



RESIDENTIAL ASSESSMENT INSTRUMENT (RAI)

DATA FILE CHECKLIST

Continuing Care Reporting System (CCRS) and
Home Care Reporting System (HCRS)

Submit this completed form to the email address:
HealthDataHA@gov.bc.ca

Questions about the request process or any part of this application
may be directed to the email address above.

MINISTRY OF HEALTH USE ONLY

File Number	Date Received
ISP Appendix	

PROJECT TITLE

APPLIES TO COHORT(S)

DATE RANGE

From (yyyy/mm/dd)

To (yyyy/mm/dd)

OTHER DATE RANGE AND FILTERING CRITERIA

RAI – CCRS AND HCRS

Date Range: April 2009 onwards

Description

The RAI (Resident Assessment Instrument) data is contained in two separate datasets; the Continuing Care Reporting System (CCRS) and the Home Care Reporting System (HCRS).

The CCRS contains demographic, clinical, functional and resource utilization information on individuals receiving continuing care services in residential care in B.C. Much of the data originates from the RAI MDS 2.0 assessment. The HCRS contains demographic, clinical, functional and resource utilization information on clients served by publicly funded home care programs in Canada. Key components of HCRS are the RAI-Home Care (RAI-HC®).

Purpose

The purpose of the CCRS and HCRS is to support front-line care planning and quality improvement at the point of care and to support planning, quality improvement, funding and accountability at the management and policy-making levels.

The data dictionary for this checklist is available at: www.gov.bc.ca/health/forms/5513datadictionary.pdf

CONTINUING CARE REPORTING SYSTEM (CCRS)

Episode - The service episode record is comprised a service start and a service end. A service end date is to be submitted when a client changes facility or service is ended due to an end reason. If there is no service end date then a client is still receiving service. This table includes client information such as name, ID, demographic information and regular routine. (CCRS_EPISODE)

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Episode ID		EPISODE_ID	
<input type="checkbox"/> Unique Registration Identifier	AA1	UNIQUE_REGISTRATION_IDENTIFIER	
<input type="checkbox"/> Sex	AA2	SEX	
<input type="checkbox"/> Birth Date (YYYYMM)	AA3a	BIRTH_DATE	
<input type="checkbox"/> Estimated Birth Date Flag	AA3b	ESTIMATED_BIRTH_DATE_FLAG	
<input type="checkbox"/> Unencrypted Health Card Number -replaced with a study specific identification number	AA5a	UNENCRYPTED_HEALTH_CARD_ NUMBER	
<input type="checkbox"/> Province Issued Health Card	AA5b	PROV_ISSUE_HEALTH_CARD	
<input type="checkbox"/> Facility Code	AA6	FACILITY	
<input type="checkbox"/> Entry Date	AB1	ENTRY_DATE	
<input type="checkbox"/> Developmental Disability No Or Not Applicable	AB10a	DD_NO_OR_NOT_APPLICABLE	
<input type="checkbox"/> Developmental Disability Downs Syndrome	AB10b	DD_DOWNS_SYNDROME	
<input type="checkbox"/> Developmental Disability Autism	AB10c	DD_AUTISM	
<input type="checkbox"/> Developmental Disability Epilepsy	AB10d	DD_EPILEPSY	
<input type="checkbox"/> Developmental Disability Organic Other Condition	AB10e	DD_ORGANIC_OTHER_CONDITION	
<input type="checkbox"/> Developmental Disability No Organic Condition	AB10f	DD_NO_ORGANIC_CONDITION	
<input type="checkbox"/> Entry Service Type	AB2a	ENTRY_SERVICE_TYPE	
<input type="checkbox"/> Admission From Facility	AB2b	ADMISSION_FROM_FACILITY	
<input type="checkbox"/> Lived Alone	AB3	LIVED_ALONE	
<input type="checkbox"/> Resident Postal Code	AB4	RESIDENT_POSTAL_CODE	
<input type="checkbox"/> Stay Here Before	AB5a	STAY_HERE_BEFORE	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Stay In Other Similar Facility	AB5b	STAY_IN_OTHER_SIMILAR_FACILITY	
<input type="checkbox"/> Stay In Other Reside Facility	AB5c	STAY_IN_OTHER_RESIDE_FACILITY	
<input type="checkbox"/> Stay In Psychiatric Setting	AB5d	STAY_IN_PSYCHIATRIC_SETTING	
<input type="checkbox"/> Stay In Developmental Disability Setting	AB5e	STAY_IN_DD_SETTING	
<input type="checkbox"/> Education Completed	AB7	EDUCATION_COMPLETED	
<input type="checkbox"/> Language	AB8	LANGUAGE	
<input type="checkbox"/> Mental Health History Or Developmental Disability	AB9	MENTAL_HEALTH_HISTORY_OR_DD	
<input type="checkbox"/> Stays Up Late At Night	AC1a	STAYS_UP_LATE_AT_NIGHT	
<input type="checkbox"/> Naps During Day	AC1b	NAPS_DURING_DAY	
<input type="checkbox"/> Goes Out Often	AC1c	GOES_OUT_OFTEN	
<input type="checkbox"/> Stays Busy With Hobbies	AC1d	STAYS_BUSY_WITH_HOBBIES	
<input type="checkbox"/> Stays Alone Or TV	AC1e	STAYS_ALONE_OR_TV	
<input type="checkbox"/> Independent Indoors	AC1f	INDEPENDENT_INDOORS	
<input type="checkbox"/> Uses Tobacco	AC1g	USES_TOBACCO	
<input type="checkbox"/> Distinct Food Prefer	AC1i	DISTINCT_FOOD_PREFER	
<input type="checkbox"/> Eats Between Meals	AC1j	EATS_BETWEEN_MEALS	
<input type="checkbox"/> Use Of Alcohol Weekly	AC1k	USE_OF_ALCOHOL_WEEKLY	
<input type="checkbox"/> Bedclothes Much Of Day	AC1m	BEDCLOTHES_MUCH_OF_DAY	
<input type="checkbox"/> Wakens To Toilet	AC1n	WAKENS_TO_TOILET	
<input type="checkbox"/> Irregular Bowel	AC1o	IRREGULAR_BOWEL	
<input type="checkbox"/> Showers For Bathing	AC1p	SHOWERS_FOR_BATHING	
<input type="checkbox"/> Bathing In Pm	AC1q	BATHING_IN_PM	
<input type="checkbox"/> Daily Contact Relative	AC1s	DAILY_CONTACT_RELATIVE	
<input type="checkbox"/> Attends Church	AC1t	ATTENDS_CHURCH	
<input type="checkbox"/> Strength In Faith	AC1u	STRENGTH_IN_FAITH	
<input type="checkbox"/> Animal Companion	AC1v	ANIMAL_COMPANION	
<input type="checkbox"/> Involved Group Activity	AC1w	INVOLVED_GROUP_ACTIVITY	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Discharge Level Of Care	R3a	DISCHARGE_LEVEL_OF_CARE	
<input type="checkbox"/> Discharge To Facility Code	R3b	DISCHARGE_TO_FACILITY	
<input type="checkbox"/> Discharge Date	R4	DISCHARGE_DATE	
<input type="checkbox"/> Bed Type At Admission		BED_TYPE_AT_ADMISSION	
<input type="checkbox"/> Bed Type At Discharge		BED_TYPE_AT_DISCHARGE	
<input type="checkbox"/> CIHI Assumed Discharge Date		CIHI_ASSUMED_DISCHARGE_DATE	
<input type="checkbox"/> CIHI Fiscal Quarter Discharge		CIHI_FISCAL_QUARTER_DISCHARGE	
<input type="checkbox"/> CIHI Fiscal Quarter Entry		CIHI_FISCAL_QUARTER_ENTRY	
<input type="checkbox"/> CIHI Fiscal Year Discharge		CIHI_FISCAL_YEAR_DISCHARGE	
<input type="checkbox"/> CIHI Fiscal Year Entry		CIHI_FISCAL_YEAR_ENTRY	
<input type="checkbox"/> Consistent Birth Date Flag		CONSISTENT_BIRTH_DATE_FLAG	
<input type="checkbox"/> Consistent Sex Flag		CONSISTENT_SEX_FLAG	
<input type="checkbox"/> Data Quality Date Problems Flag		DQ_DATE_PROBLEMS_FLAG	
<input type="checkbox"/> Data Quality Discharge Assumed Flag		DQ_DISCHARGE_ASSUMED_FLAG	
<input type="checkbox"/> Discharge Flag		DISCHARGE_FLAG	
<input type="checkbox"/> Discharge Los Days		DISCHARGE_LOS_DAYS	
<input type="checkbox"/> Discharge Reason		DISCHARGE_REASON	
<input type="checkbox"/> Entry Type		ENTRY_TYPE	
<input type="checkbox"/> Episode Assessment Status		EPISODE_ASSESSMENT_STATUS	
<input type="checkbox"/> Language Group		LANGUAGE_GROUP	
<input type="checkbox"/> Last Transfer Date		LAST_TRANSFER_DATE	
<input type="checkbox"/> LOS Days Category		LOS_DAYS_CATEGORY	
<input type="checkbox"/> Marital Status Admission		MARITAL_STATUS_ADMISSION	
<input type="checkbox"/> Number Of Assessment Episode		NUM_OF_ASSESSMENT_EPISODE	
<input type="checkbox"/> Previous Facility		PREVIOUS_FACILITY	
<input type="checkbox"/> Resident Census Division		RESIDENT_CENSUS_DIVISION	
<input type="checkbox"/> Resident Census Subdivision		RESIDENT_CENSUS_SUBDIVISION	
<input type="checkbox"/> Resident Geo Dimension Link		RESIDENT_GEO_DIMENSION_LINK	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Resident Health Region		RESIDENT_HEALTH_REGION	
<input type="checkbox"/> Resident Province		RESIDENT_PROVINCE	
<input type="checkbox"/> Resident Quintile of Annual Income Per Person Equivalent		RESIDENT_QAIPPE	
<input type="checkbox"/> Resident Statistical Area Classification Code		RESIDENT_SAC_CODE	
<input type="checkbox"/> Resident Statistical Area Classification Type		RESIDENT_SAC_TYPE	
<input type="checkbox"/> Resident Sub Health District		RESIDENT_SUB_HEALTH_DISTRICT	
<input type="checkbox"/> Resident Urban Rural Code		RESIDENT_URBAN_RURAL_CODE	
<input type="checkbox"/> Sector		SECTOR	
<input type="checkbox"/> Unit MIS Functional Centre Account Code At Admission		MIS_AT_ADMISSION	

Assessment - Contains the assessment information from RAI MDS 2.0, outcome scales, clinical assessment protocols (CAPs), and quality indicators. An assessment must have an episode record. (CCRS_ASSESSMENT)

