FORM **HHCS-3** (3-29-96)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
U.S. PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR HEALTH STATISTICS

CURRENT PATIENT QUESTIONNAIRE

NOTICE – Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to DHHS Reports Clearance Officer; Paperwork Reduction Project (0920-0298) Room 531-H; Hubert H. Humphrey Bldg.; 200 Independence Ave., SW; Washington, DC 20201. Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or establishment in accordance with Section 308(d) of the Public Health Service Act (42 LISC 242m)

	1996 NATIONAL HOME AND HOSPICE CARE SURVEY	confidence, will be used for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or establishment in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).		
	c			
	Section A - ADMINISTI	RATIVE INFORMATIO	N	
1.	Field representative name	2. FR code		3. Date of interview Month/Day/Year / /
	Section B - PATIENT IN	IFORMATION		
1.	Patient name or other identifier First M.I. Last		2.	Patient line number
	Section C - STATU	JS OF INTERVIEW		
	01 ☐ Complete 02 ☐ Partial 03 ☐ Patient included in sampling list in error 04 ☐ Incorrect sample line number selected 05 ☐ Refused 06 ☐ Assessment only 07 ☐ Unable to locate record 08 ☐ Less than 6 patients selected 09 ☐ Other noninterview – Specify 10 ☐ No current patients			
NO	TES			

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	Read to each new respondent.				
	In order to obtain national level data about the patients of hospices and home health agencies such as this one, we are collecting information about a sample of current patients. I will be asking questions about the background, health status, treatment, social contacts, and billing information for each sampled patient. The information you provide will be held in strict confidence and will be used ONLY by persons involved in the survey and only for the purposes of the survey.				
	In answering these questions, it is especially im record. Do you have the medical file(s) and reco	portant to locate the information in the patient's medical rd(s) for (Read name(s) of selected current patient(s))?			
	patient forms while the respondent gets the records.	nning the interview. Fill sections A and B on the front of all the current If no record is available for a patient, try to obtain as much e records are available and/or from the respondent's memory.			
1.	What is's sex?	I 1 01 ☐ Male 1 02 ☐ Female			
2.	What is's date of birth?	Age (at admission)			
		Month Day Year OROR			
	HAND FLASHCARD 1.	l o1 □ White			
За.	Which of these best describes's race?	02 🔲 Black			
	Mark (X) only one box.	03			
b.	Is of Hispanic origin?				
		01 ☐ Yes 1 02 ☐ No 1 03 ☐ Don't know			
4.	What is's current marital status?	on Married			
	Mark (X) only one box.	l 02 ☐ Widowed			
		o3 ☐ Divorced O4 ☐ Separated			
		05 Never married			
		06 ☐ Single Don't know			
	HAND FLASHCARD 2.	l			
5a.	Where is currently living?	02 Rented room, boarding house			
	Mark (X) only one box.	o3 Retirement home o4 Board and care assisted living or residential care facility			
		05 Other type of health facility (including mental health			
		facility) – SKIP to item 6 Introduction of Other – Specify of			
b.	Is living with family members, nonfamily	<u> </u>			
	members, both family and nonfamily members, or alone?	01 With family members 02 With nonfamily members 03 With both family members and nonfamily members 04 Alone 05 Don't know			

	Read the introductory paragraph for the Social Security Number only once for each respondent. As part of this survey, we would like to have's Social Security Number. Provision of this number is voluntary and providing or not providing the number will have no effect in any way on's benefits. This number will be useful in conducting future followup studies. It will be used to match against the vital statistics records maintained by the National Center for Health Statistics. This information is collected under the authority of Section 306 of the Public Health Service Act.				
	What is's Social Security Number?	Social Security Number O1 Refused O2 Don't know			
7.	Who referred to this agency? Mark (X) all that apply. PROBE: Any other sources?	01 Self/Family 02 Nursing home 03 Hospital 04 Physician 05 Health department 06 Social service agency 07 Home health agency 08 Hospice 09 Religious organization 10 Other - Specify 11 Don't know			
8.	What was the date of's most recent admission with your agency, that is, the date on which was admitted for the current episode of care?	Month Day Year 00 ☐ Only an assessment was done for this patient (patient was not provided services by this agency)			
9a	According to's medical record, what were the primary and other diagnoses at the time of that (admission/assessment)? PROBE: Any other diagnoses?	00 ☐ No diagnosis Primary: 1 Others: 2 3 4 5 6°			
b.	Refer to Q8. If ONLY an assessment was done for this patient, END THE INTERVIEW AND COMPLETE SECTION C ON THE COVER. THEN GO TO the next current patient questionnaire. If the patient was admitted to the agency and provided services by the agency, CONTINUE this interview. According to's medical records, what are's CURRENT primary and other diagnoses? PROBE: Any other diagnoses?	00 ☐ No diagnosis 01 ☐ Same as 9a Primary: 1 Others: 2 4			
	 	6			

