interRAI Community Health Assessment (CHA)©

[CODE FOR LAST 3 DAYS, UNLESS OTHERWISE SPECIFIED]

SECTION A. IDENTIFICATION INFORMATION

1. PROGRAM

1. Assisted Living Program
2. Personal Care Services
3. CDPAP
4. Adult Day Health Care
5. Nursing Home Transition Diversion Waiver ☐☐
6. Traumatic Brain Injury Waiver
7. Care at Home I, II Waiver
8. Managed Long Term Cared Plans
9. Long Term Home Health Care Program
10. PACE

2. REFERRAL SOURCE

1. Hospital Discharge
2. Residential Health Care Facility
3. Self ☐
4. Family or Friend
5. Physician's Office
6. Certified Home Health Agency
7. Other, list _____

3. NAME

_____

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

4. ADDRESS_____

a. (Street) b. (City) c. (State)

5. POSTAL / ZIP CODE OF USUAL LIVING ARRANGEMENT [EXAMPLE - USA]

☐☐☐☐☐ - ☐☐☐☐

6. ADDRESS LOCATION CODE ☐☐☐☐☐☐

7. COUNTY CODE ☐☐

8. GENDER

1. Male 2. Female ☐

9. BIRTHDAY ☐☐☐☐ - ☐☐ - ☐☐

Year Month Day

10. MARITAL STATUS

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

11. UNIQUE DE-IDENTIFIER

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

12. NATIONAL NUMERIC IDENTIFIER [EXAMPLE - USA]

a. **Social Security number**

☐☐☐-☐☐-☐☐☐☐

b. **Medicare number**

[Note: "+" if pending, "N" if not a Medicaid recipient]

☐☐☐☐☐☐☐☐☐☐☐☐

c. **Medicaid number**

[Note: "+" if pending, "N" if not a Medicaid recipient]

☐☐☐☐☐☐☐☐☐☐☐☐☐☐

13. FACILITY / AGENCY PROVIDER NUMBER

☐☐☐☐☐☐☐☐☐☐☐☐☐☐

14. REASON FOR ASSESSMENT

1. First assessment
2. Routine reassessment
3. Return assessment
4. Significant change in status reassessment
5. Discharge assessment, covers last 3 days of service
6. Discharge tracking only
7. Other—e.g., research

15. ASSESSMENT REFERENCE DATE

2☐☐ - ☐☐ - ☐☐

Year Month Day

16. PERSON'S EXPRESSED GOALS OF CARE

Enter primary goal in boxes at bottom

17. RESIDENTIAL/LIVING STATUS AT TIME OF ASSESSMENT

1. Private home / apartment / rented room
2. Adult Care Facilities
3. Assisted living or semi-independent living
4. Mental health residence—e.g., psychiatric group home
5. Group home for persons with physical disability
6. Setting for persons with intellectual disability
7. Psychiatric hospital or unit
8. Homeless (with or without shelter) ☐☐
9. Residential Health Care Facility (Skilled Nursing Home)
10. Rehabilitation hospital / unit
11. Hospice facility / palliative care unit
12. Acute care hospital
13. Correctional facility
14. Other

18. LIVING ARRANGEMENT

1. Alone
2. With spouse / partner only
3. With spouse / partner and other(s)
4. With child (not spouse / partner) ☐
5. With parent(s) or guardian(s)
6. With sibling(s)
7. With other relatives
8. With non-relative(s)

19. VETERAN STATUS

0. No 1. Yes

1. Veteran
2. Spouse of Veteran ☐

SECTION B. INTAKE AND INITIAL HISTORY

[Note: Complete at Admission / First Assessment only]

1. DATE CASE OPENED (this agency)

2☐☐ - ☐☐ - ☐☐

Year Month Day

2. ETHNICITY AND RACE [EXAMPLE - USA]

0. No 1. Yes

ETHNICITY

a. **Hispanic or Latino** ☐

RACE

b. **American Indian or Alaska Native** ☐
c. **Asian** ☐
d. **Black or African American** ☐
e. **Native Hawaiian or other Pacific Islander** ☐
f. **White** ☐

3. PRIMARY LANGUAGE [EXAMPLE - USA]

1. English
2. Spanish
3. French ☐
4. Chinese
5. Russian
6. Other (list)_____

4. RESIDENTIAL HISTORY OVER LAST 5 YEARS

Code for all settings person lived in during 5 years prior to date case opened [B1]