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Assessment ID		ASSESSMENT_ID	
<input type="checkbox"/> Living Will	A10a	LIVING_WILL	
<input type="checkbox"/> Do Not Resuscitate	A10b	DO_NOT_RESUSCITATE	
<input type="checkbox"/> Do Not Hospitalize	A10c	DO_NOT_HOSPITALIZE	
<input type="checkbox"/> Organ Donation	A10d	ORGAN_DONATION	
<input type="checkbox"/> Autopsy Request	A10e	AUTOPSY_REQUEST	
<input type="checkbox"/> Feeding Restrictions	A10f	FEEDING_RESTRICTIONS	
<input type="checkbox"/> Medications Restrictions	A10g	MEDS_RESTRICTIONS	
<input type="checkbox"/> Other Treatment Restrictions	A10h	OTHER_TREAT_RESTRICTIONS	
<input type="checkbox"/> Assessment Date	A3	ASSESSMENT_DATE	
<input type="checkbox"/> Marital Status	A5	MARITAL_STATUS	
<input type="checkbox"/> Legal Guardian	A9a	LEGAL_GUARDIAN	
<input type="checkbox"/> Enduring Power of Attorney Finances	A9b	ENDURING_POA_FINANCES	
<input type="checkbox"/> Other Legal Oversight	A9c	OTHER_LEGAL_OVERSIGHT	
<input type="checkbox"/> Family Responsible	A9d	FAMILY_RESPONSIBLE	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Durable Power of Attorney Health	A9e	DURABLE_POA_HEALTH	
<input type="checkbox"/> Patient Responsible	A9f	PATIENT_RESPONSIBLE	
<input type="checkbox"/> Unique Registration Identifier	AA1	UNIQUE_REGISTRATION_IDENTIFIER	
<input type="checkbox"/> Facility Code	AA6	FACILITY	
<input type="checkbox"/> Assessment Type	AA8	ASSESSMENT_TYPE	
<input type="checkbox"/> Comatose	B1	COMATOSE	
<input type="checkbox"/> Short Term Memory	B2a	SHORT_TERM_MEMORY	
<input type="checkbox"/> Long Term Memory Ok	B2b	LONG_TERM_MEMORY_OK	
<input type="checkbox"/> Current Season	B3a	CURRENT_SEASON	
<input type="checkbox"/> Location Of Own Room	B3b	LOCATION_OF_OWN_ROOM	
<input type="checkbox"/> Recall Names Faces	B3c	RECALL_NAMES_FACES	
<input type="checkbox"/> Aware In Nursing Home	B3d	AWARE_IN_NURSING_HOME	
<input type="checkbox"/> Cognitive Skills	B4	COGNITIVE_SKILLS	
<input type="checkbox"/> Easily Distracted	B5a	EASILY_DISTRACTED	
<input type="checkbox"/> Periods Of Altered Perception	B5b	PERIODS_OF_ALTERED_PERCEPTION	
<input type="checkbox"/> Episodes Of Disordered Speech	B5c	EPISODES_OF_DISORG_SPEECH	
<input type="checkbox"/> Periods Of Restlessness	B5d	PERIODS_OF_RESTLESSNESS	
<input type="checkbox"/> Periods Of Lethargy	B5e	PERIODS_OF_LETHARGY	
<input type="checkbox"/> Mental Function Varies	B5f	MENTAL_FUNCTION_VARIES	
<input type="checkbox"/> Change In Cognitive Status	B6	CHANGE_IN_COGNITIVE_STATUS	
<input type="checkbox"/> Hearing	C1	HEARING	
<input type="checkbox"/> Hearing Aid Used Regularly	C2a	HEARING_AID_USED_REGULARLY	
<input type="checkbox"/> Hearing Aid Not Used Regularly	C2b	HEARING_AID_NOT_USED_REGULARLY	
<input type="checkbox"/> Other Receptive Communication Techniques	C2c	OTHER_RECEPT_COMM_TECH	
<input type="checkbox"/> Speech	C3a	SPEECH	
<input type="checkbox"/> Writing Messages	C3b	WRITING_MESSAGES	
<input type="checkbox"/> Sign Language	C3c	SIGN_LANGUAGE	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Signs Gestures	C3d	SIGNS_GESTURES	
<input type="checkbox"/> Communication Board	C3e	COMMUNICATION_BOARD	
<input type="checkbox"/> Other Expression Mode	C3f	OTHER_EXPRESSION_MODE	
<input type="checkbox"/> Making Self Understood	C4	MAKING_SELF_UNDERSTOOD	
<input type="checkbox"/> Speech Clarity	C5	SPEECH_CLARITY	
<input type="checkbox"/> Understand Others	C6	UNDERSTAND_OTHERS	
<input type="checkbox"/> Change In Communication	C7	CHANGE_IN_COMMUNICATION	
<input type="checkbox"/> Vision	D1	VISION	
<input type="checkbox"/> Side Vision Problems	D2a	SIDE_VISION_PROBLEMS	
<input type="checkbox"/> Sees Halos	D2b	SEES_HALOS	
<input type="checkbox"/> Visual Appliances	D3	VISUAL_APPLIANCES	
<input type="checkbox"/> Negative Statements	E1a	NEGATIVE_STATEMENTS	
<input type="checkbox"/> Repetitive Questions	E1b	REPETITIVE_QUESTIONS	
<input type="checkbox"/> Repetitive Verbalizations	E1c	REPETITIVE_VERBALIZATIONS	
<input type="checkbox"/> Persistent Anger	E1d	PERSISTENT_ANGER	
<input type="checkbox"/> Self-Deprecation	E1e	SELF_DEPRECATATION	
<input type="checkbox"/> Express Unrealistic Fear	E1f	EXPRESS_UNREALISTIC_FEAR	
<input type="checkbox"/> Recurrent Terrible Statements	E1g	RECURRENT_TERRIBLE_STATEMENTS	
<input type="checkbox"/> Repeat Health Complaints	E1h	REPEAT_HEALTH_COMPLAINTS	
<input type="checkbox"/> Repeat Anxious Complaints	E1i	REPEAT_ANXIOUS_COMPLAINTS	
<input type="checkbox"/> Unpleasant Mood In Morning	E1j	UNPLEASANT_MOOD_IN_MORNING	
<input type="checkbox"/> Insomnia	E1k	INSOMNIA	
<input type="checkbox"/> Sad Facial Expression	E1l	SAD_FACIAL_EXPRESSION	
<input type="checkbox"/> Crying	E1m	CRYING	
<input type="checkbox"/> Repeat Physical Movements	E1n	REPEAT_PHYSICAL_MOVEMENTS	
<input type="checkbox"/> Withdrawal From Activities	E1o	WITHDRAWAL_FROM_ACTIVITIES	
<input type="checkbox"/> Reduced Social Interaction	E1p	REDUCED_SOCIAL_INTERACTION	
<input type="checkbox"/> Mood Persistence	E2	MOOD_PERSISTENCE	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Change In Mood	E3	CHANGE_IN_MOOD	
<input type="checkbox"/> Wandering Frequency	E4aA	WANDERING_FREQ	
<input type="checkbox"/> Wandering Alter	E4aB	WANDERING_ALTER	
<input type="checkbox"/> Verbally Abuse Frequency	E4bA	VERBALLY_ABUSE_FREQ	
<input type="checkbox"/> Verbal Abuse Alter	E4bB	VERBAL_ABUSE_ALTER	
<input type="checkbox"/> Physical Abuse Frequency	E4cA	PHYSICAL_ABUSE_FREQ	
<input type="checkbox"/> Physical Abuse Alter	E4cB	PHYSICAL_ABUSE_ALTER	
<input type="checkbox"/> Disruptive Frequency	E4dA	DISRUPTIVE_FREQ	
<input type="checkbox"/> Disruptive Alter	E4dB	DISRUPTIVE_ALTER	
<input type="checkbox"/> Resists Care Frequency	E4eA	RESISTS_CARE_FREQ	
<input type="checkbox"/> Resists Care Alter	E4eB	RESISTS_CARE_ALTER	
<input type="checkbox"/> Change In Behaviour Symptom	E5	CHANGE_IN_BEHAVIOUR_SYMPTOM	
<input type="checkbox"/> Easy Interact With Others	F1a	EASY_INTERACT_WITH_OTHERS	
<input type="checkbox"/> Easy Planned Activity	F1b	EASY_PLANNED_ACTIVITY	
<input type="checkbox"/> Easy Self Initiate Activity	F1c	EASY_SELF_INITIATE_ACTIVITY	
<input type="checkbox"/> Establish Own Goals	F1d	ESTABLISH_OWN_GOALS	
<input type="checkbox"/> Pursues Involvement	F1e	PURSUES_INVOLVEMENT	
<input type="checkbox"/> Accepts Invitations	F1f	ACCEPTS_INVITATIONS	
<input type="checkbox"/> Conflict With Staff	F2a	CONFLICT_WITH_STAFF	
<input type="checkbox"/> Unhappy With Roommate	F2b	UNHAPPY_WITH_ROOMMATE	
<input type="checkbox"/> Unhappy With Other Residents	F2c	UNHAPPY_WITH_OTHER_RESIDENTS	
<input type="checkbox"/> Conflict With Family	F2d	CONFLICT_WITH_FAMILY	
<input type="checkbox"/> No Contact With Family	F2e	NO_CONTACT_WITH_FAMILY	
<input type="checkbox"/> Recent Loss Family	F2f	RECENT_LOSS_FAMILY	
<input type="checkbox"/> Adjust To Routine Change	F2g	ADJUST_TO_ROUTINE_CHANGE	
<input type="checkbox"/> Identify Past Roles	F3a	IDENTIFY_PAST_ROLES	
<input type="checkbox"/> Sad Over Lost Roles	F3b	SAD_OVER_LOST_ROLES	
<input type="checkbox"/> Perceives Different Routine	F3c	PERCEIVES_DIFF_ROUTINE	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> ADL Bed Mobility Self Performance	G1aA	ADL_BED_MOBILITY_SELF_PERF	
<input type="checkbox"/> Bed Mobility Support	G1aB	BED_MOBILITY_SUPPORT	
<input type="checkbox"/> ADL Transfer Use Self Performance	G1bA	ADL_TRANSFER_SELF_PERF	
<input type="checkbox"/> Transfer Support	G1bB	TRANSFER_SUPPORT	
<input type="checkbox"/> ADL Walk In Room Self Performance	G1cA	ADL_WALK_IN_ROOM_SELF_PERF	
<input type="checkbox"/> Walk In Room Support	G1cB	WALK_IN_ROOM_SUPPORT	
<input type="checkbox"/> ADL Walk In Corridor Self Performance	G1dA	ADL_WALK_IN_CORRIDOR_SELF_PERF	
<input type="checkbox"/> Walk In Corridor Support	G1dB	WALK_IN_CORRIDOR_SUPPORT	
<input type="checkbox"/> ADL Locomotion On Unit Self Performance	G1eA	ADL_LOCOMOT_ON_UNIT_SELF_PERF	
<input type="checkbox"/> Locomotion On Unit Support	G1eB	LOCOMOT_ON_UNIT_SUPPORT	
<input type="checkbox"/> ADL Locomotion Off Unit Self Performance	G1fA	ADL_LOCOMOT_OFF_UNIT_SELF_PERF	
<input type="checkbox"/> Locomotion Off Unit Support	G1fB	LOCOMOT_OFF_UNIT_SUPPORT	
<input type="checkbox"/> ADL Dressing Self Performance	G1gA	ADL_DRESSING_SELF_PERF	
<input type="checkbox"/> Dressing Support	G1gB	DRESSING_SUPPORT	
<input type="checkbox"/> ADL Eating Self Performance	G1hA	ADL_EATING_SELF_PERF	
<input type="checkbox"/> Eating Support	G1hB	EATING_SUPPORT	
<input type="checkbox"/> ADL Toilet Use Self Performance	G1iA	ADL_TOILET_USE_SELF_PERF	
<input type="checkbox"/> Toilet Use Support	G1iB	TOILET_USE_SUPPORT	
<input type="checkbox"/> ADL Personal Hygiene Self	G1jA	ADL_PERSONAL_HYGIENE_SELF	
<input type="checkbox"/> Personal Hygiene Support	G1jB	PERSONAL_HYGIENE_SUPPORT	
<input type="checkbox"/> Bathing Self Performance	G2A	BATHING_SELF_PERFORMANCE	
<input type="checkbox"/> Bathing Support	G2B	BATHING_SUPPORT	
<input type="checkbox"/> Balance While Standing	G3a	BALANCE_WHILE_STANDING	
<input type="checkbox"/> Balance While Sitting	G3b	BALANCE_WHILE_SITTING	
<input type="checkbox"/> Neck Range Of Motion	G4aA	NECK_RANGE_OF_MOTION	
<input type="checkbox"/> Neck Voluntary Movement	G4aB	NECK_VOLUNTARY_MOVEMENT	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Arm Range Of Motion	G4bA	ARM_RANGE_OF_MOTION	
<input type="checkbox"/> Arm Voluntary Movement	G4bB	ARM_VOLUNTARY_MOVEMENT	
<input type="checkbox"/> Hand Range Of Motion	G4cA	HAND_RANGE_OF_MOTION	
<input type="checkbox"/> Hand Voluntary Movement	G4cB	HAND_VOLUNTARY_MOVEMENT	
<input type="checkbox"/> Leg Range Of Motion	G4dA	LEG_RANGE_OF_MOTION	
<input type="checkbox"/> Leg Voluntary Movement	G4dB	LEG_VOLUNTARY_MOVEMENT	
<input type="checkbox"/> Foot Range Of Motion	G4eA	FOOT_RANGE_OF_MOTION	
<input type="checkbox"/> Foot Voluntary Movement	G4eB	FOOT_VOLUNTARY_MOVEMENT	
<input type="checkbox"/> Other Limited Range Of Motion	G4fA	OTHER_LTD_RANGE_OF_MOTION	
<input type="checkbox"/> Other Limited Voluntary Movement	G4fB	OTHER_LTD_VOLUNTARY_MOVEMENT	
<input type="checkbox"/> Cane Walker	G5a	CANE_WALKER	
<input type="checkbox"/> Wheeled Self	G5b	WHEELED_SELF	
<input type="checkbox"/> Other Person Wheeled	G5c	OTHER_PERSON_WHEELED	
<input type="checkbox"/> Wheelchair Primary Locomotion	G5d	WHEELCHAIR_PRIMARY_LOCOMOT	
<input type="checkbox"/> Bedfast	G6a	BEDFAST	
<input type="checkbox"/> Bed Rails For Bed Mobility	G6b	BED_RAILS_FOR_BED_MOBILITY	
<input type="checkbox"/> Lifted Manually	G6c	LIFTED_MANUALLY	
<input type="checkbox"/> Lifted Mechanically	G6d	LIFTED_MECHANICALLY	
<input type="checkbox"/> Transfer Aid	G6e	TRANSFER_AID	
<input type="checkbox"/> Task Segmentation	G7	TASK_SEGMENTATION	
<input type="checkbox"/> Resident More Independence	G8a	RES_MORE_INDEPENDENCE	
<input type="checkbox"/> Staff More Independence	G8b	STAFF_MORE_INDEPENDENCE	
<input type="checkbox"/> Slow Performing Tasks	G8c	SLOW_PERFORMING_TASKS	
<input type="checkbox"/> Am Pm Difference ADLs	G8d	AM_PM_DIFFER_ADLS	
<input type="checkbox"/> Change In ADL Function	G9	CHANGE_IN_ADL_FUNCTION	
<input type="checkbox"/> Bowel Continence	H1a	BOWEL_CONTINENCE	
<input type="checkbox"/> Bladder Continence Self	H1b	BLADDER_CONTINENCE_SELF	
<input type="checkbox"/> Bowel Elimination Regular	H2a	BOWEL_ELIMINATION_REGULAR	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Constipation	H2b	CONSTIPATION	
<input type="checkbox"/> Diarrhea	H2c	DIARRHEA	
<input type="checkbox"/> Fecal Impaction	H2d	FECAL_IMPACTION	
<input type="checkbox"/> Scheduled Toileting Plan	H3a	SCHEDULED_TOILETING_PLAN	
<input type="checkbox"/> Bladder Retraining Program	H3b	BLADDER_RETRAINING_PROGRAM	
<input type="checkbox"/> External Catheter	H3c	EXTERNAL_CATHETER	
<input type="checkbox"/> Indwelling Catheter	H3d	INDWELLING_CATHETER	
<input type="checkbox"/> Intermittent Catheter	H3e	INTERMITTENT_CATHETER	
<input type="checkbox"/> Did Not Use Toilet	H3f	DID_NOT_USE_TOILET	
<input type="checkbox"/> Pads Or Briefs	H3g	PADS_OR_BRIEFS	
<input type="checkbox"/> Enemas Irrigation	H3h	ENEMAS_IRRIGATION	
<input type="checkbox"/> Ostomy Present	H3i	OSTOMY_PRESENT	
<input type="checkbox"/> Change In Urinary Continence	H4	CHANGE_IN_URINARY_CONTINENCE	
<input type="checkbox"/> Diabetes Mellitus	I1a	DIABETES_MELLITUS	
<input type="checkbox"/> Parkinson's	I1aa	PARKINSONS	
<input type="checkbox"/> Hyperthyroidism	I1b	HYPERTHYROIDISM	
<input type="checkbox"/> Quadriplegia	I1bb	QUADRIPLEGIA	
<input type="checkbox"/> Hypothyroidism	I1c	HYPOTHYROIDISM	
<input type="checkbox"/> Seizure Disorder	I1cc	SEIZURE_DISORDER	
<input type="checkbox"/> Arteriosclerotic Heart Disease	I1d	ARTERIO_HEART_DISEASE	
<input type="checkbox"/> Transient Ischemic Attack	I1dd	TRANSIENT_ISCHEMIC_ATTACK	
<input type="checkbox"/> Cardiac Dysrhythmias	I1e	CARDIAC_DYSRHYTHMIAS	
<input type="checkbox"/> Traumatic Brain Injury	I1ee	TRAUMATIC_BRAIN_INJURY	
<input type="checkbox"/> Congestive Heart Failure	I1f	CONGESTIVE_HEART_FAILURE	
<input type="checkbox"/> Anxiety Disorder	I1ff	ANXIETY_DISORDER	
<input type="checkbox"/> Deep Vein Thrombosis	I1g	DEEP_VEIN_THROMBOSIS	
<input type="checkbox"/> Depression	I1gg	DEPRESSION	
<input type="checkbox"/> Hypertension	I1h	HYPERTENSION	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Manic Depressive	I1hh	MANIC_DEPRESSIVE	
<input type="checkbox"/> Hypotension	I1i	HYPOTENSION	
<input type="checkbox"/> Schizophrenia	I1ii	SCHIZOPHRENIA	
<input type="checkbox"/> Peripheral Vascular Disease	I1j	PERIPHERAL_VASC_DISEASE	
<input type="checkbox"/> Asthma	I1jj	ASTHMA	
<input type="checkbox"/> Other Cardiovascular Disease	I1k	OTHER_CARDIOVASC_DISEASE	
<input type="checkbox"/> Emphysema Coped	I1kk	EMPHYSEMA_COPD	
<input type="checkbox"/> Arthritis	I1l	ARTHRITIS	
<input type="checkbox"/> Cataracts	I1ll	CATARACTS	
<input type="checkbox"/> Hip Fracture	I1m	HIP_FRACTURE	
<input type="checkbox"/> Diabetic Retinopathy	I1mm	DIABETIC_RETINOPATHY	
<input type="checkbox"/> Missing Limb	I1n	MISSING_LIMB	
<input type="checkbox"/> Glaucoma	I1nn	GLAUCOMA	
<input type="checkbox"/> Osteoporosis	I1o	OSTEOPOROSIS	
<input type="checkbox"/> Macular Degeneration	I1oo	MACULAR_DEGENERATION	
<input type="checkbox"/> Pathological Bone Fracture	I1p	PATHOLOGICAL_BONE_FRACTURE	
<input type="checkbox"/> Allergies	I1pp	ALLERGIES	
<input type="checkbox"/> Amyotrophic Lateral Sclerosis	I1q	AMYOTROPHIC_LAT_SCLEROSIS	
<input type="checkbox"/> Anemia	I1qq	ANEMIA	
<input type="checkbox"/> Alzheimer's	I1r	ALZHEIMERS	
<input type="checkbox"/> Cancer	I1rr	CANCER	
<input type="checkbox"/> Aphasia	I1s	APHASIA	
<input type="checkbox"/> Gastrointestinal Disease	I1ss	GASTROINTESTINAL_DISEASE	
<input type="checkbox"/> Cerebral Palsy	I1t	CEREBRAL_PALSY	
<input type="checkbox"/> Liver Disease	I1tt	LIVER_DISEASE	
<input type="checkbox"/> Cerebrovascular Accident	I1u	CEREBROVASCULAR_ACCIDENT	
<input type="checkbox"/> Renal Failure	I1uu	RENAL_FAILURE	
<input type="checkbox"/> Dementia Not Alzheimer's	I1v	DEMENTIA_NOT_ALZHEIMERS	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Hemiplegia Hemiparesis	I1w	HEMIPLEGIA_HEMIPARESIS	
<input type="checkbox"/> Huntington's Chorea	I1x	HUNTINGTONS_CHOREA	
<input type="checkbox"/> Multiple Sclerosis	I1y	MULTIPLE_SCLEROSIS	
<input type="checkbox"/> Paraplegia	I1z	PARAPLEGIA	
<input type="checkbox"/> Antibiotic Resistant Infection	I2a	ANTIBIOTIC_RESIST_INFECT	
<input type="checkbox"/> Cellulitis	I2b	CELLULITIS	
<input type="checkbox"/> Clostridium Difficile	I2c	CLOSTRIDIUM_DIFFICILE	
<input type="checkbox"/> Conjunctivitis	I2d	CONJUNCTIVITIS	
<input type="checkbox"/> HIV Infection	I2e	HIV_INFECTION	
<input type="checkbox"/> Pneumonia	I2f	PNEUMONIA	
<input type="checkbox"/> Respiratory Infection	I2g	RESPIRATORY_INFECTION	
<input type="checkbox"/> Septicemia	I2h	SEPTICEMIA	
<input type="checkbox"/> Sexually Transmit Diseases	I2i	SEXUALLY_TRANSMIT_DISEASES	
<input type="checkbox"/> Tuberculosis	I2j	TUBERCULOSIS	
<input type="checkbox"/> Urinary Tract Infection	I2k	URINARY_TRACT_INFECTION	
<input type="checkbox"/> Viral Hepatitis	I2l	VIRAL_HEPATITIS	
<input type="checkbox"/> Wound Infection	I2m	WOUND_INFECTION	
<input type="checkbox"/> Other Diagnosis A	I3a	OTHER_DIAG_A	
<input type="checkbox"/> Other Diagnosis B	I3b	OTHER_DIAG_B	
<input type="checkbox"/> Other Diagnosis C	I3c	OTHER_DIAG_C	
<input type="checkbox"/> Other Diagnosis D	I3d	OTHER_DIAG_D	
<input type="checkbox"/> Other Diagnosis E	I3e	OTHER_DIAG_E	
<input type="checkbox"/> Other Diagnosis F	I3f	OTHER_DIAG_F	
<input type="checkbox"/> Weight Fluctuation	J1a	WEIGHT_FLUCTUATION	
<input type="checkbox"/> Inability To Lie Flat	J1b	INABILITY_TO_LIE_FLAT	
<input type="checkbox"/> Dehydration	J1c	DEHYDRATION	
