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

DISCHARGED RESIDENT QUESTIONNAIRE

1999 NATIONAL NURSING HOME SURVEY

Section A – ADMINISTRATIVE INFORMATION

1. Field representative name
2. FR code
3. Date of interview
   Month Day Year

Section B – SAMPLE INFORMATION

1. Discharged resident line number
2. Date of discharge
   Month Day Year

Section C – STATUS OF INTERVIEW

01 □ Complete
02 □ Partial
03 □ Resident included in sampling list in error
04 □ Incorrect sample line number selected
05 □ Refused
06 □ Unable to locate record
07 □ Less than 6 discharges selected
08 □ Other noninterview – Specify
09 □ No discharges

Notes/Comments section
10 □ Check this box if comments are written in this section
or any other place on this questionnaire.
In order to obtain national level data about the residents of nursing homes such as this one, we are collecting information about a sample of discharges. I will be asking questions about the background, health status, and charges for each sampled resident.

The identifying 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.

Do you have the medical file(s) and record(s) for (Read name(s) of selected current resident(s))? If you have a Health Care Finance Administration Minimum Data Set for Nursing Home Resident Assessment form in the records, you may use it while we complete this questionnaire.

If not, ask the respondent to get it/them prior to beginning the interview. Fill sections A and B on the front of all the discharged resident forms while the respondent gets the records. If no record is available for a resident, try to obtain as much information as possible from whatever administrative records are available and/or from the respondent's memory.

| 1. What was the resident's sex? | 01 ☐ Male   
| 02 ☐ Female |

<table>
<thead>
<tr>
<th>2. What was (his/her) date of birth?</th>
<th>Age at admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>Day</td>
</tr>
</tbody>
</table>

| 3a. Was (he/she) of Hispanic or Latino origin? | 01 ☐ Yes   
| 02 ☐ No   
| 03 ☐ Don't know |

HAND FLASHCARD 1.

b. Which of these best described (his/her) race?

Mark (X) one or more boxes.

| 01 ☐ American Indian or Alaska Native |
| 02 ☐ Asian |
| 03 ☐ Black or African American |
| 04 ☐ Native Hawaiian or Other Pacific Islander |
| 05 ☐ White |
| 06 ☐ Other – Specify |
| 07 ☐ Don't know |

| 4. What was (his/her) marital status at the time of discharge? | 01 ☐ Married   
| 02 ☐ Widowed   
| 03 ☐ Divorced   
| 04 ☐ Separated   
| 05 ☐ Never married   
| 06 ☐ Single   
| 07 ☐ Don't know |

HAND FLASHCARD 2.

5a. Where was (he/she) staying immediately before entering this facility?

Mark (X) only one box.

| 01 ☐ Private residence (house or apartment) |
| 02 ☐ Rented room, boarding house |
| 03 ☐ Retirement home |
| 04 ☐ Board and care, assisted living or residential care facility |
| 05 ☐ Nursing home |
| 06 ☐ Hospital |
| 07 ☐ Rehabilitation facility |
| 08 ☐ Other inpatient health facility (including mental health facility) |
| 09 ☐ Other – Specify |
| 10 ☐ Don't know |

SKIP to item 6

b. At that time, was (he/she) living with family members, nonfamily 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 |
6. What was the date of (his/her) admission for the period of care which ended on (Date of discharge)?

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

7. Why was (he/she) discharged?

Mark (X) only one box.

- [ ] Recovered
- [ ] Stabilized
- [ ] Deceased
- [ ] Admitted to hospital
- [ ] Admitted to another nursing home
- [ ] Other – Specify

8a. According to (his/her) medical record, what were the primary and other diagnoses at the time of admission on (date in item 6)?

Primary: 1 ______________________

Others: 2 ______________________

PROBE: Any other diagnoses?

3 ______________________

4 ______________________

5 ______________________

6 ______________________

8b. According to (his/her) medical record, what were (his/her) primary and other diagnoses at the time of discharge on (Date of discharge)?

Primary: 1 ______________________

Others: 2 ______________________

PROBE: Any other diagnoses?

3 ______________________

4 ______________________

5 ______________________

6 ______________________

9. What level of care was (he/she) receiving from your facility? Was it skilled care, intermediate care or residential care?