0. No 1. Yes

a. **Long-term care facility**—e.g., nursing home ☐
b. **Adult Care Facilities** ☐
c. **Mental health residence**—e.g., psychiatric group home ☐
d. **Psychiatric hospital or unit** ☐
e. **Setting for persons with intellectual disability** ☐

5. EMPLOYMENT

a. Is the person currently employed, either paid or unpaid (volunteer)?
0. No 1. Yes ☐

b. If unemployed, does the person want to be employed, either paid or unpaid? If no, go to Section D.
0. No 1. Yes ☐

c. If yes, does the person have any barriers such as visual impairment or a need for specialized equipment that need to be considered to enable her/him to perform a job in a proper and safe manner? (The purpose of this question is to obtain information regarding proper placement and appropriate accommodations.)
0. No 1. Yes ☐

If yes, describe_____

SECTION C. COGNITION

1. COGNITIVE SKILLS FOR DAILY DECISION MAKING

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

0. ***Independent***—Decisions consistent, reasonable, and safe
1. ***Modified independence***—Some difficulty in new situations only
2. ***Minimally impaired***—In specific recurring situations, decisions become poor or unsafe; cues / supervision necessary at those times ☐
3. ***Moderately impaired***—Decisions consistently poor or unsafe; cues/ supervision required at all times
4. ***Severely impaired***—Never or rarely makes decisions
5. ***No discernable consciousness, coma***
[Skip to Section G]

2. MEMORY / RECALL ABILITY

Code for recall of what was learned or known

0. Yes, memory OK 1. Memory problem ☐

a. **Short-term memory OK**—Seems / appears to recall after 5 minutes

3. CHANGE IN DECISION MAKING AS COMPARED TO 90 DAYS AGO (OR SINCE LAST ASSESSMENT)

0. Improved
1. No change
2. Declined ☐
8. Uncertain

SECTION D. COMMUNICATION AND VISION

1. MAKING SELF UNDERSTOOD (Expression)

Expressing information content—both verbal and non-verbal

0. ***Understood***—Expresses ideas without difficulty
1. ***Usually understood***—Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required
2. ***Often understood***—Difficulty finding words or finishing thoughts AND prompting usually required ☐
3. ***Sometimes understood***—Ability is limited to making concrete requests
4. ***Rarely or never understood***

2. ABILITY TO UNDERSTAND OTHERS (Comprehension)

Understanding verbal information content (however able; with hearing appliance normally used)

0. ***Understands***—Clear comprehension
1. ***Usually understands***—Misses some part / intent of message BUT comprehends most conversation
2. ***Often understands***—Misses some part / intent of message BUT with repetition or explanation can often comprehend conversation ☐
3. ***Sometimes understands***—Responds adequately to simple, direct communication only
4. ***Rarely or never understands***

3. HEARING

Ability to hear (with hearing appliance normally used)

0. ***Adequate***—No difficulty in normal conversation, social interaction, listening to TV
1. ***Minimal difficulty***—Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet [2 meters] away) ☐
2. ***Moderate difficulty***—Problem hearing normal conversation, requires quiet setting to hear well
3. ***Severe difficulty***—Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)
4. ***No hearing***

4. VISION

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

0. ***Adequate***—sees fine detail, including regular print in newspapers/books
1. ***Minimal difficulty***—sees large print, but not regular print in newspapers/books
2. ***Moderate difficulty***—limited vision; not able to see newspaper headlines, but can identify objects ☐
3. ***Severe difficulty***—object identification in question, but eyes appear to follow objects; sees only light, colors, shapes
4. ***No vision***

SECTION E. MOOD

1. INDICATORS OF POSSIBLE DEPRESSED, ANXIOUS, OR SAD MOOD

Code for indicators observed in last 3 days, irrespective of the assumed cause. [Note: Whenever possible, ask person]

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

a. **Made negative statements** —e.g., "*Nothing matters; Would rather be dead; What's the use; Regret having lived so long; Let me die*" ☐
b. **Persistent anger with self or others**—e.g., easily annoyed, anger at care received ☐
c. **Expressions, including non-verbal, of what appear to be unrealistic fears**—e.g., fear of being abandoned, being left alone, being with others; intense fear of specific objects or situations ☐
d. **Repetitive health complaints** —e.g., persistently seeks medical attention, incessant concern with body functions ☐
e. **Repetitive anxious complaints / concerns (non-health related)** e.g., persistently seeks attention / reassurance regarding schedules, meals, laundry, clothing, relationships ☐
f. **Sad, pained, or worried facial expressions** —e.g., furrowed brow, constant frowning ☐
g. **Crying, tearfulness** ☐
h. **Withdrawal from activities of interest**—e.g., long-standing activities, being with family or friends ☐
i. **Reduced social interactions** ☐