<input type="checkbox"/> Insufficient Fluids	J1d	INSUFFICIENT_FLUIDS	
<input type="checkbox"/> Delusions	J1e	DELUSIONS	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Dizziness	J1f	DIZZINESS	
<input type="checkbox"/> Edema	J1g	EDEMA	
<input type="checkbox"/> Fever	J1h	FEVER	
<input type="checkbox"/> Hallucinations	J1i	HALLUCINATIONS	
<input type="checkbox"/> Internal Bleeding	J1j	INTERNAL_BLEEDING	
<input type="checkbox"/> Recurrent Lung Aspirations	J1k	RECURRENT_LUNG_ASPIRATIONS	
<input type="checkbox"/> Shortness Of Breath	J1l	SHORTNESS_OF_BREATH	
<input type="checkbox"/> Syncope	J1m	SYNCOPE	
<input type="checkbox"/> Unsteady Gait	J1n	UNSTEADY_GAIT	
<input type="checkbox"/> Vomiting	J1o	VOMITING	
<input type="checkbox"/> Pain Symptoms Frequency	J2a	PAIN_SYMPTOMS_FREQ	
<input type="checkbox"/> Pain Symptoms Intensity	J2b	PAIN_SYMPTOMS_INTENSITY	
<input type="checkbox"/> Back Pain	J3a	BACK_PAIN	
<input type="checkbox"/> Bone Pain	J3b	BONE_PAIN	
<input type="checkbox"/> Chest Pain	J3c	CHEST_PAIN	
<input type="checkbox"/> Headache	J3d	HEADACHE	
<input type="checkbox"/> Hip Pain	J3e	HIP_PAIN	
<input type="checkbox"/> Incisional Pain	J3f	INCISIONAL_PAIN	
<input type="checkbox"/> Joint Pain Hip	J3g	JOINT_PAIN_HIP	
<input type="checkbox"/> Soft Tissue Pain	J3h	SOFT_TISSUE_PAIN	
<input type="checkbox"/> Stomach Pain	J3i	STOMACH_PAIN	
<input type="checkbox"/> Other Pain	J3j	OTHER_PAIN	
<input type="checkbox"/> Fell In Past 30 Days	J4a	FELL_IN_PAST_30_DAYS	
<input type="checkbox"/> Fell In Past 31 to 180 Days	J4b	FELL_IN_PAST_31_180_DAYS	
<input type="checkbox"/> Hip Fracture In Last 180 Days	J4c	HIP_FRACTURE_IN_LAST_180_DAYS	
<input type="checkbox"/> Other Fracture	J4d	OTHER_FRACTURE	
<input type="checkbox"/> Condition Leads To Instability	J5a	CONDITION_LEADS_TO_INSTABILITY	
<input type="checkbox"/> Experiencing Acute Episode	J5b	EXPERIENCING_ACUTE_EPISODE	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> End Stage Disease	J5c	END_STAGE_DISEASE	
<input type="checkbox"/> Chewing Problem	K1a	CHEWING_PROBLEM	
<input type="checkbox"/> Swallowing Problem	K1b	SWALLOWING_PROBLEM	
<input type="checkbox"/> Mouth Pain	K1c	MOUTH_PAIN	
<input type="checkbox"/> Height	K2a	HEIGHT	
<input type="checkbox"/> Weight	K2b	WEIGHT	
<input type="checkbox"/> Weight Loss	K3a	WEIGHT_LOSS	
<input type="checkbox"/> Weight Gain	K3b	WEIGHT_GAIN	
<input type="checkbox"/> Complains About Taste	K4a	COMPLAINS_ABOUT_TASTE	
<input type="checkbox"/> Complaints Of Hunger	K4b	COMPLAINTS_OF_HUNGER	
<input type="checkbox"/> Leaves Food Uneaten	K4c	LEAVES_FOOD_UNEATEN	
<input type="checkbox"/> Parenteral IV	K5a	PARENTERAL_IV	
<input type="checkbox"/> Feeding Tube	K5b	FEEDING_TUBE	
<input type="checkbox"/> Mechanic Altered Diet	K5c	MECHANIC_ALTERED_DIET	
<input type="checkbox"/> Oral Feeding	K5d	ORAL_FEEDING	
<input type="checkbox"/> Therapeutic Diet	K5e	THERAPEUTIC_DIET	
<input type="checkbox"/> Dietary Supplement	K5f	DIETARY_SUPPLEMENT	
<input type="checkbox"/> Plate Guard	K5g	PLATE_GUARD	
<input type="checkbox"/> Planned Weight Change Program	K5h	PLANNED_WEIGHT_CHANGE_PROG	
<input type="checkbox"/> Total Calories	K6a	TOTAL_CALORIES	
<input type="checkbox"/> Average Fluids	K6b	AVERAGE_FLUIDS	
<input type="checkbox"/> Debris In Mouth	L1a	DEBRIS_IN_MOUTH	
<input type="checkbox"/> Dentures Remove Bridge	L1b	DENTURES_REMOVE_BRIDGE	
<input type="checkbox"/> Natural Teeth Lost	L1c	NATURAL_TEETH_LOST	
<input type="checkbox"/> Broken Loose Teeth	L1d	BROKEN_LOOSE_TEETH	
<input type="checkbox"/> Inflamed Gums	L1e	INFLAMED_GUMS	
<input type="checkbox"/> Daily Cleaning Teeth	L1f	DAILY_CLEANING_TEETH	
<input type="checkbox"/> Stage1 Ulcers	M1a	STAGE1_ULCERS	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Stage2 Ulcers	M1b	STAGE2_ULCERS	
<input type="checkbox"/> Stage3 Ulcers	M1c	STAGE3_ULCERS	
<input type="checkbox"/> Stage4 Ulcers	M1d	STAGE4_ULCERS	
<input type="checkbox"/> Stage Of Pressure Ulcer	M2a	STAGE_OF_PRESSURE_ULCER	
<input type="checkbox"/> Stage Of Stasis Ulcer	M2b	STAGE_OF_STASIS_ULCER	
<input type="checkbox"/> History Of Resolved Ulcers	M3	HISTORY_OF_RESOLVED_ULCERS	
<input type="checkbox"/> Abrasions Bruises	M4a	ABRASIONS_BRUISES	
<input type="checkbox"/> Burns	M4b	BURNS	
<input type="checkbox"/> Open Lesions Not Ulcers	M4c	OPEN_LESIONS_NOT_ULCERS	
<input type="checkbox"/> Rashes	M4d	RASHES	
<input type="checkbox"/> Skin Desensitized To Pain	M4e	SKIN_DESENSITIZED_TO_PAIN	
<input type="checkbox"/> Skin Tears Or Cuts	M4f	SKIN_TEARS_OR_CUTS	
<input type="checkbox"/> Surgical Wound	M4g	SURGICAL_WOUND	
<input type="checkbox"/> Relieving Device Chair	M5a	RELIEVING_DEVICE_CHAIR	
<input type="checkbox"/> Relieving Device Bed	M5b	RELIEVING_DEVICE_BED	
<input type="checkbox"/> Turning Program	M5c	TURNING_PROGRAM	
<input type="checkbox"/> Skin Nutrition Intervention	M5d	SKIN_NUTRITION_INTERVENTION	
<input type="checkbox"/> Ulcer Care	M5e	ULCER_CARE	
<input type="checkbox"/> Surgical Wound Care	M5f	SURGICAL_WOUND_CARE	
<input type="checkbox"/> Apply Dressing Not Feet	M5g	APPLY_DRESSING_NOT_FEET	
<input type="checkbox"/> Apply Ointment Not Feet	M5h	APPLY_OINTMENT_NOT_FEET	
<input type="checkbox"/> Other Preventative Skin Care Not Feet	M5i	OTHER_PREVENT_NOT_FEET	
<input type="checkbox"/> Foot Problem	M6a	FOOT_PROBLEM	
<input type="checkbox"/> Infection Of Foot	M6b	INFECTION_OF_FOOT	
<input type="checkbox"/> Open Lesions On Foot	M6c	OPEN_LESIONS_ON_FOOT	
<input type="checkbox"/> Nails Calluses Trimmed	M6d	NAILS_CALLUSES_TRIMMED	
<input type="checkbox"/> Received Prevent Foot Care	M6e	RECEIVED_PREVENT_FOOT_CARE	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Apply Dressing Foot	M6f	APPLY_DRESSING_FOOT	
<input type="checkbox"/> Time Awake Morning	N1a	TIME_AWAKE_MORNING	
<input type="checkbox"/> Time Awake Afternoon	N1b	TIME_AWAKE_AFTERNOON	
<input type="checkbox"/> Time Awake Evening	N1c	TIME_AWAKE_EVENING	
<input type="checkbox"/> Average Time Activities	N2	AVERAGE_TIME_ACTIVITIES	
<input type="checkbox"/> Preferred Activity Own Room	N3a	PREF_ACT_OWN_ROOM	
<input type="checkbox"/> Preferred Activity Activity Room	N3b	PREF_ACT_ACTIVITY_ROOM	
<input type="checkbox"/> Preferred Activity Inside	N3c	PREF_ACT_INSIDE	
<input type="checkbox"/> Preferred Activity Outside	N3d	PREF_ACT_OUTSIDE	
<input type="checkbox"/> Preferred Activity Cards Games	N4a	PREF_ACT_CARDS_GAMES	
<input type="checkbox"/> Preferred Activity Crafts	N4b	PREF_ACT_CRAFTS	
<input type="checkbox"/> Preferred Activity Exercise	N4c	PREF_ACT_EXERCISE	
<input type="checkbox"/> Preferred Activity Music	N4d	PREF_ACT_MUSIC	
<input type="checkbox"/> Preferred Activity Reading	N4e	PREF_ACT_READING	
<input type="checkbox"/> Preferred Activity Spiritual	N4f	PREF_ACT_SPIRITUAL	
<input type="checkbox"/> Preferred Activity Trips	N4g	PREF_ACT_TRIPS	
<input type="checkbox"/> Preferred Activity Walking	N4h	PREF_ACT_WALKING	
<input type="checkbox"/> Preferred Activity Watch TV	N4i	PREF_ACT_WATCH_TV	
<input type="checkbox"/> Preferred Activity Gardening	N4j	PREF_ACT_GARDENING	
<input type="checkbox"/> Preferred Activity Talking	N4k	PREF_ACT_TALKING	
<input type="checkbox"/> Preferred Activity Help Others	N4l	PREF_ACT_HELP_OTHERS	
<input type="checkbox"/> Prefers Change In Activity	N5a	PREFER_CHANGE_IN_ACTIVITY	
<input type="checkbox"/> Prefer Change In Involvement	N5b	PREFER_CHANGE_IN_INVOLVEMENT	
<input type="checkbox"/> Number Of Medications	O1	NUM_OF_MEDS	
<input type="checkbox"/> New Medications	O2	NEW_MEDS	
<input type="checkbox"/> Days Injections	O3	DAYS_INJECTIONS	
<input type="checkbox"/> Days Antipsychotic	O4a	DAYS_ANTIPSYCHOTIC	
<input type="checkbox"/> Days Antianxiety	O4b	DAYS_ANTIANXIETY	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Days Antidepressant	O4c	DAYS_ANTIDEPRESSANT	
<input type="checkbox"/> Days Hypnotic	O4d	DAYS_HYPNOTIC	
<input type="checkbox"/> Days Diuretic	O4e	DAYS_DIURETIC	
<input type="checkbox"/> Days Analgesic	O4f	DAYS_ANALGESIC	
<input type="checkbox"/> Chemotherapy	P1aa	CHEMOTHERAPY	
<input type="checkbox"/> Dialysis	P1ab	DIALYSIS	
<input type="checkbox"/> IV Meds	P1ac	IV_MEDS	
<input type="checkbox"/> Intake Output	P1ad	INTAKE_OUTPUT	
<input type="checkbox"/> Monitor Medical Condition	P1ae	MONITOR_MEDICAL_CONDITION	
<input type="checkbox"/> Ostomy Care	P1af	OSTOMY_CARE	
<input type="checkbox"/> Oxygen Therapy	P1ag	OXYGEN_THERAPY	
<input type="checkbox"/> Radiation	P1ah	RADIATION	
<input type="checkbox"/> Suctioning	P1ai	SUCTIONING	
<input type="checkbox"/> Tracheostomy	P1aj	TRACHEOSTOMY	
<input type="checkbox"/> Transfusions	P1ak	TRANSFUSIONS	
<input type="checkbox"/> Ventilator Or Respirator	P1al	VENTILATOR_OR_RESPIRATOR	
<input type="checkbox"/> Alcohol DRUG Program	P1am	ALCOHOL_DRUG_PROGRAM	
<input type="checkbox"/> Alzheimer's Care Unit	P1an	ALZHEIMERS_CARE_UNIT	
<input type="checkbox"/> Hospice Care	P1ao	HOSPICE_CARE	
<input type="checkbox"/> Pediatric Unit	P1ap	PEDIATRIC_UNIT	
<input type="checkbox"/> Respite Care	P1aq	RESPITE_CARE	
<input type="checkbox"/> Training Community Skills	P1ar	TRAINING_COMMUNITY_SKILLS	
<input type="checkbox"/> Days Speech Therapy	P1baA	DAYS_SPEECH_THERAPY	
<input type="checkbox"/> Minutes Speech Therapy	P1baB	MINS_SPEECH_THERAPY	
<input type="checkbox"/> Days Occupation Therapy	P1bbA	DAYS_OCCUPATION_THERAPY	
<input type="checkbox"/> Minutes Occupation Therapy	P1bbB	MINS_OCCUPATION_THERAPY	
<input type="checkbox"/> Days Physical Therapy	P1bcA	DAYS_PHYSICAL_THERAPY	
<input type="checkbox"/> Minutes Physical Therapy	P1bcB	MINS_PHYSICAL_THERAPY	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Days Respiratory Therapy	P1bdA	DAYS_RESPIRATORY_THERAPY	
<input type="checkbox"/> Minutes Respiratory Therapy	P1bdB	MINS_RESPIRATORY_THERAPY	
<input type="checkbox"/> Days Psycho Therapy	P1beA	DAYS_PSYCHO_THERAPY	
<input type="checkbox"/> Minutes Psycho Therapy	P1beB	MINS_PSYCHO_THERAPY	
<input type="checkbox"/> Days Recreation Therapy	P1bfA	DAYS_RECREATION_THERAPY	
<input type="checkbox"/> Minutes Recreation Therapy	P1bfB	MINS_RECREATION_THERAPY	
<input type="checkbox"/> Intervention Program Special Behaviour Symptom	P2a	INTERV_PRG_SPEC_BEHAV_SYMPTOM	
<input type="checkbox"/> Intervention Program Evaluation Mental Health Specialist	P2b	INTERV_PRG_EVAL_MH_SPECIALIST	
<input type="checkbox"/> Intervention Program Group Therapy	P2c	INTERV_PRG_GROUP_THERAPY	
<input type="checkbox"/> Intervention Program Resident Change Environment	P2d	INTERV_PRG_RESIDENT_CHANGE_ENV	
<input type="checkbox"/> Intervention Program Reorientation	P2e	INTERV_PRG_REORIENTATION	
<input type="checkbox"/> Rehab Days Rom Passive	P3a	REHAB_DAYS_ROM_PASSIVE	
<input type="checkbox"/> Rehab Days Rom Active	P3b	REHAB_DAYS_ROM_ACTIVE	
<input type="checkbox"/> Rehab Days Splint Assist	P3c	REHAB_DAYS_SPLINT_ASSIST	
<input type="checkbox"/> Rehab Days Bed Mobility	P3d	REHAB_DAYS_BED_MOBILITY	
<input type="checkbox"/> Rehab Days Transfer	P3e	REHAB_DAYS_TRANSFER	
<input type="checkbox"/> Rehab Days Walking	P3f	REHAB_DAYS_WALKING	
<input type="checkbox"/> Rehab Days Dressing	P3g	REHAB_DAYS_DRESSING	
<input type="checkbox"/> Rehab Days Eating	P3h	REHAB_DAYS_EATING	
<input type="checkbox"/> Rehab Days Amputation	P3i	REHAB_DAYS_AMPUTATION	
<input type="checkbox"/> Rehab Days Communication	P3j	REHAB_DAYS_COMMUNICATION	
<input type="checkbox"/> Rehab Days Other	P3k	REHAB_DAYS_OTHER	
<input type="checkbox"/> Full Bed Rails	P4a	FULL_BED_RAILS	
<input type="checkbox"/> Other Types Of Rails	P4b	OTHER_TYPES_OF_RAILS	
<input type="checkbox"/> Trunk Restraint	P4c	TRUNK_RESTRAINT	
<input type="checkbox"/> Limb Restraint	P4d	LIMB_RESTRAINT	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Chair Prevents Rising	P4e	CHAIR_PREVENTS_RISING	
<input type="checkbox"/> Hospital Stays	P5	HOSPITAL_STAYS	
<input type="checkbox"/> Emergency Room Visits	P6	EMERGENCY_ROOM_VISITS	
<input type="checkbox"/> Days Physician Visits	P7	DAYS_PHYSICIAN_VISITS	
<input type="checkbox"/> Days Doctor Orders Changed	P8	DAYS_DOCTOR_ORDERS_CHANGED	
<input type="checkbox"/> Abnormal Lab Values	P9	ABNORMAL_LAB_VALUES	
<input type="checkbox"/> Wants Return To Community	Q1a	WANTS_RETURN_TO_COMMUNITY	
<input type="checkbox"/> Support Positive Discharge	Q1b	SUPPORT_POSITIVE_DISCHARGE	
<input type="checkbox"/> Stay Short Duration	Q1c	STAY_SHORT_DURATION	
<input type="checkbox"/> Change In Care Needs	Q2	CHANGE_IN_CARE_NEEDS	
<input type="checkbox"/> Resident Participated Assessment	R1a	RES_PARTICIPATED_ASSESS	
<input type="checkbox"/> Family Participated Assess	R1b	FAMILY_PARTICIPATED_ASSESS	
<input type="checkbox"/> Other Participated Assess	R1c	OTHER_PARTICIPATED_ASSESS	
<input type="checkbox"/> Signed Complete Date	R2b	SIGNED_COMPLETE_DATE	
<input type="checkbox"/> ABS		ABS	
<input type="checkbox"/> ABS Change Code		ABS_CHANGE_CODE	
<input type="checkbox"/> Active New Status		ACTIVE_NEW_STATUS	
<input type="checkbox"/> Activities CAP		ACTIVITIES_CAP	
<input type="checkbox"/> ADL CAP		ADL_CAP	
<input type="checkbox"/> ADL Hierarchy		ADL_HIERARCHY	
<input type="checkbox"/> ADL Hierarchy Change Code		ADL_HIERARCHY_CHANGE_CODE	
<input type="checkbox"/> ADL Long Form		ADL_LONG_FORM	
<input type="checkbox"/> ADL Long Form Change Code		ADL_LONG_FORM_CHANGE_CODE	
<input type="checkbox"/> ADL Short Form		ADL_SHORT_FORM	
<input type="checkbox"/> ADL Short Form Change Code		ADL_SHORT_FORM_CHANGE_CODE	
<input type="checkbox"/> Appropriate Medications CAP		APPROP_MEDS_CAP	
<input type="checkbox"/> Assessment Fiscal Year Facility Flag		ASSESSMENT_FY_FACILITY_FLAG	
<input type="checkbox"/> Assessment Fiscal Year Sector Flag		ASSESSMENT_FY_SECTOR_FLAG	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Bed Type At Assessment		BED_TYPE_AT_ASSESSMENT	
<input type="checkbox"/> Behaviour CAP		BEHAVIOUR_CAP	
<input type="checkbox"/> Bowel Conditions CAP		BOWEL_CONDITIONS_CAP	
<input type="checkbox"/> Cardio Respiratory CAP		CARDIO_RESPIRATORY_CAP	
<input type="checkbox"/> Chess		CHESS	
<input type="checkbox"/> Chess Change Code		CHESS_CHANGE_CODE	
<input type="checkbox"/> CIHI Assessment Previous Quarter Flag		CIHI_ASSESSMENT_PREV_QTR_FLAG	
<input type="checkbox"/> CIHI Fiscal Quarter Assessment		CIHI_FISCAL_QUARTER_ASSESSMENT	
<input type="checkbox"/> CIHI Fiscal Year Assessment		CIHI_FISCAL_YEAR_ASSESSMENT	
<input type="checkbox"/> CIHI Quarter Flag		CIHI_QUARTER_FLAG	
<input type="checkbox"/> CMI Hierarchy		CMI_HIERARCHY	
<input type="checkbox"/> CMI Index Max		CMI_INDEX_MAX	
<input type="checkbox"/> Cognitive Loss CAP		COGNITIVE_LOSS_CAP	
<input type="checkbox"/> Comatose Change Flag		COMATOSE_CHANGE_FLAG	
<input type="checkbox"/> Communication CAP		COMMUNICATION_CAP	
<input type="checkbox"/> CPS		CPS	
<input type="checkbox"/> CPS Change Code		CPS_CHANGE_CODE	
<input type="checkbox"/> Data Quality Assessment Flag		DQ_ASSESSMENT_FLAG	
<input type="checkbox"/> Day Flag		DAY_FLAG	
<input type="checkbox"/> Dehydration CAP		DEHYDRATION_CAP	
<input type="checkbox"/> Delirium CAP		DELIRIUM_CAP	
<input type="checkbox"/> DRS		DRS	
<input type="checkbox"/> DRS Change Code		DRS_CHANGE_CODE	
<input type="checkbox"/> Episode Id		EPISODE_ID	
<input type="checkbox"/> Falls CAP		FALLS_CAP	
<input type="checkbox"/> Feeding Tube CAP		FEEDING_TUBE_CAP	
<input type="checkbox"/> ISE		ISE	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> ISE Change Code		ISE_CHANGE_CODE	
<input type="checkbox"/> Mood CAP		MOOD_CAP	
<input type="checkbox"/> No Triggered CAPs		NO_TRIGGERED_CAPS	
<input type="checkbox"/> Number Of Medication Records Submitted		NUM_OF_MEDS_RECORDS_SUBMIT	
<input type="checkbox"/> Pain		PAIN	
<input type="checkbox"/> Pain CAP		PAIN_CAP	
<input type="checkbox"/> Pain Change Code		PAIN_CHANGE_CODE	
<input type="checkbox"/> Physical Restraints CAP		PHYSICAL_RESTRAINTS_CAP	
<input type="checkbox"/> Pressure Ulcer CAP		PRESSURE_ULCER_CAP	
<input type="checkbox"/> Previous Assessment Id		PREVIOUS_ASSESSMENT_ID	
<input type="checkbox"/> PURS		PURS	
<input type="checkbox"/> PURS Score Change		PURS_SCORE_CHANGE	
<input type="checkbox"/> RUG Hierarchy Category		RUG_HIERARCHY_CATEGORY	
<input type="checkbox"/> RUG Hierarchy Code		RUG_HIERARCHY_CODE	
<input type="checkbox"/> RUG Index Max Category		RUG_INDEX_MAX_CATEGORY	
<input type="checkbox"/> RUG Index Max Code		RUG_INDEX_MAX_CODE	
<input type="checkbox"/> Sector		SECTOR	
<input type="checkbox"/> Social Relationship CAP		SOCIAL_RELATIONSHIP_CAP	
<input type="checkbox"/> Under nutrition CAP		UNDERNUTRITION_CAP	
<input type="checkbox"/> Unit MIS Functional Centre Account Code At Assessment		MIS_AT_ASSESSMENT	
<input type="checkbox"/> Urinary Incontinence CAP		URINARY_INCONTINENCE_CAP	

