SHOWCARDS & REFERENCE CARDS

Medicare Current Beneficiary Survey
Facility Component

MCBS

Medicare Current Beneficiary Survey

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FA1

Type of Place You Are Part Of...

- Continuing Care Retirement Community (CCRC)
- Retirement Community
- Hospital
- Assisted Living Facility
- Board and Home Care
- Domiciliary Care Home
- Rest Home/Retirement Home
- Other

Type of Place You Are Part Of...

- Free Standing Nursing Home
- Nursing Home/Unit Within a CCRC or Retirement Center
- Hospital
- Hospital-Based SNF Unit
- Assisted Living Facility
- Board and Care Home
- Domiciliary Care Home
- Personal Care Home
- Rest Home/Retirement Center
- Home Office or Management Office for a Chain or Group of Off-Site Nursing Facilities
- Mental Health/Psychiatric Setting
- Institution for the Mentally Retarded/Developmentally Disabled
- Rehabilitation Facility
- Other

$$\boxed{\text{FA3}}$$

Types of Hospitals

- Acute Care Hospital
- Private Psychiatric Hospital
- State or County Hospital for the Mentally Ill
- VA Hospital, VA Medical Center
- State Hospital for the Mentally Retarded
- Chronic Disease, Rehabilitation, Geriatric, or Other Long-Term Care Hospital
- Other

FA4

Types of Ownership

- For Profit (Individual, Partnership, or Corporation)
- Private Nonprofit (Religious Group, Nonprofit Corp., Etc.)
- City/County Government
- State Government
- Veterans Administration
- Other Federal Agency
- Other

Nursing Home or Rehabilitation Center:
- Nursing homes are licensed or certified facilities that provide nursing services 24 hours a day to the residents. Rehabilitation centers provide skilled nursing care or rehabilitation services and other related health services.

Personal Care Home or Residential Care Facility:
- Personal care and residential care facilities or apartment buildings offer residents help with activities, such as bathing and dressing, but do not provide 24-hour nursing services. (Some residents at a personal care or residential care facility may not require such assistance, but it must be available to them.) These facilities are sometimes called assisted-living communities, personal care homes, board and care homes, or domiciliary homes.

CCRC or Retirement Home or Center:
- CCRC and retirement centers or homes may have nursing home facilities on a campus or in one large building along with other housing and services, such as apartments, board and care services, and often a variety of community-based long-term care services.

Hospital

Private Home or Apartment

Other LTC Facility:
- Long-term care facilities provide a residence, some surveillance and available living assistance for persons no longer willing or able to live on their own for the long term.

Other

BQ1AA

- Mexican, Mexican American, (Chicano/Chicana)
- Puerto Rican
- Cuban
- Other Hispanic, Latino, Latina or Spanish Origin

BQ1B

- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other

BQ1C

- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander

BQ1

Armed Forces Service

- Iraq or Afghanistan Conflict (2001 – Present)
- Persian Gulf War (August 1990 – March 1991)
- Vietnam Era (August 1964 - May 1975)
- Korean Conflict (June 1950 - January 1955)
- World War II (September 1940 - July 1947)
- World War I (1917-1918)
- Peace Time Only (All Other Times)

BQ1A

Race

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Another

BQ2

In This Facility

Other Nursing Home or Rehabilitation Center:
- Nursing homes are licensed or certified facilities that provide nursing services 24 hours a day to the residents. Rehabilitation centers provide skilled nursing care or rehabilitation services and other related health services.

Personal Care Home/Other Residential Care Facility:
- Personal care and residential care facilities or apartment buildings offer residents help with activities, such as bathing and dressing, but do not provide 24-hour nursing services. (Some residents at a personal care or residential care facility may not require such assistance, but it must be available to them.) These facilities are sometimes called assisted-living communities, personal care homes, board and care homes, or domiciliary homes.

CCRC or Retirement Home or Center:
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Hospital

Private Home or Apartment

Spouse Deceased

Other LTC Facility:
- Long-term care facilities provide a residence, some surveillance and available living assistance for persons no longer willing or able to live on their own for the long term.