2. SELF-REPORTED MOOD

0. Not in last 3 days
1. Not in last 3 days, but often feels that way
2. In 1-2 of last 3 days
3. Daily in the last 3 days
8. Person could not (would not) respond

Ask: "In the last 3 days, how often have you felt..."

a. ***Little interest or pleasure in things you normally enjoy?*** ☐
b. ***Anxious, restless, or uneasy?*** ☐
c. ***Sad, depressed, or hopeless?*** ☐

SECTION F. PSYCHOSOCIAL WELL-BEING

1. SOCIAL RELATIONSHIPS

[Note: Whenever possible, ask person]

0. Never
1. More than 30 days ago
2. 8 to 30 days ago
3. 4 to 7 days ago
4. In the last 3 days
8. Unable to determine

a. **Participation in social activities of long-standing interest** ☐
b. **Visit with a long-standing social relation or family member** ☐
c. **Other interaction with long-standing social relation or family member**—e.g., telephone, e-mail ☐
d. **Openly expresses conflict or anger with family or friends** ☐
e. **Fearful of a family member or close acquaintance** ☐
f. **Neglected, abused, or mistreated** ☐

2. LONELY

Says or indicates that he/she feels lonely

0. No 1. Yes ☐

3. CHANGE IN SOCIAL ACTIVITIES IN LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO).

Decline in level of participation in social, religious, occupational or other preferred activities

IF THERE WAS A DECLINE, person distressed by this fact

0. No decline
1. Decline, not distressed ☐
2. Decline, distressed

4. LENGTH OF TIME ALONE DURING THE DAY (MORNING AND AFTERNOON)

0. Less than 1 hour
1. 1-2 hours ☐
2. More than 2 hours but less than 8 hours
3. 8 hours or more

5. MAJOR LIFE STRESSORS IN LAST 90 DAYS—*e.g., episode of severe personal illness; death or severe illness of close family member or friend; loss of home; major loss of income / assets; victim of a crime such as robbery or assault; loss of driving license / car*

0. No 1. Yes ☐

SECTION G. FUNCTIONAL STATUS

1. IADL SELF PERFORMANCE and CAPACITY

Code for PERFORMANCE (P) in routine activities around the home or in the community during the LAST 3 DAYS

Code for CAPACITY (C) based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.

0. ***Independent***—No help, setup, or supervision
1. ***Setup help only***
2. ***Supervision***—Oversight/cuing
3. ***Limited assistance***—Help on some occasions
4. ***Extensive assistance***—Help throughout task, but performs 50% or more of task on own
5. ***Maximal assistance***—Help throughout task, but performs less than 50% of task on own
6. ***Total dependence***—Full performance by others during entire period
8. ***Activity did not occur***—During entire period [DO NOT USE THIS CODE IN SCORING CAPACITY]

	P	C
a. **Meal preparation**—How meals are prepared (e.g., planning meals, assembling ingredients, cooking, 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, checkbook 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. **Stairs**—How full flight of stairs is managed (12-14 stairs)	☐	☐
g. **Shopping**—How shopping is performed for food and household items (e.g., selecting items, paying money) EXCLUDE TRANSPORTATION	☐	☐
h. **Transportation**—How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicles)	☐	☐

2. ADL SELF-PERFORMANCE

Consider all episodes over 3-day period.
*If **all** episodes are performed at the same level, score ADL at that level. If **any** episodes at level 6, and others less dependent, score ADL as a 5.*

Otherwise, focus on the three most dependent episodes [or all episodes if performed fewer than 3 times]. If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2-5

0. ***Independent***—No physical assistance, setup, or supervision in any episode
1. ***Independent, setup help only***—Article or device provided or placed within reach, no physical assistance or supervision in any episode
2. ***Supervision***—Oversight / cuing
3. ***Limited assistance***—Guided maneuvering of limbs, physical guidance without taking weight
4. ***Extensive assistance***—Weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks
5. ***Maximal assistance***—Weight-bearing support (including lifting limbs) by 2+ helpers —OR— Weight-bearing support for more than 50% of subtasks
6. ***Total dependence***—Full performance by others during all episodes
8. ***Activity did not occur during entire period***

a. **Bathing**—How takes a full-body bath / shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area - EXCLUDE WASHING OF BACK AND HAIR ☐
b. **Personal hygiene** —How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS ANDSHOWERS ☐
c. **Dressing upper body**—How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc. ☐
d. **Dressing lower body**—How dresses and undresses (street clothes, underwear) from the waist down including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc. ☐
e. **Walking**—How walks between locations on same floor indoors ☐
f. **Locomotion**—How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair ☐