Organization - Contains information on the organization/site where a residential care service took place. (CCRS_ORGANIZATION)

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Facility Code	AA6	FACILITY	
<input type="checkbox"/> City		CITY	
<input type="checkbox"/> End Date		DELIVERY_SITE_END_DATE	
<input type="checkbox"/> Facility Census Division		FACILITY_CENSUS_DIVISION	
<input type="checkbox"/> Facility Census Subdivision		FACILITY_CENSUS_SUBDIVISION	
<input type="checkbox"/> Health Authority Name		HA_NM	
<input type="checkbox"/> Health Authority Code		HA_CD	
<input type="checkbox"/> Facility Name		FACILITY_NAME	
<input type="checkbox"/> Facility Quintile of Annual Income Per Person Equivalent		FACILITY_QAIPPE	
<input type="checkbox"/> Facility Size		FACILITY_SIZE	
<input type="checkbox"/> Facility Statistical Area Classification Code		FACILITY_SAC_CODE	
<input type="checkbox"/> Facility Statistical Area Classification Type		FACILITY_SAC_TYPE	
<input type="checkbox"/> Health Service Delivery Area Code		HSDA_CD	
<input type="checkbox"/> Health Service Delivery Area Name		HSDA_NM	
<input type="checkbox"/> Facility Urban Rural Code		CIHI_URBAN_RURAL_CODE	
<input type="checkbox"/> Merge to Facility		MERGE_TO_FACILITY	
<input type="checkbox"/> Postal Code		PVDR_CURR_PSTL_CD	
<input type="checkbox"/> Province		PVDR_CURR_PROV_CD	