9c.	. According to's medical record, did have any diagnostic or surgical procedures that were related to's admission to this agency?	00 No procedures 1 01 Yes 1 2
10.	What type of care is currently receiving from your agency? Is it home health care or hospice care?	01 ☐ Home health care 1 02 ☐ Hospice care
11a.	. Does have a primary caregiver (outside of this agency)?	01 ☐ Yes 02 ☐ No
b.	Does usually live with (his/her) primary caregiver?	01 Yes 02 No 03 Don't know
	HAND FLASHCARD 5.	01 ☐ Spouse
c.	What is the relationship of the primary caregiver to?	02 Parent 03 Child
	to? Mark (X) only one box.	03
	HAND FLASHCARD 6.	T I 00 □ No aids used
12.	Which of these aids does currently use?	on Bedside commode
	Mark (X) all that apply.	i 02 ☐ Brace (any type) i 03 ☐ Cane
	PROBE: Any other aids?	04 Crutches 05 Dentures (full or partial) 06 Eyeglasses (including contact lenses) 07 Hearing aid 08 Hospital bed 09 Orthotics 10 Shower chair 11 Walker 12 Wheel chair – Manually operated 13 Wheel chair – Motorized 14 Other – Specify
NOTI	ES	

	For items 13a–14b, refer to item 12.	1 01 □ Yes □ 02 □ No		
13a.	Does have any difficulty in seeing (when wearing glasses)?	03 Not applicable (e.g., comatose) . SKIP to item 14a		
	HAND FLASHCARD 7.	01 Partially impaired		
b.	Is's sight (when wearing glasses) partially, severely, or completely impaired as defined on this card?	o2 ☐ Severely impaired o3 ☐ Completely lost, blind o4 ☐ Don't know		
14a.	Does have any difficulty in hearing (when wearing a hearing aid)?	01		
	HAND FLASHCARD 8.	01 Partially impaired		
b.	Is 's hearing (when wearing a hearing aid) partially, severely, or completely impaired, as defined on this card?	i 02 □ Severely impaired 1 03 □ Completely lost, deaf 1 04 □ Don't know		
15.	HAND FLASHCARD 9.			
	Ask questions 15a through 15k in PART I FIRST . As you ask each part of the question, PAUSE to allow the respondent time to refer to the flashcard. Mark (X) the "Yes" box for each item the respondent says the patient has in his/her home. Then, GO TO PART II , and ask the question for each item marked "Yes" in Part I.			
PAR	T I Which of the following items does have in (his/her) home?	PART II Does receive assistance from your agency staff in caring for or using:		
a.	Oxygen, respiratory therapy equipment?	1 1		
	(1) Ventilator/Respirator	01 Yes 02 No 03 Don't know		
	(2) Liquid oxygen delivery system $\dots \dots \dots 01 \square Yes$	01 🗆 Yes 02 🗆 No 03 🗀 Don't know		
	(3) Oxygen concentrator 01 \square Yes	¹ 01 ☐ Yes 02 ☐ No 03 ☐ Don't know		
	(4) Gaseous oxygen delivery system $\dots \dots 01 \square Yes$	•		
	(5) Nebulizer	•		
	(6) Humidifier			
	(7) Suction equipment	1		
	(8) Tracheostomy	i 01 ☐ Yes 02 ☐ No 03 ☐ Don't know		
b.	Intravenous therapy equipment?			
	(1) Peripheral catheter			
	(2) Midline catheter	l 01 ☐ Yes 02 ☐ No 03 ☐ Don't know		
	(3) Central venous catheter (e.g. Hickman, Broviac, Porta-cath., etc.)	! 		
	(4) Infusion pumps	01 ☐ Yes 02 ☐ No 03 ☐ Don't know		
c.	Decubitus ulcer prevention/treatment equipment?	1		
	(1) Air mattress/air fluidized bed 01 ☐ Yes	01 Yes 02 No 03 Don't know		
	(2) Foam mattress (egg-crate mattress) 01 \square Yes	1		
d.	Enteral nutrition equipment?			
	(1) Nasogastric tube	! ! 01 ☐ Yes 02 ☐ No 03 ☐ Don't know		
	(2) Gastrostomy/jejunostomy tube 01 ☐ Yes			
	(3) Pump	i		
	CONTINUED ON NEXT PAGE	CONTINUED ON NEXT PAGE		