3. PRIMARY MODE OF LOCOMOTION INDOORS
0. Walking, no assistive device
1. Walking, uses assistive device—e.g., cane, walker, crutch, pushing wheelchair ☐
2. Wheelchair, scooter
3. Bedbound

4. ACTIVITY LEVEL
a. **Total hours of exercise or physical activity in LAST 3 DAYS** – e.g., walking
0. None
1. Less than 1 hour ☐
2. 1-2 hours
3. 3-4 hours
4. More than 4 hours

b. **In the LAST 3 DAYS, number of days went out of the house or building in which he/she lives** (no matter how short the period)
0. No days out
1. Did not go out in last 3 days, but usually goes out over a 3-day period ☐
2. 1-2 days
3. 3 days

5. CHANGE IN ADL STATUS AS COMPARED TO 90 DAYS AGO, OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO
0. Improved
1. No change ☐
2. Declined
8. Uncertain

6. DRIVING
a. **Drove car (vehicle) in the LAST 90 DAYS**
0. No 1. Yes ☐

b. **If drove in LAST 90 DAYS, assessor is aware that someone has suggested that person limits OR stops driving**
0. No, or does not drive 1. Yes ☐

SECTION H. CONTINENCE

1. BLADDER CONTINENCE
0. ***Continent***—Complete control; DOES NOT USE any type of catheter or other urinary collection device
1. ***Control with any catheter or ostomy*** *over last 3 days*
2. ***Infrequently incontinent***—Not incontinent over last 3 days, but does have incontinent episodes
3. ***Occasionally incontinent***—Less than daily ☐
4. ***Frequently incontinent***—Daily, but some control present
5. ***Incontinent***—No control present
8. ***Did not occur***—No urine output from bladder in last 3 days

SECTION I. DISEASE DIAGNOSES

Disease code
0. Not present
1. Primary diagnosis/diagnoses for current stay
2. Diagnosis present, receiving active treatment
3. Diagnosis present, monitored but no active treatment

1. DISEASE DIAGNOSES
MUSCULOSKELETAL
a. **Hip fracture during last 30 days (or since last assessment if less than 30 days)** ☐
b. **Other fracture during last 30 days (or since last assessment if less than 30 days)** ☐
c. **Osteoarthritis** ☐

NEUROLOGICAL
d. **Alzheimers disease** ☐
e. **Dementia other than Alzheimers disease** ☐
f. **Senile/organic mental disorder** ☐
g. **Stroke/CVA** ☐
h. **TBI (traumatic brain injury other than stroke)** ☐

CARDIAC OR PULMONARY
i. **Coronary heart disease** ☐
j. **Congestive heart failure** ☐
k. **Chronic obstructive pulmonary disease** ☐
l. **Hypertension** ☐
m. **Coronary Atherosclerosis** ☐
n. **COPD** ☐
o. **Acute CVD** ☐
p. **Late effect CVD** ☐

PSYCHIATRIC
q. **Anxiety** ☐
r. **Bipolar disorder** ☐
s. **Depression** ☐
t. **Schizophrenia** ☐

OTHER
u. **Cancer** ☐
v. **Diabetes mellitus without complications** ☐
w. **Diabetes mellitus with complications** ☐
x. **HIV** ☐
y. **HCV (Hepatitis C virus)** ☐
z. **HBV (Hepatitis B virus)** ☐

2. OTHER DISEASE DIAGNOSES

	Diagnosis	Disease code	ICD code
a.			•
b.			•
c.			•
d.			•
e.			•
f.			•

[NOTE: Add additional lines as necessary for other disease diagnoses]

SECTION J. HEALTH CONDITIONS

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

2. RECENT FALLS
[Skip if last assessed more than 30 days ago or if this is first assessment]
0. No
1. Yes ☐
[blank] Not applicable (first assessment, or more than 30 days since last assessment)

3. PROBLEM FREQUENCY
Code for presence in last 3 days
0. Not present
1. Present but not exhibited in last 3 days
2. Exhibited on 1 of last 3 days
3. Exhibited on 2 of last 3 days
4. Exhibited daily in last 3 days