BQ3

Total Yearly Income (Before Taxes or Deductions) Received From:

- Jobs
- Businesses
- Interest
- Social Security
- Railroad Retirement
- Supplemental Security Income (SSI)
- Pensions
- Other Sources

HA1

Level of Self-Performance

- Independent
- Supervision
- Limited Assistance
- Extensive Assistance
- Total Dependence
- Activity Occurred Only Once or Twice
- Activity Did Not Occur

Diagnoses

- Alzheimer's Disease
- Anemia
- Anxiety Disorder
- Aphasia
- Arthritis
- Asthma, COPD, or Chronic Lung Disease
- Atrial Fibrillation or Other Dysrhythmias
- Benign Prostatic Hyperplasia
- Cancer
- Cataracts, Glaucoma, or Macular Degeneration
- Cerebral Palsy
- Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke
- Cirrhosis
- Coronary Artery Disease (E.G., Angina, MI, and ASHD)
- Deep Veneous Thrombosis (DVT), Pulmonary Embolus (PE) or Pulmonary Thrombo-Embolism (PTE)
- Dementia other than Alzheimer's
- Depression
- Diabetes Mellitus (E.G., Diabetic Retinopathy, Nephropathy, and Neuropathy)
- Gastroesophageal Reflux Disease (GERD) or Ulcer
- Heart Failure (Congestive Heart Failure (CHF) and Pulmonary Edema)
- Hemiplegia/Hemiparesis
- Hip Fracture
- Huntington's Disease
- Hyperkalemia

Diagnoses Continued

- Hyperlipidemia (Hypercholesterolemia)
- Hypertension
- Hyponatremia
- Malnutrition or at Risk for Malnutrition
- Manic Depression (Bipolar Disease)
- Multiple Sclerosis
- Neurogenic Bladder
- Obstructive Uropathy
- Orthostatic Hypotension
- Osteoporosis
- Other Fracture
- Paraplegia
- Parkinson's Disease
- Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
- Post-Traumatic Stress Disorder (PTSD)
- Psychotic Disorder (Other than Schizophrenia)
- Quadriplegia
- Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)
- Respiratory Failure
- Schizophrenia
- Seizure Disorder or Epilepsy
- Thyroid Disorder
- (Hypothyroidism, Hyperthyroidism, and Hashimoto's Thyroiditis)
- Tourette's Syndrome
- Traumatic Brain Injury
- Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease
- Other
- None of the Above

| HA4 |

Infections

- Multidrug-Resistant Organism (MDRO)
- Pneumonia
- Septicemia
- Tuberculosis
- Urinary Tract Infection in Last 30 Days
- Viral Hepatitis
- Wound Infection (Other Than Foot)
- None of the Above

Other Diagnoses

- Agitation
- Alcohol Dependency
- Allergies
- Anorexia
- Aortic Stenosis
- Ataxia
- Atypical Psychosis
- Blindness
- Breast Disorders
- Cataracts
- Cerebral Degeneration
- Clinical Obesity
- Clostridium Difficile (C.DIFF.)
- Conjunctivitis
- Constipation
- Degenerative Joint Disease
- Diaphragmatic Hernia (Hiatal Hernia)
- Diverticula of Colon
- Down's Syndrome
- Dysphagia (Swallowing Difficulties)
- Edema (Other Than Pulmonary)
- Gastritis/Duodenitis
- Gastroenteritis, Noninfectious

Other Diagnoses Continued

- Gastrointestinal Hemorrhage
- Gout
- Hemorrhage of Esophagus
- HIV Infection
- Hyperplasia of Prostate
- Hypopotassemia/Hypokalemia
- Hypotension (Other Than Orthostatic)
- Insomnia
- Kyphosis
- Missing Limb (E.G., Amputation)
- Nonpsychotic Brain Syndrome
- Organic Brain Syndrome
- Osteoarthritis
- Pathological Bone Fracture
- Renal Ureteral Disorder
- Respiratory Infection
- Scoliosis
- Sexually Transmitted Diseases
- Spinal Stenosis
- Ulcer of Leg, Chronic
- Urinary Retention
- Vertigo

HA6

IADLs

- No Difficulty at All
- A Little Difficulty
- Some Difficulty
- A Lot of Difficulty
- Not Able To Do It

US1

How Often Each Week...

- Less Than Once a Week
- Once or Twice a Week
- 3 to 5 Times a Week
- More Than 5 Times a Week
- One-Time Evaluation

How Long a Period...

- Less Than 1 Week
- 1 to 3 Weeks
- 4 to 8 Weeks
- More Than 8 Weeks but Not the Whole Time
- About the Whole Time

US3

Other Certified or Licensed Health Care Providers

- Audiologist
- Dietician
- Laboratory Technician
- Nurse Practitioner
- Ophthalmologist
- Optometrist
- Physician's Assistant
- Recreational Therapist
- Registered Nurse
- Social Worker
- X-Ray Technician
- Other

US4

Supplies and Medical Services

- Ambulance Service
- Cloth Diapers
- Diabetic Equipment or Supplies
- Disposable Diapers
- Equipment or Supplies for Kidney Dialysis
- Eye Glasses or Contact Lenses
- Hearing Aid or Other Communication Device
- Orthopedic Items
- Ostomy Supplies
- Oxygen
- Prosthesis
- None of the Above

