The WeeFIM II® Clinical Guide
Version 6.4
The WeeFIM II® Clinical Guide
Uniform Data System for Medical Rehabilitation, November 17, 2016

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Section I: Introduction
Background

The 1980s are generally thought of as the “Golden Age of Rehabilitation.” Inpatient rehabilitation units and hospitals were springing up everywhere. Length of stay and cost did not appear as deterrents to provision of a wide array of services. Shortages of allied health professionals cropped up all over the country; as the demand grew, so did their salaries. Over time, however, costs began to skyrocket as lengths of stay grew. Suddenly, rehabilitation clinicians found themselves having to justify their services and demonstrate outcomes of medical rehabilitation to internal stakeholders as well as third-party payers and accrediting bodies. There was an increasing awareness on the part of these rehabilitation clinicians that they had no universally accepted, consistent terminology to communicate about disability, although many recognized the need, its potential value, and the difficulties of achieving uniformity. Then, in 1984, the U.S. Department of Education’s National Institute on Disability and Rehabilitation Research (NIDRR) awarded a grant to the Department of Rehabilitation Medicine in the School of Medicine at the State University of New York at Buffalo to develop a system to document, in a uniform fashion, the severity of patient disability as well as the outcomes of medical rehabilitation. A task force was charged with developing a uniform data set for adult inpatient medical rehabilitation. This task force, which consisted of the codirectors of the project in Buffalo (Dr. Granger and Dr. Hamilton) and representatives of the rehabilitation community nationwide, was sponsored by the American Congress of Rehabilitation Medicine (ACRM), the American Academy of Physical Medicine and Rehabilitation (AAPM&R), and eleven other national organizations concerned with medical rehabilitation.

The goal of the task force was to develop a functional assessment data set comprising the minimum number of items (minimal data set) that would be appropriate; that is, one that included only key functional attributes that were common and useful, discipline-free, and acceptable to clinicians, administrators, and researchers. The task force also had to create a rating scale to measure the items. Finally, the instrument had to be designed so that it could be administered quickly and uniformly, yet demonstrate validity and reliability. The resulting FIM® instrument was intended to track patients from the initiation of hospital care through discharge and follow-up. Periodic reassessment would measure changes in patient performance to indicate progress toward independence primarily in personal care and mobility over time, while also providing data with which to measure rehabilitation program outcomes. Competent psychosocial skills, particularly communication and cognition, were recognized as important variables.

The items selected for the FIM® instrument were grouped as self-care, sphincter control, transfers, locomotion, communication, and social cognition. A four-level rating scale was originally proposed in the interests of simplicity, but testing in the field led to recommendations for greater detail. In response, a seven-level rating scale was adopted. In addition, patient demographic characteristics, diagnoses, impairment groups, lengths of rehabilitation inpatient stay, and rehabilitation charges were included in the data set. Since 1984, pilot, trial, and implementation studies have been conducted to improve the clinical and technical features of the data set, especially the FIM® instrument.

Interest in the data set was high from the very beginning, and it has continued to grow. Beginning on October 1, 1987, rehabilitation facilities were given an opportunity to subscribe by sending FIM® item ratings to UDSMr and receiving summary comparison reports in return. Since then, the number of participating facilities has grown to over 850, and the database now has more than six million patient records. Due to the advocacy of the medical rehabilitation field in recognition of the utility and the standards and processes that UDSMr utilized to maintain
uniformity and integrity in its database, the Health Care Financing Administration (HCFA), now known as the Centers for Medicare and Medicaid Services (CMS), approached UDSMR to provide information that would help them develop the IRF PPS, a new prospective payment system for inpatient rehabilitation facilities. In 1995, HCFA entered into a royalty-free license agreement with UDSMR to evaluate The FIM System®, as a possible basis for the new IRF PPS. Upon completion of its evaluation, and at the strong urging of the medical rehabilitation field, HCFA selected The FIM System® as the basis for its new payment system and incorporated many of its elements, including the FIM® instrument, into the new Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI).

In mid-1987, just prior to the initiation of the subscriber service for the FIM® instrument, pediatric clinicians and physicians in Buffalo became aware of the FIM® instrument and recognized that a pediatric version of such an assessment tool could be used to measure functional performance in children and adolescents with genetic, developmental, and acquired disabilities and in children with special health-care needs. Key uses of functional measures include baseline descriptive clinical assessments for assessing severity, selection of treatment goals, evaluation of treatment effects, and specification of the child’s and family’s needs for support. In the field of pediatrics, many assessment tools already in existence documented the status of development of children; however, few of these instruments were suitable for periodically tracking the progress of children toward independence in personal care, mobility, and psychosocial competence.

To meet this perceived need to measure outcomes of medical rehabilitation and habilitation in pediatric populations, the WeeFIM® instrument was developed in 1987 by a multidisciplinary team consisting of physicians, nurses, and therapists. Adult FIM® item definitions were modified to accommodate the developmental aspect of child habilitation, taking into account that varying degrees of dependence are “normal” until the approximate age of seven years old. As a direct adaptation of the FIM® instrument, the WeeFIM® instrument contains a minimal number of items that measure the severity of disability. Both instruments are based on the definition of disability in the Disablement Model put forth by the World Health Organization (WHO, 1980). The WeeFIM® instrument is a measure of functional abilities and the “need for assistance” that is associated with levels of disability in children ages six months to seven years and older.

The WeeFIM® and FIM® instruments were purposely kept as compatible as possible by utilizing the same items and rating system. This has served to foster a common language of disability that facilitates communication and measurement. The WeeFIM® items were originally organized into the same six sub-domains as the FIM® items; over time, however, these have migrated into the three sub-domains of self-care, mobility, and cognition. As with the FIM® items, each WeeFIM® item is rated on a seven-level ordinal scale that ranges from complete independence (level 7) to total assistance (level 1).

Pilot studies conducted soon after the development of the WeeFIM® instrument revealed a strong association between WeeFIM® ratings and developmental levels as reflected by the age of the child. Items on the WeeFIM® instrument progress in a developmental sequence. Less complex tasks for the child, such as locomotion, are performed independently at younger ages; more complex tasks, such as problem solving, are accomplished at older ages. A WeeFIM® normalization study (N = 450), conducted over a nine-month period beginning in late 1990, confirmed a close relationship between WeeFIM® ratings and chronological age from six months to seven years. The normalization study also revealed that typically developing children beyond seven years of age tend to achieve functional independence on each WeeFIM®
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item. Although this appears to be characteristic of typically developing children, the WeeFIM® instrument has wide applicability for use with children beyond the age of seven years when they experience delays in functional development.

Reliability studies of children one to seven years old with motor, communicative, and neurodevelopmental disabilities and of children eight to twelve years old with cerebral palsy or spina bifida revealed excellent test/retest and inter-rater reliability.\(^6,7\) Finally, the equivalence reliability of face-to-face assessments and telephone interviews is excellent, thus facilitating the follow-up of a patient’s functional status without the costly requirement of face-to-face interviews.\(^7,8\)

The validity of the individual WeeFIM® criteria was tested using the Vineland Adaptive Behavior Scale \((N = 104)\), Batelle Developmental Inventory Screen Test \((N = 101)\), and Pediatric Inventory of Disability \((N = 45)\). These studies revealed excellent robust correlation across total scores and domain scores for children with disabilities.\(^7,8\)

The validity of the WeeFIM® instrument was examined through pilot studies that included children with extreme prematurity \((N = 149)\), cerebral palsy \((N = 100)\), Down syndrome \((N = 150)\), congenital limb disorders \((N = 50)\), spina bifida \((N = 50)\), and traumatic brain injury \((N = 100)\).\(^9,6,10-12\)

Studies were also undertaken at the community level to test the instrument’s validity and reliability outside the rehabilitation setting. These studies included children who were receiving early intervention services for cerebral palsy and for language and cognitive disabilities.\(^13,14\) In addition, longitudinal studies demonstrated the ability to measure functional change after rhizotomy \((N = 90)\), after cryosurgery in infants with very low birth weight and retinopathy of prematurity \((N = 1258)\), in preadolescents with spina bifida, after pediatric brain tumors, in children with congenital heart disease, and in young adults with dysphasia and severe developmental disabilities.\(^9,14-23\) Additionally, concurrent validity using both the WeeFIM® instrument and the FIM® instrument in children eight to sixteen years old with cerebral palsy \((N = 20)\) is excellent.\(^13\)

In 1994, 21,415 children between five and seventeen years old were included in the National Health Interview Survey on Disability (NHISD). A study conducted by Hogan, et al., then applied dimensions of the WeeFIM® instrument to the NHISD data to assess functional limitations in mobility, self-care, communication, and learning ability for school-age American children.\(^24\) The study revealed mobility limitations in 1.3%, self-care limitations in 0.9%, communication limitations in 5.5%, and learning/social cognitive limitations in 10.6%. Overall, 8.1% of school-aged children have severe functional limitations, 9.0% of children have activity limitations, and 3.5% have societal limitations. WeeFIM® domains account for 30% of activity and 45% of societal limitations. Thus, a variety of normative, clinical, and longitudinal studies involving children with disabilities demonstrate that the WeeFIM® instrument is useful for describing functional limitations. By knowing a child’s functional strengths and challenges, health professionals, rehabilitation professionals, and educational professionals can work together to optimize development and direct family supports toward achievement of independent adulthood.

As with the FIM® instrument, interest in the data set was high from the beginning and continued to grow. In 1994, a pediatric subscriber service was launched. Pediatric inpatient and outpatient/community-based facilities were licensed to use the Uniform Data Set for Medical Rehabilitation, including the WeeFIM® instrument and the accompanying WeeFIMware™
software, to collect data for submission to UDSMR for aggregation. The aggregate data was used to prepare quarterly inpatient and outpatient reports that provided facility data and comparisons with national data. The database continued to grow over the next seven years. In 2001, based upon subscriber feedback and advances in software technology, UDSMR determined that enhancements to the WeeFIMware™ software and certain elements of the data set would be appropriate. Before embarking on this project, UDSMR made every effort to seek input from subscribers in order to gain a better understanding of their needs.

The first attempt to canvass the subscribers involved mailing all of them lengthy surveys that asked for opinions regarding the WeeFIM® instrument itself, the WeeFIMware™ software, the standard quarterly reports, the value of the WeeFIM® System, the quality of services provided by UDSMR, and recommendations for the future. Over 50% of the subscribers took the time to complete the surveys and to return them to UDSMR. In early 2002, UDSMR began a series of telephone and face-to-face focus group meetings to learn, in depth, how subscribers were using the WeeFIM® System, what they perceived as the major issues in pediatric inpatient and outpatient rehabilitation, and how UDSMR could better serve their needs. Subscribers were unanimous in advocating for more opportunities to network with their colleagues in environments that focused solely on pediatric rehabilitation issues. Thus, in late 2002, UDSMR made a major commitment to completely redesign the WeeFIM® System. At every step of the way, the redesign effort has been driven almost exclusively by subscriber feedback.

The WeeFIM II® System was launched in January 2004. Enhancements have been made to almost every aspect of the system. Although the eighteen items of the WeeFIM® instrument remain the same, the definitions and the descriptors for many of the ratings have been clarified. The new system is Internet-based, thus eliminating the need to download data and send information to UDSMR via courier each quarter. It allows users to track patients across settings via the software’s inpatient and outpatient modules. Other new software features include a task scheduler and a greatly expanded software report writer, which allows subscribers to create reports based on templates provided in the software. In addition, a dynamic export feature allows subscribers to select particular data elements for export to spreadsheet applications so that they can create reports of their own design. The software also contains innumerable custom fields that subscribers can use to collect additional information for their own purposes.

The impairment groups, which have evolved over the years from a mirror image of the adult FIM® codes into a system more precisely tailored to the needs of a pediatric population, have now expanded from nine to fourteen groups. Subscriber recommendations were taken into account in expanding the number of groups and in adding many new subcategories.

Prior to the redesign, subscribers received hefty reports that they described as “colorful but difficult to interpret or share with others.” In response to their suggestions, the redesigned reports are more concise and contain untransformed WeeFIM® ratings and accompanying graphs. Three new outpatient reports have been created. These reports are based on three new admission classes: children who receive day treatment, children who receive ongoing outpatient therapy services, and children who are being seen for evaluation only. The updated inpatient reports include comparisons to similar facilities as well as comparisons to facilities across the United States.
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References


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**UDSmr® Services**

UDSmr’s staff is available from Monday to Friday between 8:30 a.m. and 5:30 p.m. Eastern. You can contact us using any of the methods listed here:

- **Phone:** If you have any questions about this guide or the WeeFIM II® System, call our client services department at 716-817-7872.
- **Fax:** Send faxes to 716-568-0037. Include a cover sheet that indicates the intended recipient of the fax.
- **E-mail:** Contact us at info@udsmr.org.
- **Mail or courier:** Write to us at UDSMr, 270 Northpointe Parkway, Suite 300, Amherst, NY 14228-1897.

You can also visit our website at www.udsmr.org. The various services we offer are described below.

**Sales and Client Services**

Our sales and client services department provides general information regarding UDSMr’s services as well as assistance to facilities regarding all aspects of subscribing. This staff handles everything from contracts to special report requests, and you can reach them at 716-817-7872.

**Education and Training**

There are various ways in which you can familiarize yourself with the data set items, including the WeeFIM® instrument. You can study this guide, attend a UDSMr® training workshop, or simply examine one of your quarterly reports. Such familiarity helps ensure that your results are reliable.

**Credentialing**

Reliable collection of data is very important to us at UDSMr. To ensure that facilities are submitting reliable data, each facility goes through a credentialing process.

**Important!** UDSMr credentials facilities, not individual clinicians. Consequently, individual results of the credentialing exam **cannot** be transferred from facility to facility.

The credentialing process uses a written exam with case studies to test the rater’s knowledge of the WeeFIM® instrument definition and levels. This establishes that data is collected in a reliable manner. Credentialing renewal is required every two years.

**Data Management Service**

UDSmr’s data management service handles both the collection and the reporting of data.

- **Data collection:** Subscribing facilities use the Internet-based WeeFIM II® software to enter patient data. The patient data is transmitted to UDSMr over a secure Internet connection.
- **Data reporting:** The patient data from each WeeFIM® subscriber is aggregated in an inpatient or outpatient database (as appropriate) and used to create standard quarterly reports that provide subscribing facilities with information about themselves and comparisons with national data. Inpatient reports include comparisons to data from similar facilities across the United States, as well as national data. Outpatient subscribers receive reports based on whether children are receiving ongoing therapy services, being seen for clinic evaluations
(without therapy), or receiving services in a day treatment program. Facilities may make use of their own data locally to create profile reports for individual children and reports derived from templates in the WeeFIM II® software. Facilities also can export their data to other applications to create reports that fit their specific needs.

**Consultation**

UDSMR offers special analytic, reporting, and consultation services to help meet the unique needs of its individual subscribers. Fees for these special services are determined and agreed upon after (1) the subscribing facility has articulated its needs and (2) UDSMR and the subscribing facility reach an understanding about the deliverables. We encourage subscribers to contact us to learn more about the available options.

**Research Services**

UDSMR conducts a wide range of clinical and scientific research projects related to functional assessment. UDSMR also provides support to other researchers in this field. Credentialing is required for researchers who want to use the WeeFIM® instrument in their research.
Section II: Coding the Data Set
WeeFIM II® Case Coding Form Instructions

Throughout this document, the term “rehabilitation program” is used to identify all inpatient programs, outpatient services, day treatment programs, and habilitation programs. Unless otherwise specified, the terms “outpatient,” “outpatient program,” and “outpatient services” include day treatment programs.

Case Identification

1. **Facility code**: Enter the confidential facility code assigned to your facility by UDSMR.

2. **Patient code**: Enter a unique code (maximum of ten alphanumeric characters) that identifies the child. The code can be used to track the child’s progress from inpatient rehabilitation through outpatient rehabilitation, day treatment services, or both.
   - **Inpatient**: The code must remain the same for each hospitalization and follow-up.
   - **Outpatient**: The code must remain the same for each outpatient visit by this child. If follow-up is conducted after the child is discharged from an outpatient program, the code must remain the same. If the child is discharged from an inpatient program and returns for outpatient services at the same facility, the code must remain the same.

3. **Admission date**: Enter the date on which the child was first admitted for inpatient medical rehabilitation or first enrolled in the outpatient program. The date must take the form MM/DD/YYYY, where MM is a two-digit code for the month (e.g., 01 for January, 12 for December), DD is the two-digit day of the month, and YYYY is the full year (e.g., 2016).

Case Information

4. **Program type**: Enter the type of program.
   - **Inpatient**: Includes any child whose hospitalization requires an overnight stay.
   - **Outpatient**: Includes all other types of programs that do not require hospitalization, such as outpatient therapy services, hospital-based clinical appointments, and day treatment programs.

5. **Admission class**: Enter the child’s admission classification, selected from the list below. Admission classes 1 to 6 are for inpatient only. Admission classes 7, 8, and 9 are for outpatient only. Admission class 10 may be used by both inpatient and outpatient settings.
   - **Initial rehab**: This is the child’s first admission to an inpatient rehabilitation program for this impairment.
   - **Surgical intervention**: Use this code when a child is admitted for evaluation and treatment in connection with a surgical intervention.
   - **Pharmacological/medical intervention**: Use this code when a child is admitted for evaluation and treatment while undergoing a pharmacological or medical intervention.
   - **Assistive/adaptive technology intervention**: Use this code when a child is admitted for evaluation and treatment related to assistive or adaptive technology.
   - **Education/training intervention**: Use this code when a child is admitted for evaluation and treatment related to parent/child education that enhances functioning at home or school.
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6 **Readmission:** Use this code when a child was previously admitted to an inpatient rehabilitation program for this impairment.

7 **Outpatient therapy services:** Use this code when a child is enrolled in a hospital-based or community-based outpatient therapy program from which the child receives therapy services on a routine basis (e.g., one to five times weekly or several times per month). Do **not** use this code if the child is seen only for periodic evaluation.

8 **OP clinic visits (no therapy):** Use this code when a child is followed for periodic evaluation in an outpatient setting, provided that ongoing provision of therapy services is not part of the clinic appointment (for example, if the child is followed once every six or twelve months in a cerebral palsy or spina bifida clinic, where the child receives a comprehensive evaluation by a physician, nurse, or therapist who administers the WeeFIM® instrument as part of the evaluation).

9 **Day treatment:** Use this code when a child is enrolled in an outpatient program that admits children with specific disabilities and that provides a team approach to comprehensive pediatric rehabilitation services (including nursing, a minimum of **two** therapeutic disciplines, and school reintegration). These services are provided two to five full days or half days per week. A physiatrist (or a physician of equivalent training or experience) serves as the physician of record.

10 **Unplanned discharge:** Use this code when a child is unexpectedly discharged within the first seventy-two hours of hospitalization or does not continue ongoing outpatient therapy after the third visit.

6. **Admitted to program from:** Enter the setting from which the child was admitted to the rehabilitation program.

1 **Home:** A private, community-based dwelling (e.g., house, apartment, mobile home) that houses the child, the child’s family, and the child’s relatives.

2 **Acute care unit of own facility:** An acute medical/surgical care unit in the same facility as the rehabilitation unit.

3 **Acute care unit of another facility:** An acute medical/surgical care unit located in a facility separate from the facility where rehabilitation services are provided.

4 **Rehabilitation facility:** An inpatient setting that admits children with specific disabilities and provides a team approach to comprehensive pediatric rehabilitation services. A physiatrist (or a physician of equivalent training or experience) serves as the physician of record.

5 **Residential facility:** A group home that provides attendants for supervision of residents who typically participate in daily tasks and are often free to come and go on a voluntary basis. This category also includes residential school-based settings that wholly or mainly serve children with special education needs and that offer twenty-four-hour nursing care and access to medical care on a daily basis.

6 **Transitional living center:** A community-based, supervised setting where individuals are taught skills so that they can live independently in the community.

7 **Skilled nursing facility:** A long-term care setting that provides skilled nursing services. A registered nurse is present twenty-four hours a day. Residents live by institutional rules, care is ordered by a physician, and a medical record is maintained.
8 **Shelter:** A community-based setting that provides emergency housing and other services for homeless individuals and families.

9 **Other:** Use this code only if no other code is appropriate.

**Patient Information**

7. **First name:** Enter the child’s first name.

8. **Middle initial:** Enter the child’s middle initial if the child has one.

9. **Last name:** Enter the child’s last name.

10. **Birth date:** Enter the date on which the child was born. The date must take the form MM/DD/YYYY, where MM is a two-digit code for the month (e.g., 01 for January, 12 for December), DD is the two-digit day of the month, and YYYY is the full year (e.g., 2016).

11. **Gestational age in weeks:** Enter the gestational age. The acceptable range is twenty to forty-five weeks. If the child is known to be full-term, enter 40.

12. **Social Security number:** Enter the child’s Social Security number. Verify the number with the child’s parents or your facility’s business office.

13. **Gender:** Enter the child’s gender.
   1. Male
   2. Female

14. **Ethnicity:** Enter the child’s ethnicity.
   1. White
   2. Black/African-American
   3. Hispanic
   4. Native American
   5. Asian
   6. Other
   7. Multiracial

15. **Primary language:** Enter the child’s primary language.
   1. English
   2. Spanish
   3. French
   4. Other

**Patient Contact Information**

Use items 16–22 to enter contact information for the child. Use item 17, Street 2, if you need more room than that provided for item 16, Street 1.

16. **Street 1**

17. **Street 2**
18. City
19. State
20. ZIP code
21. Country
22. Telephone number

Medical Information

23. Impairment group: The impairment group codes (IGCs) were developed in the mid-1980s as part of the Uniform Data Set for the purpose of comparing inpatient rehabilitation outcomes using the FIM® instrument. When the WeeFIM® instrument was created in 1987, a committee of physiatrists (adult and pediatric) and developmental pediatricians was charged with the task of adapting the IGCs for use in pediatric inpatient and outpatient settings. They retained the original sixteen impairment groupings but greatly expanded the range of subcategories for developmental disabilities and neurological conditions. To facilitate the reporting of aggregate data, the impairment groups were reduced to nine over time but were later expanded to fourteen.

IGCs still aim to classify patients uniformly according to the principal diagnostic categories of the conditions that require admission to the inpatient or outpatient program. Proper assignment of patients within the impairment coding system is a requisite for making fair comparisons of the outcomes of care.

The full list of impairment group codes begins on page 21. Select from the impairment group list the code that best describes the primary reason for admission to the inpatient or outpatient program. Each IGC consists of a two-digit number, which indicates the major impairment category; a decimal point; and one to four additional digits that identify the specific code.

*Code as specifically as possible.* When possible, avoid the use of codes from category 14, Other disabling impairments. An exception is made for code 14.3, Wound care.

24. Date of onset: Enter the onset date of the impairment that was coded in item 23, Impairment group, and for which the child was admitted to the rehabilitation program. The date must take the form MM/DD/YYYY, where MM is a two-digit code for the month (e.g., 01 for January, 12 for December), DD is the two-digit day of the month, and YYYY is the full year (e.g., 2016). If a condition has an insidious onset, or if the exact date of onset is unknown for some reason, follow these guidelines to determine an onset date:

- a. If the year and month are known but the exact day is not, use the first day of the month.
- b. If the year is known but the exact month is not, use January 1 of that year.
- c. If the year is an approximation, use January 1 of the approximate year.

Instructions for coding date of onset for major impairment groups begin on page 26.

25. Etiologic diagnosis: Enter the ICD code for the etiologic problem that led to the condition for which the child is receiving rehabilitation. Consult ICD coding books for exact codes.

26. Other diagnoses: Enter up to six additional ICD codes that identify the most severe or significant impairments that currently affect the child. Consult ICD coding books for exact codes.
Payer Information

27. **Payment source:** Enter the source of payment for rehabilitation program charges. Enter the appropriate category for both primary and secondary sources of payment. Use code 21, Other, to enter specific payer sources not already included in the list. Enter the payer source on the line provided on the WeeFIM II® Case Coding Form. Use code 22, None, only as a secondary payer source.

a. Primary source
   - 01 Medicaid non-MCO
   - 02 Medicaid Waiver Program (non-MCO)
   - 03 Medicaid MCO
   - 04 Medicaid Waiver Program (MCO)
   - 05 MCO HMO
   - 06 Commercial insurance/PPO
   - 07 Medicare
   - 08 SSI
   - 09 State Education Department
   - 10 State Vocational Rehabilitation
   - 11 Developmental Disabilities Service
   - 12 Crippled Children’s Services
   - 13 State Health Department/Department of Human Services
   - 14 Children’s Health Insurance Program
   - 15 Workers’ Compensation
   - 16 TRICARE
   - 17 Private pay
   - 18 Unreimbursed care
   - 19 No-fault auto insurance
   - 20 Government program (non-U.S.)
   - 21 Other

b. Secondary source
   - As above, plus:
   - 22 None

Referral Information

28. **Referring facility:** Enter the name of the facility that referred the child to the rehabilitation program.
29. **Referring physician:** Enter the name of the physician who referred the child to the rehabilitation program.

30. **Referring ZIP code:** Enter the ZIP code or postal code of the referring facility or physician.

31. **Referring medical service:** Enter the code for the medical specialty that referred the child to the rehabilitation program.
   1. Neonatology
   2. Pediatrics
   3. Family medicine
   4. Orthopaedics
   5. Surgery
   6. Neurology
   7. Neurosurgery
   8. Physiatry
   9. Cardiology
   10. Pulmonology
   11. Hematology/oncology
   12. Genetics
   13. Rheumatology
   14. Other

**Discharge Information**

32. **Discharge date:** Enter the date the child is discharged from the rehabilitation program. The date must take the form MM/DD/YYYY, where MM is a two-digit code for the month (e.g., 01 for January, 12 for December), DD is the two-digit day of the month, and YYYY is the full year (e.g., 2016).

33. **Program interruptions:** Enter the code that indicates whether the child’s stay included one or more program interruptions.
   1. Yes
   2. No

A program interruption occurs when a child is transferred to another medical service during the rehabilitation program. This item is appropriate for children in rehabilitation units that are part of larger acute care medical facilities and for children in freestanding rehabilitation facilities that transfer children to acute care hospitals.

A child who transfers from the rehabilitation program and returns within thirty days for treatment of the same impairment is considered to have had one rehabilitation hospitalization with a program interruption. If a child is discharged from the rehabilitation program and returns after thirty days for treatment of the same impairment, code this new hospitalization as a readmission. If a child is admitted for treatment of a different impairment, regardless of the amount of time since the child was transferred or discharged, consider the child’s return
to rehabilitation as a new hospitalization rather than a program interruption. (Code this new hospitalization as initial rehab.)

Use the space provided to enter the start date, the end date, and the ICD code that represents the reason for transfer for each program interruption.

A decision tree for coding program interruptions is provided on page 29.

Resource Utilization

Use items 34 and 35 to track resource utilization at your facility. In the column marked “Month/Year,” enter each month and year in which the child receives direct services. A direct unit of service is defined as fifteen minutes of therapy or other billable services. Do not account for any time that is spent in such care-related activities as team meetings, patient care conferences, fabricating assistive/adaptive devices, preparing documentation, etc. These services are considered indirect services; they are generally not viewed as billable time.

The date must take the form MM/YYYY, where MM is a two-digit code for the month (e.g., 01 for January, 12 for December) and YYYY is the full year (e.g., 2016). Enter the total number of direct, fifteen-minute units of service in the appropriate column for occupational therapy, physical therapy, and speech/language pathology.

