Shortness of breath	e. ☐		
4	PAIN	a. Frequency with which client complains or shows evidence of pain **0**. No pain (score b–e as 0) **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 90 DAYS** (or since last assessment if less than 90 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)			☐
7	LIFESTYLE (Drinking/ Smoking)	**(Code for drinking or smoking)** **0**. No **1**. Yes			
		a. **In the LAST 90 DAYS** (or since last assessment if less than 90 days), client felt the need or was told by others to cut down on drinking, or others were concerned with client's drinking			☐
		b. **In the LAST 90 DAYS** (or since last assessment if less than 90 days), client had to have a drink first thing in the morning to steady nerves (i.e. an "eye opener") or has been in trouble because of drinking			☐
		c. Smoked or chewed tobacco daily			☐

8	HEALTH STATUS INDICATORS	**(Check all that apply)**			
		Client feels he/she has poor health (when asked)	a.	Treatments changed in **LAST 30 DAYS** (or since last assessment if less than 30 days) because of a new acute episode or condition	d.
		Has conditions or diseases that make cognition, ADL, mood, or behaviour patterns unstable (fluctuations, precarious, or deteriorating)	b.	Prognosis of less than six months to live—e.g. physician has told client or client's family that client has end-stage disease	e.
		Experiencing a flare-up of a recurrent or chronic problem	c.	*NONE OF ABOVE*	f.
9	OTHER STATUS INDICATORS	**(Check all that apply)**			
		Fearful of a family member or caregiver	a.	Physically restrained—limbs restrained, restrained to chair when sitting	e.
		Unusually poor hygiene	b.		
		Unexplained injuries, broken bones, or burns	c.	*NONE OF ABOVE*	f.
		Neglected, abused, or mistreated	d.		

SECTION L. NUTRITION/HYDRATION STATUS

1	WEIGHT	**(Code for weight items)** **0**. No **1**. Yes	
		a. Unintended weight loss of 5% or more in the **LAST 30 DAYS** (or 10% or more in the **LAST 180 DAYS**)	
		b. Severe malnutrition (cachexia)	
		c. Morbid obesity	
2	CONSUMP-TION	**(Code for consumption)** **0**. No **1**. Yes	
		a. In at least 2 of the last 3 days, ate one or fewer meals a day	
		b. **In last 3 days**, noticeable decrease in the amount of food client usually eats or fluids usually consumes	
		c. Insufficient fluid—did not consume all/almost all fluids during last 3 days	
		d. Enteral tube feeding	
3	SWALLOWING	**0**. *NORMAL*—Safe and efficient swallowing of all diet consistencies **1**. *REQUIRES DIET MODIFICATION TO SWALLOW SOLID FOODS* (mechanical diet or able to ingest specific foods only) **2**. *REQUIRES MODIFICATION TO SWALLOW SOLID FOODS AND LIQUIDS* (puree, thickened liquids) **3**. *COMBINED ORAL AND TUBE FEEDING* **4**. *NO ORAL INTAKE (NPO)*	

SECTION M. DENTAL STATUS (ORAL HEALTH)

1	ORAL STATUS	**(Check all that apply)**	
		Problem chewing (e.g. poor mastication, immobile jaw, surgical resection, decreased sensation/motor control, pain while eating)	a.
		Mouth is "dry" when eating a meal	b.
		Problem brushing teeth or dentures	c.
		NONE OF ABOVE	d.

SECTION N. SKIN CONDITION

1	SKIN PROBLEMS	Any trouble skin conditions or changes in skin condition (e.g. burns, bruises, rashes, itchiness, body lice, scabies) **0**. No **1**. Yes	
2	ULCERS (Pressure/ Stasis)	Presence of an ulcer anywhere on the body. Ulcers include any area of persistent skin redness (Stage 1); partial loss of skin layers (Stage 2); deep craters in the skin (Stage 3); breaks in skin exposing muscle or bone (Stage 4). [**Code 0 if no ulcer, otherwise record the highest ulcer stage (Stage 1–4).**]	
		a. **Pressure ulcer**—any lesion caused by pressure, shear forces, resulting in damage of underlying tissues	
		b. **Stasis ulcer**—open lesion caused by poor circulation in the lower extremities	
3	OTHER SKIN PROBLEMS REQUIRING TREATMENT	**(Check all that apply)**	
		Burns (second or third degree)	a.
		Open lesions other than ulcers, rashes, cuts (e.g. cancer)	b.
		Skin tears or cuts	c.
		Surgical wound	d.
		Corns, calluses, structural problems, infections, fungi	e.
		NONE OF ABOVE	f.
4	PRIOR PRESSURE ULCER	**0**. No **1**. Yes	
5	WOUND/ ULCER CARE	**(Check for formal care in LAST 7 DAYS)**	
		Antibiotics, systemic or topical	a.
		Dressings	b.
		Surgical wound care	c.
		Other wound/ulcer care (e.g. pressure relieving device, nutrition, turning, debridement)	d.
		NONE OF ABOVE	e.