US5

Other Medical Device or Equipment

- Bedside Commode
- Bed Pads (Cloth or Disposable)
- Catheter and Catheter Supplies
- Feeding Supplies (Include Pumps, Syringes, Tubes)
- G Tube and Supplies
- Geri Chair
- Hospital Bed
- IV Supplies
- Nebulizer
- Special Mattress, Cushions or Mattress Pads (Include Egg Crate, Air)
- Suction Machine and Supplies
- TED Hose and Supplies
- Wheelchair/Walker
- Some Other Type of Device or Equipment
- None of the Above

US6

Other Necessary Medical Items or Services

- Applying/Changing Dressings Including Band-Aids
- Applying/Monitoring Hot Packs
- Catheterization and Irrigation
- Feeding (With Spoon, Syringe, Pump or Other Device)
- G Tube Use and Care
- Incontinence
- IV Use and Care
- Pacemaker Check
- Skin Treatments for Prevention/Treatment of Skin Ulcers
- Some Other Kind of Item or Service
- Suctioning
- None of the Above

GLOSSARY OF MEDICAL ABBREVIATIONS

Medicine Form

Amp.	Ampules (elongated glass container of liquid medication)
Cap.	Capsules (gel caps, time release caps, solid caplets)
Elix.	Elixir (liquid)
hypo.	hypodermically (injection)
I.D.	intradermal (injection in skin)
I.M.	intramuscular (injection in muscle)
inf.	infusion (I.V. infusion)
Inhalant	medication administered per nose and/or mouth via mist
I.V.	intravenously (in vein)
patche	skin cover for medication or for test
per os/P.O.	by mouth
P.R.	per rectum
Pulv	powder
S.L.	Sublingual (under the tongue)
s.q./subq/S.C.	subcutaneous (under the skin)
syr	syrup
Tab	Tablet
tr	tincture
ung	ointment
vial	container (small) of sealed liquid medication usually for injections

When or How Often a Medicine is Administered

a.c.	before meals		stat.	immediately
ad. lib	as desired		t.i.d.	three times a day
b.d.	twice a day			
b.i.d.	twice a day			
b.i.n.	twice a night			
H.	hour			
h.s.	at bedtime			
non rep.	don't repeat			
noxt.	at night			
p.c.	after food (after meals)			
p.r.n.	as needed (as desired)			
q.h.	every hour			
q	every			
q 2h	every 2 hours			
q.d.	every day			
q.i.d	four times a day			
q.o.d.	every other day			
rep.	let it be repeated			

GLOSSARY OF MEDICAL ABBREVIATIONS

Dosage or Strength of a Medicine

cc.	cubic centimeter (injections and liquid medications are measured in cc.)
dr.	drams (27 gr = 1 dram; 8 drams = 1 oz.)
fl. oz.	fluid ounce
gm or g	gram
gr	grain
gtt	drops
Kg	Kilogram
M^2	square meter
mEq	milliequivalent (weight of substance in 1 milliliter)
mg	milligram (1000 mg = 1 gm)
mcg	microgram
ml	milliliter (1000 ml = 1 Liter)
mm	millimeter (1000 mm = 1 meter)
L.	Liter (1.0567 quarters = 1 Liter)

Miscellaneous

a or aa	of each	pads	sterile or non-sterile coverings
AP	apical pulse		
aq.	Water	$\bar{s}$	without
ASAP	as soon as possible	S.O.B.	short of breath
$\underline{C}$	centigrade	sp. gr.	specific gravity
$\bar{c}$	with	ss	half
CO_2	carbon dioxide	$\dot{T}$	one tablet
Comp	compound	T	temperature
dil	dilute	T.O.	telephone order
et	and	$\dot{T}\dot{T}$	two tablets
F	Fahrenheit		
Fx	fracture		
G	gauge		
GI	gastrointestinal		
I.O.	intake and output		
lauage	to wash out cavities (wounds)		
Na	sodium		
NG tube	nasal gastric tube for feeding [sizes in French (i.e., French 18]		
NS/NA C1	normal saline (Sodium Chloride Solution)		
O2	oxygen		
o.d.	right eye		
o.s.	left eye		
o.u.	both eyes		