Enter whole numbers only. Round partial units of service up to the next whole number. For example, 60 minutes of direct physical therapy is equal to four units of service, while 350 minutes of direct physical therapy qualifies as twenty-four units of service.

Item 34 and item 35 contain two additional fields: “Other (1)” and “Other (2).” You can use these fields to record units of service for two other disciplines of your own choosing. You can use the blank lines provided on the WeeFIM II® Case Coding Form to label the fields for internal use. You can also rename these “other” fields in the WeeFIM II® software so that you can display the names of the specific disciplines that you are tracking. Refer to the online Help files for instructions.

34. Internal resources: Internal resources are those resources consumed by your facility to provide direct care to each child admitted to the rehabilitation program. Use this field to track internal resource utilization by accounting only for the number of direct (billable) units of service that are provided to the child in a given month. A direct unit of service is defined as fifteen minutes of therapy or other billable services. Do not account for any time that is spent in such care-related activities as team meetings, patient care conferences, fabricating assistive/adaptive devices, preparing documentation, etc. These services are considered indirect services; they are generally not viewed as billable time.

35. External resources: External resources are resources consumed by outside providers, such as school-based therapy programs and home-based therapy services. Facilities that follow children in outpatient clinics for evaluation only (i.e., without providing therapy services) may use this field to track external resource utilization by accounting for only the number of direct (billable) units of service that are provided to the child in a given month.

Surgeries

36. Surgeries: Enter the date of each surgical procedure that the child has undergone since the last relevant date, as determined by the categories below. For each procedure, enter an appropriate ICD procedure code in the Surgery Code column. Consult ICD coding books for
exact codes. For your convenience, this item contains optional fields for tracking procedural codes (CPTs).

**Inpatient visits and first outpatient visit:** Enter the date of each surgical procedure that has occurred since the onset of this impairment.

**Subsequent outpatient visits:** Enter the date of each surgical procedure since the last outpatient visit.

**Custom Information**

37. **Custom fields:** You can use these user-defined fields to collect additional case-level information of particular importance to your facility, such as the hospital specialty clinics that follow the child, medications the child takes, emergency contact information, etc.

The WeeFIM II® Case Coding Form includes ten custom fields, but you can access a nearly limitless number of custom fields through the WeeFIM II® software. For information about using these fields, refer to the online Help files.
Impairment Group Codes

**Stroke (01)**

**Category 01, Stroke,** includes cases with a diagnosis of cerebral ischemia due to vascular thrombosis, embolism, or hemorrhage.

Cases with brain dysfunction secondary to nonvascular causes (e.g., trauma, inflammation, tumor, degenerative changes) are part of category 02.2, Traumatic brain dysfunction. Strokes from sickle-cell disease are part of category 01, Stroke.

01.1  Left body involvement, right brain
01.2  Right body involvement, left brain
01.3  Bilateral involvement
01.4  No paresis
01.9  Other stroke

**Brain Dysfunction (02)**

**Code 02.1, Nontraumatic brain dysfunction,** includes cases with such etiologies as encephalitis, inflammation, anoxia, metabolic toxicity, degenerative processes, and neoplasm (including metastases).

**Category 02.2, Traumatic brain dysfunction,** includes cases with motor or cognitive disorders secondary to brain trauma.

02.1 Nontraumatic
02.2*  **Traumatic (blow to head)**
02.21  Open injury
02.22  Closed injury
02.9  Unspecified nontraumatic brain injury

Cases with hemorrhagic stroke are part of category 01, Stroke, and should be coded under that category.

**Neurological Disorders (03)**

**Category 03, Neurological disorders,** includes cases with neurological and neuromuscular dysfunctions of various etiologies.

03.1 Multiple sclerosis
03.3 Neuropathies
03.4 Guillain-Barré syndrome
03.5*  **Cerebral palsy**
03.51  Diplegic cerebral palsy
03.52  Hemiplegic cerebral palsy
03.53  Quadriplegic cerebral palsy
03.54  Cerebral palsy with surgery¹
03.55  Other cerebral palsy
03.8  Neuromuscular disorders
03.9  Other neurological disorders

¹ This code includes children with cerebral palsy who underwent surgery directly related to the cerebral palsy deficits (e.g., rhizotomy surgery, tendon lengthening, tendon transfer).
Section II: Coding the Data Set

Spinal Cord Dysfunction (04)

Category 04, Spinal cord dysfunction, includes cases with various forms of quadriplegia/paresis and paraplegia/paresis, regardless of the etiology (whether traumatic, medical, or postoperative).

Category 04.1, Nontraumatic spinal cord dysfunction, includes cases with paraplegia or quadriplegia secondary to nontraumatic causes, including postoperative change.

Category 04.2, Traumatic spinal cord dysfunction, includes cases with paraplegia or quadriplegia secondary to traumatic causes.

04.1* Nontraumatic spinal cord dysfunction
04.110 Paraplegia, unspecified
04.111 Paraplegia, incomplete
04.112 Paraplegia, complete
04.120 Quadriplegia, unspecified
04.1211 Quadriplegia, incomplete C1–C4
04.1212 Quadriplegia, incomplete C5–C8
04.1221 Quadriplegia, complete C1–C4
04.1222 Quadriplegia, complete C5–C8
04.130 Other nontraumatic spinal cord dysfunction

04.2* Traumatic spinal cord dysfunction
04.210 Paraplegia, unspecified
04.211 Paraplegia, incomplete
04.212 Paraplegia, complete
04.220 Quadriplegia, unspecified
04.2211 Quadriplegia, incomplete C1–C4
04.2212 Quadriplegia, incomplete C5–C8
04.2221 Quadriplegia, complete C1–C4
04.2222 Quadriplegia, complete C5–C8
04.230 Other traumatic spinal cord dysfunction

Amputations (05)

Category 05, Amputations, includes cases in which cases in which the major deficit is partial or complete absence of a limb.

05.1 Unilateral upper extremity above the elbow (AE)
05.2 Unilateral upper extremity below the elbow (BE)
05.3 Unilateral lower extremity above the knee (AK)
05.4 Unilateral lower extremity below the knee (BK)
05.5 Bilateral lower extremity above the knee (AK/AK)
05.6 Bilateral lower extremity above/below the knee (AK/BK)
05.7 Bilateral lower extremity below the knee (BK/BK)
05.9 Other limb amputation
Arthritis (06)
Category 06, Arthritis, includes cases in which the major disorder is arthritis of all etiologies.
06.1 Juvenile rheumatoid arthritis
06.2 Connective tissue disorders
06.9 Other arthritis

Pain Syndromes (07)
Category 07, Pain syndromes, includes cases in which the major disorder is pain of various etiologies, unaccompanied by a neurological deficit.
07.1 Neck pain
07.2 Back pain
07.3 Extremity pain
07.9 Other pain

Orthopaedic Conditions (08)
Category 08, Orthopaedic conditions, includes cases in which the major disorder is postfracture of bone or postarthroplasty.
08.11 Status post unilateral hip fracture
08.2 Status post femur (shaft) fracture
08.3 Status post pelvic fracture
08.4 Status post major multiple fractures
08.51 Status post hip replacement(s) or reconstruction(s)
08.61 Status post knee replacement(s) or reconstruction(s)
08.8 Status post scoliosis surgery
08.9 Other orthopaedic conditions

Cardiac Disorders (09)
Code 09, Cardiac disorders, includes cases in which the major disorder is either poor activity tolerance secondary to cardiac insufficiency or general deconditioning due to a cardiac disorder.
09 Cardiac

Pulmonary Disorders (10)
Category 10, Pulmonary disorders, includes cases in which the major disorder is poor activity tolerance secondary to pulmonary insufficiency.
10.1 Bronchopulmonary dysplasia (BPD)
10.9 Other pulmonary disorders

Burns (11)
Code 11, Burns, includes cases in which the major disorder is thermal injury to major areas of the skin, underlying tissue, or both.
11 Burns

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2 This code includes systemic lupus erythematosus, scleroderma, and polymyositis.
Congenital Disorders (12)

Category 12, Congenital disorders, includes cases in which the major disorder is an anomaly or deformity of the nervous or musculoskeletal system that is associated with prenatal, perinatal, or postnatal causes.

12.1 Spina bifida
12.2 Congenital neuromuscular disorders
12.9 Other congenital disorders

Other Disabling Impairments (13)

Code 13, Other disabling impairments, includes cases that cannot be classified into a specific impairment group. Use of this code should be rare.

13 Other disabling impairments

Major Multiple Trauma (14)

Category 14, Major multiple trauma, includes cases that require more complex management due to the involvement of multiple systems or sites. Record the ICD code for the primary trauma in item 25, Etiologic diagnosis, and the ICD codes for secondary traumas in item 26, Other diagnoses.

14.1 Brain and spinal cord injury
14.2 Brain and multiple fractures/amputation
14.3 Spinal cord and multiple fractures/amputation
14.9 Other multiple trauma

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3 This code includes muscular dystrophy, other congenital neuromuscular disorders, etc.
4 This code includes cases in which the major disorder is a spinal cord disorder characterized by muscle weakness at or above the lesion, paralysis below the lesion, hydrocephalus, Arnold-Chiara malformation, kyphosis, dislocated hips, or a combination of these characteristics.
Developmental Disabilities (15)

Category 15, Developmental disabilities, includes cases in which the major disorder is a specific delay in development attributable to a physical impairment, a mental impairment, or a combination thereof.

15.1* Disorders of motor control
15.11 Without minimal cerebral dysfunction
15.12 With minimal cerebral dysfunction
15.13 Disorders of motor coordination
15.14 Disorders of praxis
15.16 Other motor delay

15.2* Developmental speech and language disorders
15.21 Expressive language delay
15.22 Receptive language delay
15.23 Receptive and expressive language delay
15.24 Motor speech delay (articulation disorder or apraxia of speech)

15.3* Developmental delay
15.31 Developmental delay
15.32 Other developmental disability

15.4* Disorders of attention, socialization, and behavior
15.41 Attention deficit disorder with hyperactivity
15.42 Attention deficit disorder without hyperactivity
15.43 Autistic spectrum disorder
15.44 Pervasive developmental disorder
15.45 Other behavioral disorders

15.5* Genetic disorders
15.51 Down’s syndrome (trisomy 21 or 22)
15.52 Other genetic disorders

Debility (16)

Code 16, Debility, includes cases with generalized deconditioning not attributable to another impairment group code. Do not use this code for cases with debility secondary to cardiac conditions or pulmonary conditions.

16 Debility

Failure to Thrive/Malnutrition (17)

Code 17, Failure to thrive/malnutrition, includes cases in which the focus of rehabilitation is feeding disorders, including behavioral feeding disorders.

17 Failure to thrive/malnutrition
Section II: Coding the Data Set

Instructions for Coding Date of Onset for Each Impairment Group

Date of onset is intended to reflect the duration of a problem prior to the child’s entry into the rehabilitation program. The date of onset for traumatic disorders and most medical conditions can be determined fairly easily, but the onset is not so readily distinguishable for other disorders, including cerebral palsy, muscular dystrophy, asthma, and BPD. Use the guidelines in this section to determine the date of onset.

**Stroke**\(^5\)

Date of admission to acute hospital. If this is not the child’s first stroke, enter the date of the most recent stroke.

**Brain Dysfunction**

Nontraumatic

  More recent date: date of surgery (e.g., removal of brain tumor) or date of diagnosis

Traumatic

  Date of injury

**Neurological Disorders**

Multiple sclerosis

  Date of exacerbation

All other neurological disorders

  Date of diagnosis

**Spinal Cord Dysfunction**

Nontraumatic

  More recent date: date of surgery (e.g., tumor) or date of diagnosis

Traumatic

  Date of injury

**Orthopaedic Conditions and Amputations**

Orthopaedic

  Fractures

    Date of fracture

Replacement / status post-scoliosis surgery

  Date of surgery

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\(^5\) If the child was not admitted to an acute hospital before being admitted to the inpatient rehabilitation program, record the date of onset as the date of diagnosis of the impairment that led to the admission to the rehabilitation program.
Osteochondropathies  
  Date of surgery  

Amputations  
  Date of amputation  

**Major Multiple Trauma**  
Date of trauma  

**Burns, Arthritis, and Pain Syndromes**  
Burns  
  Date of burn or burns  
Arthritis  
  Date of diagnosis (if arthroplasty, see “Orthopaedic Conditions and Amputations” on page 26)  
Pain syndromes  
  Date of onset related to cause (e.g., fall, injury)  

**Cardiac and Pulmonary Disorders**  
Cardiac  
  More recent date: date of diagnosis (event) or date of cardiac surgery  
Pulmonary  
  Bronchopulmonary dysplasia (BPD), asthma, cystic fibrosis  
    Date of initial diagnosis (not exacerbation)  
  Tracheostomy  
    Date of surgery  
  Ventilatory dependence  
    Date of diagnosis  
    Extracorporeal membrane oxygenation (ECMO)  
    Date of diagnosis  

**Developmental Disabilities**  
Date of birth  

**Cerebral Palsy**  
Date of diagnosis  

**Spina Bifida**  
Date of birth
Section II: Coding the Data Set

**Congenital Disorders**
Brachial plexus injury and torticollis  
   Date of birth or date of injury
All other congenital disorders  
   Date of birth

**Childhood Disorders with High Risk for Disabilities**
Prematurity/low birth weight  
   Date of birth
Small for gestational age  
   Date of birth
Failure to thrive/malnutrition  
   Date of diagnosis
Lead poisoning  
   Date of diagnosis
Chronic health conditions (sickle cell disease, diabetes, renal disorders, and gastrointestinal disorders)  
   Date of diagnosis
Immune deficiency disorders  
   Genetic  
      Date of birth
   Acquired  
      Date of diagnosis
Neoplasms  
   Date of admission to acute hospital
Transplants  
   Date of surgery

**Other Disabling Impairments**
Gastrostomy tube feedings  
   Date of admission to acute care
Intravenous feedings  
   Date of admission to acute care
Wound care  
   Date of admission to acute care
Program Interruptions Decision Tree

START

Does the child leave rehab?

NO

NOT AN INTERRUPTION, NOT A DISCHARGE

YES

Is the child discharged against medical advice (AMA)?

YES

DISCHARGE

NO

Is the child discharged to an acute care unit (of own facility or another facility)?

NO

DISCHARGE

YES

Does the child return within 30 days?

NO

DISCHARGE

YES

Does the child return with a new impairment?

NO

INTERUPTION (RECORD START AND END DATES AND THEN CONTINUE WITH ORIGINAL CASE CODING FORM)

YES

INITIAL ADMISSION ON A NEW CASE CODING FORM

Figure 1. WeeFIM II® Decision Tree for Program Interruptions
**WeeFIM II® Assessment Coding Form Instructions**

Throughout this document, the term *rehabilitation program* is used to identify all inpatient programs, outpatient services, day treatment programs, and habilitation programs. Unless otherwise specified, the terms *outpatient*, *outpatient program*, and *outpatient services* include day treatment programs.

**Case Identification**

1. **Facility code:** Enter the confidential facility code assigned to your facility by UDSMr.

2. **Patient code:** Enter a unique code (maximum of ten alphanumeric characters) that identifies the child. The code can be used to track the child’s progress from inpatient rehabilitation through outpatient rehabilitation.

   **Inpatient:** The code must remain the same for each hospitalization and follow-up.

   **Outpatient:** The code must remain the same for each visit by this child. If follow-up is conducted after the child is discharged from an outpatient program, the code must remain the same. If the child is discharged from an inpatient program and returns for outpatient services at the same facility, the code must remain the same.

3. **Admission date:** Enter the date on which the child was first admitted for inpatient medical rehabilitation or first enrolled in the outpatient program. The date must take the form MM/DD/YYYY, where MM is a two-digit code for the month (e.g., 01 for January, 12 for December), DD is the two-digit day of the month, and YYYY is the full year (e.g., 2016).

**Assessment Information**

4. **Assessment type:** Enter the appropriate code for the type of assessment that is being completed.

   0 **Preadmission:** A baseline assessment that reflects the child’s status prior to admission to the rehabilitation program.

   1 **Admission:** The first assessment completed after the child enters the rehabilitation program.

      **Inpatient:** The first assessment must be completed within seventy-two hours of admission to the inpatient rehabilitation program.

      **Outpatient:** The first assessment must be completed upon enrollment in (i.e., upon the first visit to) the outpatient program.

   2 **Interim:** Any assessment completed after the admission assessment and prior to the discharge assessment. Each facility determines how frequently to conduct interim assessments, but UDSMr recommends conducting them on a regular schedule (e.g., quarterly, every six months, annually) for children who receive ongoing outpatient therapy services for an extended period of time.

   3 **Discharge:** The last assessment completed prior to the child’s discharge from the rehabilitation program.

      **Inpatient:** The last assessment completed (1) within seventy-two hours prior to discharge from the program (not from therapy) or (2) on the last day prior to a program interruption of more than thirty days.
Outpatient: The last assessment completed before the child is discharged from the program.

4 Follow-up: An assessment completed 80–180 days after discharge from an inpatient rehabilitation program or a day treatment program.

5. Assessment date: Enter the date of the assessment. The date must take the form MM/DD/YYYY, where MM is a two-digit code for the month (e.g., 01 for January, 12 for December), DD is the two-digit day of the month, and YYYY is the full year (e.g., 2016).

6. Information source: Enter the information source for inpatient follow-up assessments and outpatient assessments (all types) only. For other assessments, leave this item blank.
   1 Staff
   2 Parent
   3 Caregiver
   4 Patient
   5 Other

7. Assessment method: Enter the method of obtaining information that has been collected by rehabilitation professionals trained in the use of the WeeFIM® instrument. Enter an assessment method for inpatient follow-up assessments and outpatient assessments (all types) only. For other assessments, leave this item blank.
   1 In person
   2 Telephone
   3 Mailed questionnaire
   4 Unable to reach

8. Living setting: Enter the child’s living setting, as determined by the categories below.

   Inpatient (admission and interim): The setting where the child was living prior to hospitalization.

   Inpatient (discharge): The setting to which the child will be discharged.

   Inpatient (follow-up): The setting where the child is currently living.

   Outpatient (all types): The setting where the child is currently living.

   1 Home: A private, community-based dwelling (e.g., house, apartment, mobile home) that houses the child, the child’s family, and the child’s relatives.

   2 Acute care unit of own facility: An acute medical/surgical care unit in the same facility as the rehabilitation unit.

   3 Acute care unit of another facility: An acute medical/surgical care unit located in a facility separate from the facility where rehabilitation services are provided.

   4 Rehabilitation facility: An inpatient setting that admits children with specific disabilities and provides a team approach to comprehensive pediatric rehabilitation services. A physiatrist (or a physician of equivalent training or experience) serves as the physician of record.
Section II: Coding the Data Set

5 **Residential facility:** A group home that provides attendants for supervision of residents who typically participate in daily tasks and are often free to come and go on a voluntary basis. This category also includes residential school-based settings that wholly or mainly serve children with special education needs and that offer twenty-four-hour nursing care and access to medical care on a daily basis.

6 **Transitional living center:** A community-based, supervised setting where individuals are taught skills so that they can live independently in the community.

7 **Skilled nursing facility:** A long-term care setting that provides skilled nursing services. A registered nurse is present twenty-four hours a day. Residents live by institutional rules, care is ordered by a physician, and a medical record is maintained.

8 **Shelter:** A community-based setting that provides emergency housing and other services for homeless individuals and families.

9 **Other:** Use this code only if no other code is appropriate.

10 **Died:** Use this code if the child has expired.

9. **Living with:** Complete this item only if you recorded code 1 for item 8, Living setting.

   **Inpatient (admission and interim):** The relationship of the individuals the child resided with prior to hospitalization.

   **Inpatient (discharge):** The relationship of the individuals the child will reside with after discharge.

   **Inpatient (follow-up):** The relationship of the individuals the child currently resides with.

   **Outpatient (all types):** The relationship of the individuals the child currently resides with.

   1 Two parents
   2 One parent
   3 Relatives
   4 Foster care
   5 Other

10. **Educational category:** Record the child’s educational level, as determined by the categories below. When recording this item, consider both certified educational programs and structured home-teaching programs.

   **Inpatient (admission and interim):** The child’s educational category prior to hospitalization.

   **Inpatient (discharge):** The child’s educational category at discharge.

   **Inpatient (follow-up):** The child’s current educational category.

   **Outpatient (all types):** The child’s current educational category.

   1 Not a student
   2 Early intervention program
   3 Preschool
4 Kindergarten–12
5 Other

11. **Educational setting:** Complete this item only if you recorded code 2, 3, or 4 in item 10, Educational category. Enter the type of school program (early intervention, preschool, or school) in which the child was or is enrolled, as determined by the categories below.

**Inpatient (admission and interim):** The type of school program the child was enrolled in prior to hospitalization.

**Inpatient (discharge):** The type of school program the child will be enrolled in after discharge.

**Inpatient (follow-up):** The type of school program the child is currently enrolled in.

**Outpatient (all types):** The type of school program the child is currently enrolled in.

1 Regular class
2 Regular class with accommodation
3 Special class
4 Home-based or home-schooled
5 Daycare, nursery, center-based, or community

12. **Health maintenance:** Enter the person primarily responsible for performing routine personal care and managing the personal environment (whether at home or in the institution) for the child. Record code 1 if the child performs routine personal care and manages his personal environment without assistance from a helper. Record this item for inpatient follow-up assessments and outpatient assessments (all types) only. For other assessments, leave this item blank.

1 Own care
2 Unpaid person or family
3 Paid attendant or aide
4 Paid skilled professional

13. **Therapy:** Enter the setting for any paid professional therapy received by the child outside of the rehabilitation program, as determined by the categories below. Record this item for inpatient admission assessments, inpatient follow-up assessments, and outpatient assessments (all types) only. For other assessments, leave this item blank.

**Inpatient (admission):** The setting for any paid professional therapy the child received prior to hospitalization.

**Inpatient (follow-up):** The setting for any paid professional therapy the child currently receives.

**Outpatient (admission):** The setting for any paid professional therapy the child received prior to enrolling in the outpatient program.
Outpatient (interim and discharge): The setting for any paid professional therapy the child currently receives.
1. None
2. Outpatient
3. Home-based paid professional therapy
4. Both 2 and 3
5. Inpatient hospital
6. Day treatment
7. School-based
8. Other

14. **Therapy services**: Enter the type of paid professional therapy the child received outside of the rehabilitation program, as determined by the categories below. Record this item for inpatient admission assessments, inpatient follow-up assessments, and outpatient assessments (all types) only. For other assessments, leave this item blank.

   **Inpatient (admission)**: The type of paid professional therapy the child received prior to hospitalization.
   **Inpatient (follow-up)**: The type of paid professional therapy the child currently receives.
   **Outpatient (admission)**: The type of paid professional therapy the child received prior to enrolling in the outpatient program.
   **Outpatient (interim and discharge)**: The type of paid professional therapy the child currently receives.
   1. None
   2. Physical therapy
   3. Occupational therapy
   4. Speech therapy
   5. Physical and occupational therapy
   6. Physical, occupational, and speech therapy
   7. Other combination

15. **Gait training equipment**: Choose the piece of gait training equipment the child uses most frequently. Your facility’s choices of gait training equipment are established in the WeeFIM II® software. Refer to the online Help files for instructions.

16. **Communication devices**: Choose the communication device the child uses most frequently. Your facility’s choices of communication devices are established in the WeeFIM II® software. Refer to the online Help files for instructions.

**Custom Information**
You can use these user-defined fields to collect additional assessment-level information of particular importance to your facility, such as the frequency of services provided by each
discipline, individual versus group therapy services, the names of therapists who provide treatment to the child, unique groups of patients for in-house or custom reporting needs, etc.

The WeeFIM II® Assessment Coding Form provides five custom fields, but you can access a nearly limitless number of custom fields through the WeeFIM II® software. For information about using these fields, refer to the online Help files.

17. **WeeFIM® instrument**: Refer to the item descriptions, which begin on page 46, for instructions.
WeeFIM II® Family-Centered Feedback Form Instructions

The items on the WeeFIM II® Family-Centered Feedback Form should be completed at the time of discharge from inpatient rehabilitation and day treatment programs and again at follow-up 80–180 days after discharge. The frequency of administration of this form in outpatient settings should be determined by the individual facility.

Case Identification

1. **Facility code:** Enter the confidential facility code assigned to your facility by UDSMR.

2. **Patient code:** Enter a unique code (maximum of ten alphanumeric characters) that identifies the child. The code can be used to track the child’s progress from inpatient rehabilitation through outpatient rehabilitation, day treatment services, or both.

   **Inpatient:** The code must remain the same for each hospitalization and follow-up.

   **Outpatient:** The code must remain the same for each outpatient visit by this child. If follow-up is conducted after the child is discharged from an outpatient program, the code must remain the same. If the child is discharged from an inpatient program and returns for outpatient services at the same facility, the code must remain the same.

3. **Admission date:** Enter the date on which the child was first admitted for inpatient medical rehabilitation or first enrolled in the outpatient program. The date should take the form MM/DD/YYYY, where MM is a two-digit code for the month (e.g., 01 for January, 12 for December), DD is the two-digit day of the month, and YYYY is the full year (e.g., 2016).

4. **Assessment date:** Enter the date of the assessment, as determined by the categories below. The date should take the form MM/DD/YYYY, where MM is a two-digit code for the month (e.g., 01 for January, 12 for December), DD is the two-digit day of the month, and YYYY is the full year (e.g., 2016).

   **Inpatient and day treatment:** The discharge assessment date.

   **All other outpatient:** An interim assessment date or the discharge assessment date.

Patient Information

5. **First name:** Enter the child’s first name.

6. **Middle initial:** Enter the child’s middle initial, if the child has one.

7. **Last name:** Enter the child’s last name.

Patient Contact Information

Use items 8–14 to record contact information for the child. Use item 9, Street 2, if you need more room than that provided for item 8, Street 1.

8. **Street 1**

9. **Street 2**

10. **City**

11. **State**

12. **ZIP code**
13. Country
14. Telephone number

**Completion Information**
Use item 15 to record the date on which the form was completed.

**Family-Centered Feedback**
Clinicians may administer the questions in items 16 and 17 in an interview format; alternatively, the Family-Centered Feedback section may be self-administered by the caregiver (or by the child if the child is considered old enough to answer appropriately). These items were adapted with permission as indicated on the WeeFIM II® Family-Centered Feedback Form.

**Return Contact Information**
Enter the facility mailing address in the space provided if the form will be taken out of the facility and returned by mail.
Section III: The WeeFIM® Instrument
Underlying Principles for Use of the WeeFIM® Instrument

The WeeFIM® instrument is designed for use with children ages six months to seven years. It can be used with children well over the age of seven as long as they exhibit delays in functional abilities below the age of seven. As originally constructed, the WeeFIM® instrument incorporates the same eighteen items the FIM® instrument does, but these items have been adapted to measure function within a developmental context. The WeeFIM® instrument is intended to help monitor children with disabilities as they grow into adults who function at a maximum level of independence. It includes a minimal number of items. It is not intended to incorporate all the activities that could possibly be measured, or that might need to be measured, for clinical purposes. Rather, the WeeFIM® instrument is a basic indicator of severity of disability that can be administered comparatively quickly. Therefore, the data that is generated by assessing large groups of children can be used to track changes in disability over the course of rehabilitation and in the analysis of rehabilitation outcomes.