SECTION O. ENVIRONMENTAL ASSESSMENT

1	HOME ENVIRON-MENT	**[Check any of following that make home environment hazardous or uninhabitable (if none apply, check NONE OF ABOVE, if temporarily in institution, base assessment on home visit)]**	
		Lighting in evening (including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors)	a.
		Flooring and carpeting (e.g. holes in floor, electric wires where client walks, scatter rugs)	b.
		Bathroom and toilet room (e.g. non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet)	c.
		Kitchen (e.g. dangerous stove, inoperative refrigerator, infestation by rats or bugs)	d.
		Heating and cooling (e.g. too hot in summer, too cold in winter, wood stove in a home with an asthmatic)	e.
		Personal safety (e.g. fear of violence, safety problem in going to mailbox or visiting neighbours, heavy traffic in street)	f.
		Access to home (e.g. difficulty entering/leaving home)	g.
		Access to rooms in house (e.g. unable to climb stairs)	h.
		NONE OF ABOVE	i.

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2	LIVING ARRANGE-MENT	a. As compared to 90 DAYS AGO (or since last assessment), client now lives with other persons—e.g. moved in with another person, other moved in with client **0**. No **1**. Yes	☐
		b. Client or primary caregiver feels that client would be better off in another living environment **0**. No **1**. Client only **2**. Caregiver only **3**. Client and caregiver	☐

SECTION P. SERVICE UTILIZATION (IN LAST 7 DAYS)

1	FORMAL CARE (Minutes rounded to even 10 minutes)	Extent of care or care management in **LAST 7 DAYS** (or since last assessment if less than 7 days) since involving			
		#of:	**(A) Days**	**(B) Hours**	**(C) Mins**
		a. Home health aides	☐	☐☐☐	☐☐
		b. Visiting nurses	☐	☐☐☐	☐☐
		c. Homemaking services	☐	☐☐☐	☐☐
		d. Meals	☐	☐☐☐	☐☐
		e. Volunteer services	☐	☐☐☐	☐☐
		f. Physical therapy	☐	☐☐☐	☐☐
		g. Occupational therapy	☐	☐☐☐	☐☐
		h. Speech therapy	☐	☐☐☐	☐☐
		i. Day care or day hospital	☐	☐☐☐	☐☐
		j. Social worker in home	☐	☐☐☐	☐☐

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		**THERAPIES**	
		a. Oxygen	☐	n. Exercise therapy	☐
		b. Respirator for assistive breathing	☐	o. Occupational therapy	☐
		c. All other respiratory treatments	☐	p. Physical therapy	☐
		OTHER TREATMENTS		**PROGRAMS**	
		d. Alcohol/drug treatment program	☐	q. Day center	☐
				r. Day hospital	☐
		e. Blood transfusion(s)	☐	s. Hospice care	☐
		f. Chemotherapy	☐	t. Physician or clinic visit	☐
		g. Dialysis	☐	u. Respite care	☐
		h. IV infusion—central	☐	**SPECIAL PROCEDURES DONE IN HOME**	
		i. IV infusion—peripheral	☐	v. Daily nurse monitoring (e.g. EKG, urinary output)	☐
		j. Medication by injection	☐	w. Nurse monitoring less than daily	☐
		k. Ostomy care	☐	x. Medical alert bracelet or electronic security alert	☐
		l. Radiation	☐	y. Skin treatment	☐
		m. Tracheostomy care	☐	z. Special diet	☐
				aa. *NONE OF ABOVE*	☐

3	MANAGE-MENT 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	☐
		b. IV	☐
		c. Catheter	☐
		d. Ostomy	☐
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	☐

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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 "**O**", if more than 9, code "**9**".]*	☐
2	RECEIPT OF PSYCHO-TROPIC 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	☐
		b. Anxiolytic	☐
		c. Antidepressant	☐
		d. Hypnotic or Analgesic	☐
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 MEDICA-TIONS	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*	☐
5	LIST OF ALL MEDICATIONS	List prescribed and nonprescribed medications taken in **LAST 7 DAYS** (or since last assessment) a. **Name**: Record the name of the medication. b. **Dose**: Record the dosage. c. **Form**: Code the route of Administration using the following list: **1**. By mouth (PO) **6**. Rectal (R) **2**. Sub lingual (SL) **7**. Topical **3**. Intramuscular (IM) **8**. Inhalation **4**. Intravenous (IV) **9**. Enteral tube **5**. Subcutaneous (SQ) **10**. Other d. **Freq**: Code the number of times per day, week, or month the medication is administered using the following list: ***PRN***. As necessary; ***QH***. Every hour; ***Q2H***. Every two hours; ***Q3H***. Every three hours; ***Q4H***. Every four hours; ***Q6H***. Every six hours; ***Q8H***. Every eight hours; ***QD***. Once daily; ***HS***. Bedtime; ***BID***. Two times daily (includes every 12 hrs); ***TID***. Three times daily; ***QID***. Four times daily; ***5D***. Five times daily; ***QOD***. Every other day; ***QW***. Once each week; ***2W***. Two times every week; ***3W***. Three times every week; ***4W***. Four times every week; ***5W***. Five times every week; ***6W***. Six times every week; ***1M***. Once every month; ***2M***. Twice every month; ***C***. Continuous; ***O***. Other e. **If PRN**: record number of doses taken in last 7 days.	

	a. Name	b. Dose	c. Form	d. Freq	e. If PRN # of times taken in last 7 days
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					

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

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 ☐☐☐☐ Year ☐☐ Month ☐☐ Day

Other Signatures	Title	Sections	Date
d.			
e.			
f.			
g.			
h.			
i.			