MEDICAL CHART ABBREVIATIONS AND SYMBOLS

A	-	assessment
AB, Ab	-	abortion
Abd	-	Abdomen, abdominal
ABG	-	arterial blood gases
Abx	-	antibiotics
AFB	-	acid fast baccili (tuberculosis culture)
AIDS	-	acquired immune deficiency syndrome
AP	-	anteroposterior
A/P	-	assessment, plan
ARC	-	AIDS related complex
Asx	-	asymptomatic
AMA	-	against medical advice
A&P	-	auscultation and percussion
Ax	-	axillary (armpit)
Appt	-	appointment
AZT	-	azidodideoxythymidine
B	-	black race
BC	-	blood culture; birth control (pills)
BM	-	bowel movement, brain mass
bid	-	two times a day
BOM	-	bilateral otitis media (earache)
BP, B/P	-	blood pressure
BUN	-	blood urea nitrogen (blood chemistry test for kidney function)
BS	-	breath sounds (chest exam); bowel sounds (abdominal exam)
Bx	-	biopsy
$\bar{c}$	-	with
C	-	Caucasian race
Ca	-	cancer
CAT	-	computerized axial tomography
CBC	-	complete blood count
CC, C/C	-	chief complaint
CCE	-	clubbing, cyanosis, edema (extremities)
CHD	-	congenital heart disease
CHF	-	congestive heart failure
chr	-	chronic
cl	-	clear
CIS	-	carcinoma in situ
C-section	-	cesarean section
cm	-	centimeter
CMV	-	cytomegalovirus
CN	-	cranial nerve
CNS	-	central nervous system
COR	-	coronary
CP	-	chest pain; cerebral palsy

MEDICAL CHART ABBREVIATIONS AND SYMBOLS

C&S	-	culture and sensitivity
CSF	-	cerebrospinal fluid
CT	-	computed tomography
CTA, CTAP	-	clear to auscultation, percussion (lungs)
CV	-	cardiovascular
CVA	-	cerebrovascular accident (stroke); costovertebral angle (abdomen)
cx	-	cervical (nodes)
CXR	-	chest x-ray
D	-	dorsal spine
D&C	-	dilation and curettage (uterus)
D/C	-	discharge
dc/dc'd	-	discontinue, discontinued
def	-	deficit
Dig	-	Digoxin (used in treatment of congestive heart failure and other heart disorders)
DKA	-	diabetic ketoacidosis
DM	-	diabetes mellitus
DNR	-	do not resuscitate
DOA	-	data of admission; dead on arrival
DOB	-	date of birth
DOE	-	dyspnea on exertion (shortness of breath)
DPT	-	diphtheria, pertussis, tetanus immunization
DTR	-	deep tendon reflexes
Dx	-	diagnosis
ECG, EKG	-	electrocardiogram
ECHO	-	echocardiogram
EEG	-	electroencephalogram
EENT	-	eye, ear, nose, and throat
EMT	-	emergency medical technician
ENT	-	ear, nose, and throat
EOM, EOMI	-	extraocular movement, intact (eye exam)
ER	-	emergency room
Ext	-	extremity
ETOH	-	ethanol (alcohol)
F	-	female
FAS	-	fetal alcohol syndrome
FBS, FS	-	fasting blood sugar, fasting sugar
FE	-	iron
FH	-	family history
FT	-	fluorescent titer antibody (syphilis test)
F/U	-	follow up
FUO	-	fever of unknown origin
Fx	-	fracture
GB	-	gallbladder

MEDICAL CHART ABBREVIATIONS AND SYMBOLS

GC	-	gonococcus (organism causing gonorrhea)
GI	-	gastrointestinal
GU	-	genitourinary
GYN	-	gynecology
HA	-	headache; health assessment
HCM	-	health care maintenance
Hct	-	hematocrit
HD	-	heart disease
Hgb	-	hemoglobin
HEENT	-	head, eyes, ears, nose, throat
HBP	-	high blood pressure
H&P	-	history and physical
H	-	Hispanic
HMO	-	health maintenance organization
HSM	-	hepatosplenomegaly
HIV	-	human immunodeficiency virus
H/O, h/o	-	history of
HPI	-	history of present illness
HPV	-	human papilloma virus
HR	-	heart rate
H/S megaly	-	hepatosplenomegaly
HSV	-	herpes simplex virus
Ht	-	heart, height
HTN	-	hypertension
Hx, hx	-	history
ICD	-	International Classification of Diseases
ICU	-	intensive care unit
ID	-	identification
IDDM	-	insulin dependent diabetes mellitus
imm-UTD	-	immunization up-to-date
Inf	-	infection
INH	-	isonicotine hydrazine (drug for tuberculosis)
IP	-	inpatient
IV	-	intravenous
IVDA	-	intravenous drug abuse
IVDU	-	intravenous drug user
IVP	-	intravenous pyelogram (x-ray exam of kidneys)
IUP	-	intrauterine pregnancy
JVD	-	jugular vein distension
KS	-	Kaposi's sarcoma
L,Ⓛ	-	left
LAD	-	left axial deviation; left anterior descending
LAS	-	lymphadenopathy syndrome
lat	-	lateral