BALANCE
a. **Dizziness** ☐
b. **Unsteady gait** ☐

CARDIAC
c. **Chest pain** ☐

PSYCHIATRIC
d. **Abnormal thought process**—e.g., loosening of associations, blocking, flight of ideas, tangentiality, circumstantiality ☐
e. **Delusions**—Fixed false beliefs ☐
f. **Hallucinations**—False sensory perceptions ☐

GI STATUS
g. **Acid reflux**—Regurgitation of acid from stomach to throat ☐
h. **Constipation**—No bowel movement in 3 days or difficult passage of hard stool ☐
i. **Diarrhea** ☐
j. **Vomiting** ☐

SLEEP PROBLEMS

k. **Difficulty falling asleep or staying asleep; waking up too early; restlessness; non-restful sleep** ☐

l. **Too much sleep**—Excessive amount of sleep that interferes with person's normal functioning ☐

4. DYSPNEA (Shortness of breath)

0. Absence of symptom
1. Absent at rest, but present when performed moderate activities ☐
2. Absent at rest, but present when performed normal day-to-day activities
3. Present at rest

5. FATIGUE

Inability to complete normal daily activities—e.g., ADLs, IADLs

0. ***None***
1. ***Minimal***—Diminished energy but completes normal day-to-day activities
2. ***Moderate***—Due to diminished energy, UNABLE TO FINISH normal day-to-day activities ☐
3. ***Severe***—Due to diminished energy, UNABLE TO START SOME normal day-to-day activities
4. ***Unable to commence any normal day-to-day activities***—Due to diminished energy

6. PAIN SYMPTOMS

[Note: Always ask the person about pain frequency, intensity, and control. Observe person and ask others who are in contact with the person.]

a. **Frequency with which person complains or shows evidence of pain (including grimacing, teeth clenching, moaning, withdrawal when touched, or other nonverbal signs suggesting pain)**
   0. No pain
   1. Present but not exhibited in last 3 days
   2. Exhibited on 1-2 of last 3 days ☐
   3. Exhibited daily in last 3 days

b. **Intensity of highest level of pain present**
   0. No pain
   1. Mild
   2. Moderate ☐
   3. Severe
   4. Times when pain is horrible or excruciating

c. **Consistency of pain**
   0. No pain
   1. Single episode during last 3 days ☐
   2. Intermittent
   3. Constant

d. **Breakthrough pain**—Times in last 3 days when person experienced sudden, acute flare-ups of pain
   0. No 1. Yes ☐

e. **Pain control—**Adequacy of current therapeutic regimen to control pain (from person's point of view)
   0. No issue of pain
   1. Pain intensity acceptable to person; no treatment regimen or change in regimen required
   2. Controlled adequately by therapeutic regimen ☐
   3. Controlled when therapeutic regimen followed, but not always followed as ordered
   4. Therapeutic regimen followed, but pain control not adequate
   5. No therapeutic regimen being followed for pain; pain not adequately controlled

7. INSTABILITY OF CONDITIONS

0. No 1. Yes

a. **Conditions / diseases make cognitive, ADL, mood or behavior patterns unstable** (fluctuating, precarious, or deteriorating) ☐

b. **Experiencing an acute episode or a flare-up of a recurrent or chronic problem** ☐

8. SELF-RATED HEALTH

Ask: "In general, how would you rate your health"

0. Excellent
1. Good ☐
2. Fair
3. Poor
8. Could not (would not) respond

9. TOBACCO ALCOHOL AND SUBSTANCE ABUSE

a. **Smokes tobacco daily**
   0. No
   1. Not in last 3 days, but is usually a daily smoker ☐
   2. Yes

b. **If smokes, does so safely** ☐
   1. No
   2. Yes

c. **Alcohol—**Highest number of drinks in any "single sitting" in last 14 days
   0. None
   1. 1 ☐
   2. 2-4
   3. 5 or more

d. **Patterns of Drinking or Other Substance Use**
   Presence of behavioral indicators of potential substance-related addiction in LAST 3 MONTHS
   0. No 1. Yes

   a. Person felt the need or was told by others to cut down on drinking or drug use, or others were concerned about person's substance use ☐
   b. Person has been bothered by criticism from others about drinking or drug use ☐
   c. Person has reported feelings of guilt about drinking or drug use ☐
   d. Person had to have a drink or use drugs first thing in the morning, e.g. to steady nerves, an "eye opener" ☐

