



Facility ID

This questionnaire is a scannable form. Please follow the instructions closely. For optimum accuracy, please print carefully and avoid contact with the edges of the box. The following will serve as an example.

Example:

1	2	3	4	5	6	7	8
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**1. Clinician ID**

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**2. Patient/Medicare ID**

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**3. Age at Admission**

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**4. Admission Date**

		/			/				
Month			Day			Year			

Please mark your response with an "X" using a black pen as in the example

Example:  Choice A

**5. Medical Diagnosis/es** (Select all that apply)

Primary    Secondary

- Neoplasm Lip/Pharynx (140.00 - 149.99)
- Other Neoplasm (150.00 - 160.99 & 162.00 - 239.99)
- Neoplasm Larynx (161.00 - 161.99)
- Mental Disorders (290.00 - 319.00)
- Anoxia (348.10)
- Encephalopathy (348.30)
- CNS Diseases (320.00 - 348.00 & 348.40 - 359.90)
- Cerebrovascular Disease (430.00 - 432.99 & 436.00 - 438.99)
  - Left     Right     Bilateral     Unknown
- Occlusion/TIA (433.00 - 435.90)
- Respiratory Diseases (460.00 - 519.99)
- Hemorrhage/Injury (852.00 - 852.99)
- Head Injury (854.00 - 854.99)
- Other

**6. Onset of Primary Medical Diagnosis**

		/					<input type="checkbox"/> Unknown
Month			Year				

**7. Gender**

- Male     Female

**8. Race/Ethnicity**

(Select one or more as applicable)

- American Indian or Alaska Indian
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Unknown

**9. SLP Diagnosis**

(Select all that apply)

- Aphasia (784.3)
- Apraxia (784.69)
- Cognitive-Communication Disorder (438.0 - 438.10)
- Dysarthria (784.5)
- Dysphagia (787.2)
- Fluency Disorder (307.0)
- Voice Disorder (784.4 - 784.49)
- Other



**10. Current Treatment Setting**

- Acute Hospital
- Inpatient Rehab
- Subacute
- Skilled Nursing
- Home Health
- Outpatient Rehab
- Comprehensive Outpatient Rehab
- Day Treatment
- Assisted Living
- Office-Based
- Other

**11. Setting Previous to Current Admission**

- Acute Hospital
- Inpatient Rehab
- Subacute
- Skilled Nursing
- Home
- Assisted Living
- Unknown
- Other

**12. Did the Patient Receive SLP Services in the Previous Setting?**

- Yes
- No
- Unknown

**13. Funding Source at Admission**

- Medicare - Part A
- Medicare - Part B
- Medicare - Part C/Advantage
- Medicaid (Fee-for-service)
- Medicaid (Managed Care)
- Veteran's Administration
- Commerical Fee-for Service Insurance
- Managed Care Plan (HMO, PPO, IPA)
- Self-Pay
- Unknown

**14. Functional Communication Measures**

*Score only those that apply to the patient's treatment plan*

	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Alaryngeal Communication (AL) .....	<input type="checkbox"/>					
Alaryngeal Communication (TEP) .....	<input type="checkbox"/>					
Alaryngeal Communication (ES) .....	<input type="checkbox"/>					
Attention .....	<input type="checkbox"/>					
Augmentative-Alternative Communication...	<input type="checkbox"/>					
Fluency .....	<input type="checkbox"/>					
Memory .....	<input type="checkbox"/>					
Motor Speech .....	<input type="checkbox"/>					
Pragmatics .....	<input type="checkbox"/>					
Problem Solving .....	<input type="checkbox"/>					
Reading .....	<input type="checkbox"/>					
Spoken Language Comprehension.....	<input type="checkbox"/>					
Spoken Language Expression .....	<input type="checkbox"/>					
Swallowing .....	<input type="checkbox"/>					
Voice .....	<input type="checkbox"/>					
Voice Following Tracheostomy .....	<input type="checkbox"/>					
Writing .....	<input type="checkbox"/>					





# NOMS: Adults in Health Care DISCHARGE FORM

Facility ID

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Example:

1	2	3	4	5	6	7	8
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**1. Clinician ID**

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**2. Patient/Medicare ID**

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**3. Discharge Date**

		/			/						
Month			Day			Year					

Please mark your response with an "X" using a black pen as in the example

Example:  Choice A

**4. Were the Treatment Goals for this Level of Care Met?**

- No
- Yes (If Yes, Skip directly to Question 6)

**5. Primary Reason for Discharge From SLP Services**

- Patient Progress Plateaued
- Discharge From Facility
- Change in Medical Condition
- Insurance Declined Coverage
- Insurance Benefits Exhausted
- Discharge Due to PPS
- Other

**6. Are Continued SLP Services Recommended upon Discharge?**

- Yes
- No

**7. Funding Source at Discharge**

- Medicare - Part A
- Medicare - Part B
- Medicare - Part C/Advantage
- Medicaid (Fee-for-service)
- Medicaid (Managed Care)
- Veteran's Administration
- Commercial Fee-for-Service Insurance
- Managed Care Plan (HMO, PPO, IPA)
- Self-Pay
- Unknown

**8. Patient Setting Subsequent to Discharge**

- Acute Hospital
- Inpatient Rehab
- Subacute
- Skilled Nursing
- Home
- Assisted Living
- Unknown
- Other

**9. Average Number of Sessions per Week**

- Less than One
- One
- Two
- Three
- Four
- Five
- More than Five

**10. Length of Typical Session**

- 15 minutes or less
- 16 to 30 minutes
- 31 to 45 minutes
- 46 to 60 minutes
- More than 60 minutes



**11. Total Number of 15-Minute SLP Treatment Units**

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**12. Total Number of 15-Minute SLP Evaluation Units**

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**13. Functional Communication Measures. Score only the FCMs that were included at admission or added on the Add/Close FCM form that have not already been closed. Indicate the percentage of treatment time spent on each FCM. The percentages across all FCMs and Other Category must total 100%.**

	Level	% Tx Time	Predominant Service Delivery Model								
	1	2	3	4	5	6	7		Ind	Grp	T/C
Alaryngeal Communication (AL).....	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Alaryngeal Communication (TEP).....	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Alaryngeal Communication (ES) .....	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Attention .....	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Augmentative-Alternative Communication..	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Fluency .....	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Memory .....	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Motor Speech .....	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Pragmatics .....	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Problem Solving .....	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Reading .....	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Spoken Language Comprehension.....	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Spoken Language Expression .....	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Swallowing .....	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Voice .....	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Voice Following Tracheostomy.....	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Writing .....	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Other <input style="width: 200px;" type="text"/>								<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Must Equal 100%

**14. Is English the Primary Language of this Patient?**

- Yes (If Yes, Please **STOP**)
- No (If No, Please Continue)

**15. What Language(s) was/were Used in Treatment?**

- English Only
- Primary Language Only
- English and Primary Language
- Third Language

**16. Who Assisted the SLP in Communicating with this Patient?**

- No Assistance
- Family Member as Translator
- Other Translator
- Other