15.	PART I - Continued	15. PART II - Continued		
	Which of the following items does have in (his/her) home?	Does receive assistance from your agency staff in caring for or using:		
e.	Dialysis equipment?	[
	(1) Peritoneal Dialysis – Manual (continuous) 01 \square Yes	01 🗆 Yes 02 🗀 No 03 🗆 Don't know		
i	(2) Peritoneal Dialysis – Automated (intermittent/continuous cyclic) 01 \square Yes	01 ☐ Yes 02 ☐ No 03 ☐ Don't know		
	(3) Peritoneal – unspecified	01 ☐ Yes 02 ☐ No 03 ☐ Don't know		
	(4) Hemodialysis			
f.	Blood glucose monitor?	01 ☐ Yes 02 ☐ No 03 ☐ Don't know		
g.	Drainage devices?	01 🗆 Yes 02 🗔 No 03 🗔 Don't know		
	(1) Wound/bile duct/ureteral drainage catheter 01 \square Yes	01 ☐ Yes 02 ☐ No 03 ☐ Don't know		
	(2) Foley catheter	01 🗆 Yes 02 🗆 No 03 🗆 Don't know		
	(3) Intermittent bladder catheterization \dots 01 \square Yes	01 🗆 Yes 02 🗆 No 03 🗀 Don't know		
	(4) External urinary collection devices (e.g. condom catheter)	01 Ves 02 No 03 Don't know		
	(5) Urostomy			
	(6) Ileostomy/Colostomy			
h.	Protective restraints (e.g. vests, belts)? 01 Yes			
	Pediatric care?			
	(1) Apnea monitor			
	(2) Phototherapy lights/equipment			
i.	Prenatal uterine monitoring?			
-	Other? – Specify 01 \(\subseteq \text{Yes} \)			
16.	Does have any difficulty in controlling (his/her) bowels?	01 ☐ Yes		
		02 ☐ No 03 ☐ Not applicable (e.g. infant, has an ostomy)		
		04 🔲 Don't know		
17.	Does have any difficulty in controlling			
	(his/her) bladder?	01		
		03 🗌 Not applicable (e.g. infant, has an indwelling		
		catheter, has an ostomy) 04 Don't know		
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18.	HAND FLASHCARD 10. Does currently receive personal help from this agency in any of the following activities as defined on this card	I I Yes	No	Don't know	Not applicable (e.g., patient is bedfast)	
	Mark (X) one box for each activity.	1				
a.	Bathing or showering?	01 🗆	02 🗌	03 🗆	04 🗆	
b.	Dressing?	I I 01 🗆	02 🗆	03 🗆	04 🗆	
c.	Eating?	I i 01 🗆	02 🗆	03 🗆	04 🗆	
d.	Transferring in or out of beds or chairs?	01 🗆	02 🗆	03 🗆	04 🗆	
e.	Walking?	01 🗆	02 🗆	03 🗆	04 🗆	
f.	Using the toilet room?	01 🗆	02 🗆	03 🗆	04 🗆	
19.	HAND FLASHCARD 11. Does receive personal help from your agency in any of the following activities –	I I Yes I	No	Don't know	Not applicable (e.g., patient is bedfast)	
	Mark (X) one box for each activity.	I I I 01 🗆	02 🔲	03 🗆	04 🗆	
	Doing light housework? Managing money?	01	02 🗆	03 🗆	04 🗆	
	Shopping for groceries or clothes?	01 🗌	02 🗆	03 🗌	04 🗀	
d.	Using the telephone (dialing or receiving calls)?	l l 01 🗆	02 🗌	03 🗆	04 🗌	
e.	Preparing meals?	01 🗆	02 🗆	03 🗌	04 🗆	
f.	Taking medications?	01 🗆	02 🗆	03 🗆	04 🗆	
20a.	Which of these services does currently receive FROM YOUR AGENCY? Mark (X) all that apply. PROBE: Any other services?	00 None 01 Continuous home care 02 Counseling 03 Homemaker-household services 04 Medications 05 Mental health services 06 Nursing services 07 Nutritionist services 08 Occupational therapy 09 Physical therapy 10 Physician services 11 Social services 12 Speech therapy/Audiology 13 Transportation 14 Volunteers 15 Other services - Specify				
NOTE	:S	 				

