



NOMS: Adults in Health Care

ADMISSION FORM

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

		/					
Month			Year				

☐ Unknown

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

--	--	--	--	--	--	--	--	--	--

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

- | | |
|--|---|
| <input type="checkbox"/> Medicare - Part A | <input type="checkbox"/> Veteran's Administration |
| <input type="checkbox"/> Medicare - Part B | <input type="checkbox"/> Commercial Fee-for-Service Insurance |
| <input type="checkbox"/> Medicare - Part C/Advantage | <input type="checkbox"/> Managed Care Plan (HMO, PPO, IPA) |
| <input type="checkbox"/> Medicaid (Fee-for-service) | <input type="checkbox"/> Self-Pay |
| <input type="checkbox"/> Medicaid (Managed Care) | <input type="checkbox"/> 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 1	Level 2	Level 3	Level 4	Level 5	Level 6	Level 7	% Tx Time	Predominant Service Delivery Model		
									Ind	Grp	T/C
Alaryngeal Communication (AL).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alaryngeal Communication (TEP).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alaryngeal Communication (ES)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Augmentative-Alternative Communication..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motor Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pragmatics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problem Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spoken Language Comprehension.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spoken Language Expression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Voice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Voice Following Tracheostomy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other <input 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