MEDICAL CHART ABBREVIATIONS AND SYMBOLS

LLL	-	left lower lobe (lung)
LLQ	-	left lower quadrant (abdomen)
LMP	-	last menstrual period
LN	-	lymph nodes
LNMP	-	last normal menstrual period
LP	-	lumbar puncture
LS	-	lumbosacral (spine)
LUE	-	left upper extremity
LUQ	-	left upper quadrant (abdomen)
Ⓜ	-	murmur (heart)
M	-	male
meds	-	medications
ml	-	milliliter
mm	-	millimeter
MAR	-	Medicine Administration Record
MPAF	-	Medicare PPS Assessment Form
MR	-	medical record
MRI	-	magnetic resonance imaging
NAD	-	no apparent distress
NC	-	no complaints
NEG, neg	-	negative
NIDDM	-	noninsulin dependent diabetes mellitus
NKA, NKDA	-	no known allergies; no known drug allergies
nl	-	normal
NPH	-	a type of insulin (Isophone)
NPO	-	nothing by mouth
NSR	-	normal sinus rhythm (heart)
NT	-	not tender (abdomen)
NV, N/V	-	nausea & vomiting
NVD	-	nausea, vomiting, diarrhea
��	-	without
O	-	objective
OB	-	obstetrics
occ	-	occasional
OD	-	right eye
OM	-	otitis media
O-P	-	oral pharynx
O+P	-	ova and parasites
OP	-	outpatient
OPD	-	outpatient department
OR	-	operating room
OS	-	left eye
OT	-	oral thrush
OTC	-	over the counter

MEDICAL CHART ABBREVIATIONS AND SYMBOLS

p	-	after; following
p	-	pulse; plan
PA	-	posteroanterior
PAP	-	Papanicolaou smear
Path	-	pathology
PCP	-	pneumocystis carinii pneumonia
PE, Pex	-	physical examination
Pen	-	penicillin
PERRLA	-	pupils equal, round, react to light and accommodation
PGL	-	progressive generalized lymphadenopathy
PID	-	pelvic inflammatory disease
PLH	-	pulmonary lymphoid hyperplasia
PMH	-	past medical history
PMI	-	point of maximum intensity (heart)
PML	-	progressive multifocal leukoencephalopathy
po	-	by mouth
PPD	-	tuberculosis skin test
PPS	-	Prospective Payment System
prn	-	as needed
pt	-	patient
PT	-	physical therapy
PTA	-	prior to admission
PUD	-	peptic ulcer disease
pul	-	pulmonary
q, Q	-	every
qd, QD	-	every day
qid, QID	-	four times a day
q4h	-	every four hours
R,Ⓡ	-	right, respiration
RBC	-	red blood cells
RCM	-	right coastal margin
RF	-	rheumatic fever
RHD	-	rheumatic heart disease
RLE	-	right lower extremity
RLL	-	right lower lobe (lung)
RLQ	-	right lower quadrant (abdomen)
RO, R/O	-	rule out
ROM	-	range of motion (extremities)
ROS	-	review of systems
RPR	-	syphilis test
RRR	-	regular rhythm & rate
RTI	-	respiratory tract infection
RUE	-	right upper extremity
RUL	-	right upper lobe (lung)

MEDICAL CHART ABBREVIATIONS AND SYMBOLS

RUQ	-	right upper quadrant (abdomen)
Rx	-	prescription
$\bar{s}$	-	without
S	-	subjective
S_1, S_2	-	first, second heart sound
SBE	-	subacute bacterial endocarditis
sen	-	sensory
SH	-	social history
sl	-	slight
SOB	-	short of breath
SP, S/P	-	status post
STD	-	sexually transmitted disease
STS	-	serology test for syphilis
SW	-	social worker
Sx	-	symptom
syst	-	systolic (blood pressure, murmur)
T	-	temperature
TB, TBC	-	tuberculosis
TM	-	tympanic membrane (ear)
TOXO	-	toxoplasmosis
TPR	-	temperature, pulse, respiration
Tx, Tx'ed	-	treat, treated
UA, U/A	-	urinalysis
URI	-	upper respiratory infection
UTI	-	urinary tract infection
VDRL	-	lab test for syphilis
VN, VNA	-	visiting nurse, visiting nurse association
VS, V/S	-	vital signs; versus
w/	-	with
W	-	white
WBC	-	white blood cells
W&D	-	warm and dry (skin)
WDWN	-	well developed, well nourished
WNL	-	within normal limits
wt	-	weight
x	-	times
yo	-	years old
♀	-	female
♂	-	male
⊕, (+), +	-	positive, plus, present
⊖, (-), -	-	negative, absent
⊂	-	heart
Δ	-	change
⌀	-	no, none