The WeeFIM® instrument uses a seven-level ordinal scale to rate each WeeFIM® item. The scale represents major gradations from independence to dependence. It rates children on their performance of an activity by taking into account their need for assistance from a helper or a device. If help is needed, the scale quantifies that need. This need for assistance (burden of care) translates into the time and energy that another person must expend serving the dependent needs of a disabled child so that a certain quality of life can be achieved and maintained.

The WeeFIM® instrument is a measure of disability, not impairment. It is intended to measure what a child with a disability actually does, whatever the child’s diagnosis or impairment, not what the child ought to be able to do or might be able to do if circumstances were different. As an experienced clinician, you may be well aware that a depressed person could do many things he is not doing; nevertheless, you should assess what the person actually does. Note also that there is no provision to consider an item “not applicable.” All WeeFIM® items must be completed.

The WeeFIM® instrument is designed to be useful across disciplines; that is, a measure usable by any trained clinician, regardless of discipline. However, under a particular set of circumstances, some clinicians may have difficulty assessing certain activities. In these cases, a more appropriate clinician may participate in assessing a patient. If the staff members believe that only a speech pathologist can assess the communication items, that a nurse is more knowledgeable with respect to bowel and bladder management, that a physical therapist has the expertise to evaluate transfers, and that an occupational therapist should rate self-care and social cognition items, the assessment may be divided among them.

Read the definitions of the items carefully before beginning to use the WeeFIM® instrument. Commit to memory what each activity includes. Rate the child only with respect to the tasks described for a specific item. For example, when rating a child with regard to bowel and bladder management, do not consider whether the child can get to the toilet. That information will be obtained when you assess the items Locomotion: Walk, Wheelchair, Crawl and Transfers: Toilet. Similarly, preparation for Grooming does not include getting to the washbasin.

To be categorized at a given level, the child must complete either all the tasks included in the definition or only one of several tasks. If all must be completed, the series of tasks will be connected by the word “and” in the text of the definition. If only one must be completed, the series of tasks will be connected by the word “or.” For example, Grooming includes oral care,
hair grooming, washing the hands, and washing the face. Communication includes clear comprehension of either auditory or visual communication.

Implicit in each definition, and stated in many of them, is a concern that the child perform these activities with reasonable safety. With respect to level 6, ask yourself whether the child is at risk of injury when performing the task. As is true of all human endeavors, your judgment should take into account the balance between the risk of a child’s participating in some activities and a corresponding but different risk if the child does not.

Implicit in each definition is an understanding that, in order to be rated level 7, a child must perform the tasks safely, without a helper, and in a reasonable amount of time.

UDSMR actively solicits subscriber feedback. If you have suggestions for enhancements or encounter problems in rating specific items or in collecting data, call 716-817-7800 or send e-mail to info@udsmr.org.
**General Rating Guidelines for the WeeFIM® Instrument**

Each of the eighteen items that compose the WeeFIM® instrument is rated on a seven-level ordinal scale. The maximum rating of 7 on this scale represents complete independence, and the minimum rating of 1 represents total assistance. The total rating for all eighteen items can range from 18 to 126.

The following table shows when each type of assessment should be performed:

<table>
<thead>
<tr>
<th>Assessment Type</th>
<th>Inpatient or Day Treatment</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission</td>
<td>Within 72 hours after admission</td>
<td>During first visit</td>
</tr>
<tr>
<td>Discharge</td>
<td>Within 72 hours prior to discharge</td>
<td>Day of discharge or last visit prior to discharge</td>
</tr>
<tr>
<td>Follow-up</td>
<td>80–180 days(^6) after discharge</td>
<td>Voluntary(^7)</td>
</tr>
<tr>
<td>Interim</td>
<td>Any time during hospitalization or day treatment</td>
<td>Any time between admission/enrollment and discharge</td>
</tr>
</tbody>
</table>

*Table 1. Assessment guidelines*

- Record the rating that best describes the child’s level of function for each WeeFIM® item on the assessment coding form. Do not leave any WeeFIM® item blank, and do not enter “N/A” for any WeeFIM® item. If the child does not, will not, or cannot perform an activity, rate the child level 1 for that item. For example, a child who requires a bed bath should be rated level 1 for Transfers: Tub, Shower.

- If testing the child for an item would put the child at risk of injury, rate the child level 1 for that item.

- Clinicians should assess function by directly observing the child. When direct observation is not possible, assessments may be completed by interviewing parents or primary caregivers who are familiar with the child’s everyday activities.

- Record actual performance. Do **not** record a child’s capacity for performance.

- Differences in function may occur in different environments or at different times of the day. These differences may result in different ratings. In such cases, you should always record the lowest rating, which represents the most dependent level. Typically, these differences arise because (1) the child has not mastered the function, (2) the child is too tired to perform the function, or (3) the child lacks the motivation to perform the activity outside of a therapy setting. Team members may need to discuss the child’s performance to determine an appropriate rating.

- If a child requires an assistive or adaptive device to complete tasks related to an item, do not rate the child higher than level 6 for the item. Prostheses and orthoses are considered assistive/adaptive devices for an item if the child requires them to perform tasks related to the item.

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\(^6\) Follow-up assessments may be performed at any time, but only those within the 80–180 day window will be included in reports.

\(^7\) Follow-up reports for outpatient facilities are not available at this time.
• If there is some concern for the child’s safety but not enough to warrant the presence of a helper, rate the child level 6. If the concern for safety is great enough to warrant the presence of a helper and the helper does not have physical contact with the child, rate the child level 5.

• If the child requires assistance from a helper, do not rate the child higher than level 5.

• Setup of items needed to complete a task is uniformly rated level 5 for all items.

• If the child requires touching assistance from a helper, do not rate the child higher than level 4.

• If the child requires two helpers to perform tasks for an item, rate the child level 1 for that item.

• Check the most usual mode in the appropriate areas on the coding forms for the items Locomotion: Walk, Wheelchair, Crawl; Comprehension; and Expression.

• The mode of locomotion for Locomotion: Walk, Wheelchair, Crawl must be the same at admission and discharge. If the child changes modes from admission to discharge (usually from wheelchair to walking), record both admission modes and rate the item based on the more frequent mode of locomotion at discharge. Specific directions appear in the item descriptions for Locomotion: Walk, Wheelchair, Crawl on page 82.

• “Percentage of effort” can be measured in two ways. First, it may be used to describe the amount of effort the child expends to complete all activities for a given item; second, it may be used to measure the percentage of tasks the child performs without assistance. For example, Grooming has four tasks. Each task accounts for 25% of the total tasks for Grooming. If the child completes two of the four tasks without assistance and a helper completes the other two tasks with no effort from the child, the child has completed 50% of the tasks and should be rated level 3 for Grooming. If the child completes 50% of each of the four tasks and a helper provides the other 50% of the effort required to perform each task, the child has completed 50% of the tasks and should be rated level 3 for Grooming.
General Level Descriptions for the WeeFIM® Instrument

Each of the eighteen items that compose the WeeFIM® instrument is rated on a seven-level ordinal scale. The maximum rating of 7 on this scale represents complete independence, and the minimum rating of 1 represents total assistance. The level descriptions below provide a general overview of the ratings. See the item descriptions for specific guidelines. See the general guidelines regarding “percentage of effort.”

**No Helper:** The child performs all tasks without assistance from another person.

- **7 Complete Independence:** The child safely performs all the tasks described as making up the activity without assistance from a helper, within a reasonable amount of time, and without modification, assistive devices, or aids.

- **6 Modified Independence:** The child performs all tasks without assistance from a helper, and one or more of the following are true:
  - The child requires an assistive device or aid to perform the tasks.
  - The child requires a prosthesis or an orthosis that is necessary for performing the tasks.
  - The child takes more than a reasonable amount of time to perform the tasks.
  - There is a concern for the child’s safety when he performs the tasks.

**Helper:** The child requires another person (whether for supervision or physical assistance) to perform the tasks, or the child does not perform the tasks.

- **Modified Dependence:** The child performs 50% or more of the tasks.

- **5 Supervision/Setup:** The child performs all the tasks but requires either supervision (standby supervision, cues, or coaxing) without physical contact or setup assistance (e.g., setting up necessary items or helping to apply an assistive/adaptive device, a prosthesis, or an orthosis).

- **4 Minimal Assistance:** The child performs 75% or more of the tasks, requiring no more help than touching.

- **3 Moderate Assistance:** The child performs 50% to 74% of the tasks, requiring physical assistance beyond touching.

**Complete Dependence:** The child performs less than 50% of the tasks, requiring maximal or total assistance from a helper, or does not perform the activity.

- **2 Maximal Assistance:** The child performs 25% to 49% of the tasks.

- **1 Total Assistance:** One or more of the following are true:
  - The child performs less than 25% of the tasks (includes nonperformance of tasks).
  - The child requires assistance from two helpers to perform the tasks.
  - The activity does not occur.
Instructions for Using the WeeFIM II® Decision Trees

To use the WeeFIM II® Decision Trees, begin in the upper left corner. Answer the questions and follow the branches to the correct rating. Follow the YES path if you answer “yes” to any question; follow the NO path if you answer “no” to all questions. Behaviors and ratings above the dashed line indicate that NO HELPER is needed; behaviors and ratings below the dashed line indicate that a HELPER is needed.

The WeeFIM II® Decision Trees are intended to complement the WeeFIM® instrument item descriptions and should not be used as a substitute for them. Refer to the item descriptions, which begin on page 46, for rating specifics.
Generic WeeFIM II® Decision Tree

Does the child need help to perform tasks?

YES

NO

Does the child perform 50% or more of tasks?

YES

NO

Does the child perform less than 25% of tasks? Does the child require assistance from two helpers to perform tasks?

YES

NO

Does the child perform 75% or more of tasks, with a helper providing only incidental assistance?

YES

NO

Does the child need more time to perform tasks? Does the child need an assistive device to perform tasks? Is there a concern for safety when the child performs tasks?

YES

NO

LEVEL 7

COMPLETE INDEPENDENCE

LEVEL 6

MODIFIED INDEPENDENCE

LEVEL 5

SUPERVISION OR SETUP

LEVEL 4

MINIMAL ASSISTANCE

LEVEL 3

MODERATE ASSISTANCE

LEVEL 2

TOTAL ASSISTANCE

LEVEL 1

MAXIMAL ASSISTANCE

START

Figure 2. Generic WeeFIM II® Decision Tree
Eating

*Eating* includes the use of suitable utensils to bring food and liquid to the mouth, chewing and swallowing, once a meal has been presented in the customary manner on a table or tray.

**Rating guidelines:**

- Presenting a meal in the customary manner includes opening containers, cutting meat, buttering bread, and pouring liquids.
- When rating this item, do not consider the child’s use of a knife.
- If the child functions at different levels during the day (for example, level 5 in the morning and level 4 in the evening), record the **lower** rating.
- If the child has a feeding tube that is *not* used for hydration or nutrition and a helper flushes the tube to maintain patency, do **not** consider the feeding tube and the parenteral line when rating this item.

**No Helper:**

7 **Complete Independence:** The child safely performs all the eating tasks without assistance by eating from a dish, managing a variety of food consistencies, and drinking from a cup or glass after the meal is presented in the customary way on a table or tray. The child uses a spoon or fork to bring food to the mouth, where it is chewed and swallowed.

6 **Modified Independence:** The child performs all the eating tasks without assistance from a helper, and one or more of the following are true:

- The child requires an assistive/adaptive device (e.g., long straw, spork, plate guard) to eat.
- The child requires more than a reasonable amount of time to eat.
- The child requires modified food consistency, modified liquid consistency, or blenderized food.
- The child self-administers parenteral or gastrostomy feedings.
- There is a concern for the child’s safety when he eats.

**Helper:**

5 **Supervision/Setup:** The child performs all the eating tasks, and one or both of the following are true:

- The child requires supervision (standby supervision, cues, or coaxing) to eat.
- The child requires setup (including application of an orthosis or an assistive/adaptive device necessary for eating) to eat.

  Example: A helper applies a universal cuff, after which the child eats without assistance.

4 **Minimal Assistance:** The child performs 75% or more of the eating tasks.

  Example: The child eats most of each meal by himself and only requires a helper to feed him the last three or four bites.
Section III: The WeeFIM® Instrument

3 **Moderate Assistance:** The child performs 50% to 74% of the eating tasks.

Example: A helper scoops each bite of food onto a fork or spoon, after which the child brings the food to his mouth, chews the food, and swallows it.

2 **Maximal Assistance:** The child performs 25% to 49% of the eating tasks by eating solid food, finger feeding, or holding a bottle, but the child requires maximal assistance to do so.

Example: A helper scoops each bite of food and provides hand-over-hand assistance to the child.

Example: The child uses his fingers to feed himself crackers, cookies, and bite-size pieces of fruit, but a helper must feed him other foods.

1 **Total Assistance:** One or more of the following are true:

- The child performs less than 25% of the eating tasks (or none of them) by taking a bottle or breast-feeding within a reasonable amount of time, but the child requires total assistance to do so.

- The child does not eat or drink full meals by mouth, relying instead on other means of alimentation (e.g., parenteral feedings, gastrostomy feedings).

- The child requires assistance from two helpers to eat.

Example: The child takes three or four bites of each meal, and a helper feeds the remainder of each meal to the child.

Example: A helper performs 100% of the work necessary to feed the child.
Figure 3. WeeFIM II® Decision Tree for Item 17A, Eating
Grooming

Grooming includes oral care (brushing teeth); hair grooming (combing or brushing hair); washing, rinsing, and drying the hands; and washing, rinsing, and drying the face.

Rating guidelines:

- Grooming does not include flossing teeth, shampooing hair, or arranging hair in braids, ponytails, or other hairstyles.
- Grooming consists of four tasks. Each task is 25% of the total. If the child does not have hair, do not assess hair grooming. If the child does not have any teeth, do not assess oral care.
- Grooming includes obtaining articles necessary for grooming (e.g., toothbrush, towels, combs, brushes). It also includes initial setup (e.g., applying toothpaste to a toothbrush).

No Helper:

7 Complete Independence: The child safely performs all the grooming tasks without assistance from a helper and without a device.

6 Modified Independence: The child performs all the grooming tasks without assistance from a helper, and one or more of the following are true:

- The child requires an assistive/adaptive device (e.g., orthosis, prosthesis, wash mitt, adapted toothbrush, adapted comb, adapted brush).
- The child takes more than a reasonable amount of time to perform grooming tasks.
- There is a concern for the child’s safety when he performs grooming tasks.

Helper:

5 Supervision/Setup: The child performs all the grooming tasks but requires supervision (standby supervision, cues, or coaxing) or setup assistance (e.g., applying an orthosis necessary for grooming, setting out grooming supplies, assisting with such initial preparation as applying toothpaste to toothbrush).

Example: The child performs all grooming tasks, but a helper verbally sequences the steps in each task and sets a toothbrush where the child can easily reach it.

4 Minimal Assistance: The child performs 75% or more of the grooming tasks.

Example: The child requires minimal assistance with some of the tasks, but not necessarily all four tasks.

3 Moderate Assistance: The child performs 50% to 74% of the grooming tasks.

Example: The child performs two of the four tasks.

2 Maximal Assistance: The child performs 25% to 49% of the grooming tasks.

Example: The child requires maximal assistance to perform three of the four tasks.

1 Total Assistance: One or both of the following are true.

- The child performs less than 25% of the grooming tasks (or none of them).
- The child requires assistance from two helpers to perform the grooming tasks.
Does the child need help to perform grooming tasks?

---

No

---

Yes

---

Does the child take more time to perform grooming tasks? Does the child need an assistive device (e.g., adapted toothbrush or comb) to perform grooming tasks? Is there a concern for safety when the child performs grooming tasks?

---

No

---

Yes

---

LEVEL 7

COMPLETE INDEPENDENCE

---

LEVEL 6

MODIFIED INDEPENDENCE

---

NO HELPER

HELPER

---

NO

---

Yes

---

LEVEL 5

SUPERVISION OR SETUP

---

LEVEL 4

MINIMAL ASSISTANCE

---

LEVEL 3

MODERATE ASSISTANCE

---

LEVEL 2

TOTAL ASSISTANCE

---

LEVEL 1

MAXIMAL ASSISTANCE

---

Does the child perform 50% or more of grooming tasks?

---

Yes

---

No

---

Does the child perform less than 25% of grooming tasks? Does the child need assistance from two helpers to perform grooming tasks?

---

Yes

---

LEVEL 1

---

NO

---

LEVEL 2

TOTAL ASSISTANCE

---

Does the child perform 75% or more of grooming tasks, with a helper providing only incidental assistance (e.g., brushing the back teeth or drying one hand)?

---

Yes

---

LEVEL 4

MINIMAL ASSISTANCE

---

NO

---

LEVEL 3

MODERATE ASSISTANCE

---

Does the child perform 50% or more of grooming tasks?

---

Yes

---

No

---

Does the child perform 75% or more of grooming tasks, with a helper providing only incidental assistance (e.g., brushing the back teeth or drying one hand)?

---

Yes

---

LEVEL 5

SUPERVISION OR SETUP

---

NO

---

LEVEL 6

MODIFIED INDEPENDENCE

---

LEVEL 7

COMPLETE INDEPENDENCE

---

Does the child need a helper to be in the room but not physically help with grooming tasks? Does a helper give instructions, set out grooming equipment, or put toothpaste on a toothbrush? Does the child need help to put on an orthosis?

---

Yes

---

LEVEL 5

SUPERVISION OR SETUP

---

NO

---

LEVEL 4

MINIMAL ASSISTANCE

---

LEVEL 3

MODERATE ASSISTANCE

---

LEVEL 2

TOTAL ASSISTANCE

---

LEVEL 1

MAXIMAL ASSISTANCE

---

Does the child need help to perform grooming tasks?

---

Yes

---

No

---

Does the child take more time to perform grooming tasks? Does the child need an assistive device (e.g., adapted toothbrush or comb) to perform grooming tasks? Is there a concern for safety when the child performs grooming tasks?

---

Yes

---

LEVEL 7

COMPLETE INDEPENDENCE

---

NO

---

LEVEL 6

MODIFIED INDEPENDENCE

---

Does the child perform 50% or more of grooming tasks?

---

Yes

---

No

---

Does the child perform 75% or more of grooming tasks, with a helper providing only incidental assistance (e.g., brushing the back teeth or drying one hand)?

---

Yes

---

LEVEL 5

SUPERVISION OR SETUP

---

NO

---

LEVEL 4

MINIMAL ASSISTANCE

---

LEVEL 3

MODERATE ASSISTANCE

---

LEVEL 2

TOTAL ASSISTANCE

---

LEVEL 1

MAXIMAL ASSISTANCE

---

Does the child need help to perform grooming tasks?

---

Yes

---

No

---

Does the child take more time to perform grooming tasks? Does the child need an assistive device (e.g., adapted toothbrush or comb) to perform grooming tasks? Is there a concern for safety when the child performs grooming tasks?

---

Yes

---

LEVEL 7

COMPLETE INDEPENDENCE

---

NO

---

LEVEL 6

MODIFIED INDEPENDENCE

---

Does the child perform 50% or more of grooming tasks?

---

Yes

---

No

---

Does the child perform 75% or more of grooming tasks, with a helper providing only incidental assistance (e.g., brushing the back teeth or drying one hand)?

---

Yes

---

LEVEL 5

SUPERVISION OR SETUP

---

NO

---

LEVEL 4

MINIMAL ASSISTANCE

---

LEVEL 3

MODERATE ASSISTANCE

---

LEVEL 2

TOTAL ASSISTANCE

---

LEVEL 1

MAXIMAL ASSISTANCE

---

Figure 4. WeeFIM II® Decision Tree for Item 17B, Grooming
Bathing

Bathing includes washing, rinsing, and drying the body below the neck (excluding the back) in a tub, shower, or sponge/bed bath.

Rating guidelines:

- Bathing includes initial preparation, such as preparing water and setting out bathing supplies.
- To determine the rating for this item, divide the body into ten areas:
  1. Chest
  2. Left arm
  3. Right arm
  4. Abdomen
  5. Perineal area
  6. Buttocks
  7. Left upper leg
  8. Right upper leg
  9. Left lower leg (including foot)
  10. Right lower leg (including foot)
- Each area accounts for 10% of the total. Count the number of areas that the child bathes to identify the percentage of bathing effort. Use this number to help you determine the rating for Bathing.

  Example: A child who bathes (washes, rinses, and dries) only his chest and abdomen washes 20% of the total body area and should be rated level 1, Total Assistance.

- If the child is missing a limb that would normally be assessed for this item, do not count that limb in the total.

  Example: A child with a right leg amputation below the knee has only nine areas to bathe. Each area accounts for approximately 11% of the total.

- Prostheses and orthoses are considered adaptive/assistive devices if used to bathe.
- For more information regarding “percentage of effort,” see “General Rating Guidelines for the WeeFIM® Instrument” on page 41.

No Helper:

7 Complete Independence: The child safely bathes all ten areas without assistance from a helper and without a device.

6 Modified Independence: The child bathes all ten areas without assistance from a helper, and one or more of the following are true:

  - The child requires an assistive/adaptive device to bathe.
  - The child takes more than a reasonable amount of time to bathe.
  - There is a concern for the child’s safety when he bathes.
Helper:

5 **Supervision/Setup:** The child bathes all ten areas but requires supervision (standby supervision, cues, or coaxing) or setup assistance (e.g., applying an assistive/adaptive device, setting out bathing equipment, preparing water or washing materials).

Example: The child bathes all ten areas, but a helper verbally sequences the steps in each task, regulates the water temperature, and sets a washcloth where the child can easily reach it.

4 **Minimal Assistance:** The child performs 75% or more of the bathing tasks.

Example: The child bathes eight or nine areas without assistance or performs 75% or more of the effort required to bathe all ten areas.

3 **Moderate Assistance:** The child performs 50% to 74% of the bathing tasks.

Example: The child bathes five to seven areas without assistance or performs 50% to 74% of the effort required to bathe all ten areas.

2 **Maximal Assistance:** The child performs 25% to 49% of the bathing tasks.

Example: The child bathes three or four areas without assistance or performs 25% to 49% of the effort required to bathe all ten areas.

1 **Total Assistance:** One or both of the following are true:

- The child performs less than 25% of the bathing tasks (or none of them).
- The child requires assistance from two helpers to bathe.

Example: The child bathes only one or two areas without assistance or performs less than 25% of the effort required to bathe all ten areas.
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Figure 5. WeeFIM II® Decision Tree for Item 17C, Bathing
**Dressing: Upper Body**

*Dressing: Upper Body* includes dressing and undressing above the waist (including pullover garments or front-opening garments). This item also includes obtaining clothes from customary places (such as drawers and closets); managing buttons, zippers, and snaps as needed; and applying and removing prostheses and orthoses when applicable.

**Rating guidelines:**

- The child must wear clothing that is appropriate to wear in public.
- If the child applies a prosthesis or an orthosis that is **not** required as an assistive device to complete upper-body dressing tasks, rate the child level 7. If the child applies a prosthesis or an orthosis that **is** required as an assistive device to complete upper-body dressing tasks, rate the child level 6. If a helper applies a prosthesis or an orthosis that **is** required as an assistive device to complete upper-body dressing tasks, rate the child level 5.
- Jobst® garments and Ace® wraps are considered orthoses.

**No Helper:**

7  **Complete Independence:** The child safely performs all the upper-body dressing tasks without assistance from a helper and without a device.

For information regarding prostheses and orthoses, see “General Rating Guidelines for the WeeFIM® Instrument” on page 41.

6  **Modified Independence:** The child performs all upper-body dressing tasks without assistance from a helper, and one or more of the following are true:

- The child requires a special adaptive closure, such as an extra hook-and-loop fastener, to dress the upper body.
- The child requires an assistive device, such as a buttonhook or zipper pull, to dress the upper body.
- The child requires a prosthesis or an orthosis that is necessary for performing upper-body dressing tasks.
- The child takes more than a reasonable amount of time to perform upper-body dressing tasks.
- There is a concern for the child’s safety when he performs upper-body dressing tasks.

For information regarding prostheses and orthoses, see “General Rating Guidelines for the WeeFIM® Instrument” on page 41.

**Helper:**

5  **Supervision/Setup:** The child performs all the upper-body dressing tasks but requires supervision (standby supervision, cues, or coaxing) or setup assistance (e.g., applying an upper body or limb prosthesis/orthosis, applying an assistive/adaptive device, setting out clothes or specialized dressing equipment).

Example: The child puts on a pullover garment with cues from a helper to sequence the steps in the task.
4 **Minimal Assistance:** The child performs 75% or more of the upper-body dressing tasks.

Example: The child puts on a button-front shirt and removes the shirt without assistance. A helper manages the buttons.

3 **Moderate Assistance:** The child performs 50% to 74% of the upper-body dressing tasks.

Example: A helper pulls the left sleeve of a front-opening shirt up to the child’s shoulder and brings the shirt around the child’s back. The child reaches behind his back, inserts his right arm through the sleeve, and manages the buttons. The child unbuttons the shirt and removes it without assistance.

2 **Maximal Assistance:** The child performs 25% to 49% of the upper-body dressing tasks.

Example: A helper pulls a shirt over the child’s head and threads both of the child’s arms through the sleeves. The child pulls the shirt down to his waist. The helper takes one of the child’s arms out of a sleeve, after which the child removes the shirt without further assistance.

1 **Total Assistance:** One or more of the following are true:

- The child performs less than 25% of the upper-body dressing tasks (or none of them).
- The child wears only hospital gowns, nightgowns, or pajamas.
- The child requires assistance from two helpers to perform upper-body dressing tasks.
- The activity does not occur. (The child does not dress himself, and a helper does not dress the child.)
Figure 6. WeeFIM II® Decision Tree for Item 17D, Dressing—Upper Body
Dressing: Lower Body

_Dressing: Lower Body_ includes dressing and undressing from the waist down (including underpants, slacks, skirts, socks, and shoes). This item also includes obtaining clothes from customary places (such as drawers and closets); managing buttons, zippers, and snaps as needed; and applying and removing prostheses and orthoses when applicable.

**Rating guidelines:**

- The child must wear clothing that is appropriate to wear in public.
- If the child applies a prosthesis or an orthosis that is not required as an assistive device to complete lower-body dressing tasks, rate the child level 7. If the child applies a prosthesis or an orthosis that is required as an assistive device to complete lower-body dressing tasks, rate the child level 6. If a helper applies a prosthesis or an orthosis that is required as an assistive device to complete lower-body dressing tasks, rate the child level 5.
- _Jobst®_ stockings and lower body garments, _Ace®_ wraps, and antiembolic stockings are considered orthoses.
- Do not include tying shoes when rating this item.

**No Helper:**

**7 Complete Independence:** The child safely performs all the lower-body dressing tasks without assistance from a helper and without a device.

For information regarding prostheses and orthoses, see “General Rating Guidelines for the WeeFIM® Instrument” on page 41.

**6 Modified Independence:** The child performs all the lower-body dressing tasks without assistance from a helper, and one or more of the following are true:

- The child requires a special adaptive closure, such as an extra hook-and-loop fastener, to dress the lower body.
- The child requires an assistive device, such as a buttonhook or zipper pull, to dress the lower body.
- The child requires a prosthesis or an orthosis that is necessary for performing lower-body dressing tasks.
- The child takes more than a reasonable amount of time to perform lower-body dressing tasks.
- There is a concern for the child’s safety when he performs lower-body dressing tasks.

For information regarding prostheses and orthoses, see “General Rating Guidelines for the WeeFIM® Instrument” on page 41.

**Helper:**

**5 Supervision/Setup:** The child performs all the lower-body dressing tasks but requires supervision (standby supervision, cues, or coaxing) or setup assistance (e.g., applying a lower body or limb prosthesis/orthosis, applying an assistive/adaptive device, setting out clothes or specialized dressing equipment).