Medication - Contains information on the medications listed during the RAI MDS 2.0 assessment. An assessment can list multiple medications. (CCRS_MEDICATION)

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Assessment ID		ASSESSMENT_ID	
<input type="checkbox"/> Route Administered	U2	ADMIN_ROUTE	
<input type="checkbox"/> Frequency Administered	U3	ADMIN_FREQUENCY	
<input type="checkbox"/> Amount Administered	U4	ADMIN_AMOUNT	
<input type="checkbox"/> Number of Doses	U5	PRN_DOSES_NUMBER	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Drug Identification Number	U6	DIN	
<input type="checkbox"/> Medication Sequence Number		MEDS_SEQ_NUMBER	

Functional Centre - Contains information on the MIS functional centre where MIS functional centre fields are referenced at admission, discharge and assessment. (CCRS_FUNCTIONAL_CENTRE)

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Unique Registration Identifier - replaced with a study specific identification number	AA1	UNIQUE_REGISTRATION_IDENTIFIER	
<input type="checkbox"/> MIS Functional Centre Account Code	AD3	MIS_ACCOUNT_CODE	
<input type="checkbox"/> MIS Functional Centre Data Quality Flag		MIS_DQ_FLAG	
<input type="checkbox"/> MIS Functional Centre Effective Date		MIS_EFFECTIVE_DATE	

HOME CARE REPORTING SYSTEM (HCRS)

Episode - The service episode record is comprised a service start and a service end. A service end date is to be submitted when a client changes facility or service is ended due to an end reason. If there is no service end date then a client is still receiving service. (HCRS_EPISODE)

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Episode ID		EPISODE_ID	
<input type="checkbox"/> Unencrypted Health Card Number - replaced With A Study Specific Identification Number	AA3a	UNENCRYPTED_HEALTH_CARD_ NUMBER	
<input type="checkbox"/> Client Postal Code	AA4	CLIENT_POSTAL_CODE	
<input type="checkbox"/> Sex	BB1	SEX	
<input type="checkbox"/> Birth Date (YYYYMM)	BB2a	BIRTH_DATE	
<input type="checkbox"/> Estimated Birth Date Flag	BB2b	ESTIMATED_BIRTH_DATE_FLAG	
<input type="checkbox"/> Marital Status	BB4	MARITAL_STATUS	
<input type="checkbox"/> Language	BB5a	LANGUAGE	
<input type="checkbox"/> Date Case Opened Reopened	CC1	DATE_CASE_OPENED_REOPENED	
<input type="checkbox"/> Discharge Date	X30	DISCHARGE_DATE	
<input type="checkbox"/> Service Goals Met At Discharge	X31	SERVICE_GOALS_MET_AT_ DISCHARGE	
<input type="checkbox"/> Discharge Reason	X32	DISCHARGE_REASON	
<input type="checkbox"/> Referral To Other Health Service	X33	REFERRAL_TO_OTH_HEALTH_ SERVICE	
<input type="checkbox"/> Program Type	X4	PROGRAM_TYPE	
<input type="checkbox"/> Referral Source	X5	REFERRAL_SOURCE	
<input type="checkbox"/> Acceptance Date	X6	ACCEPTANCE_DATE	
<input type="checkbox"/> Organization Identifier	Z1a	ORGANIZATION_IDENTIFIER	
<input type="checkbox"/> Client Group at Admission		CLIENT_GROUP_ADMISSION	
<input type="checkbox"/> Client Group at Discharge		CLIENT_GROUP_DISCHARGE	

Assessment - Contains the RAI-HC assessment information, outcome scales, Method for Assigning Priority Levels (MAPLe), clinical assessment protocols (CAPs), and quality indicators. An assessment must have an episode record. (HCRS_ASSESSMENT)