MEDICAL CHART ABBREVIATIONS AND SYMBOLS

<	-	less than, caused by
>	-	greater than
↓	-	down, decreased
↑	-	up, increased
→	-	shows, results
1°	-	primary; first degree
2°	-	secondary; second degree
/	-	slash mark signifying per, and, with (can be mistaken for "1" or "I")

EXAMPLES OF MEDICAL RECORDS ORDER

TABS	FORMS
Patient Care Plans	MDS, Trigger Sheet Patient Care Plan Discharge Plan
Nurses Notes	Vital Sign Flow Sheet I&O (Intake & Output) Sheet Weight Record Nurses Notes Nursing Assessment
Doctors' Orders	Physician Orders
Progress Notes	Physician Progress Notes
H & P	History & Physical Discharge Summary Transfer Form
Lab	X-ray Reports Laboratory Reports
Dietary	Dietary Notes
Activities	Activity Notes, Assessment, Plan of Care
Social Services	Social Service Notes
Rehabilitation	Physical Therapy Speech Therapy Occupational Therapy
Medication	Medication Record Treatment Record PRN Medical Record
Nursing Assistance	ADL Records
Miscellaneous	Personal Possession Record
Admission	Face Sheet/Admission Record
In Front/Back of Chart	Legal Representative Record Living Will Advance Directives

GUIDE TO PATIENT RECORDS

<u>Reminder</u>: Information may be in multiple places.

QUESTIONNAIRE SECTION	TYPE OF PATIENT RECORD
Facility Questionnaire (FQ)	Must be completed with facility administrator or other knowledgeable respondent.
Residence History (RH)	Admission Record Discharge or Death Summary Face Sheet Final Nurses Notes or Progress Notes Patient Transfer Form
Background (BQ)	Admission Record Social History
Health Insurance (IN)	Medicare number and limited information about other health insurance coverage can be found on forms completed at the time of admission (e.g., Admission Record). Otherwise, this section will require a respondent in the business/billing office.
Health Status (HS)	Admission/Discharge Summary from the hospital Admission History and Physical ADL Records Doctor orders Nursing Assessment Sheet Nurses' Notes Patient Transfer Form Progress Notes Resident Basic Needs Assessment Form Minimum Data Set, or MDS
Prescribed Medicines (PM)	Medication Record/Chart PRN Medical Record Treatment Records
Expenditures (EX)	Admission Record Records from the business office
Use (US)	Consultation Reports Doctors' Orders Lab and Specialists' Reports Patient Care Plan Physician Progress Notes Nurses' Notes Rehabilitation and Therapy Reports Treatment Logs X-ray Reports

MEDICAL PROVIDERS

1. DENTIST/DENTAL PROVIDER
2. MEDICAL DOCTOR ⟶
3. AUDIOLOGIST
29. ACUPUNCTURIST
4. CHIROPRACTOR
5. CLINICAL SOCIAL WORKER
6. DIETITIAN/NUTRITIONST
7. HEARING THERAPIST
8. HOME HEALTH/HEALTH AIDE
9. HOMEMAKER
30. HOMEOPATH
10. HOSPICE WORKER
11. I.V. THERAPIST
28. LICENSED PRACTICAL NURSE (LPN)
31. MASSAGE THERAPIST
32. NATUROPATH
12. NURSE (RN)
13. NURSE PRACTITIONER
14. NURSE'S AIDE
15. OCCUPATIONAL THERAPIST (OT)
16. OPTOMETRIST
17. OSTEOPATH
18. PARAMEDIC
19. PHYSICAL THERAPIST (PT)
20. PHYSICIAN'S ASSISTANT
21. PODIATRIST (FOOT DOCTOR)
22. PSYCHOLOGIST
23. RESPIRATORY THERAPIST
24. SOCIAL/CASE WORKER
25. SPEECH THERAPIST
26. THERAPIST (MENTAL HEALTH)
27. X-RAY TECHNICIAN
91. OTHER MEDICAL PROVIDER SPECIALTY (<u>NON-MD</u>) SPECIFY

EXAMPLES OF TYPES OF
MEDICAL DOCTORS

ALLERGIST
ANESTHESIOLOGIST
CARDIOLOGIST
DERMATOLOGIST
ENDOCRINOLOGIST
GASTROENTEROLOGIST
GERIATRIC DOCTOR
GYNECOLOGIST
HEMATOLOGIST
INTERNAL MD/INTERNIST
NEPHROLOGIST
NEUROLOGIST
ONCOLOGIST
OPHTHALMOLOGIST
ORTHOPEDIST
PATHOLOGIST
PROCTOLOGIST
PULMONOLOGIST
PSYCHIATRIST
RADIOLOGIST
RHEUMATOLOGIST
SURGEON:
- CARDIOVASCULAR
- COLON/RECTAL
- EYE
- GENERAL
- HAND
- NEUROLOGICAL
- ORTHOPEDIC
- PLASTIC
- THORACIC
- VASCULAR
UROLOGIST