- [ ] Skilled care
- [ ] Intermediate care
- [ ] Residential care

Notes/Comments
For items 10 through 21, use the phrase "AT THE TIME OF DISCHARGE" if the resident was discharged alive. Use the phrase "IMMEDIATELY PRIOR TO DISCHARGE" if the resident was discharged dead.

### HAND FLASHCARD 3.

10. The following questions refer to the resident's status at the (time of discharge/immediately prior to discharge) on (Date of discharge). (At the time of discharge/immediately prior to discharge), which of these aids did (he/she) regularly use?

Mark (X) all that apply.

**PROBE:** Any other aids?

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>No aids used</td>
<td></td>
</tr>
<tr>
<td>01</td>
<td>Eye glasses (including contact lenses)</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Hearing aid</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>Dentures</td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>Transfer equipment</td>
<td></td>
</tr>
<tr>
<td>05</td>
<td>Wheelchair</td>
<td></td>
</tr>
<tr>
<td>06</td>
<td>Cane</td>
<td></td>
</tr>
<tr>
<td>07</td>
<td>Walker</td>
<td></td>
</tr>
<tr>
<td>08</td>
<td>Crutches</td>
<td></td>
</tr>
<tr>
<td>09</td>
<td>Brace (any type)</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Oxygen</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Bedside commode</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Other aids or devices - Specify</td>
<td></td>
</tr>
</tbody>
</table>

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For items 11a-12b, refer to item 10.

11a. (At the time of discharge/immediately prior to discharge), did (he/she) have any difficulty in seeing (when wearing glasses)?

**HAND FLASHCARD 4.**

b. Was (his/her) sight (when wearing glasses) partially, severely, or completely impaired as defined on this card?

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>Not applicable (e.g., comatose)</td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>Don't know</td>
<td></td>
</tr>
</tbody>
</table>

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12a. (At the time of discharge/immediately prior to discharge), did (he/she) have any difficulty in hearing (when wearing a hearing aid)?

**HAND FLASHCARD 5.**

b. Was (his/her) hearing (when wearing a hearing aid) partially, severely, or completely impaired, as defined on this card?

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>Not applicable (e.g., comatose)</td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>Don't know</td>
<td></td>
</tr>
</tbody>
</table>

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13a. (At the time of discharge/immediately prior to discharge), did (he/she) receive any assistance in bathing or showering?

b. Did (he/she) bathe or shower with the help of:

   - (1) Special equipment? ....................................
   - (2) Another person? ........................................

<table>
<thead>
<tr>
<th>Item</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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14a. (At the time of discharge/immediately prior to discharge), did (he/she) receive any assistance in dressing?

b. Did (he/she) dress with the help of:

   - (1) Special equipment? ....................................
   - (2) Another person? ........................................

<table>
<thead>
<tr>
<th>Item</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Questionnaire Sections

**Section 15a.** 
(At the time of discharge/immediately prior to discharge), did (he/she) receive any assistance in eating?

- **Yes** (□)
- **No** (□) — **SKIP to item 16a**

**b.** Did (he/she) eat with the help of:

1. **Special equipment?**
   - **Yes** (□)
   - **No** (□)

2. **Another person?**
   - **Yes** (□)
   - **No** (□)

**Section 16a.**
During the last 7 days before discharge, from (Date 7 days prior to discharge) to (Date of discharge), was (he/she) bedfast?

- **Yes** (□) — **SKIP to item 20a**
- **No** (□)

**b.** Was (he/she) chairfast?

- **Yes** (□) — **SKIP to item 20a**
- **No** (□)

**Section 17a.**
(At the time of discharge/immediately prior to discharge), did (he/she) receive any assistance in transferring in and out of bed or a chair?

- **Yes** (□)
- **No** (□) — **Skip to item 18a**

**b.** Did (he/she) require the help of:

1. **Special equipment?**
   - **Yes** (□)
   - **No** (□)

2. **Another person?**
   - **Yes** (□)
   - **No** (□)

**Section 18a.**
(At the time of discharge/immediately prior to discharge), did (he/she) receive any assistance in walking?

- **Yes** (□)
- **No** (□) — **Skip to item 19a**

**b.** Did (he/she) walk with the help of:

1. **Special equipment?**
   - **Yes** (□)
   - **No** (□)

2. **Another person?**
   - **Yes** (□)
   - **No** (□)

**Section 19a.**
(At the time of discharge/immediately prior to discharge), did (he/she) go outside the grounds of this facility?