Example: The child puts on pants, socks, and shoes after they are set out by a helper.
### Minimal Assistance
The child performs 75% or more of the lower-body dressing tasks.

Example: The child completes all the lower-body dressing tasks, but a helper provides assistance to manage zippers and snaps.

### Moderate Assistance
The child performs 50% to 74% of the lower-body dressing tasks.

Example: The child puts on underpants and both socks. A helper puts on the child’s pants and shoes.

### Maximal Assistance
The child performs 25% to 49% of the lower-body dressing tasks.

### Total Assistance
One or more of the following are true:
- The child performs less than 25% of the lower-body dressing tasks (or none of them).
- The child wears only hospital gowns, nightgowns, or pajamas.
- The child requires assistance from two helpers to perform lower-body dressing tasks.
- The activity does not occur. (The child does not dress himself, and a helper does not dress the child.)

Example: The child removes socks, but a helper manages all other lower-body dressing tasks.
Figure 7. WeeFIM II® Decision Tree for Item 17E, Dressing—Lower Body
Toileting

Toileting includes maintaining perineal hygiene (i.e., wiping oneself) and adjusting clothing before and after using a toilet or bedpan.

Rating guidelines:

- Do not include flushing the toilet when rating this item.
- Toileting consists of three tasks. Each task is approximately 33% of the total. Assess all three tasks when rating the child for this item. For example, a child who performs two of the three tasks performs 67% of the total and should be rated level 3. A child who performs one of the three tasks performs 33% of the total and should be rated level 2. A child who requires moderate assistance with all three tasks should be rated level 3.

No Helper:

7 Complete Independence: The child safely cleanses himself after voiding and moving his bowels and adjusts his clothing before and after using a toilet or bedpan without assistance from a helper and without a device.

6 Modified Independence: The child performs all the toileting tasks without assistance from a helper, and one or more of the following are true:

- The child requires specialized equipment, such as an orthosis, prosthesis, or assistive/adaptive device, to perform the toileting tasks.
- The child takes more than a reasonable amount of time to perform toileting tasks.
- There is a concern for the child’s safety when he performs toileting tasks.

Helper:

5 Supervision/Setup: The child performs all the toileting tasks but requires supervision (standby supervision, cues, or coaxing) or setup assistance (e.g., applying an assistive/adaptive device).

4 Minimal Assistance: The child performs 75% or more of the toileting tasks.

Example: The child performs all three toileting tasks but requires steadying assistance from a helper.

3 Moderate Assistance: The child performs 50% to 74% of the toileting tasks.

Example: The child adjusts his clothing before and after voiding, but a helper completes perineal hygiene.

2 Maximal Assistance: The child performs 25% to 49% of the toileting tasks.

Example: The child pulls down his pants before voiding, but a helper completes perineal hygiene and pulls the child’s pants back up.

1 Total Assistance: One or more of the following are true:

- The child performs less than 25% of the toileting tasks (or none of them).
- The child requires assistance from two helpers to perform the toileting tasks.
- The child has a Foley catheter and did not have a bowel movement.
Figure 8. WeeFIM II® Decision Tree for Item 17F, Toileting
Bladder Management: Level of Assistance

Bladder Management includes the safe use of any equipment or agents (medication) necessary for bladder control.

Rating guidelines:

- The functional goal of bladder management is to open the urinary sphincter only when needed and to keep it closed the rest of the time. This may require devices, medications (agents), or assistance for some children.
- This item therefore deals with two variables that should be rated separately:
  1. Level of assistance
  2. Frequency of accidents
- When assessing Bladder Management, first rate the level of assistance the child requires; second, rate the frequency of accidents. If the two ratings are equal, record the rating as the child’s Bladder Management rating. If the two ratings are different, record the lower rating, which represents a greater burden of care.
- Nocturnal enuresis is considered a common childhood problem until age 7. It represents a burden of care in terms of changing linen and washing laundry. If the child experiences nocturnal enuresis only but otherwise controls his bladder completely and intentionally, rate the child level 5.

No Helper:

7 Complete Independence: The child controls his bladder completely and intentionally without assistance from a helper and without equipment or devices.

6 Modified Independence: The child controls his bladder completely and intentionally, and one or more of the following are true:
- The child requires an assistive device (e.g., urinal, bedpan, catheter, commode, diaper, urinary collecting device) for control.
- The child requires a urinary diversion for control.
- The child requires a nocturnal alarm for control.
- The child requires medication (agents) for control.
- The child performs intermittent self-catheterization without assistance.
- If a catheter is used, the child cleans, sterilizes, and sets up the equipment for irrigation without assistance.
- The child assembles and applies an external catheter with drainage bags without assistance; the child also empties, puts on, removes, and cleans the leg bag.
- The child applies an ileal appliance without assistance and also empties and cleans the ileal appliance bag.
- The child takes more than a reasonable amount of time to perform the bladder management tasks.
There is a concern for the child’s safety when he performs bladder management tasks.

Helper:

5 **Supervision/Setup:** The child controls his bladder completely and intentionally but requires supervision (standby supervision, cues, or coaxing) or setup of equipment necessary for the child to maintain a satisfactory voiding pattern or to maintain an external device.

See the rating guidelines comment on page 62 about nocturnal enuresis.

4 **Minimal Assistance:** One or both of the following are true:

- The child performs 75% or more of the bladder management tasks.
- The child requires minimal assistance to maintain an external device.

3 **Moderate Assistance:** One or both of the following are true:

- The child performs 50% to 74% of the bladder management tasks.
- The child requires moderate assistance to maintain an external device.

2 **Maximal Assistance:** Both of the following are true:

- The child performs 25% to 49% of the bladder management tasks.
- Despite assistance, the child wears diapers even if a catheter or ostomy device is in place.

1 **Total Assistance:** Despite assistance, the child wears diapers even if a catheter or ostomy device is in place, and one or both of the following are true:

- The child performs less than 25% of the bladder management tasks (or none of them).
- The child requires assistance from two helpers to perform bladder management tasks.
Does the child need help to perform bladder management tasks?

Does the child need a helper to be in the room but not physically help with bladder management tasks? Does a helper give instructions or set up bladder management equipment?

Does the child perform 75% or more of bladder management tasks, with a helper providing only incidental assistance?

Does the child perform 50% or more of bladder management tasks?

Does the child perform less than 25% of bladder management tasks? Does the child require assistance from two helpers to perform bladder management tasks?

Does the child need an assistive device, such as a diaper, a urinal, or a catheter? Does the child use medication (agents) for bladder control? Is there a concern for safety when the child performs bladder management tasks?

Figure 9. WeeFIM II® Decision Tree for Bladder Management—Level of Assistance
Bladder Management: Frequency of Accidents

Bladder Management includes complete intentional control of the urinary bladder and, if necessary, the use of equipment or agents (medication) for bladder control.

Rating guidelines:

- The functional goal of bladder management is to open the urinary sphincter only when needed and to keep it closed the rest of the time. This may require devices, agents (medication), or assistance for some children. This item therefore deals with two variables that should be rated separately:
  1. Level of assistance
  2. Frequency of accidents

- When assessing Bladder Management, first rate the level of assistance the child requires; second, rate the frequency of accidents. If the two ratings are equal, record the rating as the child’s Bladder Management rating. If the two ratings are different, record the lower rating, which represents a greater burden of care.

- A child cannot be rated level 6 for Bladder Management: Frequency of Accidents. If the child never has bladder accidents, rate the child level 7, Complete Independence.

- Nocturnal enuresis is considered a common childhood problem until seven years of age. If the child experiences nocturnal enuresis only, but does not have daytime accidents, rate the child level 5 no matter how frequently the child has nighttime accidents. If the child is older than seven, use the standard rating guidelines.

Definitions:

- Bladder accident: The act of wetting linen or clothing with urine. It includes bedpan and urinal spills. If the child wets a diaper but does not wet linen or clothing, do not consider the incident a bladder accident.

- No Helper:

  7 Complete Independence: The child controls his bladder completely and intentionally and never has accidents.

  6 Modified Independence: The child controls his bladder completely and intentionally and never has accidents, but the child uses a device or requires medication. Refer to “Bladder Management: Level of Assistance” on page 62.

- Helper:

  5 Supervision/Setup: One or both of the following are true:
   - The child has occasional bladder accidents or bedpan or urinal spills because of the lapse of time needed to get to the toilet or bedpan, but this happens only once every two to three months.
   - The child experiences nocturnal enuresis only (no matter how frequently).

  4 Minimal Assistance: The child has one to three bladder accidents per month.

  3 Moderate Assistance: The child has one to six bladder accidents per week.
2 Maximal Assistance: The child has **one or more bladder accidents per day** and gives some indication of being wet.

1 Total Assistance: The child has **one or more bladder accidents per day** but gives no indication of being wet.
Figure 10. WeeFIM II® Decision Tree for Bladder Management—Frequency of Accidents
Bowel Management: Level of Assistance

Bowel Management includes the safe use of any equipment or agents (medication) for bowel control.

Rating guidelines:

- The functional goal of bowel management is to open the anal sphincter only when needed and to keep it closed the rest of the time. This may require devices, agents (medication), or assistance for some children.
- This item therefore deals with two variables that should be rated separately:
  1. Level of assistance
  2. Frequency of accidents (level of success in bowel management)
- When assessing Bowel Management, first rate the level of assistance the child requires; second, rate the frequency of accidents. If the two ratings are equal, record the rating as the child’s Bowel Management rating. If the two ratings are different, record the lower rating, which represents a greater burden of care.

No Helper:

7 Complete Independence: The child controls his bowels completely and intentionally without assistance from a helper and without equipment or devices.

6 Modified Independence: The child controls his bowels completely and intentionally, and one or more of the following are true:
- The child requires an assistive device such as a bedpan or commode.
- The child requires self-administered digital stimulation, suppositories, or enemas on a regular basis.
- The child requires stool softeners or laxatives (other than natural laxatives such as prunes).
- The child requires medication (agents) for control.
- The child maintains a colostomy without assistance.
- The child takes more than a reasonable amount of time to perform bowel management tasks.
- There is a concern for the child’s safety when he performs bowel management tasks.

Helper:

5 Supervision/Setup: The child controls his bowels completely and intentionally but requires supervision (standby supervision, cues, or coaxing) or setup of equipment necessary for the child to maintain a satisfactory excretory pattern or to maintain an ostomy device.

4 Minimal Assistance: One or both of the following are true:
- The child performs 75% or more of the bowel management tasks.
• The child requires minimal assistance to maintain a satisfactory excretory pattern by using suppositories, enemas, or an external device.

3 **Moderate Assistance:** One or both of the following are true:

• The child performs 50% to 74% of the bowel management tasks.
• The child requires moderate assistance to maintain a satisfactory excretory pattern by using suppositories, enemas, or an external device.

2 **Maximal Assistance:** Both of the following are true:

• The child performs 25% to 49% of the bowel management tasks.
• Despite assistance, the child wears diapers even if an ostomy device is in place.

1 **Total Assistance:** Despite assistance, the child wears diapers even if an ostomy device is in place, and one or both of the following are true:

• The child performs less than 25% of the bowel management tasks (or none of them).
• The child requires assistance from two helpers to perform bowel management tasks.
Does the child need help to perform bowel management tasks?

NO

Does the child need an assistive device, such as a diaper, a colostomy, or a bedpan? Does the child use medication (agents) for bowel control? Is there a concern for safety when the child performs bowel management tasks?

NO

LEVEL 7

COMPLETE INDEPENDENCE

YES

LEVEL 6

MODIFIED INDEPENDENCE

NO

NO HELPER

HELPER

YES

NO

Does the child perform 50% or more of bowel management tasks?

YES

Does the child need a helper to be in the room but not physically help with bowel management tasks? Does a helper give instructions or set out bowel management equipment?

NO

LEVEL 5

SUPERVISION OR SETUP

YES

LEVEL 4

MINIMAL ASSISTANCE

NO

LEVEL 3

MODERATE ASSISTANCE

NO

LEVEL 2

MAXIMAL ASSISTANCE

NO

LEVEL 1

TOTAL ASSISTANCE

Figure 11. WeeFIM II® Decision Tree for Bowel Management—Level of Assistance
Bowel Management: Frequency of Accidents

*Bowel Management* includes complete intentional control of bowel movements and, if necessary, the use of equipment or agents (medication) for bowel control.

**Rating guidelines:**

- The functional goal of bowel management is to open the anal sphincter only when needed and to keep it closed the rest of the time. This may require devices, agents (medication), or assistance for some children.

- This item therefore deals with two variables that should be rated separately:
  1. Level of assistance
  2. Frequency of accidents

- When assessing Bowel Management, **first** rate the level of assistance the child requires; **second**, rate the frequency of accidents. If the two ratings are equal, record the rating as the child’s Bowel Management rating. If the two ratings are different, record the **lower** rating, which represents a greater burden of care.

- A child cannot be rated level 6 for Bowel Management: Frequency of Accidents. If the child never has bowel accidents, rate the child level 7, Complete Independence.

**Definitions:**

*Bowel accident*: The act of soiling linen or clothing with feces. It includes bedpan spills. If the child soils a diaper but does not soil linen or clothing, do not consider the incident a bowel accident.

**No Helper:**

7  **Complete Independence**: The child controls his bowel completely and intentionally and never has bowel accidents.

6  **Modified Independence**: The child controls his bowel completely and intentionally and never has bowel accidents, but the child uses a device or requires medication. Refer to “Bowel Management: Level of Assistance” on page 68.

**Helper:**

5  **Supervision/Setup**: The child has occasional bowel accidents, but this happens only once every two to three months.

4  **Minimal Assistance**: The child has one to three bowel accidents per month.

3  **Moderate Assistance**: The child has one to six bowel accidents per week.

2  **Maximal Assistance**: The child has one or more bowel accidents per day and gives some indication of being soiled.

1  **Total Assistance**: The child has one or more bowel accidents per day but gives no indication of being soiled.
Figure 12. WeeFIM II® Decision Tree for Bowel Management—Frequency of Accidents
Transfers: Chair, Wheelchair

*Transfers: Chair, Wheelchair* includes all aspects of transferring to and from a chair or wheelchair. This includes coming to a standing position if walking is the typical mode of locomotion.

**Rating guidelines:**

- When rating this item, assess the child’s transfers to and from a regular (i.e., standard, adult-sized) chair.
- Rate the child level 5, Supervision/Setup, if a helper provides assistance only with one or more of the following activities:
  - Locking brakes
  - Unlocking brakes
  - Lifting and lowering footrests
  - Removing and replacing footrests
  - Removing and replacing armrests
  - Positioning a sliding board
  - Applying an orthosis
- Prostheses and orthoses are considered assistive devices if used for a transfer.

**No Helper:**

7 **Complete Independence:**

If walking, the child safely approaches, sits down in and gets up to a standing position from a regular chair without assistance from a helper and without a device.

If in a wheelchair, the child approaches a chair, locks brakes, lifts footrests, removes armrests if necessary, performs either a standing pivot or sliding transfer (without a board), and then returns to the wheelchair. The child performs this activity safely.

6 **Modified Independence:** The child transfers to and from a chair without assistance from a helper, and one or more of the following are true:

- The child requires an adaptive/assistive device (e.g., sliding board, special seat, toddler chair, brace, crutches) to transfer.
- The child takes more than a reasonable amount of time to transfer.
- There is a concern for the child’s safety when he transfers.

**Helper:**

5 **Supervision/Setup:** The child transfers to and from a chair but requires supervision (standby supervision, cues, or coaxing) or setup assistance (e.g., positioning a sliding board or moving footrests).

Example: The child transfers without touching assistance, but a helper provides instructions and moves a footrest.
4 **Minimal Assistance:** One or more of the following are true:
   - The child performs 75% or more of the transferring tasks.
   - The child requires only touching, guiding, or contact assistance to complete the transfer.
   - The child requires assistance to lift one leg onto and/or off a wheelchair’s footrest.
   
   Example: The child transfers from a wheelchair to a chair and back with only steadying assistance from a helper. The helper does not lift the child.

3 **Moderate Assistance:** One or more of the following are true:
   - The child performs 50% to 74% of the transferring tasks.
   - The child approaches a chair or wheelchair with no more than contact assistance but requires lifting assistance to sit down or stand up.
   - The child requires assistance to lift both legs onto and/or off a wheelchair’s footrest.
   
   Example: A helper provides moderate lifting assistance as the child rises from a wheelchair to a standing position and moderate lowering assistance as the child returns to the wheelchair.

2 **Maximal Assistance:** One or both of the following are true:
   - The child performs 25% to 49% of the transferring tasks.
   - The child approaches a chair or wheelchair with no more than contact assistance but requires assistance to sit down and stand up.
   
   Example: A helper provides maximal assistance to lower the child to a chair. The helper also provides maximal assistance as the child rises from the chair to a standing position.

1 **Total Assistance:** One or more of the following are true:
   - The child performs less than 25% of the transferring tasks (or none of them).
   - The child requires more than contact assistance to approach a chair or wheelchair, sit down, and stand up.
   - The child requires a mechanical lift to transfer.
   - The child requires assistance from two helpers to transfer.
   - The activity does not occur.
Figure 13. WeeFIM II® Decision Tree for Item 17I, Transfers: Chair, Wheelchair
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**Transfers: Toilet**

*Transfers: Toilet* includes all aspects of transferring on and off a toilet.

**Rating guidelines:**

- When rating this item, assess the child’s transfers to and from a standard toilet.
- If walking is the child’s typical mode of locomotion, this item includes coming to a standing position.
- Rate the child level 5, Supervision/Setup, if a helper provides assistance only with one or more of the following activities:
  - Locking brakes
  - Unlocking brakes
  - Lifting and lowering footrests
  - Removing and replacing footrests
  - Removing and replacing armrests
  - Positioning a sliding board
  - Applying an orthosis

- Prostheses and orthoses are considered assistive devices if used for a transfer.

**No Helper:**

7  **Complete Independence:**

If walking, the child safely approaches, sits down on, and gets up from a standard toilet without assistance from a helper and without a device.

If in a wheelchair, the child approaches a toilet, locks the brakes, lifts footrests, removes armrests if necessary, performs either a standing pivot or sliding transfer (without a board), and returns to the wheelchair. The child performs this activity safely.

6  **Modified Independence:** The child transfers to and from a toilet without assistance from a helper, and one or more of the following are true:

- The child requires an adaptive/assistive device (e.g., sliding board, grab bar, potty chair, special seat, footstool) to transfer.
- The child takes more than a reasonable amount of time to transfer.
- There is a concern for the child’s safety when he transfers.

**Helper:**

5  **Supervision/Setup:** The child transfers to and from a toilet but requires supervision (standby supervision, cues, or coaxing) or setup assistance (e.g., positioning a sliding board, moving footrests).

Example: The child transfers without touching assistance, but a helper provides instructions and positions a sliding board.
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4 **Minimal Assistance:** One or both of the following are true:
- The child performs 75% or more of the transferring tasks.
- The child requires only touching, guiding or contact assistance to complete the transfer.

Example: The child transfers from a wheelchair to a toilet and back with only steadying assistance from a helper. The helper does not lift the child.

3 **Moderate Assistance:** One or both of the following are true:
- The child performs 50% to 74% of the transferring tasks.
- The child approaches a toilet or commode with no more than contact assistance but requires lowering assistance to sit down or lifting assistance to stand up.

Example: The child transfers onto a toilet with steadying assistance and regains a standing position with moderate lifting assistance from a helper.

2 **Maximal Assistance:** One or both of the following are true:
- The child performs 25% to 49% of the transferring tasks.
- The child approaches a toilet or commode with no more than contact assistance but requires lifting assistance to sit down and stand up.

Example: A helper provides maximal lifting assistance as the child lowers himself to a toilet and as the child returns to a standing position.

1 **Total Assistance:** One or more of the following are true:
- The child performs less than 25% of the transferring tasks (or none of them).
- The child requires more than contact assistance to approach a toilet or commode, lowering assistance to sit down, and lifting assistance to stand up.
- The child requires a mechanical lift to transfer.
- The child requires assistance from two helpers to transfer.
- The activity does not occur.
Figure 14. WeeFIM II® Decision Tree for Item 17J, Transfers: Toilet

Does the child need help to transfer onto and off a standard toilet?

Does the child take more time to transfer? Does the child need an assistive device (e.g., potty chair, special chair, foot stool) to transfer? Is there a concern for safety when the child transfers?

Does the child perform 50% or more of transfer tasks?

Does the child perform less than 25% of transfer tasks? Does the child require assistance from two helpers to transfer?

Does the child perform 75% or more of transfer tasks, with a helper providing only incidental assistance (e.g., using a slight touch to steady the child during the transfer)?

Does the child need help to transfer onto and off a standard toilet?

Does the child perform 50% or more of transfer tasks?

Does the child perform less than 25% of transfer tasks? Does the child require assistance from two helpers to transfer?

Does the child perform 75% or more of transfer tasks, with a helper providing only incidental assistance (e.g., using a slight touch to steady the child during the transfer)?
**Transfers: Tub, Shower**

*Transfers: Tub, Shower* includes getting into and out of a tub or shower stall.

**Rating guidelines:**

- Prostheses and orthoses are considered assistive devices if used for a transfer.
- Rate the child level 5, Supervision/Setup, if a helper provides assistance only with one or more of the following activities:
  - Locking the brakes
  - Unlocking brakes
  - Lifting and lowering footrests
  - Removing and replacing footrests
  - Removing and replacing armrests
  - Positioning a sliding board
  - Applying an orthosis
- Rate the child level 4, Minimal Assistance, if a helper lifts one of the child’s legs into a tub.
- Rate the child level 3, Moderate Assistance, if a helper lifts both of the child’s legs into a tub.

**No Helper:**

7 **Complete Independence:**

If walking, the child safely approaches, gets into, and gets out of a tub or shower stall without assistance from a helper and without a device.

If in a wheelchair, the child approaches the tub or shower stall, locks the brakes, lifts footrests, removes armrests if necessary, performs either a standing pivot or sliding transfer (without a board), and returns to the wheelchair. The child performs this activity safely.

6 **Modified Independence:** The child transfers into and out of a tub or shower stall without assistance from a helper, and one or more of the following are true:

- The child requires an adaptive or assistive device (e.g., sliding board, grab bar, tub bench, special seat) to transfer.
- The child takes more than a reasonable amount of time to transfer.
- There is a concern for the child’s safety when he transfers.

**Helper:**

5 **Supervision/Setup:** The child transfers into and out of a tub or shower stall but requires supervision (standby supervision, cues, or coaxing) or setup assistance (e.g., positioning a sliding board, moving footrests).

Example: The child transfers without touching assistance, but a helper provides instructions and moves a footrest.
4 **Minimal Assistance:** One or more of the following are true:
   - The child performs 75% or more of the transferring tasks.
   - The child requires only touching, guiding, or contact assistance to complete the transfer.
   - The child requires assistance to lift **one** leg into and out of the tub or shower.
   
   **Example:** The child transfers into and out of a tub with handholding from a helper. The helper does not lift the child.

3 **Moderate Assistance:** One or more of the following are true:
   - The child performs 50% to 74% of the transferring tasks.
   - The child approaches a tub or shower with no more than contact assistance but requires lifting assistance to transfer into **or** out of it.
   - The child requires assistance to lift **two** legs into and out of a tub or shower.
   
   **Example:** The child transfers onto a tub bench with assistance from a helper, who lifts both of the child’s legs into the tub. The helper provides the same amount of lifting assistance as the child gets out of the tub.

2 **Maximal Assistance:** One or both of the following are true:
   - The child performs 25% to 49% of the transferring tasks.
   - The child approaches a tub or shower with no more than contact assistance but requires lifting assistance to transfer into **and** out of it.
   
   **Example:** A helper provides maximal lifting assistance as the child transfers from a wheelchair into a tub. The helper lowers the child to a sitting position in the tub. The helper provides the same amount of lifting assistance as the child returns to the wheelchair.

1 **Total Assistance:** One or more of the following are true:
   - The child performs less than 25% of the transferring tasks (or none of them).
   - The child requires more than contact assistance to approach a tub or shower, transfer into it, **and** transfer out of it.
   - The child requires a mechanical lift to transfer.
   - The child requires assistance from two helpers to transfer.
   - The activity does not occur.
Figure 15. WeeFIM II® Decision Tree for Item 17K, Transfers: Tub, Shower
Locomotion: Walk, Wheelchair, Crawl

*Locomotion: Walk, Wheelchair, Crawl* includes walking, once in a standing position; using a wheelchair, once in a seated position; and crawling on a level surface.

*Locomotion: Walk* includes walking, once in a standing position on a level surface, for a minimum of 150 feet (45 meters) **at one time**.

*Locomotion: Wheelchair* includes operating a manual or motorized wheelchair on a level surface, once in a seated position in a situation free of physical hazards, for a minimum of 150 feet (45 meters) **at one time**.

*Locomotion: Crawl* includes crawling or self-mobilizing on a level surface in a situation free of physical hazards for a distance of 50 feet (15 meters) **at one time**, safely and without assistance.

**Rating guidelines:**

- When rating this item, **first** assess the distance traveled by the child; **second**, assess the amount of help the child requires.

- **The mode of locomotion must be the same for admission and discharge.** If the child uses two or three modes about equally, code B for Combination.

- If the child’s mode of locomotion **remains the same** for admission and discharge, or from assessment to assessment, follow these steps:

  **At admission:**
  - Determine the most frequent mode of locomotion.
  - Assess the distance traveled by the child.
  - Assess the amount of help the child requires.
  - Determine the appropriate rating.
  - Choose the appropriate mode (W for walk, C for wheelchair, L for crawl), and then enter the admission rating for that mode on the WeeFIM II® Assessment Coding Form.

  **At discharge:**
  - Assess the distance traveled by the child.
  - Assess the amount of help the child requires.
  - Determine the appropriate rating.
  - Choose the **same** mode you marked at admission (W for walk, C for wheelchair, L for crawl), and then record the discharge rating for that mode on the WeeFIM II® Assessment Coding Form.

- If the child’s locomotion is **expected to change** from admission to discharge, or from assessment to assessment, follow these steps.

  **At admission:**
  - Assess the distance that traveled by the child **for both modes**.
  - Assess the amount of help the child requires **for both modes**.
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- Determine the appropriate rating for both modes.
- Record the tentative admission ratings for both modes on the WeeFIM II® Assessment Coding Form.

At discharge:
- Determine the most frequent mode of locomotion.
- Assess the distance traveled by the child.
- Assess the amount of help the child requires.
- Enter the mode that represents the most frequent mode of locomotion at discharge, and then record the discharge rating for that mode on the WeeFIM II® Assessment Coding Form.
- Adjust your tentative admission modes and admission ratings to match the mode that represents the most frequent mode of locomotion upon discharge. For example, if a child progresses from using a wheelchair to walking, record the admission Walk rating in the admission column on the WeeFIM II® Assessment Coding Form and disregard the admission rating for Wheelchair. If the child continues to use a wheelchair as the most frequent mode of locomotion, however, record the admission Wheelchair rating in the admission column and disregard the admission Walk rating.
- If the mode of locomotion changes, it is possible for the child to receive a higher rating at admission and a lower rating for discharge (e.g., level 6 for Wheelchair at admission and level 5 for Walk at discharge). Making the modes match controls for the mode of locomotion and allows the two ratings to accurately reflect the child’s progress.
- If the child requires an assistive device for walking (e.g., prosthesis, walker, cane, AFO, adapted shoe, RGO), do not rate the child higher than level 6.
- If the child uses a wheelchair, the only ratings that can be used are 6, 5, 4, 3, 2, and 1.
- If the child crawls, the only ratings that can be used are 5, 4, 3, and 1.