FACILITY SPECIAL KEYS AND FUNCTIONS

SPECIAL KEYS	FUNCTIONS
Enter	Tells the computer to move the cursor to the next field; OR Select a choice on a roster or select a button within a box.
Esc	Moves you out of any box, for example, COMMENTS, PM LOOK UP. Stores and returns cursor to answer space.
Backspace	Erases previous character(s) on line where cursor is located.
Delete	Deletes a field value when highlighted.
F9	Calls up a comment window and moves cursor there so a comment can be entered.
F6	Stores a "refused" response in the data file.
F5	Stores a "don't know" response in the data file.
F1	Used to access help screens.
Space Bar	Adds a dash between values in a "Select All That Apply" field. Adds spaces in a text field.
Up Arrow	Takes you to the previous field entered.
TAB	Moves cursor to next field, or button within a box.
END	Moves cursor to last field entered.
S	Suppresses a soft error message and returns the cursor to next field.
C	Closes an error message and returns cursor to answer space.
G	Closes an error message and returns cursor to the highlighted "Question Involved" within the error message.
Ctrl/R	Add or Edit an entry to Person Roster.
Ctrl/S	Takes you to the Stay Report.
Ctrl/B	Takes you to the Break Off screen.
Ctrl/E	Escapes from Break Off screen, Person Roster, or Stay Report. (Interview can be started again in the instrument at the same place the Ctrl/E was entered.
NOTE: **When CTRL key is used -- hold the CTRL key down then press the appropriate key.**	

STATE ABBREVIATIONS

Alabama	AL	Montana	MT
Alaska	AK	Nebraska	NE
Arizona	AZ	Nevada	NV
Arkansas	AR	New Hampshire	NH
California	CA	New Jersey	NJ
Colorado	CO	New Mexico	NM
Connecticut	CT	New York	NY
Delaware	DE	North Carolina	NC
District of Columbia	DC	North Dakota	ND
Florida	FL	Ohio	OH
Georgia	GA	Oklahoma	OK
Hawaii	HI	Oregon	OR
Idaho	ID	Pennsylvania	PA
Illinois	IL	Puerto Rico	PR
Indiana	IN	Rhode Island	RI
Iowa	IA	South Carolina	SC
Kansas	KS	South Dakota	SD
Kentucky	KY	Tennessee	TN
Louisiana	LA	Texas	TX
Maine	ME	Utah	UT
Maryland	MD	Vermont	VT
Massachusetts	MA	Virginia	VA
Michigan	MI	Washington	WA
Minnesota	MN	West Virginia	WV
Mississippi	MS	Wisconsin	WI
Missouri	MO	Wyoming	WY

IDENTIFYING SPECIAL FACILITY CASES

We continue to need your help in identifying these special facility cases. When the cases are fielded, review each of your facility cases with the following questions:

- Is this a Group/Adult/Family Care Home setting?

- Are all of the Group Homes on one campus? If yes, we still consider this one facility.

If you identify a Group/Adult/Family Care Home setting, do not complete the case; follow these steps:

1. Call the facility and find out the name, address, phone number, and contact person for the Group Home. Obtain the following information for every R residing in the facility:

   - The physical address of the Group Home and,

   - The contact address where you will go to talk to the contact person.

2. Does the Group Home have three or more beds? If it does not, the case is not eligible for the Facility Component and will be crossed over to the Community Component.

3. Write an e-mail to your supervisor explaining the situation, making sure to include all necessary information:

   - Respondent ID #

   - The facility ID# of the case as originally fielded in the current round.

   - Do residents reside in the Facility where the case was fielded?

   - The name, address, and phone # of new Facility (Group Home).

   - The main contact name (the person you will contact to make an appointment).

Once all the details are worked out, the case will be resent to you electronically with the new Facility ID# and the "old" Facility will be deleted from your computer.

Facility Questionnaire Procedures for Group/Adult/Family Care Home Facilities

An interviewer instruction and additional response categories are included in FQ1. These direct and allow you to avoid asking this question in the Group/Adult/Family Care Home situations. The intent of this question is to confirm that we have the correct address for the group home location (where the R resides).

1. For interviewing purposes, we treat the respondent for the FQ as the administrator at FQ3 (select response category - RESPONDENT CONSIDERED ADMINISTRATOR).

2. You are to collect the address of the FQ respondent at FQ4.

3. Verify the phone number at the Group Home location at FQ5. It would be best if this is done from previously obtained information; don't read this question aloud.