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Assessment ID		ASSESSMENT_ID	
<input type="checkbox"/> Assessment Date	A1	ASSESSMENT_DATE	
<input type="checkbox"/> Assessment Reason	A2	ASSESSMENT_REASON	
<input type="checkbox"/> Short Term Memory	B1a	SHORT_TERM_MEMORY	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Procedural Memory	B1b	PROCEDURAL_MEMORY	
<input type="checkbox"/> Decision Making	B2a	DECISION_MAKING	
<input type="checkbox"/> Worsening Decision Making	B2b	WORSENING_DECISION_MAKING	
<input type="checkbox"/> Delirium 7 Days	B3a	DELIRIUM_7_DAYS	
<input type="checkbox"/> Delirium 90 Days	B3b	DELIRIUM_90_DAYS	
<input type="checkbox"/> Sex	BB1	SEX	
<input type="checkbox"/> Birth Date	BB2a	BIRTH_DATE	
<input type="checkbox"/> Estimated Birth Date Flag	BB2b	ESTIMATED_BIRTH_DATE_FLAG	
<input type="checkbox"/> Marital Status	BB4	MARITAL_STATUS	
<input type="checkbox"/> Language	BB5a	LANGUAGE	
<input type="checkbox"/> Interpreter Needed	BB5b	INTERPRETER_NEEDED	
<input type="checkbox"/> Education Completed	BB6	EDUCATION_COMPLETED	
<input type="checkbox"/> Legal Guardian	BB7a	LEGAL_GUARDIAN	
<input type="checkbox"/> Advance Medical Directives	BB7b	ADV_MEDICAL_DIRECTIVES	
<input type="checkbox"/> Hearing	C1	HEARING	
<input type="checkbox"/> Making Self Understood	C2	MAKING_SELF_UNDERSTOOD	
<input type="checkbox"/> Ability To Understand Others	C3	ABILITY_TO_UNDERSTAND_OTHERS	
<input type="checkbox"/> Communication Decline	C4	COMMUNICATION_DECLINE	
<input type="checkbox"/> Date Case Opened Reopened	CC1	DATE_CASE_OPENED_REOPENED	
<input type="checkbox"/> Reason For Referral	CC2	REASON_FOR_REFERRAL	
<input type="checkbox"/> Understand Nursing Treatment	CC3a	UNDERSTAND_NURSING_TREATMENT	
<input type="checkbox"/> Understand Monitoring	CC3b	UNDERSTAND_MONITORING	
<input type="checkbox"/> Understand Rehabilitation	CC3c	UNDERSTAND_REHABILITATION	
<input type="checkbox"/> Understand Family Education	CC3d	UNDERSTAND_FAMILY_EDUCATION	
<input type="checkbox"/> Understand Family Respite	CC3e	UNDERSTAND_FAMILY_RESPITE	
<input type="checkbox"/> Understand Palliative Care	CC3f	UNDERSTAND_PALLIATIVE_CARE	
<input type="checkbox"/> Last Hospital Stay	CC4	LAST_HOSPITAL_STAY	
<input type="checkbox"/> Lived Time Of Referral	CC5	LIVED_TIME_OF_REFERRAL	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Living Arrangement	CC6	LIVING_ARRANGEMENT	
<input type="checkbox"/> Prior Resident Care Facility	CC7	PRIOR_RESIDENT_CARE_FACILITY	
<input type="checkbox"/> Residence History	CC8	RESIDENCE_HISTORY	
<input type="checkbox"/> Vision	D1	VISION	
<input type="checkbox"/> Visual Limitations	D2	VISUAL_LIMITATIONS	
<input type="checkbox"/> Visual Decline	D3	VISUAL_DECLINE	
<input type="checkbox"/> Sad Mood	E1a	SAD_MOOD	
<input type="checkbox"/> Persistent Anger	E1b	PERSISTENT_ANGER	
<input type="checkbox"/> Unrealistic Fears	E1c	UNREALISTIC_FEARs	
<input type="checkbox"/> Repetitive Health Complaints	E1d	REPETITIVE_HEALTH_COMPLAINTS	
<input type="checkbox"/> Repetitive Anxious Complaints	E1e	REPETITIVE_ANXIOUS_COMPLAINTS	
<input type="checkbox"/> Sad Facial Expression	E1f	SAD_FACIAL_EXPRESSION	
<input type="checkbox"/> Recurrent Crying Tearfulness	E1g	RECURRENT_CRYING_TEARFULNESS	
<input type="checkbox"/> Withdrawal From Activities	E1h	WITHDRAWAL_FROM_ACTIVITIES	
<input type="checkbox"/> Reduced Social Interaction	E1i	REDUCED_SOCIAL_INTERACTION	
<input type="checkbox"/> Mood Decline	E2	MOOD_DECLINE	
<input type="checkbox"/> Wandering Frequency	E3a	WANDERING_FREQ	
<input type="checkbox"/> Verbally Abuse Frequency	E3b	VERBALLY_ABUSE_FREQ	
<input type="checkbox"/> Physical Abuse Frequency	E3c	PHYSICAL_ABUSE_FREQ	
<input type="checkbox"/> Disruptive Frequency	E3d	DISRUPTIVE_FREQ	
<input type="checkbox"/> Resists Care Frequent	E3e	RESISTS_CARE_FREQ	
<input type="checkbox"/> Decline In Behaviour Symptom	E4	DECLINE_IN_BEHAVIOUR_SYMPOM	
<input type="checkbox"/> Easy Interact With Others	F1a	EASY_INTERACT_WITH_OTHERS	
<input type="checkbox"/> Conflict With Family	F1b	CONFLICT_WITH_FAMILY	
<input type="checkbox"/> Decline In Social Activities	F2	DECLINE_IN_SOCIAL_ACTIVITIES	
<input type="checkbox"/> Length Of Time Alone In Day	F3a	LENGTH_OF_TIME_ALONE_IN_DAY	
<input type="checkbox"/> Client Feels Lonely	F3b	CLIENT_FEELS_LONELY	
<input type="checkbox"/> Lives With Client Primary	G1eA	LIVES_WITH_CLIENT_PRIMARY	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Lives With Client Secondary	G1eB	LIVES_WITH_CLIENT_SECONDARY	
<input type="checkbox"/> Relationship Client Primary	G1fA	RELATIONSHIP_CLIENT_PRIMARY	
<input type="checkbox"/> Relationship Client Secondary	G1fB	RELATIONSHIP_CLIENT_SECONDARY	
<input type="checkbox"/> Emotional Support Primary	G1gA	EMOTIONAL_SUPPORT_PRIMARY	
<input type="checkbox"/> Emotional Support Secondary	G1gB	EMOTIONAL_SUPPORT_SECONDARY	
<input type="checkbox"/> IADL Care Primary	G1hA	IADL_CARE_PRIMARY	
<input type="checkbox"/> IADL Care Secondary	G1hB	IADL_CARE_SECONDARY	
<input type="checkbox"/> ADL Care Primary	G1iA	ADL_CARE_PRIMARY	
<input type="checkbox"/> ADL Care Secondary	G1iB	ADL_CARE_SECONDARY	
<input type="checkbox"/> Willing More Support Primary	G1jA	WILLING_MORE_SUPPORT_PRIMARY	
<input type="checkbox"/> Willing More Support Secondary	G1jB	WILLING_MORE_SUPPORT_SECONDARY	
<input type="checkbox"/> Willing More IADL Care Primary	G1kA	WILLING_MORE_IADL_CARE_PRIMARY	
<input type="checkbox"/> Willing More IADL Care Second	G1kB	WILLING_MORE_IADL_CARE_SECOND	
<input type="checkbox"/> Willing More ADL Care Primary	G1lA	WILLING_MORE_ADL_CARE_PRIMARY	
<input type="checkbox"/> Willing More ADL Care Second	G1lB	WILLING_MORE_ADL_CARE_SECOND	
<input type="checkbox"/> Caregiver Unable To Continue	G2a	CAREGIVER_UNABLE_TO_CONTINUE	
<input type="checkbox"/> Caregiver Not Satisfied Support	G2b	CAREGIVER_NO_SATISFIED_SUPPORT	
<input type="checkbox"/> Caregiver Express Distress	G2c	CAREGIVER_EXPRESS_DISTRESS	
<input type="checkbox"/> Caregiver Status None Of Above	G2d	CAREGIVER_STATUS_NONE_OF_ABOVE	
<input type="checkbox"/> Informal Help 5 Weekdays	G3a	INFORMAL_HELP_5_WEEKDAYS	
<input type="checkbox"/> Informal Help 2 Weekend Days	G3b	INFORMAL_HELP_2_WEEKEND_DAYS	
<input type="checkbox"/> IADL Meal Prep Self Performance	H1aA	IADL_MEAL_PREP_SELF_PERF	
<input type="checkbox"/> IADL Meal Prep Difficulty	H1aB	IADL_MEAL_PREP_DIFFICULTY	
<input type="checkbox"/> IADL Housework Self Performance	H1bA	IADL_HOUSEWORK_SELF_PERF	
<input type="checkbox"/> IADL Housework Difficulty	H1bB	IADL_HOUSEWORK_DIFFICULTY	
<input type="checkbox"/> IADL Manage Finances Self Performance	H1cA	IADL_MANAGE_FINANCES_SELF_PERF	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> IADL Manage Finance Difficulty	H1cB	IADL_MANAGE_FINANCE_DIFFICULTY	
<input type="checkbox"/> IADL Manage Meds Self Performance	H1dA	IADL_MANAGE_MEDS_SELF_PERF	
<input type="checkbox"/> IADL Manage Meds Difficulty	H1dB	IADL_MANAGE_MEDS_DIFFICULTY	
<input type="checkbox"/> IADL Phone Use Self Performance	H1eA	IADL_PHONE_USE_SELF_PERF	
<input type="checkbox"/> IADL Phone Use Difficulty	H1eB	IADL_PHONE_USE_DIFFICULTY	
<input type="checkbox"/> IADL Shopping Self Performance	H1fA	IADL_SHOPPING_SELF_PERF	
<input type="checkbox"/> IADL Shopping Difficulty	H1fB	IADL_SHOPPING_DIFFICULTY	
<input type="checkbox"/> IADL Transportation Self Performance	H1gA	IADL_TRANSPORTATION_SELF_PERF	
<input type="checkbox"/> IADL Transportation Difficulty	H1gB	IADL_TRANSPORTATION_DIFFICULTY	
<input type="checkbox"/> ADL Mobility In Bed Self Performance	H2a	ADL_MOBILITY_IN_BED_SELF_PERF	
<input type="checkbox"/> ADL Transfer Self Performance	H2b	ADL_TRANSFER_SELF_PERF	
<input type="checkbox"/> ADL Locomotion In Home Self Performance	H2c	ADL_LOCOMOT_IN_HOME_SELF_PERF	
<input type="checkbox"/> ADL Locomotion Out Home Self Performance	H2d	ADL_LOCOMOT_OUT_HOME_SELF_PERF	
<input type="checkbox"/> ADL Dress Upper Body Self Performance	H2e	ADL_DRESS_UPPER_BODY_SELF_PERF	
<input type="checkbox"/> ADL Dress Lower Body Self Performance	H2f	ADL_DRESS_LOWER_BODY_SELF_PERF	
<input type="checkbox"/> ADL Eating Self Performance	H2g	ADL_EATING_SELF_PERF	
<input type="checkbox"/> ADL Toilet Use Self Performance	H2h	ADL_TOILET_USE_SELF_PERF	
<input type="checkbox"/> ADL Personal Hygiene Self Performance	H2i	ADL_PERSONAL_HYGIENE_SELF_PERF	
<input type="checkbox"/> ADL Bathing Self Performance	H2j	ADL_BATHING_SELF_PERF	
<input type="checkbox"/> ADL Decline	H3	ADL_DECLINE	
<input type="checkbox"/> Mode Of Locomotion Indoors	H4a	MODE_OF_LOCOMOTION_INDOORS	
<input type="checkbox"/> Mode Of Locomotion Outdoors	H4b	MODE_OF_LOCOMOTION_OUTDOORS	
<input type="checkbox"/> Stair Climbing	H5	STAIR_CLIMBING	
<input type="checkbox"/> Days Went Out Of House	H6a	DAYS_WENT_OUT_OF_HOUSE	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Hours Of Physical Activity	H6b	HOURS_OF_PHYSICAL_ACTIVITY	
<input type="checkbox"/> Client More Independence	H7a	CLIENT_MORE_INDEPENDENCE	
<input type="checkbox"/> Caregiver More Independence	H7b	CAREGIVER_MORE_INDEPENDENCE	
<input type="checkbox"/> Good Prospect Of Recovery	H7c	GOOD_PROSPECT_OF_RECOVERY	
<input type="checkbox"/> Functional None Of The Above	H7d	FUNCTIONAL_NONE_OF_THE_ABOVE	
<input type="checkbox"/> Bladder Continence Self Performance	I1a	BLADDER_CONTINENCE_SELF	
<input type="checkbox"/> Worsening Of Incontinence	I1b	WORSENING_OF_INCONTINENCE	
<input type="checkbox"/> Pads Or Briefs	I2a	PADS_OR_BRIEFS	
<input type="checkbox"/> Indwelling Urinary Catheter	I2b	INDWELLING_URINARY_CATHETER	
<input type="checkbox"/> Bladder Device None Of Above	I2c	BLADDER_DEVICE_NONE_OF_ABOVE	
<input type="checkbox"/> Bowel Continence	I3	BOWEL_CONTINENCE	
<input type="checkbox"/> Cerebrovascular Accident	J1a	CEREBROVASCULAR_ACCIDENT	
<input type="checkbox"/> Renal Failure	J1aa	RENAL_FAILURE	
<input type="checkbox"/> Thyroid Disease	J1ab	THYROID_DISEASE	
<input type="checkbox"/> Disease None Of The Above	J1ac	DISEASE_NONE_OF_THE_ABOVE	
<input type="checkbox"/> Congestive Heart Failure	J1b	CONGESTIVE_HEART_FAILURE	
<input type="checkbox"/> Coronary Heart Disease	J1c	CORONARY_HEART_DISEASE	
<input type="checkbox"/> Hypertension	J1d	HYPERTENSION	
<input type="checkbox"/> Heart/circulation disease - Irregularly Pulse	J1e	IRREGULARLY_IRREGULAR_PULSE	
<input type="checkbox"/> Peripheral Vascular Disease Monitored	J1f	PERIPH_VASC_DISEASE_MONITORED	
<input type="checkbox"/> Alzheimer's	J1g	ALZHEIMERS	
<input type="checkbox"/> Dementia Other Than Alzheimer's	J1h	DEMENTIA_OTHER_THAN_ALZHEIMERS	
<input type="checkbox"/> Head Trauma	J1i	HEAD_TRAUMA	
<input type="checkbox"/> Hemiplegia Hemiparesis Disease	J1j	HEMIPLEGIA_HEMIPARESIS	
<input type="checkbox"/> Multiple Sclerosis	J1k	MULTIPLE_SCLEROSIS	
<input type="checkbox"/> Parkinson's Monitored	J1l	PARKINSONS_MONITORED	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Arthritis	J1m	ARTHRITIS	
<input type="checkbox"/> Hip Fracture	J1n	HIP_FRACTURE	
<input type="checkbox"/> Other Fracture Wrist Vertebra	J1o	OTHER_FRACTURE_WRIST_VERTEBRA	
<input type="checkbox"/> Osteoporosis	J1p	OSTEOPOROSIS	
<input type="checkbox"/> Cataracts	J1q	CATARACTS	
<input type="checkbox"/> Glaucoma	J1r	GLAUCOMA	
<input type="checkbox"/> Any Psychiatric Diagnosis	J1s	ANY_PSYCHIATRIC_DIAGNOSIS	
<input type="checkbox"/> HIV Infection	J1t	HIV_INFECTION	
<input type="checkbox"/> Pneumonia	J1u	PNEUMONIA	
<input type="checkbox"/> Tuberculosis	J1v	TUBERCULOSIS	
<input type="checkbox"/> Urinary Tract Infection	J1w	URINARY_TRACT_INFECTION	
<input type="checkbox"/> Cancer Not Including Skin	J1x	CANCER_NOT_INCLUDING_SKIN	
<input type="checkbox"/> Diabetes	J1y	DIABETES	
<input type="checkbox"/> Emphysema COPD Asthma	J1z	EMPHYSEMA_COPD_ASTHMA	
<input type="checkbox"/> Other Disease A	J2a	OTHER_A_ICD_10_CA	
<input type="checkbox"/> Other Disease B	J2b	OTHER_B_ICD_10_CA	
<input type="checkbox"/> Other Disease C	J2c	OTHER_C_ICD_10_CA	
<input type="checkbox"/> Other Disease D	J2d	OTHER_D_ICD_10_CA	
<input type="checkbox"/> Blood Pressure Measured	K1a	BLOOD_PRESSURE_MEASURED	
<input type="checkbox"/> Received Influenza Vaccination	K1b	RECEIVED_INFLUENZA_VACCINATION	
<input type="checkbox"/> Test Stool Blood Endoscopy	K1c	TEST_STOOL_BLOOD_ENDOSCOPY	
<input type="checkbox"/> Breast Exam Mammography	K1d	BREAST_EXAM_MAMMOGRAPHY	
<input type="checkbox"/> Preventive None Of The Above	K1e	PREVENTIVE_NONE_OF_THE_ABOVE	
<input type="checkbox"/> Diarrhea	K2a	DIARRHEA	
<input type="checkbox"/> Change In Urinating	K2b	CHANGE_IN_URINATING	
<input type="checkbox"/> Fever	K2c	FEVER	
<input type="checkbox"/> Loss Of Appetite	K2d	LOSS_OF_APPETITE	
<input type="checkbox"/> Vomiting	K2e	VOMITING	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Conditions None Of The Above	K2f	CONDITIONS_NONE_OF_THE_ABOVE	
<input type="checkbox"/> Chest Pain	K3a	CHEST_PAIN	
<input type="checkbox"/> No Bowel Movement In 3 Days	K3b	NO_BOWEL_MOVEMENT_IN_3_DAYS	
<input type="checkbox"/> Dizziness	K3c	DIZZINESS	
<input type="checkbox"/> Edema	K3d	EDEMA	
<input type="checkbox"/> Shortness Of Breath	K3e	SHORTNESS_OF_BREATH	
<input type="checkbox"/> Delusions	K3f	DELUSIONS	
<input type="checkbox"/> Hallucinations	K3g	HALLUCINATIONS	
<input type="checkbox"/> Mental Health None Of The Above	K3h	MENTAL_HLTH_NONE_OF_THE_ABOVE	
<input type="checkbox"/> Pain Frequency	K4a	PAIN_FREQUENCY	
<input type="checkbox"/> Pain Intensity	K4b	PAIN_INTENSITY	
<input type="checkbox"/> Pain Disrupts Usual Activities	K4c	PAIN_DISRUPTS_USUAL_ACTIVITIES	
<input type="checkbox"/> Character Of Pain	K4d	CHARACTER_OF_PAIN	
<input type="checkbox"/> Adequate Medications For Pain	K4e	ADEQUATE_MEDS_FOR_PAIN	
<input type="checkbox"/> Falls Frequency	K5	FALLS_FREQUENCY	
<input type="checkbox"/> Unsteady Gait	K6a	UNSTEADY_GAIT	
<input type="checkbox"/> Limit Going Out Afraid Falling	K6b	LIMIT_GOING_OUT_AFRID_FALLING	
<input type="checkbox"/> Advise Reduce Drinking	K7a	ADVISE_REDUCE_DRINKING	
<input type="checkbox"/> Alcohol In Morning Or Trouble	K7b	ALCOHOL_IN_MORNING_OR_TROUBLE	
<input type="checkbox"/> Smoke Or Chew Tobacco Daily	K7c	SMOKE_OR_CHEW_TOBACCO_DAILY	
<input type="checkbox"/> Client Feels Has Poor Health	K8a	CLIENT_FEELS_HAS_POOR_HEALTH	
<input type="checkbox"/> Condition Unstable Behaviour	K8b	CONDITION_UNSTABLE_BEHAVIOUR	
<input type="checkbox"/> Flare-up Recurrent Problem	K8c	FLAREUP_RECURRENT_PROBLEM	
<input type="checkbox"/> Treatment Changed Last 30 Days	K8d	TREATMENT_CHANGED_LAST_30_DAYS	
<input type="checkbox"/> Less Than 6 Months To Live	K8e	LESS_THAN_6_MONTHS_TO_LIVE	
<input type="checkbox"/> Status None Of The Above	K8f	STATUS_NONE_OF_THE_ABOVE	
<input type="checkbox"/> Fears Family Caregiver	K9a	FEARS_FAMILY_CAREGIVER	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Unusually Poor Hygiene	K9b	UNUSUALLY_POOR_HYGIENE	
<input type="checkbox"/> Unexplained Injury Broken Bone	K9c	UNEXPLAINED_INJURY_BROKEN_BONE	
<input type="checkbox"/> Neglected Abused	K9d	NEGLECTED_ABUSED	
<input type="checkbox"/> Physically Restrained	K9e	PHYSICALLY_RESTRAINED	
<input type="checkbox"/> Other Status None Of The Above	K9f	OTHER_STATUS_NONE_OF_THE_ABOVE	
<input type="checkbox"/> Weight Loss	L1a	WEIGHT_LOSS	
<input type="checkbox"/> Severe Malnutrition	L1b	SEVERE_MALNUTRITION	
<input type="checkbox"/> Morbid Obesity	L1c	MORBID_OBESITY	
<input type="checkbox"/> One Or Fewer Meals A Day	L2a	ONE_OR_FEWER_MEALS_A_DAY	
<input type="checkbox"/> Decrease Food Fluids Consumed	L2b	DECREASE_FOOD_FLUIDS_CONSUMED	
<input type="checkbox"/> Insufficient Fluids	L2c	INSUFFICIENT_FLUIDS	
<input type="checkbox"/> Enteral Tube Feeding	L2d	ENTERAL_TUBE_FEEDING	
<input type="checkbox"/> Swallowing Difficulty	L3	SWALLOWING_DIFFICULTY	
<input type="checkbox"/> Problem Chewing	M1a	PROBLEM_CHEWING	
<input type="checkbox"/> Dry Mouth	M1b	DRY_MOUTH	
<input type="checkbox"/> Problem Brushing Teeth Denture	M1c	PROBLEM_BRUSHING_TEETH_DENTURE	
<input type="checkbox"/> Oral Status None Of The Above	M1d	ORAL_STATUS_NONE_OF_THE_ABOVE	
<input type="checkbox"/> Skin Problems	N1	SKIN_PROBLEMS	
<input type="checkbox"/> Pressure Ulcer	N2a	PRESSURE_ULCER	
<input type="checkbox"/> Stasis Ulcer	N2b	STASIS_ULCER	
<input type="checkbox"/> Burns	N3a	BURNS	
<input type="checkbox"/> Open Lesions Other Than Ulcers	N3b	OPEN_LESIONS_OTHER_THAN_ULCERS	
<input type="checkbox"/> Skin Tears Or Cuts	N3c	SKIN_TEARS_OR_CUTS	
<input type="checkbox"/> Surgical Wound	N3d	SURGICAL_WOUND	
<input type="checkbox"/> Corns Callus Infections Fungi	N3e	CORNS_CALLUS_INFECTIONS_FUNGI	
<input type="checkbox"/> Skin None Of The Above	N3f	SKIN_NONE_OF_THE_ABOVE	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Prior Pressure Ulcer	N4	PRIOR_PRESSURE_ULCER	
<input type="checkbox"/> Antibiotics	N5a	ANTIBIOTICS	
<input type="checkbox"/> Dressings	N5b	DRESSINGS	
<input type="checkbox"/> Surgical Wound Care	N5c	SURGICAL_WOUND_CARE	
<input type="checkbox"/> Other Wound Ulcer Care	N5d	OTHER_WOUND_ULCER_CARE	
<input type="checkbox"/> Wound Care None Of The Above	N5e	WOUND_CARE_NONE_OF_THE_ABOVE	
<input type="checkbox"/> Lighting	O1a	LIGHTING	
<input type="checkbox"/> Floors Carpets	O1b	FLOORS_CARPETS	
<input type="checkbox"/> Bathroom Toilet	O1c	BATHROOM_TOILET	
<input type="checkbox"/> Kitchen	O1d	KITCHEN	
<input type="checkbox"/> Heating And Cooling	O1e	HEATING_AND_COOLING	
<input type="checkbox"/> Personal Safety	O1f	PERSONAL_SAFETY	
<input type="checkbox"/> Access To Home	O1g	ACCESS_TO_HOME	
<input type="checkbox"/> Access To Rooms In House	O1h	ACCESS_TO_ROOMS_IN_HOUSE	
<input type="checkbox"/> Home Environment None Of The Above	O1i	HOME_ENVIRON_NONE_OF_THE_ABOVE	
<input type="checkbox"/> Client Lives With Others	O2a	CLIENT_LIVES_WITH_OTHERS	
<input type="checkbox"/> Other Living Environ Better	O2b	OTHER_LIVING_ENVIRON_BETTER	
<input type="checkbox"/> Home Health Aides Visit Days	P1aA	HOME_HEALTH_AIDES_VISIT_DAYS	
<input type="checkbox"/> Home Health Aides Hours	P1aB	HOME_HEALTH_AIDES_HOURS	
<input type="checkbox"/> Home Health Aides Minutes	P1aC	HOME_HEALTH_AIDES_MINS	
<input type="checkbox"/> Visiting Nurses Visit Days	P1bA	VISITING_NURSES_VISIT_DAYS	
<input type="checkbox"/> Visiting Nurses Hours	P1bB	VISITING_NURSES_HOURS	
<input type="checkbox"/> Visiting Nurses Minutes	P1bC	VISITING_NURSES_MINS	
<input type="checkbox"/> Homemaking Services Visit Days	P1cA	HOMEMAKING_SERVICES_VISIT_DAYS	
<input type="checkbox"/> Homemaking Services Hours	P1cB	HOMEMAKING_SERVICES_HOURS	
<input type="checkbox"/> Homemaking Services Minutes	P1cC	HOMEMAKING_SERVICES_MINS	
<input type="checkbox"/> Meals Delivered Days	P1dA	MEALS_DELIVERED_DAYS	
<input type="checkbox"/> Meals Delivered Hours	P1dB	MEALS_DELIVERED_HOURS	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Meals Delivered Minutes	P1dC	MEALS_DELIVERED_MINS	
<input type="checkbox"/> Volunteer Services Days	P1eA	VOLUNTEER_SERVICES_DAYS	
<input type="checkbox"/> Volunteer Services Hours	P1eB	VOLUNTEER_SERVICES_HOURS	
<input type="checkbox"/> Volunteer Services Minutes	P1eC	VOLUNTEER_SERVICES_MINS	
<input type="checkbox"/> Physical Therapy Days	P1fA	PHYSICAL_THERAPY_DAYS	
<input type="checkbox"/> Physical Therapy Hours	P1fB	PHYSICAL_THERAPY_HOURS	
<input type="checkbox"/> Physical Therapy Minutes	P1fC	PHYSICAL_THERAPY_MINS	
<input type="checkbox"/> Occupational Therapy Days	P1gA	OCCUPATIONAL_THERAPY_DAYS	
<input type="checkbox"/> Occupational Therapy Hours	P1gB	OCCUPATIONAL_THERAPY_HOURS	
<input type="checkbox"/> Occupational Therapy Minutes	P1gC	OCCUPATIONAL_THERAPY_MINS	
<input type="checkbox"/> Speech Therapy Days	P1hA	SPEECH_THERAPY_DAYS	
<input type="checkbox"/> Speech Therapy Hours	P1hB	SPEECH_THERAPY_HOURS	
<input type="checkbox"/> Speech Therapy Minutes	P1hC	SPEECH_THERAPY_MINS	
<input type="checkbox"/> Day Care Or Day Hospital Days	P1iA	DAY_CARE_OR_DAY_HOSPITAL_DAYS	
<input type="checkbox"/> Day Care Or Day Hospital Hours	P1iB	DAY_CARE_OR_DAY_HOSPITAL_HOURS	
<input type="checkbox"/> Day Care Or Day Hospital Minutes	P1iC	DAY_CARE_OR_DAY_HOSPITAL_MINS	
<input type="checkbox"/> Social Worker In Home Days	P1jA	SOCIAL_WORKER_IN_HOME_DAYS	
<input type="checkbox"/> Social Worker In Home Hours	P1jB	SOCIAL_WORKER_IN_HOME_HOURS	
<input type="checkbox"/> Social Workers In Home Minutes	P1jC	SOCIAL_WORKERS_IN_HOME_MINS	
<input type="checkbox"/> Oxygen Treatment Adhere	P2a	OXYGEN_TREATMENT_ADHERE	
<input type="checkbox"/> Treatment None Of The Above	P2aa	TREATMENT_NONE_OF_THE_ABOVE	
<input type="checkbox"/> Respirator Assistive Adhere	P2b	RESPIRATOR_ASSISTIVE__ADHERE	
<input type="checkbox"/> Other Respiratory Treatment	P2c	OTHER_RESPIRATORY_TREATMENT	
<input type="checkbox"/> Alcohol Drug Program Adhere	P2d	ALCOHOL_DRUG_PROGRAM_ADHERE	
<input type="checkbox"/> Blood Transfusion Adhere	P2e	BLOOD_TRANSFUSION_ADHERE	
<input type="checkbox"/> Chemotherapy Adherence	P2f	CHEMOTHERAPY_ADHERE	
<input type="checkbox"/> Dialysis Adherence	P2g	DIALYSIS_ADHERE	
<input type="checkbox"/> Infusion Central IV Adhere	P2h	INFUSION_CENTRAL_IV_ADHERE	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Infusion Peripheral IV Adhere	P2i	INFUSION_PERIPHERAL_IV_ADHERE	
<input type="checkbox"/> Medications By Injection Adherence	P2j	MEDS_BY_INJECTION_ADHERE	
<input type="checkbox"/> Ostomy Care Adhere	P2k	OSTOMY_CARE_ADHERE	
<input type="checkbox"/> Radiation Adherence	P2l	RADIATION_ADHERE	
<input type="checkbox"/> Tracheostomy Care Adhere	P2m	TRACHEOSTOMY_CARE_ADHERE	
<input type="checkbox"/> Exercise Therapy Adhere	P2n	EXERCISE_THERAPY_ADHERE	
<input type="checkbox"/> Occupational Therapy Adhere	P2o	OCCUPATIONAL_THERAPY_ADHERE	
<input type="checkbox"/> Physical Therapy Adherence	P2p	PHYSICAL_THERAPY_ADHERE	
<input type="checkbox"/> Day Centre Adhere	P2q	DAY_CENTRE_ADHERE	
<input type="checkbox"/> Day Hospital Adhere	P2r	DAY_HOSPITAL_ADHERE	
<input type="checkbox"/> Hospice Care Adherence	P2s	HOSPICE_CARE_ADHERE	
<input type="checkbox"/> Physician Clinic Visit Adhere	P2t	PHYSICIAN_CLINIC_VISIT_ADHERE	
<input type="checkbox"/> Respite Care Adhere	P2u	RESPITE_CARE_ADHERE	
<input type="checkbox"/> Daily Nurse Monitoring Adherence	P2v	DAILY_NURSE_MONITORING_ADHERE	
<input type="checkbox"/> Non Daily Nurse Monitor Adhere	P2w	NON_DAILY_NURSE_MONITOR_ADHERE	
<input type="checkbox"/> Medical Bracelet Electronic Alert Adherence	P2x	MED_BRACELET_ELEC_ALERT_ADHERE	
<input type="checkbox"/> Skin Ulceration Treat Adhere	P2y	SKIN_ULCERATION_TREAT_ADHERE	
<input type="checkbox"/> Special Diet	P2z	SPECIAL_DIET	
<input type="checkbox"/> Manage Oxygen Equipment	P3a	MANAGE_OXYGEN_EQUIPMENT	
<input type="checkbox"/> Manage IV	P3b	MANAGE_IV	
<input type="checkbox"/> Manage Catheter	P3c	MANAGE_CATHETER	
<input type="checkbox"/> Manage Ostomy	P3d	MANAGE_OSTOMY	
<input type="checkbox"/> Overnight Hospital Admission	P4a	OVERNIGHT_HOSPITAL_ADMISSION	
<input type="checkbox"/> Emergency Room Visits	P4b	EMERGENCY_ROOM_VISITS	
<input type="checkbox"/> Emergent Care Visits	P4c	EMERGENT_CARE_VISITS	
<input type="checkbox"/> Treatment Goals Achieved	P5	TREATMENT_GOALS_ACHIEVED	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Overall Change In Care Needs	P6	OVERALL_CHANGE_IN_CARE_NEEDS	
<input type="checkbox"/> Spending Trade Offs	P7	SPENDING_TRADE_OFFS	
<input type="checkbox"/> Number Of Medications	Q1	NUM_OF_MEDS	
<input type="checkbox"/> Antipsychotic Neuroleptic Medications	Q2a	ANTIPSYCHOTIC_NEUROLEPTIC	
<input type="checkbox"/> Anxiolytic Medications	Q2b	ANXIOLYTIC	
<input type="checkbox"/> Antidepressant	Q2c	ANTIDEPRESSANT	
<input type="checkbox"/> Hypnotics Or Analgesics	Q2d	HYPNOTICS_OR_ANALGESICS	
<input type="checkbox"/> Medical Oversight	Q3	MEDICAL_OVERSIGHT	
<input type="checkbox"/> Compliance Adherence With Meds	Q4	COMPLIANCE_ADHERENCE_WITH_MEDS	
<input type="checkbox"/> Date Assessment Complete	R1c	DATE_ASSESSMENT_COMPLETE	
<input type="checkbox"/> Client Group	X2	CLIENT_GROUP	
<input type="checkbox"/> Assessment Location	X70	ASSESSMENT_LOCATION	
<input type="checkbox"/> Facility Admission Date	X71	FACILITY_ADMISSION_DATE	
<input type="checkbox"/> Abuse CAP HC		ABUSE_CAP_HC	
<input type="checkbox"/> Abuse CAP2008 HC		ABUSE_CAP2008_HC	
<input type="checkbox"/> Adherence CAP HC		ADHERENCE_CAP_HC	
<input type="checkbox"/> ADL CAP2008 HC		ADL_CAP2008_HC	
<input type="checkbox"/> ADL Long Form HC		ADL_LONG_FORM_HC	
<input type="checkbox"/> ADL Rehab CAP HC		ADL_REHAB_CAP_HC	
<input type="checkbox"/> ADL Self Performance HC		ADL_SELF_PERFORM_HC	
<input type="checkbox"/> ADL Short Form HC		ADL_SHORT_FORM_HC	
<input type="checkbox"/> Alcohol CAP HC		ALCOHOL_CAP_HC	
<input type="checkbox"/> Appropriate Meds CAP2008 HC		APPROP_MEDS_CAP2008_HC	
<input type="checkbox"/> Behaviour CAP HC		BEHAVIOUR_CAP_HC	
<input type="checkbox"/> Behaviour CAP2008 HC		BEHAVIOUR_CAP2008_HC	
<input type="checkbox"/> Bowel Conditions CAP2008 HC		BOWEL_CONDITIONS_CAP2008_HC	
<input type="checkbox"/> Bowel Management CAP HC		BOWEL_MGMT_CAP_HC	
<input type="checkbox"/> Brittle CAP HC		BRITTLE_CAP_HC	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Cardio Respiratory CAP HC		CARDIO_RESPIRATORY_CAP_HC	
<input type="checkbox"/> Cardio Respiratory CAP2008 HC		CARDIO_RESPIRATORY_CAP2008_HC	
<input type="checkbox"/> Chess HC		CHESS_HC	
<input type="checkbox"/> Cognition CAP HC		COGNITION_CAP_HC	
<input type="checkbox"/> Cognitive CAP2008 HC		COGNITIVE_CAP2008_HC	
<input type="checkbox"/> Communication CAP HC		COMMUNICATION_CAP_HC	
<input type="checkbox"/> Communication CAP2008 HC		COMMUNICATION_CAP2008_HC	
<input type="checkbox"/> CPS HC		CPS_HC	
<input type="checkbox"/> Dehydration CAP HC		DEHYDRATION_CAP_HC	
<input type="checkbox"/> Dehydration CAP2008 HC		DEHYDRATION_CAP2008_HC	
<input type="checkbox"/> Delirium CAP2008 HC		DELIRIUM_CAP2008_HC	
<input type="checkbox"/> Depression CAP HC		DEPRESSION_CAP_HC	
<input type="checkbox"/> DRS HC		DRS_HC	
<input type="checkbox"/> Environment CAP HC		ENVIRONMENT_CAP_HC	
<input type="checkbox"/> Environment CAP2008 HC		ENVIRONMENT_CAP2008_HC	
<input type="checkbox"/> Episode ID		EPISODE_ID	
<input type="checkbox"/> Falls CAP HC		FALLS_CAP_HC	
<input type="checkbox"/> Falls CAP2008 HC		FALLS_CAP2008_HC	
<input type="checkbox"/> Feeding CAP2008 HC		FEEDING_CAP2008_HC	
<input type="checkbox"/> Health CAP HC		HEALTH_CAP_HC	
<input type="checkbox"/> IADL CAP HC		IADL_CAP_HC	
<input type="checkbox"/> IADL CAP2008 HC		IADL_CAP2008_HC	
<input type="checkbox"/> IADL Difficulty HC		IADL_DIFFICULTY_HC	
<input type="checkbox"/> IADL Involvement HC		IADL_INVOLVEMENT_HC	
<input type="checkbox"/> Institutional Risk CAP HC		INSTITUTIONAL_RISK_CAP_HC	
<input type="checkbox"/> Institutional Risk CAP2008 HC		INSTITUTIONAL_RISK_CAP2008_HC	
<input type="checkbox"/> Maple HC		MAPLE_HC	
<input type="checkbox"/> Medications CAP HC		MEDS_CAP_HC	