- **Yes** (□)
- **No** (□) — **SKIP to item 20a**

**b.** When (he/she) went outside the grounds, did (he/she) require the help of:

1. **Special equipment?**
   - **Yes** (□)
   - **No** (□)

2. **Another person?**
   - **Yes** (□)
   - **No** (□)

**Section 20a.**
(At the time of discharge/immediately prior to discharge), did (he/she) have an ostomy, an indwelling catheter or similar device?

- **Yes** (□)
- **No** (□) — **SKIP to item 20c**

**b.** Did (he/she) receive personal help from another person in caring for this device?

- **Yes** (□)
- **No** (□)

**c.** Did (he/she) receive any assistance using the toilet room?

- **Yes** (□)
- **No** (□)

- **Does not use toilet room (ostomy patient, chairfast, etc.)** — **SKIP to item 21**

**d.** Did (he/she) require the help of:

1. **Special equipment?**
   - **Yes** (□)
   - **No** (□)

2. **Another person?**
   - **Yes** (□)
   - **No** (□)
21. (At the time of discharge/immediately prior to discharge), did (he/she) have any difficulty in controlling (his/her) bowels?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not applicable (e.g., infant, had a colostomy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01</td>
<td>02</td>
<td>03</td>
</tr>
</tbody>
</table>

22. Did (he/she) have any difficulty in controlling (his/her) bladder?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not applicable (e.g., infant, has an indwelling catheter, had an ostomy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01</td>
<td>02</td>
<td>03</td>
</tr>
</tbody>
</table>

**HAND FLASHCARD 6.**

23. (At the time of discharge/immediately prior to discharge), did (he/she) receive personal help or supervision in any of the following activities:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01</td>
<td>02</td>
</tr>
</tbody>
</table>

- a. Care of personal possessions?
- b. Managing money?
- c. Securing personal items such as newspapers, toilet articles, snack food?
- d. Using the telephone (dialing or receiving calls)?

**HAND FLASHCARD 7.**

24. During the billing period that included (Date of discharge) which of these services were received by (him/her) either inside or outside this facility?

Mark (X) all that apply.

**PROBE:** Any other services?

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Dental care</th>
<th>Equipment or devices</th>
<th>Hospice services</th>
<th>Medical services</th>
<th>Mental health services</th>
<th>Nursing services</th>
<th>Nutritional services</th>
<th>Occupational therapy</th>
<th>Personal care</th>
<th>Physical therapy</th>
<th>Prescribed medicines or nonprescribed medicines</th>
<th>Sheltered employment</th>
<th>Social services</th>
<th>Special education</th>
<th>Speech or hearing therapy</th>
<th>Transportation</th>
<th>Vocational rehabilitation</th>
<th>Other – Specify</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>00</td>
<td>01</td>
<td>02</td>
<td>03</td>
<td>04</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
</tr>
</tbody>
</table>

**HAND FLASHCARD 8.**

25. What was the PRIMARY source of payment for (his/her) care for the month of (Month and year of discharge)?

Refer to item B2 on the cover.

Mark (X) only one source.

<table>
<thead>
<tr>
<th></th>
<th>Private insurance</th>
<th>Own income, family support, Social Security benefits, retirement funds</th>
<th>Supplemental Security Income (SSI)</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Other government assistance or welfare</th>
<th>Religious organizations, foundations, agencies</th>
<th>VA contract, pensions, or other VA compensation</th>
<th>Payment source not yet determined</th>
<th>Other – Specify</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01</td>
<td>02</td>
<td>03</td>
<td>04</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11</td>
</tr>
</tbody>
</table>
26. What were all the secondary sources of payment for (his/her) care for the month of (Month and year of discharge)?
Mark (X) all that apply.

PROBE: Any other sources?

27. What were the total charges billed for (his/her) care, including all charges for services, drugs and special medical supplies?

Mark (X) only one box.

Put dates in the boxes shown ONLY if the charge is NOT for a month, day, or week.

$ ____________________ per ___

on Mark (X) if drugs and medical supplies are included in this total.

Month Day Year

TO

Month Day Year

Month Day Year

Date of Birth – Question 2 on page 2

Date of Admission – Question 6 on page 3

Date of Discharge – Item B2 on cover

Date of Interview – Item A3 on cover

Notes/Comments