4. At FA12 (NUMBER OF FACILITY BEDS), probe for and enter the number of beds at the SP's physical location only.

5. Finally, if this is a newly identified Group/adult/Family Care Home. Be sure to enter the admission date.

GUIDELINES FOR MAKING COMMENTS
IN THE FACILITY QUESTIONNAIRE

General Guidelines: Identify what questionnaire you are in and which question you are referring to. Then identify the problem and what action you think needs to be taken. Remember to include the following information in comments:

FQ: Add a PLACE or UNIT
- Place name.   - Type of place.   - Number of beds.   - Bed Certification: Medicare, Medicaid, ICF.
RH: Add a STAY
- Dates: begin and end.   - Name of the place.   - Type of STAY (hospital, home, facility or "other" facility) *See Showcard FA1.*   - If the place is not already listed on the Place Roster, also add the address and phone number of the place.
RH: Need to Change Respondent Disposition
[For example: case was coded complete in the facility and the R was really discharged or deceased.]   - Name of the place the SP was discharged to or where the R died.   - If R was discharged or deceased in a new place, (not included on the Place Roster), also include the address and phone number of the new place.   - Date of discharge or death.   - Include any missing charges, payments and Sources of Payment through the date of death or discharge.
EX: Adding a Billing Period, or Additional Charge Information
- Billing Period Date(s): begin and end.   - How many days were billed during each period.   - Total amount charged to the SP.   - Total amount paid.   - All Sources of Payment.
IN: Medicaid Coverage
[For example: "No" is entered at IN1 {Has SP ever been covered by Medicaid} and Medicaid is listed as a SOP in EX.]   - The year the SP was first covered by Medicaid.   - The Medicaid #.
PM: Adding Missed Medicine(s)
- The month(s) it was administered in.   - Name of the prescribed medicine.   - The form (tab/liquid/etc.) and strength (number and unit (MG/CC/etc.) - the single dosage.*   - How often the dosage was administered (QD/PRN/etc.)*   - The total number of times it was administered for that month.   *Use your prescribed medicine reference Showcards.*

MISSING DATA REFERENCE GUIDE

Sections with missing data may remain open for you to access and make corrections in certain situations. These sections are eventually locked to protect the data and a missing data section is activated. While it is preferable to go back into the original section to correct the missing data, you must use the MD section once the original section is locked. Below are items in each section that trigger the MD sections.

FACILITY QUESTIONNAIRE (FQ)

If any of the following questions are answered "don't know" or "refused", the section will be coded MD.

Question #	Question Topic
FQ1A	IS FACILITY'S NAME CORRECT?
FQ2	IS FACILITY'S ADDRESS CORRECT?
FQ4	IS FACILITY'S MAILING ADDRESS CORRECT?
FQ3	IS FACILITY'S ADMINISTRATOR CORRECT?
FQ5	IS FACILITY'S PHONE NUMBER CORRECT?
FA1	WHAT IS THE TYPE OF PLACE FOR FACILITY?
FA12	WHAT IS THE NUMBER OF BEDS IN FACILITY?
FA13	IS THERE MEDICAID CERTIFICATION FOR FACILITY?
FA14	IS THERE MEDICARE CERTIFICATION FOR FACILITY?
FA15	IS THERE MEDICAID-ICF/MR CERTIFICATION FOR FACILITY?
FA16	IS THERE STATE DEPARTMENT LICENSING FOR FACILITY?
FA18	IS THERE NON-NURSING LICENSING FOR FACILITY?

RESIDENCE HISTORY (RH)

If any of the following questions are answered "don't know" or "refused", the section will be coded MD.

Question #	Question Topic
RH7	IS SP ALIVE?
RH8	WHAT IS SP'S DATE OF DEATH?
RH13	WHAT ARE THE DATES FOR PLACE (SP) WAS IN (CURRENT YEAR)?

BACKGROUND QUESTIONNAIRE (BQ)

If any of the following questions are answered "don't know" or "refused", the section will be coded MD.

Question #	Question Topic
BQ11A	WHAT IS SP'S RACE?
BQ13	WHAT IS SP'S MARITAL STATUS?

MISSING DATA REFERENCE GUIDE

HEALTH INSURANCE (IN)

No Missing Data Questions.

HEALTH STATUS (HS)

No Missing Data Questions.

PRESCRIBED MEDICINE (IN)

If PM data is missing for any month within the reference period, the section will be coded MD.

EXPENDITURE (HS)

No Missing Data Questions.

HEALTH STATUS (EX)

No Missing Data Questions.

USE (US)

No Missing Data Questions.

2014

JANUARY

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FEBRUARY

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JUNE

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2014

JULY

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2015

JANUARY

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2015

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OCTOBER

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DECEMBER

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