Definitions:
A 3% grade is a very slight incline, equivalent to wheeling a wheelchair over a doorsill.

No Helper:
7 Complete Independence: The child safely walks a minimum of 150 feet (45 meters) without assistance from a helper and without a device (including a wheelchair).

6 Modified Independence:
    Walk: The child walks a minimum of 150 feet (45 meters) without assistance from a helper, and one or more of the following are true:
    - The child uses an assistive/adaptive device (e.g., leg brace, special adaptive shoes, cane, crutches, walkerette) to walk.
    - The child takes more than a reasonable amount of time to walk.
    - There is a concern for the child’s safety when he walks.
Wheelchair: The child operates a wheelchair for a minimum of 150 feet (45 meters) without assistance from a helper; turns around; maneuver to a table, bed, and toilet; negotiates at least a 3% grade; and maneuvers on rugs and over doorsills.

5 Exception, Household Locomotion:

Walk: The child walks a minimum of 50 feet (15 meters) without assistance from a helper, with or without a device.

Wheelchair: The child operates a wheelchair at least 50 feet (15 meters) without assistance from a helper.

Crawl: The child crawls at least 50 feet (15 meters)—enough to go through at least two rooms.

Helper:

5 Supervision:

Walk: The child walks at least 150 feet (45 meters) but requires supervision (standby supervision, cues, or coaxing).

Example: The child walks 200 feet (60 meters) without touching assistance, but a helper must coax the child to begin walking.

Wheelchair: The child operates a wheelchair for a minimum of 150 feet (45 meters) but requires supervision (standby supervision, cues, or coaxing).

4 Minimal Assistance:

Walk: The child performs 75% or more of the effort to walk a minimum of 150 feet (45 meters).

Example: The child walks 150 feet (45 meters) with only steadying assistance from a helper.

Wheelchair: The child performs 75% or more of the effort to operate a wheelchair a minimum of 150 feet (45 meters).

Crawl: The child crawls at least 30 feet (9 meters).

Example: The child crawls 40 feet (12 meters) as he travels from one room to another.

3 Moderate Assistance:

Walk: The child performs 50% to 74% of the effort to walk a minimum of 150 feet (45 meters).

Wheelchair: The child performs 50% to 74% of the effort to operate a wheelchair a minimum of 150 feet (45 meters).

Crawl: The child crawls at least 15 feet (4.5 meters).

Example: The child crawls 20 feet (6 meters) as he changes location within a single room.
2 Maximal Assistance:

Walk: The child performs 25% to 49% of the effort to walk a minimum of 50 feet (15 meters), requiring assistance from only one helper.

Wheelchair: The child performs 25% to 49% of the effort to operate a wheelchair a minimum of 50 feet (15 meters), requiring assistance from only one helper.

1 Total Assistance: One or more of the following are true:

- The child performs less than 25% of the effort (or none of it) to walk or to operate a wheelchair a minimum of 50 feet (15 meters).
- The child walks or operates a wheelchair less than 50 feet (15 meters).
- The child requires assistance from two helpers to walk or to operate a wheelchair.
- The child crawls less than 15 feet (4.5 meters).
- The child does not self-mobilize.
Figure 16. WeeFIM II® Decision Tree for Locomotion: Walk
Figure 17. WeeFIM II® Decision Tree for Locomotion: Wheelchair
Figure 18. WeeFIM II® Decision Tree for Locomotion: Crawl
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Locomotion: Stairs

Locomotion: Stairs includes going up and down twelve to fourteen stairs (one flight) indoors.

Rating guidelines:
When rating this item, first determine the number of stairs the child goes up and down; second, assess the level of assistance the child requires.

Definitions:
Flight of stairs: A flight consists of twelve to fourteen stairs.

No Helper:

7 Complete Independence: The child safely goes up and down at least one flight of stairs without assistance from a helper and without depending on any type of handrail or support.

6 Modified Independence: The child goes up and down at least one flight of stairs without assistance from a helper, and one or more of the following are true:

- The child requires an assistive device (e.g., side support, handrail, cane, portable supports) to climb stairs.
- The child takes more than a reasonable amount of time to climb stairs.
- There is a concern for the child’s safety when he climbs stairs.

5 Exception, Household Ambulation: The child goes up and down four to eleven stairs without assistance from a helper, with or without a device, and one or both of the following are true:

- The activity takes more than a reasonable amount of time.
- There is a concern for the child’s safety.

Helper:

5 Supervision: The child requires supervision (standby supervision, cues, or coaxing) to go up and down one flight of stairs.

Example: The child goes up and down one flight of stairs without touching assistance, but a helper must coax the child to climb the stairs.

4 Minimal Assistance: The child performs 75% or more of the effort to go up and down one flight of stairs.

Example: The child goes up and down one flight of stairs with only steadying assistance from a helper.

3 Moderate Assistance: The child performs 50% to 74% of the effort to go up and down one flight of stairs.

Example: A helper provides moderate assistance as the child goes up and down one flight of stairs by providing support and advancing a foot to or from each step.
2 **Maximal Assistance:** The child performs 25% to 49% of the effort to go up and down four to six stairs, requiring assistance from **only one helper.**

Example: A helper provides any level of assistance as the child goes up and down four to six stairs.

1 **Total Assistance:** One or more of the following are true:

- The child performs less than 25% of the effort (or none of it) to climb stairs.
- The child goes up and down fewer than four stairs or is carried.
- The child requires assistance from two helpers to climb stairs.
- The activity does not occur. (The child does not go up or down stairs, **and** a helper does not carry the child up or down stairs.)
Figure 19. WeeFIM II® Decision Tree for Item 17M, Locomotion: Stairs

Does the child need help to go up and down 12–14 stairs? 

- NO: Does the child take more time to go up and down 12–14 stairs? Does the child need an assistive device (e.g., a handrail or cane)? Is there a concern for safety when the child goes up and down stairs? 
  - YES: COMPLETE INDEPENDENCE 
  - NO: LEVEL 7

- YES: LEVEL 5

Does the child go up and down at least 4 stairs without assistance? 

- NO: EXCEPTION: HOUSEHOLD AMBULATION

- YES: LEVEL 5

Does the child go up and down 12–14 stairs with assistance from only one helper? 

- NO: NO HELPER

- YES: LEVEL 5

Does the child perform 75% or more of the effort to go up and down 12–14 stairs, with a helper providing only incidental assistance (e.g., holding the child’s hand)? 

- YES: LEVEL 4

- NO: LEVEL 3

Does the child need a helper to be present but not physically help with going up and down 12–14 stairs? Does a helper give instructions? 

- YES: SUPERVISION OR SETUP 

- NO: LEVEL 5

Does the child need a helper to go up and down 12–14 stairs? Does the child require assistance from two helpers to go up and down stairs? 

- YES: LEVEL 1

- NO: LEVEL 2

Does the child go up and down fewer than 4 stairs? Does the child need to be carried up and down stairs? 

- YES: TOTAL ASSISTANCE 

- NO: MAXIMAL ASSISTANCE

Does the child go up and down fewer than 4 stairs without assistance? 

- YES: LEVEL 1

- NO: LEVEL 2

Does the child need help to go up and down 12–14 stairs? 

- YES: LEVEL 5

- NO: LEVEL 6

LEVEL 7

COMPLETE INDEPENDENCE

LEVEL 6

MODIFIED INDEPENDENCE

LEVEL 5

EXCEPTION: HOUSEHOLD AMBULATION

LEVEL 4

MINIMAL ASSISTANCE

LEVEL 3

MODERATE ASSISTANCE

LEVEL 2

MAXIMAL ASSISTANCE

LEVEL 1

TOTAL ASSISTANCE
Comprehension

Comprehension includes understanding either auditory or visual communication (for example, speech, written language, manual signs, gestures, or pictures).

Rating guidelines:
Evaluate the child’s understanding and then indicate the more usual mode of comprehension, whether auditory or visual. If both are used about equally, record “B” for both. These modes do not need to match from assessment to assessment.

Base the child’s Comprehension rating on the child’s usual language, which might not be English. You may need an interpreter’s help to rate the child for Comprehension. Do not consider the interpreter’s role when rating this item.

Definitions:

Prompting: Includes slowing speech rate, repeating words, cuing, rephrasing, stressing particular words and phrases, pausing, and providing visual and gestural cues.

Unrelated multistep command: A series of verbal directions in which the feedback from carrying out one task does not give clues to carrying out other tasks.

Example: “Put away your toys, wash your hands, and get your coat.”

Related multistep command: A series of verbal directions in which the feedback from carrying out one task does give clues to carrying out other tasks.

Example: “Get your shirt, get your pants, and get your socks.”

No Helper:

7 Complete Independence: The child understands everyday conversations and follows unrelated three-step directions without prompting from a helper, without a device, and not necessarily in English.

6 Modified Independence: In most situations, the child understands everyday conversations readily or with only mild difficulty and follows unrelated three-step commands without prompting from a helper, and one or both of the following are true:

- The child requires an assistive device (e.g., hearing aid, visual aid, communication device).
- The child requires more than a reasonable amount of time to comprehend.

Helper:

5 Standby Prompting: The child understands everyday conversations more than 90% of the time and follows related three-step commands, requiring prompting less than 10% of the time.

4 Minimal Prompting: The child understands everyday conversations 75% to 90% of the time and follows unrelated two-step directions, requiring prompting no more than 25% of the time.

3 Moderate Prompting: The child understands everyday conversations 50% to 74% of the time and follows related two-step directions, requiring prompting more than 25% of the time.
2 **Maximal Prompting:** One or both of the following are true:

- The child understands everyday conversation 25% to 49% of the time.
- The child understands only simple words (such as “no”), his own name, brief phrases, or one-step commands with gestures (e.g., pointing a finger and saying “stop”).

1 **Total Assistance:** One or more of the following are true:

- The child understands everyday conversations less than 25% or none of the time.
- The child does not understand simple, commonly used words (such as “hello”), brief phrases (such as “come here”), or gestures (such as waving hello and goodbye).
- The child does not respond appropriately or consistently despite prompting.
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Figure 20. WeeFIM II® Decision Tree for Item 39N, Comprehension
Expression

*Expression* includes clear vocal or nonvocal expression of basic needs and ideas. It includes intelligible speech or clear expression of language using written language, gestures, manual signs, or communication devices.

**Rating guidelines:**

Evaluate and indicate the more usual mode of expression, whether *vocal* or *nonvocal*. If both are used about equally, record “B” for *both*. The mode of expression does not need to remain the same from assessment to assessment.

Base the child’s Expression rating on the child’s usual language, which might not be English. You may need an interpreter’s help to rate the child for Expression. Do not consider the interpreter’s role when rating this item.

**Definitions:**

- **Basic needs and ideas:** Necessary daily activities such as hunger, thirst, elimination, hygiene, sleep, fear, pain, and other physiological needs.

**No Helper:**

- **7 Complete Independence:** The child expresses basic needs and ideas clearly and fluently without assistance from a helper, without a device, and not necessarily in English.

- **6 Modified Independence:** In most situations, the child expresses basic needs and ideas relatively clearly or with only mild difficulty, without assistance from a helper, and one or more of the following are true:
  - The child requires an augmentative communication device or system.
  - The child takes more than a reasonable amount of time to express basic needs and ideas.

**Helper:**

- **5 Standby Prompting:** The child expresses basic needs and ideas clearly more than 90% of the time, requiring prompting (e.g., frequent repetition) less than 10% of the time.

- **4 Minimal Prompting:** The child expresses basic needs and ideas clearly 75% to 90% of the time, requiring prompting no more than 25% of the time.

- **3 Moderate Prompting:** The child uses words, gestures, and pictures to express basic needs and ideas clearly 50% to 74% of the time, requiring prompting more than 25% of the time.

- **2 Maximal Prompting:** The child appropriately uses “mama,” “dada,” and other single words and gestures to express basic daily needs and ideas clearly 25% to 49% of the time, requiring prompting more than 50% of the time.

- **1 Total Assistance:** One of the following is true:
  - The child expresses basic needs and ideas clearly less than 25% of the time (or not at all).
  - The child does not express basic needs appropriately or consistently despite prompting.
Figure 21. WeeFIM II® Decision Tree for Item 39O, Expression
Social Interaction

*Social Interaction* includes interacting appropriately with other children (peers) in play and social situations. This interaction includes getting along with, cooperating with, and participating with others. It represents how the child deals with his own needs together with the needs of other children.

**Rating guidelines:**

All references to *interactions* are between the child and other children (peers), not between the child and an adult.

Examples of socially inappropriate behaviors include temper tantrums, loud/foul/abusive language, excessive laughing, excessive crying, physical attacks, and very withdrawn or noninteractive behavior.

**No Helper:**

7 **Complete Independence:** The child safely and appropriately interacts with peers and exhibits reasonable self-restraint (e.g., controlling temper, accepting criticism, being aware that words and actions have an impact on others) without supervision from an adult helper and without medication for behavior control.

6 **Modified Independence:** The child interacts appropriately without supervision from a helper, and one or more of the following are true:

- The child loses control only occasionally.
- The child takes more than a reasonable amount of time to adjust when interacting.
- The child requires a structured or modified environment (e.g., a room with adjusted lighting) for interaction.
- The child uses medication for control.
- There is a concern for the child’s safety when he interacts.

**Helper:**

5 **Supervision:** The child interacts appropriately more than 90% of the time and one or both of the following are true:

- The child requires supervision or prompting (monitoring, verbal control, cues, or coaxing) less than 10% of the time only under stressful or unfamiliar conditions.
- An adult supervises the child from a distance.

4 **Minimal Direction:** The child interacts appropriately 75% to 90% of the time, needing a helper to structure his play or social activities no more than 25% of the time (e.g., during interactive group play).

Example: The child requires occasional assistance with problems but can play independently. An adult resolves occasional conflicts.

3 **Moderate Direction:** The child interacts appropriately 50% to 74% of the time, needing a helper to structure his play or social activities no more than 50% of the time.

Example: An adult initiates play and prevents or resolves conflicts 50% of the time.
2 **Maximal Direction:** The child interacts appropriately 25% to 49% of the time, needing an adult to structure his play or social activities more than 50% of the time (e.g., parallel play).

Example: The child interacts with peers, but only for short periods. The child engages in parallel play.

1 **Total Assistance:** One or more of the following are true:

- The child interacts appropriately less than 25% or none of the time.
- An adult structures all of the child’s play activities (e.g., solitary play or sensorimotor play).
- The child requires assistance from two helpers to interact appropriately.
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Figure 22. WeeFIM II® Decision Tree for Item 39P, Social Interaction
Problem Solving

*Problem Solving* includes recognizing everyday problems when they occur, initiating plans to solve them, carrying out plans until the problem is solved, and self-correcting if errors are made. It also includes making reasonable, safe, and timely decisions regarding everyday problems.

**Rating guidelines:**

*Everyday problems:* Includes daily tasks, unplanned events, and hazards that occur during daily activities. More specific examples include asking for assistance appropriately and trying to get an object that is out of reach.

**No Helper:**

7 **Complete Independence:** The child safely and consistently recognizes existing problems, makes appropriate decisions, initiates and carries out a sequence of steps to solve everyday problems until the task is completed, and self-corrects if errors are made, without assistance from a helper.

6 **Modified Independence:** In most situations, the child recognizes that existing problems and, with only mild difficulty, makes appropriate decisions and initiates and carries out a sequence of steps to solve everyday problems without assistance from a helper, and one or more of the following are true:

- The child takes more than a reasonable amount of time to make appropriate decisions or to solve problems.
- There is a concern for the child’s safety when he solves problems.

**Helper:**

5 **Supervision:** The child solves everyday problems more than 90% of the time, requiring supervision (cues or coaxing) less than 10% of the time only under stressful or unfamiliar conditions.

4 **Minimal Direction:** The child solves everyday problems 75% to 90% of the time.

3 **Moderate Direction:** The child solves everyday problems 50% to 74% of the time.

2 **Maximal Direction:** The child solves everyday problems 25% to 49% of the time and needs direction more than 50% of the time to initiate, plan, or complete simple daily activities.

The child may require a restraint for safety at level 2.

1 **Total Assistance:** One or more of the following are true:

- The child seldom recognizes existing problems.
- The child solves everyday problems less than 25% of the time (or not at all).
- The child requires constant one-to-one direction to complete simple daily activities.

The child may require a restraint for safety at level 1.
Does the child need help to recognize and solve everyday problems?

Yes

No

Does the child take more time to recognize and solve everyday problems? Does the child have slight difficulty in unfamiliar situations?

Yes

No

Level 7

Complete Independence

Level 6

Modified Independence

Does the child recognize and solve everyday problems 50% or more of the time?

Yes

No

Level 5

Supervision

Does the child recognize and solve everyday problems more than 90% of the time, needing help less than 10% of the time under stressful or unfamiliar situations?

Yes

No

Level 4

Minimal Direction

Does the child recognize and solve everyday problems less than 25% of the time?

Yes

No

Level 2

Maximal Direction

Does the child recognize and solve everyday problems less than 25% of the time?

No

Level 1

Total Assistance

Does the child recognize and solve everyday problems more than 75% of the time?

Yes

No

Level 3

Moderate Direction

Does the child recognize and solve everyday problems more than 75% of the time, needing help less than 10% of the time under stressful or unfamiliar situations?

No

Figure 23. WeeFIM II® Decision Tree for Item 39Q, Problem Solving
Memory

Memory includes skills related to recognizing and remembering while performing daily activities. It includes storing and retrieving information, particularly verbal and visual. The functional evidence of memory includes recognizing people frequently encountered, remembering daily routines, and executing requests without being reminded. A deficit in memory impairs learning as well as performance of tasks.

Rating guidelines:

Functional evidence of memory in very young children may be limited to displays of anticipation and recognition (e.g., changing behavior, facial expression, or vocalizations).

No Helper:

7 Complete Independence: The child recognizes people frequently encountered, remembers daily routines, and executes requests without being reminded; the child does so without assistance from a helper and without a device.

6 Modified Independence: The child recognizes people frequently encountered, remembers daily routines, and executes requests without being reminded; in addition, one or more of the following are true:

- The child does so with mild difficulty.
- The child needs more than a reasonable amount of time to do so.
- The child uses an assistive device (e.g., a memory book) to do so.

Helper:

5 Supervision: The child recognizes and remembers more than 90% of the time, requiring prompting (cues, repetition, or reminders) only under stressful or unfamiliar conditions. The child relates significant aspects about holidays, birthdays, and special events.

4 Minimal Prompting: The child recognizes and remembers 75% to 90% of the time, requiring prompting the rest of the time. The child recalls parts of activities or events after a helper provides an initial prompt such as “What happened next in the story?” or “Where did we go today?”

3 Moderate Prompting: The child recognizes and remembers 50% to 74% of the time, requiring prompting the rest of the time. The child says or acts out parts of familiar rhymes or songs by himself.

Example: The child sings or hums parts of “Twinkle, Twinkle, Little Star” or “The Itsy Bitsy Spider” by himself, requiring prompting with the rest.

2 Maximal Prompting: The child recognizes and remembers 25% to 49% of the time, requiring prompting the rest of the time. The child remembers the locations of toys and other items after a short period.

1 Total Assistance: The child recognizes and remembers less than 25% of the time (or not at all). The child may show anticipation of regularly occurring events in everyday care. The child recognizes familiar toys or people. Anticipation or recognition may be evidenced by a change in behavior or facial expression or vocalizations.
Figure 24. WeeFIM II® Decision Tree for Item 39R, Memory
Appendix A: Case Studies

This appendix contains three case studies that clinicians can use to gain a better understanding of the WeeFIM® rating system. The case studies may also be used for practice prior to taking the credentialing exam. Answer keys with rationales are provided for each case study.

Keep in mind that ratings for each item should be based solely on the information that has been provided, not on what the child might be capable of doing if additional details were available. The purpose of the case studies is to ensure that clinicians understand the rating system and descriptors for each WeeFIM® item prior to assessing patients or taking the credentialing exam. The descriptions of function in the case studies intentionally duplicate terminology in The WeeFIM II®: Clinical do not reflect the way parents or caregivers might describe performance in the course of an interview.

UDSMR suggests that clinicians who are new to the WeeFIM II® System begin with the first case study, which describes a typically developing child who does not have any documented disability or developmental delay. This exercise is critical to gaining an understanding of the WeeFIM® rating system without being concerned about the potential for variance in functional performance due to disability.

Because the WeeFIM® instrument can be administered to persons up to age twenty-one, this appendix includes three case studies that reflect the diversity of ages and diagnoses encountered in pediatric settings. The first case study, Joshua, describes the functional status of a five-year-old boy who exhibits typical development. The second case study, Brian, describes the functional status of a sixteen-year-old male who sustained a traumatic brain injury prior to his admission to the rehabilitation unit. The third case study, Joseph, describes the functional status of a five-year-old boy who exhibits developmental delays.

Clinicians may rate these case studies independently and compare their results with the answer keys provided at the end of the appendix. The case studies may also be used as teaching tools—clinicians working in pairs can rate each case independently and then compare their results with each other prior to referring to the answer keys. This approach fosters discussion between clinicians to resolve rating differences.
Case Study: Joshua (Typical Development)

Joshua is a five-year-old child who attends kindergarten. He was born full-term and has consistently demonstrated normal development.

Eating
After a meal has been prepared and placed in front of Joshua, he eats a variety of food consistencies independently using a spoon and a fork. He drinks from a cup independently. He eats neatly in a safe, timely manner.

Grooming
Joshua washes, rinses, and dries his hands independently. He washes, rinses, and dries his face, but his helper checks whether he did a good job. He requires minimal assistance to brush his teeth. When reminded to do so, he combs his own hair.

Bathing
Joshua typically takes a shower. His helper sets the temperature of the water. Joshua washes and rinses his entire body independently. His helper completely dries him off.

Dressing: Upper Body
Joshua’s helper sets out his clothes every day. He independently puts on and removes pullover and front-opening garments. He also manages buttons and zippers by himself.

Dressing: Lower Body
Once his clothes have been laid out for him, Joshua dresses and undresses himself independently, including underwear, pants, socks, and shoes.

Toileting
Joshua adjusts his clothing independently before and after toileting. His helper performs perineal hygiene.

Bladder Management
Joshua never has bladder accidents during the day. During the night, he wets the linens in his bed about five times a year.

Bowel Management
Joshua never has bowel accidents. He is not on a bowel management program.

Transfers: Chair, Wheelchair
Joshua independently gets on and off a standard adult-sized chair in a timely and safe manner.

Transfers: Toilet
Joshua gets onto and off a standard toilet independently in a timely, safe manner.

Transfers: Tub, Shower
Joshua’s helper always holds his hand while he is getting in or out of the bathtub.

Locomotion: Walk, Wheelchair, Crawl
Joshua walks 150 feet or more independently in a safe and timely manner. He does not require supervision.
**Locomotion: Stairs**
Joshua walks up and down a full flight of fourteen stairs. He holds on to a railing for safety.

**Comprehension**
Joshua follows unrelated two-step directions. He understands everyday conversations 80% of the time.

**Expression**
Joshua expresses basic needs and ideas clearly more than 90% of the time. He requires prompting to repeat words 5% of the time due to occasional slurred speech.

**Social Interaction**
Joshua safely interacts appropriately with his friends at home and at school. He requires supervision only under unfamiliar conditions (for example, when he goes to a friend’s house for the first time).

**Problem Solving**
Joshua always recognizes a problem when one has occurred. He informs his helper and attempts to solve the problem, requiring moderate prompting from his helper.

**Memory**
Joshua recognizes and remembers more than 90% of the time. When conditions are unfamiliar, he requires reminders from his helper.

**Answer Key: Joshua (Typical Development)**

**Eating**
*Level 7, Complete Independence*

**Grooming**
*Level 4, Minimal Assistance*

Joshua washes, rinses, and dries his hands independently (level 7). He requires cues or supervision to wash, rinse, and dry his face and comb his hair (level 5). He requires minimal assistance to brush his teeth (level 4). In such cases, record the **lowest** rating, which represents the most dependent level.

**Bathing**
*Level 3, Moderate Assistance*

A helper adjusts the water temperature prior to bathing (level 5). Joshua washes and rinses his body from the neck down (excluding the back), and the helper dries him completely. Joshua and the helper each perform about half of the effort to complete the bathing tasks (level 3). In such cases, record the **lowest** rating, which represents the most dependent level.

**Dressing: Upper Body**
*Level 5, Supervision/Setup*

Joshua performs all the tasks associated with upper-body dressing independently (level 7), but he requires a helper to obtain his clothing and lay it out for him (level 5). In such cases, record the **lowest** rating, which represents the most dependent level.
Appendix A: Case Studies

**Dressing: Lower Body**
*Level 5, Supervision/Setup*
Same rationale as Dressing: Upper Body.

**Toileting**
*Level 3, Moderate Assistance*
Toileting consists of three tasks:
1. Adjusting pants prior to toileting
2. Performing perineal hygiene
3. Adjusting pants after toileting
Joshua performs two of the three tasks (or 67% of the effort) independently.

**Bladder Management**
*Level 5, Supervision/Setup*
Nighttime enuresis is a common childhood problem and is uniformly rated level 5.

**Bowel Management**
*Level 7, Complete Independence*

**Transfers: Chair, Wheelchair**
*Level 7, Complete Independence*

**Transfers: Toilet**
*Level 7, Complete Independence*

**Transfers: Tub, Shower**
*Level 4, Minimal Assistance*
A helper provides touching assistance by holding one hand when Joshua gets in and out of the tub.

**Locomotion: Walk, Wheelchair, Crawl**
*Level 7, Complete Independence*

**Locomotion: Stairs**
*Level 6, Modified Independence*
Joshua requires a railing for safety when he goes up and down stairs; therefore, the railing is considered an assistive device.

**Comprehension**
*Level 4, Minimal Assistance*
Joshua understands everyday conversations 80% of the time and follows unrelated two-step directions.
Expression
*Level 5, Supervision/Setup*
Joshua occasionally needs to repeat his words, but this occurs just 5% of the time.

Social Interaction
*Level 5, Supervision/Setup*
Joshua requires supervision only in unfamiliar situations.

Problem Solving
*Level 3, Moderate Prompting*
Joshua solves problems 50% to 74% of the time.

Memory
*Level 5, Supervision/Setup*
Joshua requires supervision only in unfamiliar situations.
Case Study: Joseph (Developmental Delay)

Joseph is a five-year-old male with a diagnosis of developmental delay. He attends a special half-day preschool program five times per week, during which he receives occupational therapy, physical therapy, speech therapy, and special education services. Joseph is very active and has a short attention span. He requires medication to help control his behavior.

Eating

Joseph eats a variety of food consistencies using a spoon and an open cup. He requires supervision because he occasionally tips over his plate or spills his milk.

Grooming

Joseph washes, rinses, and dries his hands and face independently. His mother brushes his teeth and combs his hair for him.

Bathing

Joseph washes, rinses, and dries both of his upper legs, his chest, and his abdomen. His mother bathes all other areas of his body.

Dressing: Upper Body

Joseph’s mother sets all his clothes out for him each day. He wears an undershirt and a pullover shirt. His mother dresses him because he refuses to dress himself. Joseph takes off his undershirt and shirt every night before bed.

Dressing: Lower Body

Joseph removes his underwear, pants, socks, and shoes. He undoes the fasteners himself. He refuses to get dressed, so his mother dresses him every day.