	HAND FLASHCARD 13.	T			
ŀ	TIAND LEASTICATED 15.	. 00 [] None		
20b.	Which of these service providers FROM YOUR	\$	Chaplain		
	AGENCY visited during the last 30 days?		Dieticians/Nutritionists		
	Manula IVI all the at a new land	i	Home health aides		
	Mark (X) all that apply.	—] Homemakers/Personal caretal		
	PROBE: Any other providers?		_		
	Thobe. Any other providers.	Ŧ	Licensed practical or vocation	al nurses	
			Nursing aides and attendants		
ĺ		1 07	Occupational therapists		
		08	Physical therapists		
		. os [] Physicians		
			Registered nurses		
			Respiratory therapists		
			Social workers		
		ı			
			Speech pathologists/audiologi	sts	
		i	Volunteers		
	ů	¦ 15 □	Other providers – Specify д		
		i İ			
		l			
		l			
,	AND FLASHCARD 14.			Home Health	Hospice
· /	IAND FLASHCARD 14.	l I		Care	Care
21 V	Vhat is the PRIMARY expected source of	01	Private insurance	01 🔲	01 🔲
21.	payment for 's care?		Own income, family support,	02 🗆	02 🔲
•	,	I 02 L	Social Security benefits,	02 🗀	السا 02
/	Mark (X) only one source.		retirement funds, or welfare		
Ι,		่หงโ	Supplemental Security	03 🗌	03 🗆
	For the source of payment ask: s the (source of payment) for home health care	 I	Income (SSI)		33 —
	or hospice care?	04] Medicare	04 🗌	04 🗀
`] Medicaid	05 🗆	05 🗌
1					
1		! 06 <u>L</u>	Other government medical assistance	oe 🗀	06 🗌
		' 		[🗆
		07 └	Religious organizations, foundations, agencies	07 🗀	07 🗆
			_	08 🗆	08 🗆
		! 08 ∟	VA contract, pensions, or other VA compensation	08 🗀	08 🗀
			No charge made for care	09 🔲	09 🗆
		ĺ		10 🗆	10 🗌
		10 L	Payment source not yet determined	10 🗀	10 🗀
			Other – <i>Specify _Z</i>	11 🗌	11 🔲
		13 <u>L</u> _	Other - Specify	11 🗀	11 📖
		! 			
			Don't know		
		12 🗀	J Don t know		
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HAND FLASHCARD 14.		Home Health Care	Hospice Care
22. What are ALL the secondary sources of	। 1 01 ☐ Private insurance	01 🔲	01 🔲
payment for 's care? Mark (X) all that apply.	o2 Own income, family support, Social Security benefits, retirement funds, or welfare	02 🗌	02 🗌
PROBE: Any other sources of payment?	03 ☐ Supplemental Security Income (SSI)	03 🗌	03 🗆
For the source of payment ask:	04 ☐ Medicare	04 🔲	04 🔲
Is the (source of payment) for home health care or hospice care?	^I 05 ☐ Medicaid	05 🗌	05 🗀
or nospice care:	06 Other government medical assistance	06 🗌	06 🗌
	l 07 ☐ Religious organizations, foundations, agencies	07 🗌	07 🗌
	08 VA contract, pensions, or other VA compensation	08 🗌	08 🗆
	□ 09 ☐ No charge made for care	оэ 🔲	09 🔲
	l 10 ☐ Payment source not yet determined	10 🗌	10 🗌
	11 ☐ Other – Specify _▼	11 🗌	11 🗆
	l		
	12 Don't know		
23. When was the last time service was provided?	Month Day Year		
	OF THIS FORM AND CONTINUE PATIENT QUESTIONNAIRE.		
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