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Mood CAP2008 HC		MOOD_CAP2008_HC	
<input type="checkbox"/> Number Of Medications Records Submit		NUM_OF_MEDS_RECORDS_SUBMIT	
<input type="checkbox"/> Nutrition CAP HC		NUTRITION_CAP_HC	
<input type="checkbox"/> Oral CAP HC		ORAL_CAP_HC	
<input type="checkbox"/> Pain CAP HC		PAIN_CAP_HC	
<input type="checkbox"/> Pain CAP2008 HC		PAIN_CAP2008_HC	
<input type="checkbox"/> Pain HC		PAIN_HC	
<input type="checkbox"/> Palliative CAP HC		PALLIATIVE_CAP_HC	
<input type="checkbox"/> Physical Activity CAP2008 HC		PHYSICAL_ACTIVITY_CAP2008_HC	
<input type="checkbox"/> Pressure Ulcer CAP2008 HC		PRESSURE_ULCER_CAP2008_HC	
<input type="checkbox"/> Pressure Ulcers CAP HC		PRESSURE_ULCERS_CAP_HC	
<input type="checkbox"/> Preventive CAP HC		PREVENTIVE_CAP_HC	
<input type="checkbox"/> Psychotropic Drug CAP HC		PSYCH_DRUG_CAP_HC	
<input type="checkbox"/> PURS HC		PURS_HC	
<input type="checkbox"/> Reduced Formal Services CAP HC		REDUCED_FORMAL_SERVICES_CAP_HC	
<input type="checkbox"/> Rug III HC		RUG_III_HC	
<input type="checkbox"/> Rug III HC Category		RUG_III_HC_CATEGORY	
<input type="checkbox"/> Skin CAP HC		SKIN_CAP_HC	
<input type="checkbox"/> Social CAP HC		SOCIAL_CAP_HC	
<input type="checkbox"/> Social CAP2008 HC		SOCIAL_CAP2008_HC	
<input type="checkbox"/> Support CAP2008 HC		SUPPORT_CAP2008_HC	
<input type="checkbox"/> Urinary CAP HC		URINARY_CAP_HC	
<input type="checkbox"/> Urinary CAP2008 HC		URINARY_CAP2008_HC	
<input type="checkbox"/> Visual CAP HC		VISUAL_CAP_HC	