Toileting

Joseph’s mother adjusts his underwear and pants before toileting and completes perineal hygiene for him. Joseph always adjusts his clothing after toileting.

Bladder Management

Joseph has daytime accidents twice a month. He no longer has nighttime accidents.

Bowel Management

Joseph controls his bowels without help and does not have accidents.

Transfers: Chair, Wheelchair

Joseph gets into and out of an adult-sized chair safely without supervision.

Transfers: Toilet

Due to safety concerns, Joseph’s mother supervises him as he transfers to and from a standard toilet.

Transfers: Tub, Shower

Joseph holds his mother’s hand as he gets in and out of the tub.
Locomotion: Walk, Wheelchair, Crawl
Joseph walks 150 feet at varying rates of speed and does not always watch where he is going. He requires supervision at all times due to safety concerns.

Locomotion: Stairs
Joseph requires handrails to go up and down a full flight of stairs. He takes longer to come down the stairs because he is fearful, and therefore a helper must coax Joseph to come downstairs.

Comprehension
Joseph understands everyday conversations half of the time. He follows related two-step directions.

Expression
Joseph expresses his basic needs most of the time, and he needs minimal help to be understood.

Social Interaction
Joseph requires medication to help control his behavior. His mother is present to supervise during play situations. She structures his play 50% of the time.

Problem Solving
Joseph solves everyday problems 30% of the time. His awareness that a problem has occurred is limited.

Memory
Joseph recalls the day’s events at preschool when given an initial prompt like, “What did you do in school today?” He recognizes people frequently encountered 75% to 90% of the time.

Answer Key: Joseph (Developmental Delay)

Eating
Level 5, Supervision/Setup
A helper is present at every meal to supervise Joseph due to his behavior.

Grooming
Level 3, Moderate Assistance
Grooming consists of four tasks:
1. Brushing teeth
2. Combing or brushing hair
3. Washing, rinsing, and drying the hands
4. Washing, rinsing, and drying the face

By washing, rinsing, and drying his hands and his face, Joseph completes two of the four tasks independently. This represents 50% of the effort and should be rated level 3.
Appendix A: Case Studies

**Bathing**

*Level 2, Maximal Assistance*

Joseph washes, rinses, and dries four of the ten body areas without assistance. This represents 40% of the total body area and is therefore rated level 2.

**Dressing: Upper Body**

*Level 1, Total Assistance*

Joseph removes all his upper-body clothing independently. Due to his refusal to dress himself, his mother performs 100% of the upper-body dressing tasks by dressing him daily.

**Dressing: Lower Body**

*Level 1, Total Assistance*

Same rationale as Dressing: Upper Body.

**Toileting**

*Level 2, Maximal Assistance*

Toileting consists of three tasks:

1. Adjusting clothing prior to toileting
2. Performing perineal hygiene
3. Adjusting clothing after toileting

Each task accounts for approximately 33% of the total. By independently completing one of the three tasks, Joseph performs 33% of the effort.

**Bladder Management**

*Level 4, Minimal Assistance*

Joseph has two accidents per month. Rate a child level 4 for Frequency of Accidents if the child has one to three accidents per month.

**Bowel Management**

*Level 7, Complete Independence*

**Transfers: Chair, Wheelchair**

*Level 7, Complete Independence*

**Transfers: Toilet**

*Level 5, Supervision/Setup*

Due to safety concerns, a helper must supervise Joseph during toilet transfers.

**Transfers: Tub, Shower**

*Level 4, Minimal Assistance*

Joseph’s mother offers minimal assistance by holding Joseph’s hand as he gets in and out of the tub.
**Locomotion: Walk, Wheelchair, Crawl**

*Level 5, Supervision/Setup*

Joseph requires supervision during walking because of safety concerns.

**Locomotion: Stairs**

*Level 5, Supervision/Setup*

Joseph must use a handrail when going up and down a full flight of stairs. To help him overcome his fear, a helper must coax him down the stairs.

**Comprehension**

*Level 3, Moderate Prompting*

Joseph understands everyday conversations 50% of the time and follows related two-step directions.

**Expression**

*Level 4, Minimal Prompting*

Joseph expresses his needs 75% to 90% of the time and requires only minimal assistance to be understood.

**Social Interaction**

*Level 3, Moderate Direction*

Joseph requires medication to manage behavior (level 6). His mother provides supervision (level 5) and structures play 50% of the time (level 3).

**Problem Solving**

*Level 2, Maximal Direction*

Joseph solves everyday problems 25% to 49% of the time and needs direction more than 50% of the time to complete daily activities.

**Memory**

*Level 4, Minimal Prompting*

Joseph recognizes and remembers 75% to 90% of the time. When provided with an initial prompt by a helper, Joseph recalls events that occurred during the day.
Appendix A: Case Studies

Case Study: Brian (Traumatic Brain Injury)

Brian is a sixteen-year-old right-handed male who sustained a traumatic brain injury in a skiing accident. Prior to his accident, he was performing well in tenth grade.

Following his acute hospitalization, Brian was admitted to an inpatient rehabilitation unit in a children’s hospital for a twenty-five-day stay. He has right hemiparesis and wears a right forearm cast secondary to a fracture. The following is his WeeFIM® assessment at admission to the rehabilitation program.

Eating

Brian uses a spoon to eat his puréed diet and uses a straw to drink from a cup. He requires one-to-one supervision for pacing and monitoring intake.

Grooming

Brian performs all grooming tasks while seated in his wheelchair at the sink. His comb and toothbrush must be set out for him. After Brian’s helper applies toothpaste to Brian’s toothbrush, Brian brushes his teeth by himself. He washes, rinses, and dries his face and his hands and combs his hair without assistance.

Bathing

Brian washes and rinses his entire body independently once his helper sets the water temperature for him and lays out his bathing supplies. He requires reminders to dry his body thoroughly.

Dressing: Upper Body

Brian’s helper sets all his clothes out on the bed for him each day. Brian needs minimal assistance from his helper to get the right sleeve of his shirt or sweatshirt over his cast. He completes all other aspects of dressing and undressing his upper body with cues to sequence the steps.

Dressing: Lower Body

Brian’s helper puts on his pants, socks, and shoes for him each day. He removes his shoes and socks by himself and shifts his weight so that his helper can remove his pants for him.

Toileting

Brian holds a grab bar with his left hand while his helper adjusts his clothing before and after toileting. His helper performs perineal hygiene.

Bladder Management

Brian wears diapers because he has daily bladder accidents, but he does not give any indication that he is wet. Brian requires total assistance for bladder management.

Bowel Management

Brian has one or two bowel accidents each week. He requires total assistance for bowel management.

Transfers: Chair, Wheelchair

Brian uses a sliding board to transfer to and from his wheelchair. Brian’s helper puts on the brakes, removes the armrest, lifts the footrest, and positions the sliding board. During the transfer, Brian’s helper provides moderate assistance to move him along the sliding board.
Transfers: Toilet
Brian requires a grab bar to come to a standing position. He performs a pivot transfer from his wheelchair onto the toilet as his helper supervises. The helper provides moderate lifting assistance as Brian rises from the toilet. Brian uses the grab bar to perform a pivot transfer back to the wheelchair.

Transfers: Tub, Shower
Brian uses his sliding board and moderate assistance from his helper to transfer from his wheelchair onto a tub transfer bench. After bathing, Brian’s helper lifts both of Brian’s legs out of the tub and provides moderate assistance as Brian returns to his wheelchair.

Locomotion: Walk, Wheelchair, Crawl
Brian propels his wheelchair fifty feet with assistance from one helper.

Locomotion: Stairs
Brian is unable to walk up or down stairs due to weakness, poor balance, and impulsivity.

Comprehension
Brian follows related two-step directions with extra time due to slow processing of information.

Expression
Brian expresses his basic needs with single words and gestures.

Social Interaction
Brian tries to interact with other teens in the rehabilitation day room. He requires constant adult supervision due to impulsivity. His helper structures the sequence of interactions more than half the time.

Problem Solving
Brian attempts to identify problems when they arise and sometimes attempts to initiate solving those problems. Yet, due to impulsivity, his helper must solve the problems more than half the time.

Memory
Brian cannot remember the words to familiar songs or rhymes. With maximal prompting from a helper, Brian recognizes people he frequently encounters in the hospital, such as his therapists, and recalls the location of the rehab day room and the vending machines on the unit after a short delay.

Answer Key: Brian (Traumatic Brain Injury)

Eating
*Level 5, Supervision/Setup*
Modified diets are rated level 6, but the presence of a helper at every meal for pacing and monitoring intake reduces the rating to level 5.
Appendix A: Case Studies

**Grooming**

*Level 5, Supervision/Setup*

A helper sets out Brian’s grooming supplies (comb and toothbrush) and applies toothpaste to Brian’s toothbrush.

**Bathing**

*Level 5, Supervision/Setup*

A helper adjusts the water temperature for Brian and sets out his supplies for him. The helper offers verbal cues to remind Brian to dry himself thoroughly.

**Dressing: Upper Body**

*Level 4, Minimal Assistance*

A helper sets out all of Brian’s clothes (level 5) and provides verbal cues to sequence the steps of dressing (level 5). Brian requires minimal assistance to get the right sleeve over his cast (level 4). In such cases, record the **lowest** rating, which represents the most dependent level.

**Dressing: Lower Body**

*Level 2, Maximal Assistance*

As noted in Dressing: Upper Body, a helper sets out all of Brian’s clothing (level 5). Brian wears pants, socks, and shoes. The helper puts on all the articles of clothing. Brian independently removes his socks and shoes and shifts his weight so that the helper can remove his pants (level 2). In such cases, record the **lowest** rating, which represents the most dependent level.

**Toileting**

*Level 1, Total Assistance*

Brian is totally dependent in regard to toileting.

**Bladder Management**

*Level 1, Total Assistance*

- **Frequency of accidents:** Daily (level 1)
- **Level of assistance:** Brian is totally dependent and gives no indication of being wet (level 1).

When the ratings for frequency of accidents and level of assistance differ, use the **lower** rating.

**Bowel Management**

*Level 1, Total Assistance*

- **Frequency of accidents:** Once or twice a week (level 3)
- **Level of assistance:** Brian is dependent (level 1).

When the ratings for frequency of accidents and level of assistance differ, use the **lower** rating.

**Transfers: Chair, Wheelchair**

*Level 3, Moderate Assistance*

A helper sets up the wheelchair for the transfer, including putting on the brakes, removing the armrest and footrest, and positioning the sliding board (level 5). The helper offers moderate
assistance to slide Brian along the transfer board (level 3). In such cases, you should always record the lowest rating, which represents the most dependent level.

**Transfers: Toilet**

*Level 3, Moderate Assistance*

Brian holds on to a grab bar to come to a standing position (level 6). He performs a pivot transfer to the toilet with supervision from his helper (level 5). The helper offers moderate lifting assistance as Brian rises to return to the wheelchair (level 3). In such cases, record the lowest rating, which represents the most dependent level.

**Transfers: Tub, Shower**

*Level 3, Moderate Assistance*

Brian uses a sliding board to transfer from his wheelchair to the tub bench in the bathtub (level 6). The helper offers moderate assistance to Brian as he slides across the board and onto the tub bench (level 3). After bathing, the helper lifts both of Brian’s legs out of the tub and provides moderate assistance as Brian moves across the sliding board to return to the wheelchair (level 3). In such cases, record the lowest rating, which represents the most dependent level.

**Locomotion: Walk, Wheelchair, Crawl**

*Level 2, Maximal Assistance*

Distance: Brian propels his wheelchair fifty feet with assistance from one helper.

**Locomotion: Stairs**

*Level 1, Total Assistance*

Brian is unable to use the stairs at this time.

**Comprehension**

*Level 3, Moderate Prompting*

Brian requires extra time to comprehend (level 6). He follows related two-step directions.

**Expression**

*Level 2, Maximal Prompting*

Brian expresses his basic needs with single words and gestures.

**Social Interaction**

*Level 2, Maximal Prompting*

A helper structures the sequence of interactions more than 50% of the time.

**Problem Solving**

*Level 2, Maximal Prompting*

A helper must solve problems more than 50% of the time.

**Memory**

*Level 2, Maximal Prompting*

A helper prompts Brian to recall familiar people and locations 75% of the time.
Appendix B: WeeFIM® Normative Data

Normative values for the WeeFIM® instrument are presented in figure 25 through figure 28, which appear on pages 119–122. The normative figures summarize the mean age and range of values around the total WeeFIM® rating and the three individual domains:

1. **Self-care** (self-care and sphincter control)
2. **Mobility** (transfers and locomotion)
3. **Cognition** (communication and social cognition)

These norms were based upon a stratified sample of 424 children with no documented developmental delay or disability. The sample upon which these norms are based is well described in a previous publication (Msall, DiGaudio, Duffy, LaForest, Braun, and Granger, 1994). The normative sample size in the published study was N = 417, but several cases were removed in the present analysis, resulting in a final sample size for this appendix of N = 414. The age range presented in the normative tables and figures includes children aged 5.62 months through 107.44 months. Data is presented in three-month intervals. The first grouping includes children aged five through seven months, the second group includes children aged eight through ten months, and the last group includes children eighty-three months and older. Data was grouped in this fashion so that familiar milestone ages (e.g., twelve months, eighteen months, twenty-four months) would be represented as the approximate center of each three-month age interval. Because WeeFIM® total ratings tend to flatten beyond eighty-three months at a total rating of 120, no further specific breakdown was provided beyond this age range. (See table 2.)

Table 2 demonstrates a clear age-related function in WeeFIM® rating distribution. WeeFIM® ratings for the youngest members of the normative sample—those within the five- through seven-month age range—are expected to reflect dependence in most activities (i.e., a rating of level 1 for all WeeFIM® items). An increase in age corresponds with an increase in functional ability and an increase in WeeFIM® item and total ratings. By seventy-seven months, almost all the normative sample subjects are independent on most of the WeeFIM® items. (See table 2.)

Certain precautions should be recognized when using these normative tables. Although the sample size as a whole is reasonably large, the sample size within each of the three-month age groupings is sometimes small. (The range is six to twenty-nine, as shown in the third column in table 2.) When using the mean or average value of a sample to represent central tendency, an important consideration is whether the distribution from which the mean is derived is normal or bell-shaped. Normal distributions can often be found in natural phenomena, especially when the sample size is very large. When the sample size is small, however, the assumption that the distribution is normal is often not met. When the distribution is not normal, the mean or average value tends to vary from such measures of central tendency as the median, which is defined as “the point at or below which exactly 50% of the cases fall” (Hays, 1988, p. 156). All of this suggests that caution must be used when interpreting mean normative values presented in these figures, especially values from small samples. Table 2 can be used to compare mean scores versus median scores for each age interval.

At the item level, these norms were used to establish the age-specific norms in the WeeFIM II® software and the WeeFIM® Profile Report. These norm values are also used to calculate the functional quotient values at the total and domain (self-care, mobility, cognition) rating levels for children of various ages. The functional quotient values are also produced in the WeeFIM II® software and displayed in the WeeFIM® Profile Report.
### Appendix B: WeeFIM® Normative Data

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Table 2. Source data for normative data figures

References:

Appendix B: WeeFIM® Normative Data

Figure 25. Self-care normative data
Mobility Domain: Norm Data

3 transfer and 2 locomotion items
(minimum = 5, maximum = 35)
Appendix B: WeeFIM® Normative Data

Figure 27. Cognitive normative data

Cognition Domain: Norm Data
2 communication and 3 social cognition items
(minimum = 5, maximum = 35)
Figure 28. Total WeeFIM® normative data.

Total WeeFIM® Rating: Norm Data

All 18 items
(minimum = 18, maximum = 126)
Appendix C: WeeFIM® References


Appendix D: Glossary

Accreditation: Official approval to an organization determined by a set of industry-derived standards and granted by a recognized accreditation agency.

Activities of daily living (ADLs): Activities performed as part of a person’s daily routine, such as self-care, bathing, dressing, eating, and toileting.

Activity: The performance of a task or action by an individual (definition from the World Health Organization ICIDH-2).

Activity limitation: A restriction or lack of ability to perform an activity in the manner or within a range considered normal for a person of the same age, culture, and education. Formerly known as disability.

Acute care discharge: The number or percentage of patients discharged to an acute care setting.

Adaptive devices: Items used during the performance of everyday activities that improve function and compensate for physical, sensory, or cognitive limitations.

Admission WeeFIM® assessment: The initial functional assessment done using the WeeFIM® instrument at the time of admission to the rehabilitation program. The WeeFIM® instrument should be administered within three days of admission to the inpatient rehabilitation program or day treatment program and on the first visit to the outpatient program.

Ancillary services: Health services other than room and board. These may include X-ray, laboratory, and therapy services.

Bathing: Includes washing, rinsing, and drying the body below the neck (excluding the back) in a tub, shower, or sponge/bed bath.

Benchmarking: Measuring products and services for comparison.

Bladder accident: The act of wetting linen or clothing with urine, including bedpan and urinal spills.

Bladder Management: Includes complete, intentional control of the urinary bladder and use of equipment or agents necessary for bladder control.

Bowel accident: The act of soiling linen or clothing with stool, including bedpan spills.

Bowel Management: Includes complete, intentional control of bowel movements and use of equipment or agents necessary for bowel control.

CARF: The Rehabilitation Accreditation Commission: A private, not-for-profit agency, founded in 1966, that establishes standards of quality for services to persons with disabilities.

Cognitive subscale: The last five items of the WeeFIM® instrument: Comprehension, Expression, Social Interaction, Problem Solving, and Memory.

Community discharge: The number or percentage of patients discharged to a community-based setting, including a home (of the patient, a relative, or another person), transitional living setting, or shelter.

Comorbidity: A specific patient condition that is secondary in importance to the patient’s principle diagnosis or impairment.
**Complete Dependence**: The child expends less than half (less than 50%) of the effort. Maximal or total assistance is required, or the activity is not performed. This includes the rating levels *Maximal Assistance* and *Total Assistance*.

**Complete Independence**: All the tasks described as making up an activity on the WeeFIM® instrument are typically performed safely without modification, assistive devices, or aids, and within a reasonable amount of time.

**Comprehension**: Includes understanding either auditory or visual communication (e.g., speech, written language, manual signs, gestures, pictures).

**Comprehensive medical rehabilitation (CMR)**: Intensive pediatric medical rehabilitation in an inpatient setting.

**Contact guard**: Placing one hand on the child to ensure the child’s safety.

**Cue**: A gesture, facial expression, verbal instruction, or reminder provided to the child just before or during the performance of an activity.

**Discharge**: A Medicare patient in an inpatient rehabilitation facility is considered discharged when one of the following occurs:

1. The patient is formally released.
2. The patient stops receiving Medicare-covered Part A inpatient rehabilitation services.
3. The patient dies in the inpatient rehabilitation facility.

**Discharge WeeFIM® assessment**: The assessment of the child’s functional status using the WeeFIM® instrument at discharge. The WeeFIM® instrument should be administered within three days of the discharge from the inpatient rehabilitation program or day treatment program or at the time of discharge from the outpatient program.

**Dressing: Lower Body**: Includes dressing and undressing from the waist down (including underpants, slacks, skirts, socks, and shoes). This item also includes obtaining clothes from customary places (such as drawers and closets); managing buttons, zippers, and snaps as needed; and applying and removing prostheses and orthoses when applicable.

**Dressing: Upper Body**: Includes dressing and undressing above the waist (including pullover garments or front-opening garments). This item also includes obtaining clothes from customary places (such as drawers and closets); managing buttons, zippers, and snaps as needed; and applying and removing prostheses and orthoses when applicable.

**Eating**: Includes the use of suitable utensils to bring food to the mouth, chewing and swallowing, once a meal is appropriately prepared.

**Effectiveness**: The degree to which care is provided to achieve the desired outcome for the child.

**Efficiency**: The effects or results achieved in relation to the effort expended in terms of resources, time, and money.

**Expression**: Includes clear vocal and nonvocal expression of basic needs and ideas. It includes intelligible speech and clear expression of language using written language, gestures, manual signs, or communication devices.

**Flight of stairs**: A flight of stairs consists of twelve to fourteen stairs.
Appendix D: Glossary

**Grooming:** Includes oral care (brushing teeth); hair grooming (combing or brushing hair); washing, rinsing, and drying the hands; and washing, rinsing, and drying the face.

**ICIDH-2:** International Classification of Impairment, Disability, and Handicap; now referred to as International Classification of Functioning, Disability, and Health.

**Impairment:** Any loss or abnormality of psychological, physiological, or anatomical structure or function.

**Impairment group code (IGC):** Describes the primary reason that the patient is being admitted to the rehabilitation program.

**Independence:** The ability to perform a task within a reasonable amount of time *without* physical or cognitive assistance or supervision.

**Initial rehabilitation:** A child’s first admission to a rehabilitation program for this impairment.

**International Classification of Diseases, 9th Edition, Clinical Management:** A listing of diagnoses and identifying codes used to report diagnoses for individuals.

**Interrupted stay:** A stay at an inpatient rehabilitation facility during which a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within three consecutive calendar days. The duration of the interruption of the stay begins with the day of discharge from the inpatient rehabilitation facility and ends on midnight of the third day.

**The Joint Commission (TJC):** A private, not-for-profit organization that evaluates and accredits hospitals and other health-care organizations that provide home care, mental health care, ambulatory care, and long-term care services.

**Length of stay (LOS):** The number of days a patient spends in the rehabilitation program.

**Locomotion: Stairs:** Includes going up and down twelve to fourteen stairs (one flight) indoors.

**Locomotion: Walk, Wheelchair, Crawl:** Includes walking, once in a standing position; using a wheelchair, once in a seated position; and crawling on a level surface.

**Long-term care discharge:** The number or percentage of patients discharged to a long-term care setting, including an intermediate care setting, a skilled nursing facility, or a chronic hospital.

**Maximal Assistance:** The child expends less than 25% of the effort to perform an activity assessed by the WeeFIM® instrument, resulting in a rating of 1 for that activity.

**Medicaid:** A federally funded, state-administered program of medical assistance for people with low incomes.

**Medicare:** A national health payment program for persons over sixty-five years old and persons who are disabled.

**Memory:** Includes skills related to recognizing and remembering while performing daily activities. It includes storing and retrieving information, particularly verbal and visual. The functional evidence of memory includes recognizing people frequently encountered, remembering daily routines, and executing requests without being reminded. A deficit in memory impairs learning and the performance of tasks.
**Minimal Contact Assistance:** The child requires no more help than touching and expends 75% or more of the effort to perform an activity assessed by the WeeFIM® instrument, resulting in a rating of 4 for that activity.

**Moderate Assistance:** The child requires more help than touching or expends half (50%) or more (but less than 75%) of the effort to perform an activity assessed by the WeeFIM® instrument, resulting in a rating of 3 for that activity.

**Modified Dependence:** The child expends half (50%) or more of the effort to perform an activity assessed by the WeeFIM® instrument. This includes the levels Supervision/Setup, Minimal Contact Assistance, and Moderate Assistance.

**Modified Independence:** In the performance of an activity assessed by the WeeFIM® instrument, one or more of the following may be true: the activity requires an assistive device, the activity takes more than reasonable time, or there are safety (risk) considerations. This level is rated 6.

**More than a reasonable amount of time:** The child expends the equivalent of three times longer than other members of the family to complete an activity.

**Motor subscale:** The first thirteen items of the WeeFIM® instrument: Eating; Grooming; Bathing; Dressing: Upper Body; Dressing: Lower Body; Toileting; Bladder Management; Bowel Management; Transfers: Chair, Wheelchair; Transfers: Toilet; Locomotion: Walk, Wheelchair, Crawl; and Locomotion: Stairs.

**Multistep command, related:** A series of verbal directions in which the feedback from carrying out one task gives clues to carrying out other tasks.

**Multistep command, unrelated:** A series of verbal directions in which the feedback from carrying out one task does not give clues to carrying out other tasks.

**Onset days:** The number of days from acute onset of the impairment to admission to the rehabilitation program.

**Orthosis:** An appliance (i.e., a device) applied over a portion of a limb or the trunk and used to support or immobilize body parts, correct or prevent deformity, or assist or restore function. Antiembolic stockings, abdominal binders, and Ace® wraps are examples of orthoses.

**ORYX® program:** An initiative that identifies and uses core standardized performance measures that can be applied across accredited health-care organizations in each of The Joint Commission’s accreditation programs.

**Outlier:** An observation outside a certain range that differs widely from the rest of the data.

**Outcome:** The result or endpoint achieved by a defined point following delivery of services.

**Pain:** Any type of physical pain or discomfort in any part of the body.

**Participation:** An individual’s involvement in life situations in relation to health conditions, body functions and structures, activities, and contextual factors (definition from the World Health Organization’s ICIDH-2). Formerly known as handicap.

**Problem Solving:** Includes recognizing everyday problems when they occur, initiating plans to solve them, carrying out plans until the problem is solved, and self-correcting if errors are made. It also includes making reasonable, safe, and timely decisions regarding everyday problems.
Prompting: Includes slowing speech rate, repeating words, cuing, rephrasing, stressing particular words and phrases, pausing, and providing visual and gestural cues.

Program evaluation: A recognized method of determining quality, effectiveness, and efficiency of services that allows an organization to identify the results of services and the effects of the program on the persons served.

Prospective Payment System (PPS): A system of payments to a health-care facility at a predetermined rate for treatment regardless of the cost of care for a specific patient.

Prosthesis: A device that replaces a body part.

Readmission: A child’s readmission to an inpatient rehabilitation program for the same impairment.

Reliability: The degree to which results obtained by a measurement can be replicated.

Risk adjustment: A statistical process for reducing, removing, or clarifying influences of confounding factors that differ among groups.

Self-care activities: Basic activities necessary for daily personal care, including the WeeFIM® items Eating, Grooming, Bathing, Dressing: Upper Body, Dressing: Lower Body, and Toileting.

Setup: Assistance with preparation before the child performs an activity (prior preparation), or removal and disposal of equipment or materials after the child performs an activity.

Social Interaction: Includes interacting appropriately with other children (peers) in play and social situations. This interaction includes getting along with, cooperating with, and participating with others. It represents how the child deals with his own needs together with the needs of other children.

Supervision/Setup: For safety reasons, the caregiver monitors a child. Supervision may be standby (within arm’s reach) or distant. In regard to assessing activities with the WeeFIM® instrument, Supervision/Setup refers to help such as standby or distant supervision, cues or coaxing without physical contact, setup of needed items, or application of orthoses. Performance of an activity at this level is rated 5.

Toileting: Includes maintaining perineal hygiene (i.e., wiping self) and adjusting clothing before and after using a toilet, or bedpan.

Total Assistance: The child expends less than 25% of the effort to perform an activity assessed by the WeeFIM® instrument, resulting in a rating of 1.

Touching assistance: The caregiver touches the child in order to prompt the child to perform the desired physical movement.

Transfer: The release of a Medicare inpatient from one inpatient rehabilitation facility to another inpatient rehabilitation facility, a short-term hospital, a long-term care hospital, or a nursing home that qualifies to receive Medicare or Medicaid payments.

Transfers: Chair, Wheelchair: Includes all aspects of transferring to and from a chair or wheelchair. This includes coming to a standing position if walking is the typical mode of locomotion.

Transfers: Toilet: Includes all aspects of transferring onto and off a toilet.

Transfers: Tub, Shower: Includes getting into and out of a tub or shower stall.
Urinary diversion: A new, surgically created way for urine to pass out of the body. Also known as a cystectomy.