SECTION K. ORAL AND NUTRITIONAL STATUS

1. NUTRITIONAL ISSUES

0. No 1. Yes

a. **Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in last 180 days** ☐

b. **Dehydrated or BUN / Cre ratio>25** ☐
   [Ratio, country specific]

c. **Fluid intake less than 1,000 cc per day (less than four 8 oz cups/day)** ☐

d. **Fluid output exceeds input** ☐

SECTION L. MEDICATIONS

1. LIST OF ALL MEDICATIONS

List all active prescriptions, and any non-prescribed (over the counter) medications taken in the LAST 3 DAYS

[Note: Use computerized records if possible; hand enter only when absolutely necessary]

For each drug record:

a. **Name**

b. **Dose**—A positive number such as 0.5, 5, 150, 300.
   [NOTE: Never write a zero by itself after a decimal point (X mg). Always use a zero before a decimal point (0.X mg)]

c. **Unit**—Code using the following list:

gtts (Drops)	**mEq** (Milli-equivalent)	**Puffs**
gm (Gram)	**mg** (Milligram)	**%** (Percentage)
L (Liters)	**ml** (Milliliter)	**Units**
mcg (Microgram)	**oz** (Ounce)	**OTH** (Other)

d. **Route of administration**—Code using the following list:

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

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

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

f. **PRN** 0. No 1. Yes

g. **Computer-entered drug code**

	a. Name	b. Dose	c. Unit	d. Route	e. Freq	f. PRN	g. ATC or NDC code	h. Indic-ation
1.								
2.								
3.								
4.								
5.								

[Note: Add additional lines, as necessary, for other drugs taken]
[Abbreviations are Country Specific for Unit, Route, Frequency]

2. ALLERGY TO ANY DRUG

0. No known drug allergies 1. Yes ☐

3. OTHER ALLERGIES

List:_____

SECTION M. TREATMENTS AND PROCEDURES

1. PREVENTION

0. No 1. Yes

a. **Blood pressure measured in LAST YEAR** ☐
b. **Colonoscopy test in LAST 5 YEARS** ☐
c. **Dental exam in LAST YEAR** ☐
d. **Eye exam in LAST YEAR** ☐
e. **Hearing exam in LAST 2 YEARS** ☐
f. **Influenza vaccine in LAST YEAR** ☐
g. **Mammogram or breast exam in LAST 2 YEARS (for women)** ☐
h. **Pneumovax vaccine in LAST 5 YEARS or after age 65** ☐

2. HOSPITAL USE, EMERGENCY ROOM USE, PHYSICIAN VISIT

Code for number of times during the LAST 90 DAYS (or since last assessment if less than 90 days)

a. **Inpatient acute hospital with overnight stay** ☐☐
b. **Emergency room visit (not counting overnight stay)** ☐☐
c. **Physician visit (or authorized assistant or practitioner)** ☐☐
d. **Residential care facility** ☐☐

SECTION N. SOCIAL RELATIONSHIPS

1. STRONG AND SUPPORTIVE RELATIONSHIP WITH FAMILY

0. No 1. Yes ☐

SECTION O. ENVIRONMENTAL ASSESSMENT

1. FINANCES

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

0. No 1. Yes ☐

SECTION P. DISCHARGE

[Note: Complete Section P at Discharge only]

1. LAST DAY OF STAY

20☐☐ - ☐☐ - ☐☐
Year Month Day

2. LIVING STATUS AT DISCHARGE

1. Private home / apartment / rented room
2. Board and care
3. Assisted living or semi-independent living
4. Mental health residence—e.g., psychiatric group home
5. Group home for persons with physical disability
6. Setting for persons with intellectual disability
7. Psychiatric hospital or unit
8. Homeless (with or without shelter)
9. Long-term care facility (nursing home)
10. Rehabilitation hospital / unit
11. Hospice facility / Palliative care unit
12. Acute care hospital
13. Correctional facility
14. Other
15. Deceased

☐☐

SECTION Q. ASSESSMENT INFORMATION

SIGNATURE OF PERSON COORDINATING / COMPLETING THE ASSESSMENT

_____

1. **Signature (sign on above line)**
2. **Date assessment signed as complete**

20☐☐ - ☐☐ - ☐☐
Year Month Day

Additional Signatures

_____
Signature
20☐☐ - ☐☐ - ☐☐
Year Month Day

_____
Signature
20☐☐ - ☐☐ - ☐☐
Year Month Day

_____
Signature
20☐☐ - ☐☐ - ☐☐
Year Month Day

_____
Signature
20☐☐ - ☐☐ - ☐☐
Year Month Day