Medication - Contains information on the medications listed during the RAI-HC assessment. An assessment can list multiple medications. (HCRS_MEDICATION)

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Assessment ID		ASSESSMENT_ID	
<input type="checkbox"/> Medication Name	Q5a	MEDS_NAME	
<input type="checkbox"/> Medication Dose	Q5b	MEDS_DOSE	
<input type="checkbox"/> Medication Route	Q5c	MEDS_FORM	
<input type="checkbox"/> Medication Frequency	Q5d	MEDS_FREQUENCY	
<input type="checkbox"/> Medication on Pro Re Nata basis	Q5e	MEDS_ON_PRN_BASIS	
<input type="checkbox"/> Medication Sequence Number	X40	MEDS_SEQUENCE_NUMBER	
<input type="checkbox"/> Drug Identification Number	X41	DIN	

Service - Contains information on the home care services provided to the client. A service must have an episode record. (HCRS_SERVICE)

NAME	RAI ID	DATA FIELD	REASON FOR REQUEST
<input type="checkbox"/> Acute Services Flag	X14	ACUTE_SERVICES_FLAG	
<input type="checkbox"/> Discharge Date	X30	DISCHARGE_DATE	
<input type="checkbox"/> Episode ID		EPISODE_ID	
<input type="checkbox"/> Home Care Discipline	X12	HOME_CARE_DISCIPLINE	
<input type="checkbox"/> Minutes Of Service	X16	MINS_OF_SERVICE	
<input type="checkbox"/> Number Of Service Visits	X15	NUM_OF_SERVICE_VISITS	
<input type="checkbox"/> Reporting Fiscal Year	Y12	REPORTING_FISCAL_YEAR	
<input type="checkbox"/> Reporting Period	Y13	REPORTING_PERIOD	
<input type="checkbox"/> Service Delivery Setting	X13	SERVICE_DELIVERY_SETTING	
<input type="checkbox"/> Service End Date	X17	SERVICE_END_DATE	
<input type="checkbox"/> Service Start Date	X10	SERVICE_START_DATE	
<input type="checkbox"/> Service Type	X11	SERVICE_TYPE	

Note – not all health authorities are submitting service data

<input type="checkbox"/> Additional Variables	Please provide a detailed list of variables, description and rationale in a separate document (blank checklist available). The Ministry will assess the availability upon request.
<input type="checkbox"/> Quality Indicators	Quality Indicators are available upon request