Validity: The degree to which a measurement instrument measures what it is intended to measure.

Visual cue: Any visible gesture, posture, or facial expression used to aid in the performance of a task.

WeeFIM® instrument: The pediatric functional assessment instrument included in the Uniform Data Set for Medical Rehabilitation. It consists of eighteen items rated on a seven-level scale that represents gradations in function from complete independence (level 7) to total assistance (level 1).
Appendix E: Frequently Asked Questions
Appendix E: Frequently Asked Questions

**General Questions**

Q. What is the conceptual basis for the WeeFIM® instrument?

A. The WeeFIM® instrument measures the severity of disability in terms of the need for assistance (burden of care). The need for assistance translates into (1) the time and energy that another person must expend to serve the dependent needs of a child with a disability so that the child can achieve and maintain a certain quality of life or (2) the extra time a child with a disability must spend to complete activities of daily living.

Q. Why does the WeeFIM® instrument address only eighteen areas of function?

A. The WeeFIM® instrument was designed to measure a minimal number of items. It is not expected to include all the activities that would be possible to measure or that might need to be measured for clinical purposes. Rather, the WeeFIM® instrument is a basic indicator of severity of disability that can be administered comparatively quickly and therefore can be used to generate data on large groups of children.

Q. How can we encourage clinicians who feel that collecting WeeFIM® data will take too much time or affect their workload too much?

A. Clinicians routinely assess activities of daily living for patient management. Recording the WeeFIM® ratings and comments from these assessments requires little extra time. Evaluators are not required to set aside specific time to rate the WeeFIM® items. Most of the information is already gathered when performing other assessments of daily living, by observing actual performance during the day, or, in the case of outpatient settings, when interviewing parents or primary caregivers.

Q. How should you rate an item if a child does not perform the functional activity even though you know he can? Here are some examples: A child refuses to attempt a tub transfer even though he may be physically capable of doing so, and he prefers to be lifted into the tub. Another child, who has a halo brace, might be able to perform a shower transfer but is given a bed bath every day.

A. The WeeFIM® instrument is intended to measure what the child actually does, not what he might be capable of doing under certain circumstances or what another person perceives that the child ought to be able to do. Although the children in the examples above do not perform tub or shower transfers for different reasons, both of them should be rated level 1, Total Assistance, because neither of them performs a tub or shower transfer.

Q. What are the guidelines for “more time”?

A. “More time” or “more than a reasonable amount of time” is the equivalent of three times longer than the time normally required by other members of the family to complete an activity. For example, if a family generally eats meals in thirty minutes but the child routinely takes ninety minutes, rate the child level 6, Modified Independence if he otherwise eats independently.
Q. What rating should be assigned when staff members have different opinions about a child’s performance of a task? For example, how should I rate a child if a nurse reports that toilet transfers require moderate assistance but a therapist reports that they require only supervision?

A. In these situations, UDSMR recommends recording the lower rating, which represents the greater need for assistance and may be a more realistic indicator of actual performance as opposed to peak performance. Variations in a child’s performance of a specific activity are not uncommon in different settings, at different times of the day or night, or in the presence of a parent rather than a clinician or teacher. It is also possible that individual clinicians are rating the same item differently.

Q. Why doesn’t the WeeFIM® instrument address neglect or spatial problems?

A. Although the WeeFIM® instrument is not a measure of visual perception, it can be used to determine the amount of help that a child with limitations resulting from these deficits may require when performing tasks associated with many of the WeeFIM® items. For example, if a child has a left-sided neglect and needs help to bathe or dress the left side of his body, the ratings for the bathing and dressing items may be lower because of the physical assistance the child requires.
Eating

Q. How should Eating be rated when a child’s diet consists of puréed foods?

A. Even though the child eats independently, he requires all his food to be puréed and thus should be rated level 6, Modified Independence. The child must be able to manage all consistencies of food by himself in order to be rated level 7, Complete Independence.

Q. The definition for Eating includes “chewing and swallowing.” How do you rate a child who has a swallowing disorder?

A. Since the WeeFIM® instrument is a measure of the need for assistance or burden of care, the rating should reflect the amount of help the child requires from another person as the result of his restricted ability to eat. For example, if a helper supervises the child during each meal to monitor the child’s speed of intake or the size of each bite, rate the child level 5, Supervision/Setup. If the helper feeds the child the last three or four bites of each meal, rate the child level 4, Minimal Assistance. If the child receives tube feedings that are administered by a helper who remains present for the duration of the feedings, rate the child level 1, Total Assistance.

Q. When assessing Eating, do you rate the left and right hands separately?

A. It does not matter whether the child uses his left hand or his right hand or is ambidextrous. The WeeFIM® instrument measures disability, not impairment.
Appendix E: Frequently Asked Questions

**Grooming**

Q. How do you rate a child with a head injury who needs constant cues for Grooming?

A. If the child requires cues, coaxing, or supervision only, rate the child level 5, Supervision/Setup, for Grooming. If the child does not initiate the task and the helper begins any of the grooming activities, rate the child level 4, Minimal Assistance.

Q. What rating should you use when a child needs help shampooing her hair?

A. The Grooming item does not include shampooing hair.
Bathing

Q. Why is the back excluded from Bathing?
A. The WeeFIM® instrument measures disability. If the back was included in this item, then children who do not have disabilities might be rated lower than level 7, Complete Independence, because they may not wash their backs or they may use assistive devices such as long-handled sponges. If the back is not included, a clearer picture of the child’s level of disability can be obtained.

Q. How is a handheld shower accounted for the child requires it to bathe?
A. Rate the child level 6, Modified Independence, because the use of the device is required.

Q. When a child needs someone to wring a washcloth for him, how does that affect the rating for Bathing?
A. If the helper only wrings the washcloth as part of initial preparation for bathing, rate the child level 5, Supervision/Setup. If the helper wrings the washcloth and hands it to the child many times during bathing, rate the child level 4, Minimal Assistance.
Dressing: Upper Body

Q. How should I rate a child who needs assistance only with buttoning a shirt or zipping the zipper on a cardigan sweater?
A. Rate the child level 4, Minimal Assistance, if a helper provides assistance for fastenings only.

Q. How do you rate Dressing: Upper Body if a child wears only sweatshirts? Do you need to test the child’s ability to put on and remove all the other types of clothing that are listed in the definition for Dressing: Upper Body?
A. Base your assessment on whatever clothing the child wears routinely. For example, if the child wears only pullover shirts or sweatshirts, base the rating on the amount of assistance the child requires to put on and remove those items. If the child wears sweatshirts during the week and button-down shirts on the weekends, base the rating on what the child wears most of the time.

Q. How should I rate a child who needs help applying a thoracolumbosacral orthosis (TLSO) or back brace?
A. If one helper applies the TLSO or back brace prior to dressing and the child then dresses himself without additional assistance from the helper, rate the child level 5, Supervision/Setup, for Dressing: Upper Body. “Setup” includes application of an orthosis.

Q. How should I rate a child who wears an upper body or limb prosthesis?
A. If the child applies the upper body or limb prosthesis by himself, does not use it to dress himself, and does not require any other device or assistance to dress his upper body, rate the child level 7, Complete Independence.

If the child applies the upper body or limb prosthesis by himself and then uses that prosthesis or another device to complete upper body dressing, rate the child level 6, Modified Independence.

If a helper applies the upper body or limb prosthesis but does not provide any further assistance for upper body dressing, rate the child level 5, Supervision/Setup.
Dressing: Lower Body

Q. How should I rate a child who only needs assistance tying his shoes?
A. Tying shoes is not included in the Dressing: Lower Body item.

Q. Are sneakers with Velcro® closures considered an adaptive device?
A. Because tying shoes is not included in the Dressing: Lower Body item, the Velcro® closures on the sneakers should not be considered when determining the rating for this item.

Q. How should I rate a child who needs help putting on antiembolic stockings?
A. Antiembolic stockings are considered orthoses. If a child requires help putting on any type of specialty stockings but completes all other lower-body dressing tasks himself, rate the child level 5, Supervision/Setup.

For example, if a child wears underpants, pants, antiembolic stockings, socks, and shoes and a helper puts on the antiembolic stockings before the child begins dressing, the highest possible rating is level 5, Supervision/Setup, because of the assistance the helper provides with the stockings. If the child then puts on her underpants and pants, after which the helper puts on both socks and both shoes, the child performs half the dressing tasks, and the helper performs the other half. Rate the child level 3, Moderate Assistance.

Q. How should I rate a child who wears a lower limb prosthesis?
A. If the child puts on the lower limb prosthesis by himself, does not use it to dress himself, and does not require any other device or assistance to dress his lower body, rate the child level 7, Complete Independence.

If the child applies the lower limb prosthesis by himself and then uses that prosthesis or another device to complete lower-body dressing tasks, rate the child level 6, Modified Independence.

If the helper applies the lower limb prosthesis but does not provide any further assistance for lower-body dressing tasks, rate the child level 5, Supervision/Setup.

Q. Can you provide examples of level 1, Total Assistance, for Dressing: Lower Body?
A. If two helpers are ever needed to complete any activity, the rating will be level 1, Total Assistance. This rating convention applies even when one helper supervises while the other gives hands-on assistance. A child who requires two helpers to pull his pants over his hips should be rated level 1, Total Assistance, for Dressing: Lower Body. A child who starts dressing his lower body but requires two helpers to complete the dressing tasks also should be rated level 1, Total Assistance (for example, a child who is very unsteady on his feet, so one helper provides steadying assistance while another pulls the child's underwear and pants up over his hips).

Rate a child level 1, Total Assistance, for Dressing: Lower Body if the child does not dress his lower body at all or performs less than 25% of the work to do so.

Q. How should I rate a child who dresses his lower body while he is still in bed? His ability to dress in bed is very different from his ability to dress while in a standing position.
A. Base the rating on what the child actually does. Rate the child level 5, Supervision/Setup, if he dresses himself in bed after a helper brings the clothes. If the child typically dresses his
lower body while standing and requires a helper to provide moderate assistance, rate the child level 3, Moderate Assistance, for Dressing: Lower Body. The WeeFIM® instrument measures the need for assistance (i.e., the burden of care) required to complete activities. In this case, more assistance is needed if the child dresses while standing.
Dressing: Upper Body and Dressing: Lower Body

Q. While in the hospital, how should I rate both dressing items if someone else gets clothing for a child whose routine does not involve getting his clothing out of drawers and closets?

A. Rate the child level 5, Supervision/Setup, for both Dressing: Upper Body and Dressing: Lower Body. These ratings capture the child’s actual performance, not what the child could do if circumstances were different.

Q. A child performs all upper- and lower-body dressing tasks independently but uses a walker while ambulating to get her clothes. Should I rate her level 6, Modified Independence, or level 7, Complete Independence?

A. Rate the child level 7, Complete Independence, for both Dressing: Upper Body and Dressing: Lower Body. Opening closets and drawers is included in the ratings for both dressing items. Getting to and from the closet and the drawers is rated as part of Locomotion: Walk, Wheelchair, Crawl.

Q. Would the application of pressure garments require children with burns to be rated level 5, Supervision/Setup?

A. If a child can dress himself after a helper puts pressure garments on the child, rate the child level 5, Supervision/Setup, for both Dressing: Upper Body and Dressing: Lower Body.

Q. How should I rate a child who is unable to get to the closet because of the arrangement of the hospital room? When a wheelchair cannot fit in the narrow space between the bed and the closet, someone else must always get the clothes for the child.

A. Rate the child level 5, Supervision/Setup, for Dressing: Upper Body and Dressing: Lower Body. In this situation, a helper always gets the clothes for the child. The WeeFIM® instrument rates the child’s actual performance, not what the child could do if circumstances were different.

Q. Why are upper-body and lower-body dressing rated separately?

A. The amount of assistance needed for upper body dressing is different than the amount needed for lower body dressing, and the skills required to complete the former differ from those needed to complete the latter. Dressing the lower body is usually more difficult.
Toileting

Q. How should you rate Toileting for a child who requires different levels of assistance for voiding and bowel movements?
A. Assess the amount of assistance required for both, and then use the lower rating.

Q. How should I rate Toileting for a child who pulls her pants up and down with steadying assistance from one helper and wipes herself without assistance?
A. If the child requires steadying or contact guard assistance during one or all of the Toileting tasks, rate the child level 4, Minimal Assistance. If the child uses a grab bar (an assistive device) while she stands to pull her pants up and down, thus eliminating the need for a helper, rate the child level 6, Modified Independence.

Q. How should I rate a child who needs help to wipe and to adjust clothing after using a toilet?
A. Rate the child level 2, Maximum Assistance. The Toileting item includes three activities: adjusting clothing before using the toilet, performing perineal hygiene (i.e., wiping), and adjusting clothing after using the toilet. In this case, the child performs one of the three activities.

Q. Should I rate this item if a child uses a bedpan instead of a toilet?
A. Yes. Toileting includes performing perineal hygiene and adjusting clothing before and after toilet or bedpan use. The child’s use of the bedpan will be addressed when assessing Bladder Management, Bowel Management, and Transfers: Toilet.
**Bladder Management**

Q. How should I rate Bladder Management for a child who uses a urinal?

A. Rate the child level 6, Modified Independence, for Bladder Management if the child uses the urinal independently and does not have any bladder accidents (wetting of linen or clothing) or spills. Rate the child level 5, Supervision/Setup, if a helper sets up or empties the urinal and the child does not have any bladder accidents or spills.

Q. How should I rate Bladder Management for a child who has one bladder accident a week?

A. When the frequency of bladder accidents is less often than daily and the child does not need any help (level of assistance) to manage the bladder, rate the child level 3, Moderate Assistance. Do not rate the child level 4, Minimal Assistance, unless the frequency of accidents is less often than weekly.

Q. How should I rate Bladder Management for a child who puts on a diaper independently and does not wet the linen or his clothing (bladder accident)?

A. Rate the child level 6, Modified Independence.

Q. How should I rate Bladder Management for a child who is on renal dialysis and does not void?

A. Rate the child level 7, Complete Independence. The child does not have any accidents and does not need assistance to void. The need for renal dialysis results from an impairment of the kidney, not the bladder. As a result, there is no disability related to Bladder Management.

Q. Our facility undertakes an intensive bladder training program as part of its rehabilitation program. As part of this program, nurses place patients on timed voiding programs every two hours. How should we assess patients who are essentially accident-free but only because of the effectiveness of the program?

A. When assessing bladder function, the level of assistance and the frequency of accidents are assessed separately, and the lower of the two ratings is recorded. If the child is on a timed voiding program and is completely dependent on nursing staff to implement the program, rate the child level 1, Total Assistance; however, if the child manages her bladder program during the day but has accidents at night, rate the child level 2, Maximal Assistance (daily accidents with some performance of the bladder management tasks by the child). One method for determining the rating for the level of assistance is to have the nursing staff outline the tasks required for each individual’s bladder program and then to determine what portion of the activity the child performs and what portion the helper performs. Next, determine the frequency of accidents and assign a rating. Finally, record the lower of the two ratings as the rating for Bladder Management.

Q. How should I rate Bladder Management for a child who performs intermittent straight catheterization for his bladder program? What about a child with an indwelling catheter? Neither child has bladder accidents (wetting of linen or clothing).

A. If the child performs intermittent catheterizations independently, including gathering the equipment and emptying the urine, rate the child level 6, Modified Independence, for Bladder Management. Even though the child uses a device, he performs the tasks independently. If a helper performs the intermittent catheterization, rate the child level 1, Total Assistance. As
the child learns to perform the catheterization himself, his rating will reflect his acquisition of new skills and thus increase.

A child who has an indwelling catheter and takes care of inserting the catheter and emptying the leg bag or drainage bag should be rated level 6, Modified Independence. If a helper inserts the catheter and empties the urine bags, rate the child level 1, Total Assistance.

Q. How do you determine whether to assign a rating of level 2, Maximal Assistance, or level 1, Total Assistance, when a child has bladder accidents every day?

A. Rate the child level 2, Maximal Assistance, if the child has accidents every day, requires wearing diapers, and shows some awareness of being wet or makes some effort to help with bladder management tasks. Rate the child level 1, Total Assistance, if the child has accidents every day, requires wearing diapers, and is not aware of being wet or makes no effort to help with bladder management tasks.

Q. Could you give some examples of performance at level 4, Minimal Assistance, and level 3, Moderate Assistance?

A. Rate the child level 4, Minimal Assistance, when the child voids independently and has bladder accidents two or three times per month (less often than weekly) or when the child never has bladder accidents and requires minimal assistance for the Bladder Management tasks.

Rate the child level 3, Moderate Assistance, when the child voids independently and has bladder accidents three or four times per week (less often than daily) or when the child has accidents less often than daily and requires moderate assistance with bladder management tasks.
**Bowel Management**

Q. How should I rate Bowel Management for a child who has a colostomy?

A. If a child with a colostomy completes all the tasks associated with bowel management independently (changing the bag, changing the wafer, emptying the bag into the toilet, etc.) and does not have any bowel accidents, rate the child level 6, Modified Independence. If a helper takes care of the colostomy, rate the child level 1, Total Assistance.

Q. A child is independent with his own bowel program but infrequently uses such bowel medication as stool softeners, laxatives, and suppositories. Should I rate the child level 6, Modified Independence, or level 7, Complete Independence? What if he uses the medication three times a week?

A. Rate the child level 6, Modified Independence.

Q. How should I rate Bowel Management for a child who uses a suppository every other day as his bowel management program?

A. The rating depends on the amount of assistance that is required. If the child administers the suppository independently, rate the child level 6, Modified Independence, for use of medication. If the child needs setup of supplies (diapers or incontinence pads) or supervision each time, rate the child level 5, Supervision/Setup. If the child needs the suppository inserted only, rate the child level 4, Minimal Assistance. If the child needs a helper for positioning, placement of a diaper or an absorbent pad, lubrication and insertion of the suppository, and help to evacuate the bowel (digital stimulation), rate the child level 1, Total Assistance. Cleansing and clothing adjustment are assessed when rating the Toileting item.

Q. How should I rate Bowel Management, Toileting, and Transfers: Toilet if a child has a colostomy and empties it into a bedpan at the bedside?

A. If a helper brings the bedpan to the child, takes it away, and empties it, rate the child level 5, Supervision/Setup, for Bowel Management. (This assumes that there are no bowel accidents where the linen or clothing is soiled.) Rate the child level 7, Complete Independence, for Toileting if the child adjusts clothing in bed before and after colostomy care. (Note: If cleansing the end of the bag is required, rate that under Toileting; if rinsing the appliance itself is required, rate that under Bowel Management.) Base the Transfers: Toilet rating on the child’s ability to transfer onto and off the toilet. If the child uses the bedpan for bowel movements, rate the child level 1, Total Assistance, for Transfers: Toilet because the child is not performing the activity.
Transfers: Chair, Wheelchair

Q. How can you evaluate whether a child has performed 50% of the transfer tasks?

A. Most clinicians find it easier to take a different approach to rating this item. If the child transfers in a safe and timely manner and does not use a device, rate the child level 7, Complete Independence. If the child takes more than a reasonable amount of time, if there is a safety concern, or if the child uses a device, rate the child level 6, Modified Independence. Rate the child level 5, Supervision/Setup, if a helper provides supervision, locks the wheels, positions the chair, removes an armrest, etc. If steadying assistance is required, or if help is needed to scoot the child forward in the chair only (no lifting), or if assistance with lifting one limb is required, rate the child level 4, Minimal Assistance. Once lifting of the body is required, rate the child level 3, Moderate Assistance. If a lot of lifting is required, rate the child level 2, Maximal Assistance. If the child is unable to bear weight and does not help at all, rate the child level 1, Total Assistance.

Q. If a child transfers nearly independently from a wheelchair, should I rate him level 5, Supervision/Setup?

A. Yes, if the child merely requires supervision. If the child requires steadying or contact assistance, rate the child level 4, Minimal Assistance.

Q. How should I rate a child who requires minimal assistance to transfer from a surface and moderate assistance to transfer back?

A. If the child has different levels of ability transferring to and from a surface, record the lower rating. In this case, the correct rating is level 3, Moderate Assistance.
Appendix E: Frequently Asked Questions

**Transfers: Toilet**

**Q.** How should I rate Transfers: Toilet when all the toilet seats in our facility are elevated? Does that mean I should never rate a child higher than level 6, Modified Independence, for this item?

**A.** The definition for level 6, Modified Independence, indicates that the child requires an adaptive or assistive device. Unless the child requires an elevated toilet seat, rate the child level 7, Complete Independence, if the child does not require any help.

**Q.** Is a bedside commode transfer the same as a toilet transfer?

**A.** No. A bedside commode is an assistive device, so a child who uses one cannot be rated higher than level 6, Modified Independence, for Transfers: Toilet. If a helper empties the commode bucket, do not rate the child higher than level 5, Supervision/Setup, for Bladder Management and Bowel Management.

**Q.** In transferring to a toilet, a child must be able to adjust his clothing as he sits down and stands up from the toilet. When rating Transfers: Toilet, managing clothing is not taken into consideration; only the physical part of sitting down and getting up again is evaluated. How should I rate a child who transfers independently but can’t adjust his clothing at the same time?

**A.** The tasks you describe are actually rated in two separate items, Toileting and Transfers: Toilet. The Toileting item assesses performing perineal hygiene and adjusting clothing before and after toilet or bedpan use. The Transfers: Toilet item assesses the child’s ability to get on and off a standard toilet. The child described above transfers onto and off a toilet independently. If he performs the transfer safely, in a timely manner, and without the use of assistive devices, rate him level 7, Complete Independence, for Transfers: Toilet. If he performs his own perineal hygiene but needs help pulling his pants down and then back up, rate him level 2, Maximal Assistance, for Toileting.

**Q.** The height of a toilet makes a difference in a child’s ability to transfer. For Transfers: Toilet, how should I rate a child who needs maximal assistance to transfer onto a regular toilet but only minimal assistance to transfer onto a raised commode?

**A.** Do not rate the child level 7, Complete Independence, unless he transfers to and from a regular (standard) toilet independently. If he transfers independently to and from a raised toilet seat, rate him level 6, Modified Independence, for Transfers: Toilet. The raised toilet seat is an assistive device. In the example described above, the child needs maximal assistance to transfer to and from a standard toilet seat and minimal assistance to transfer onto a raised toilet seat. Rate what the child actually does on a day-to-day basis. If he uses a raised toilet seat and requires contact guard assistance, rate him level 4, Minimal Assistance. If he uses a regular toilet seat and requires maximal assistance, rate him level 2, Maximal Assistance.
**Transfers: Tub, Shower**

Q. Is it acceptable to simulate a tub or shower transfer when assessing this item? We practice getting in and out of a tub while the children are fully dressed and wearing shoes.

A. The Transfer: Tub, Shower item must be assessed when the child is not wearing clothing or shoes and the tub is filled with water. Many children require different levels of assistance to perform tub or shower transfers when they are clothed and the tub is dry.

Q. During a tub transfer, a child requires moderate assistance to get onto a tub bench but requires maximum assistance to move one leg into the tub. Should I base the Transfer: Tub, Shower rating on the aspect of the tub transfer that requires the most assistance?

A. Base the rating on the child’s overall ability to get into and out of the tub or shower stall. This includes getting onto the tub bench and getting the legs over the threshold of the tub or shower. The child described above should be rated level 3, Moderate Assistance, if he needs light lifting assistance to get the transfer started and any level of assistance to lift one leg into the tub.

Q. At the time of the admission assessment, the child transfers to the tub bench in the shower with just contact guard assistance. Then the child progresses to transferring to a shower seat in the shower, which is a more difficult task, with minimal assistance. Under these circumstances, the child's rating dropped even though the child is now performing a more difficult task. Why doesn’t the WeeFIM® instrument distinguish between these differences in rating?

A. The WeeFIM® instrument measures a child’s level of ability in terms of need for assistance. Occasionally, a child’s rating for an item will go down as the child transitions from using one type of assistive device to another or requires more assistance from a helper instead of using an assistive device. With time and practice, the rating should improve as the child becomes more proficient in the new skill.
Appendix E: Frequently Asked Questions

**Locomotion: Walk, Wheelchair, Crawl**

Q. Why is 150 feet (50 meters) used as the standard when assessing Locomotion: Walk, Wheelchair, Crawl?

A. The distance of 150 feet (50 meters) represents the approximate length of one city block and is used as the minimum criterion for community ambulation. Traveling this distance should allow an individual to be able to walk from his home to a corner store or a friend’s house or from a car to his doctor’s office door.

Q. Should a child who uses a manual wheelchair be rated differently from a child who uses a motorized wheelchair?

A. No, he should not be. So long as he travels a distance of 150 feet (50 meters), rate him level 6, Modified Independence, regardless of whether he uses a manual or motorized wheelchair.

Q. A child is admitted to an inpatient therapy program and uses a wheelchair as the more frequent mode of locomotion. Between the admission assessment and the discharge assessment, the child’s ambulatory skills progress to the point that she walks more than she uses the wheelchair. Should I rate the child based on her wheelchair mobility, her walking ability, or both?

A. The admission and discharge Locomotion: Walk, Wheelchair, Crawl ratings should always be based on the same mode of locomotion. If a child changes mode of locomotion from admission to discharge (usually wheelchair to walking), record the admission mode, and then determine the rating based on the more frequent mode of locomotion.

If you anticipate that the child’s mode of locomotion will change (for example, from wheelchair to walking) during the rehabilitation program, or if you are unsure what mode the child will use most often at the time of the next assessment, determine and save the appropriate ratings for both wheelchair mobility and walking at the time of the admission assessment. At the time of discharge, determine the more frequent mode of locomotion and the appropriate rating for this mode, and then record that rating. Use the admission Locomotion: Walk, Wheelchair, Crawl rating of the corresponding mode.

Q. If a child is not ambulating on admission but ambulates 50 feet (17 meters) on discharge, the rating increases by only one level. Is this correct?

A. If the child ambulates 50 feet (17 meters) *with assistance*, that is correct. The discharge rating will be level 2, Maximum Assistance. If the child ambulates 50 feet (17 meters) *independently*, the discharge rating is level 5, Exception: Household Ambulation.

Q. Does level 5, Exception: Household Ambulation, imply independent ambulation status?

A. Yes, but to a limited extent. Rate a child level 5, Exception: Household Ambulation, when the child (a) *walks independently* a minimum of 50 feet (17 meters) with or without a device or (b) *operates a manual or power wheelchair independently* a minimum of 50 feet (17 meters). Rate the child level 2, Maximal Assistance, if the child ambulates 50 feet (17 meters) and *requires supervision or assistance* from one person.
Q. If a child ambulates 100 feet (34 meters) with only contact guard assistance, should I rate the child level 2, Maximal Assistance, based on distance?

A. Yes. The helper may be providing any level of assistance from maximal assistance to supervision.

Q. If a child’s walking and wheelchair usage is evaluated, and if both modes are used in therapy, how should I determine the WeeFIM® rating?

A. Record the admission and discharge ratings for Locomotion: Walk, Wheelchair, Crawl in the more frequently used mode at discharge. For example, if the child received training for both walk and wheelchair mobility, identify the mode the child used more frequently at the time of discharge. You may need input from several team members to determine this information.
**Locomotion: Stairs**

Q. In Florida, we have many one-story dwellings, so we are often not very concerned about a child’s ability to go up and down a full flight of stairs. If stair climbing is not one of our goals, can we disregard this item?

A. No, you cannot. You must rate every WeeFIM® item. If we were to tailor the items around each individual child’s goals, we would end up with an instrument that was different for each child. Because we want to compare data, we must use a uniform measure of functional assessment. The WeeFIM® instrument is an adjunct to your comprehensive clinical assessment and progress reports that will reflect the child’s individual goals.

Q. How should I rate a child who manages a set of training stairs that has four stairs?

A. If the child manages four stairs (up and down) with assistance, rate the child level 2, Maximal Assistance. If the child goes up and down four stairs independently, rate the child level 5, Exception: Household Ambulation.

Q. How should I rate a child in a wheelchair who uses an elevator only? Is the elevator considered an assistive device?

A. The elevator is not considered an assistive device. Because the child does not go up and down stairs, rate the child level 1, Total Assistance, for Locomotion: Stairs.

Q. How should I rate a child who ascends and descends stairs by scooting on her buttocks?

A. If the child scoots up and down a full flight of stairs (twelve to fourteen stairs) safely and in a reasonable amount of time, rate the child level 7, Complete Independence. If the child takes longer than a reasonable amount of time (compared to ambulatory means) to scoot up and down a full flight of stairs, rate the child level 6, Modified Independence.

Q. If a child goes up and down four stairs with minimal assistance or supervision, how should I rate Locomotion: Stairs? I often have children who need to go up and down three to six stairs and who lack the endurance to manage twelve to fourteen steps (or have cardiac restrictions, etc.), so a full flight of stairs is not a goal.

A. If the child goes up and down four stairs independently, rate the child level 5, Exception: Household Ambulation. If the child requires touching assistance or supervision, rate the child level 2, Maximal Assistance.

Q. Our facility does not have a full flight of twelve to fourteen stairs. We have four stairs in our PT gym and six steps outdoors. Can we have our children climb both of these stairs multiple times, or must we rate all our children level 1, Total Assistance, on admission and discharge? If we rate each child level 1, Total Assistance, some of the children who become independent on stairs will be portrayed inaccurately, and our overall ratings will not reflect the decreased need for assistance.

A. You may have the children climb a staircase of four to six steps multiple times as long as the stair climbing is continuous.
Q. Should a child who has morning stiffness as the result of juvenile rheumatoid arthritis be rated level 3, Moderate Assistance, for Locomotion: Stairs if her rating is level 1, Total Assistance, in the morning and level 5, Exception: Household Ambulation, in the evening?

A. Record the lower rating within the twenty-four-hour period. In this example, rate the child level 1, Total Assistance, for Locomotion: Stairs.

Q. If a child’s rating for going up the stairs is level 3, Moderate Assistance, and her rating for going down the stairs is level 2, Maximal Assistance, what should her overall rating be?

A. If there is a difference in the level of ability going up and down the stairs, record the lower rating.

Q. If a child manages eight steps with contact guard assistance, should I rate her level 2, Maximal Assistance, because she manages less than a full flight of stairs?

A. If a child manages only eight stairs with supervision from one person, rate the child level 2, Maximal Assistance. Do not rate the child level 3, Moderate Assistance, or higher, unless the child manages a full flight of stairs. Do not rate the child level 5, Exception: Household Ambulation, unless the child manages four to six stairs independently.
Comprehension

Q. How should I rate a child who cannot understand what is being said because of a hearing deficit? The child processes information but requires others to speak in loud voices so that he can hear them.

A. Significantly increasing the volume of your voice or repeating the message is a form of cuing. If it is done *almost all the time*, the rating may be as low as level 2, Maximal Prompting. Although one could argue that the assessment is confusing two issues (auditory comprehension and auditory acuity), from a functional standpoint, one cannot occur without the other. This situation is similar to that of a child who needs assistance to dress because of apraxia. Although apraxia is a motor-processing deficit, it affects dressing ability.

Q. How do you define cues for Comprehension?

A. Examples of cues include slowed speech rate, the use of repetition, stressing particular words or phrases, pauses, and visual or gestural cues.

Q. If a child with aphasia can understand what the helper means by looking at the helper’s gestures, should I rate him level 2, Maximal Prompting?

A. Yes. If the child understands only simple, commonly used vocal expressions or gestures, rate the child level 2, Maximal Prompting.

Q. How should I rate a child’s ability to express herself or comprehend if she speaks a language I do not understand? Is an interpreter considered an assistive device?

A. Base the child’s Comprehension and Expression ratings on her ability to comprehend and express herself in her usual language, which might not be English. Do not consider the use of an interpreter when rating these items. If you do not understand the child’s language, ask the child’s family, the child’s friends, or an interpreter whether the child understands everyday ideas.
Expression

Q. If a child expresses basic needs and ideas in writing or using manual signs, can she be rated level 7, Complete Independence?
A. Yes. The definition of Expression includes either vocal or nonvocal expression of basic needs and ideas. Therefore, a child who uses writing or manual signs to express basic needs and ideas can be rated level 7, Complete Independence.

Q. How should I rate Expression if a child uses only single words to express his basic needs and ideas?
A. Rate the child level 2, Maximal Prompting.

Q. What is the definition of “basic needs and ideas”?
A. “Basic needs and ideas” refers to the child’s ability to communicate about such necessary daily activities as hunger, thirst, elimination, hygiene, sleep, fear, pain, and other physiological needs.

Q. How should I rate Expression if a child expresses his basic needs and ideas only by pointing to pictures on a communication board?
A. Because the child uses gestures to express himself, rate him level 2, Maximal Prompting.
Social Interaction

Q. How should I rate a child who does not engage in play activities with others and who appears withdrawn? According to her parents, she has always been a loner.

A. When rating Social Interaction, consider the child’s degree of withdrawal and her behavior’s effects on her ability to have her needs met. If she simply chooses solitary activities because she is “introverted” or “shy” but she exhibits appropriate behaviors in group situations, rate her level 7, Complete Independence; however, if she exhibits inappropriate social behavior that requires verbal or nonverbal redirection when in group situations, base the rating on the amount of cues required. The rating can range from level 5, Supervision, to level 1, Total Assistance.

Q. How should I rate a child who is somewhat unsociable but does not cause trouble? He needs a few minutes to adjust but then interacts appropriately.

A. Rate the child level 6, Modified Independence.
**Problem Solving**

Q. Could you give some examples of problems that would be defined as “routine” in the WeeFIM® instrument?

A. “Routine” problems are everyday problems associated with daily tasks, unplanned events, and hazards that occur during daily activities. A more specific example is asking for assistance appropriately.

Q. How should I rate a child who solves routine, everyday problems 75% of the time?

A. Rate the child level 4, Minimal Direction, if the child needs occasional assistance with routine, everyday problems.

Q. What is the difference between level 4, Minimal Direction, and level 5, Supervision, when rating Problem Solving?

A. At level 4, Minimal Direction, the child solves routine problems most of the time. He requires occasional cues for completion of tasks or self-correction.

At level 5, Supervision, the child solves problems more than 90% of the time and only requires supervision (cues or coaxing) to solve problems under stressful or unfamiliar conditions.
Memory

Q. Can I rate a child level 7, Complete Independence, for Memory if he cannot remember each of his therapists by name?

A. No. The child does not need to remember individual names, but he must recognize the therapists he frequently encounters as people he has previously met.

Q. If a child recognizes his therapist but cannot remember her name, should I rate him level 3, Moderate Prompting, for Problem Solving?

A. “Recognizing familiar people frequently encountered” is only one aspect of Problem Solving. The child’s ability to remember daily routines and execute requests without being reminded also must be assessed when determining the rating for Problem Solving.

Q. How should I rate Problem Solving if a child uses a memory book?

A. If the child uses a memory book without reminders, rate the child level 6, Modified Independence. In this case, the memory book is an assistive device that the child uses by himself.

If the child needs to be reminded to use the memory book, rate the child level 5, Supervision.
Appendix F: Blank Coding Forms

This appendix contains copies of each of the five WeeFIM II® coding forms:

1. Case Coding Form
2. Assessment Coding Form
3. Family-Centered Feedback Form
4. Resource Utilization Form
5. Surgery Form

Master copies were included in the front inside cover of this guide.

Although you may use these blank coding forms for photocopying purposes, if you need additional copies, we recommend that you log in to the WeeFIM II® software and then generate the forms via the Report Generator module. For more information, log in to the WeeFIM II® software, and then select Help Topics from the Help menu. If you require additional assistance, contact our technical support department at 716-817-7834 or techsupport@udsmr.org.
## Case Coding Form

### Case Identification
1. Facility Code  
2. Patient Code  
3. Admission Date  

### Case Information
4. Program Type  
   (1) Inpatient (2) Outpatient  
5. Admission Class  
   Options: 6 for inpatient only, 7 for outpatient only, 10 for either  
   (1) Acute Illness (2) Surgical Intervention (3) Pharmacological Intervention  
   (4) Allergy/Immunological Intervention (5) Education/Outpatient Services (6) Other (ex. IH, VA)  
6. Admitted to Program From  
   (1) Home (2) Acute care unit of own facility (3) Acute care unit of another facility  
   (4) Rehabilitation facility (5) Residential facility (6) Transitional living center  
   (7) Skilled nursing facility (8) Other (9) Other  

### Medical Information
23. Impairment Group  
   Record the condition that requires admission to rehabilitation. Use UDS® impairment group codes  
24. Date of Onset  
25. Etiologic Diagnosis  
   Use ICD codes only.  
26. Other Diagnoses  
   Record the most significant other diagnoses below. Use ICD codes only.  
   a.  
   b.  
   c.  
   d.  
   e.  
   f.  

### Payment Information
27. Payment Source  
   a. Primary Source  
      (1) Medicaid (2) Managed care (3) Medicare (4) Private insurance (5) SCHIP  
      (6) Commercial insurance (7) Other  
   b. Secondary Source  
      Use codes listed for Primary Source as well as (20) None  

### Referral Information
28. Referring Facility  
29. Referring Physician  
30. Referring ZIP/Postal Code  
31. Referring Medical Service  
   (1) Medical (2) Physical Therapy (3) Speech Therapy (4) Occupational Therapy (5) Other  
   (6) Psychology (7) Social Work (8) Rehabilitation (9) Other  

### Discharge Information
32. Discharge Date  
33. Program Interruptions  
   (1) Yes (2) No  
   Enter start date, end date, and the reason for transfer in the ICD Code column.
# Case Coding Form

## WeeFIM II® Case Coding Form

### Resource Utilization

34. **Internal Resources**

Track internal resource utilization in the space provided below. Record only direct service resources in 15-minute units. If you need additional space, use the Resource Utilization Form provided.

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<tr>
<th>Month/Year</th>
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<th>SP</th>
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35. **External Resources**

Track external resource utilization in the space provided below. Record only direct service resources in 15-minute units. If you need additional space, use the Resource Utilization Form provided.

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### Surgeries

36. **Surgeries**

Record all surgeries, dates, and codes below. Use ICD codes in the Surgery Code column. If you need additional space, use the Surgery Form provided.

<table>
<thead>
<tr>
<th>Surgery Date</th>
<th>Surgery Code</th>
<th>CPT Code</th>
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### Custom Information

37. **Custom Fields**

Record all custom information in the fields provided.

- Custom Field #1
- Custom Field #2
- Custom Field #3
- Custom Field #4
- Custom Field #5
- Custom Field #6
- Custom Field #7
- Custom Field #8
- Custom Field #9
- Custom Field #10
### Assessment Coding Form

#### WeeFIM II® Assessment Coding Form

<table>
<thead>
<tr>
<th>Case Identification</th>
<th>WeeFIM® Instrument</th>
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<tbody>
<tr>
<td>1. Facility Code</td>
<td>17. WeeFIM® Instrument</td>
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<tr>
<td>2. Patient Code</td>
<td>Rate the child for each of the items below.</td>
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<td>3. Admission Date</td>
<td>Self-Care</td>
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#### Assessment Information

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<td>a. Eating</td>
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<td>b. Grooming</td>
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<td>c. Bathing</td>
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<tr>
<td>d. Dressing—Upper Body</td>
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<tr>
<td>e. Dressing—Lower Body</td>
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<tr>
<td>f. Toileting</td>
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<td>g. Bladder Management</td>
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<td>h. Bowel Management</td>
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<td>i. Self-Care Total</td>
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#### Mobility

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<tr>
<td>j. Toilet</td>
<td>Mobility Total</td>
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<tr>
<td>k. Tub, Shower</td>
<td>Mobility Total</td>
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<tr>
<td>l. Walk, Wheelchair, Crawl</td>
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<tr>
<td>m. Stairs</td>
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#### Cognition

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<td>o. Expression</td>
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<tr>
<td>p. Social Interaction</td>
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</tr>
<tr>
<td>q. Problem Solving</td>
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<td>r. Memory</td>
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#### WeeFIM® Total

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**Custom Information**

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**WeeFIM® Rating Levels**

- NoHelper
  - 1. Complete Independence (no device, timely, safely)
  - 6. Modified Independence (device, not timely, or not safely)
- Helper—Moderated Dependence
  - 2. Supervision (subject performs 100% of the effort)
  - 4. Minimal Assistance (subject performs 75% or more of the effort)
  - 3. Moderate Assistance (subject performs 50% to 74% of the effort)
- Helper—Complete Dependence
  - 3. Total Assistance or Not Testable (subject performs less than 25% of the effort)

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## Family-Centered Feedback Form

### WeeFIM II® Family-Centered Feedback Form

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<td>4. Assessment Date</td>
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### Family-Centered Feedback

16. Communication and Partnership

Indicate your answers to these questions on the lines provided.

a. To what extent do the people who work with your child discuss with you everyone’s expectations for your child so that all agree on what is best?

   - (1) Never  (2) Sometimes  (3) Frequently  (4) Always

b. To what extent do the people who work with your child make sure you have opportunities to explain what you think are important goals for your child?

   - (1) Never  (2) Sometimes  (3) Frequently  (4) Always

c. To what extent do the people who work with your child make you feel like a partner in your child’s care?

   - (1) Never  (2) Sometimes  (3) Frequently  (4) Always

17. Support and Advocacy

Indicate your answers to these questions on the lines provided.

a. To what extent does the center where you receive services provide support to help you cope with the impact of childhood disability by advocating on your behalf?

   - (1) Never  (2) Sometimes  (3) Frequently  (4) Always

b. To what extent does the center where you receive services give you information about the types of services offered in your community?

   - (1) Never  (2) Sometimes  (3) Frequently  (4) Always

c. To what extent does the center where you receive services satisfy your needs for family-centered care?

   - (1) Never  (2) Sometimes  (3) Frequently  (4) Always

---


### Return Contact Information

Once you have completed this form, please return it via postal mail to the following address:

[Insert Address]
## Resource Utilization Form

### WeeFIM II® Resource Utilization Form

#### Case Identification
1. Facility Code
2. Patient Code
3. Admission Date

#### Resource Utilization

**34. Internal Resources**
Track internal resource utilization in the space provided below. Record only direct service resources in 15-minute units. This information should supplement the information you provide on the Case Coding Form.

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>OT</th>
<th>PT</th>
<th>SP</th>
<th>OTHER (1)</th>
<th>OTHER (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**35. External Resources**
Track external resource utilization in the space provided below. Record only direct service resources in 15-minute units. This information should supplement the information you provide on the Case Coding Form.

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>OT</th>
<th>PT</th>
<th>SP</th>
<th>OTHER (1)</th>
<th>OTHER (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
## Surgery Form

### WeeFIM II® Surgery Form

<table>
<thead>
<tr>
<th>Case Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Facility Code</td>
</tr>
<tr>
<td>2. Patient Code</td>
</tr>
<tr>
<td>3. Admission Date</td>
</tr>
<tr>
<td>MM/DD/YYYY</td>
</tr>
</tbody>
</table>

### Surgeries

36. Surgeries

Record all surgeries, dates, and codes below. Use ICD codes in the Surgery Code column. This information should supplement the information you provide on the Case Coding Form.

<table>
<thead>
<tr>
<th>Surgery Date</th>
<th>Surgery Code</th>
<th>CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix F: Blank Coding Forms

0–3 Form

WeeFIM II® 0–3 Form

If this form contains preprinted information, please review all the information, draw a line through any incorrect data, and provide the correct answers. For example, if the zip code is wrong, draw a line through the incorrect zip code, and write the new zip code above or alongside the incorrect one. If this first page is blank, please complete all fields except Assessment Type.

Today's date: ___________  Assessment type: ___________________ (office use only)

MM/DD/YYYY

Last name: ___________________  First name: ___________________  Middle initial: ______

Date of birth: ________________

MM/DD/YYYY

Child's home zip code: ________________

Gender: ________________________

(a) Male  (b) Female

Who is filling out this form? (Choose one.)

(a) Mother  (b) Father  (c) Caregiver  (d) Therapist

(e) Teacher  (f) Other  (g) Combination

If you are asked to complete this form on-site, please return the completed form to the appropriate facility staff member. Otherwise, please complete the form and return it via one of the following methods:

☐ Fax: ________________

☐ Mail:

____________________

____________________

____________________
# 0–3 Form

## WeeFIM II® 0–3 Form

Answer all questions to the best of your ability. If you have trouble deciding between "rarely" and "sometimes," select "rarely." If you have trouble deciding between "sometimes" and "usually," select "sometimes." If your child NEVER performs an activity, select "rarely" for that activity.

<table>
<thead>
<tr>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Tube | Combination | Mouth
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Liquids | Baby Foods | Table Foods
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 0–3 Form

<table>
<thead>
<tr>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.</td>
<td></td>
<td>Crawls over or onto low obstacles such as your leg, large toy, pillow, or a single step.</td>
</tr>
<tr>
<td>15.</td>
<td></td>
<td>Climbs up onto higher surfaces such as a coffee table, couch, or adult chair.</td>
</tr>
<tr>
<td>None</td>
<td>Creeping/ Crawling</td>
<td>Walking</td>
</tr>
<tr>
<td>16.</td>
<td></td>
<td>Usual method of self-locomotion:</td>
</tr>
<tr>
<td></td>
<td>(a) None</td>
<td>(a) None</td>
</tr>
<tr>
<td></td>
<td>(b) Creeping/crawling</td>
<td>(b) Creeping/crawling</td>
</tr>
<tr>
<td></td>
<td>(c) Walking</td>
<td>(c) Walking</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.</td>
<td></td>
<td>Calms down and relaxes when you cuddle and comfort him/her.</td>
</tr>
<tr>
<td>18.</td>
<td></td>
<td>When awake and alert, he/she shows you affection.</td>
</tr>
<tr>
<td>19.</td>
<td></td>
<td>Seems interested in looking at people, objects, or pictures.</td>
</tr>
<tr>
<td>20.</td>
<td></td>
<td>Sits with you to look at a book or play with a toy for a few minutes.</td>
</tr>
<tr>
<td>21.</td>
<td></td>
<td>When playing with a toy, involves you in his/her play.</td>
</tr>
<tr>
<td>22.</td>
<td></td>
<td>Recognizes familiar faces and voices of immediate family members and caregivers.</td>
</tr>
<tr>
<td>23.</td>
<td></td>
<td>Looks for a toy or object that moves out of sight.</td>
</tr>
<tr>
<td>24.</td>
<td></td>
<td>Anticipates the next step in a game or interaction when you play with him/her.</td>
</tr>
<tr>
<td>25.</td>
<td></td>
<td>Tries to find the source of a familiar sound or voice (e.g., doorbell, ringing phone, dog barking, musical toy, mom talking).</td>
</tr>
<tr>
<td>26.</td>
<td></td>
<td>Knows the meaning of at least five words that you use frequently with him/her (e.g., “bottle,” “ball,” “book”).</td>
</tr>
</tbody>
</table>
# Appendix F: Blank Coding Forms

## 0–3 Form

### WeeFIM II® 0–3 Form

Answer all questions to the best of your ability. If you have trouble deciding between “rarely” and “sometimes,” select “rarely.” If you have trouble deciding between “sometimes” and “usually,” select “sometimes.” If your child NEVER performs an activity, select “rarely” for that activity.

<table>
<thead>
<tr>
<th></th>
<th>Cries</th>
<th>Gestures</th>
<th>Words</th>
</tr>
</thead>
<tbody>
<tr>
<td>27.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Let’s you know what he/she wants mainly by using one of the following means:

(a) Cries, sounds, or body movements
(b) Looking at or pointing to an object, or using gestures
(c) Words, sound combinations, or manual signs

<table>
<thead>
<tr>
<th></th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
</tr>
</thead>
<tbody>
<tr>
<td>28.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

When encountering an obstacle, solves the problem by going around the obstacle or moving it out of the way.

| 29. | ☐      | ☐         | ☐       |

When an object is out of reach, solves the problem by using or creating a tool from another object to extend his/her reach (e.g., uses a stick to pull something closer, uses a stool to get something that’s too high).

| 30. | ☐      | ☐         | ☐       |

Is persistent when attempting to solve problems (i.e., tries more than one time, or tries more than one strategy).

| 31. | ☐      | ☐         | ☐       |

Mealtimes lasts less than 30 minutes.

| 32. | ☐      | ☐         | ☐       |

Sleeps through the night so that your sleep is not disturbed.

| 33. | ☐      | ☐         | ☐       |

Bathing is a pleasant experience for you and your child.

| 34. | ☐      | ☐         | ☐       |

Dressing is a pleasant experience for you and your child.

<table>
<thead>
<tr>
<th>A Lot</th>
<th>Moderate</th>
<th>Little</th>
</tr>
</thead>
<tbody>
<tr>
<td>35.</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

When your child becomes upset, in order to calm him/her, you must expend:

(a) A Lot of effort
(b) A Moderate amount of effort
(c) Little or no effort

<table>
<thead>
<tr>
<th></th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
</tr>
</thead>
<tbody>
<tr>
<td>36.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

You can comfortably leave your child in someone else’s care when necessary or desired.
Appendix G: The 0–3 Module

The WeeFIM® Instrument: 0–3 Module consists of thirty-six items arranged in three domains. It measures precursors to function in children zero to three years old who have a variety of disabilities. The 0–3 Module can be administered quickly and easily to parents by interview or self-report. The new module is intended to complement the WeeFIM® instrument. It measures both early functional performance and changes in performance over time. It is useful across many settings, including early intervention and preschool.
## Domains and Items

The WeeFIM® Instrument: 0–3 Module includes three domains:

1. Motor (sixteen items)
2. Cognitive (thirteen items)
3. Behavioral (seven items)

The following table lists the items within each domain in the order of their appearance on the WeeFIM II® Family-Centered 0–3 Form:

<table>
<thead>
<tr>
<th>Motor</th>
<th>Cognitive</th>
<th>Behavioral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holds Cup</td>
<td>Shows Affection</td>
<td>Cuddles</td>
</tr>
<tr>
<td>Scoops Food</td>
<td>Looks at People</td>
<td>Mealtime</td>
</tr>
<tr>
<td>Reaches and Grasps</td>
<td>Looks at Book</td>
<td>Sleeping</td>
</tr>
<tr>
<td>Transfers Objects</td>
<td>Joint Attention</td>
<td>Bathing</td>
</tr>
<tr>
<td>Plays with Toys</td>
<td>Recognizes Faces</td>
<td>Dressing</td>
</tr>
<tr>
<td>Imitates Use</td>
<td>Looks for Objects</td>
<td>Calming</td>
</tr>
<tr>
<td>Nutritional Intake Method</td>
<td>Anticipates Next Step</td>
<td>Separation Anxiety</td>
</tr>
<tr>
<td>Food Texture</td>
<td>Familiar Sounds</td>
<td></td>
</tr>
<tr>
<td>Lifts Head</td>
<td>Knows Meaning of Five Words</td>
<td></td>
</tr>
<tr>
<td>Lifts Chest</td>
<td>Cries, Gestures, Words</td>
<td></td>
</tr>
<tr>
<td>Hands and Knees</td>
<td>Goes around Obstacles</td>
<td></td>
</tr>
<tr>
<td>Sits</td>
<td>Creative Solutions</td>
<td></td>
</tr>
<tr>
<td>Stands</td>
<td>Persists</td>
<td></td>
</tr>
<tr>
<td>Crawls over Obstacles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climbs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creeps/Crawls/Walks</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Rating Scale

The WeeFIM® Instrument: 0–3 Module uses a three-level rating scale:

- Level 3, Usually
- Level 2, Sometimes
- Level 1, Rarely

The total motor rating ranges from 16 to 48, the total cognitive rating ranges from 14 to 42, and the total behavioral rating ranges from 6 to 18. Lower ratings for the behavioral items may indicate a need for earlier intervention than might otherwise be thought.
Appendix G: The 0–3 Module

WeeFIM II® Family-Centered 0–3 Form Instructions

Throughout this document, the term rehabilitation program is used to identify all inpatient programs, outpatient services, day treatment programs, and habilitation programs. Unless otherwise specified, the terms outpatient, outpatient program, and outpatient services include day treatment programs.

The intent of the WeeFIM II® Family-Centered 0–3 Form is to collect information from the family’s perspective. When this is not feasible, clinicians may complete the form based on direct observation of the child. Use of this form is optional and can begin and end at any point during the child’s hospitalization or enrollment in an outpatient program.

As a general guideline, UDSMR recommends that you begin using the 0–3 module when the child’s total WeeFIM® rating is less than 30 and that you discontinue using it when the child’s total 0–3 rating is 70 or higher. If the child’s WeeFIM® rating is in the 30–40 range, you may find the use of the 0–3 module beneficial.

Remember that the use of the eighteen-item WeeFIM® instrument is mandatory at admission, discharge, and follow-up; the 0–3 module is optional for these assessments. Interim assessments are strictly voluntary. For these assessments, you may use the WeeFIM® instrument by itself, the 0–3 module by itself, or both. The frequency of these optional interim assessments should be determined by your facility.

Instructions for Page 1

- **Today’s date:** Enter the date of the assessment. The date must take the form MM/DD/YYYY, where MM is a two-digit code for the month (e.g., 01 for January, 12 for December), DD is the two-digit day of the month, and YYYY is the full year (e.g., 2016).

- **Assessment type:** Enter the appropriate code for the type of assessment that is being completed:
  
  0 **Preadmission:** A baseline assessment that reflects the child’s status prior to admission to the rehabilitation program.
  
  1 **Admission:** The first assessment completed after the child enters the rehabilitation program.
    
    **Inpatient:** The first assessment must be completed within seventy-two hours of admission to the inpatient rehabilitation program.
    
    **Outpatient:** The first assessment must be completed upon enrollment in (i.e., the first visit to) the outpatient program.

  2 **Interim:** Any assessment completed after the admission assessment and prior to the discharge assessment. The frequency of interim assessments is determined by each facility, but we recommend that interim assessments be performed on a regular schedule (e.g., quarterly, every six months, annually) for children who receive ongoing outpatient therapy services for an extended period.
3 **Discharge:** The last assessment completed prior to the child’s discharge from the rehabilitation program.

**Inpatient:** The last assessment completed (a) within seventy-two hours prior to discharge from the program (not from therapy) or (b) on the last day prior to a program interruption of more than thirty days.

**Outpatient:** The last assessment completed before the child is discharged from the program.

4 **Follow-up:** An assessment completed 80–180 days after discharge from an inpatient rehabilitation program or a day treatment program.

• **Last name:** Enter the child’s last name.

• **First name:** Enter the child’s first name.

• **Middle initial:** Enter the child’s middle initial, if the child has one.

• **Date of birth:** Enter the date on which the child was born. The date must take the form MM/DD/YYYY, where MM is a two-digit code for the month (e.g., 01 for January, 12 for December), DD is the two-digit day of the month, and YYYY is the full year (e.g., 2016).

• **Child’s home ZIP code:** Enter the ZIP code of the child’s primary home living address.

• **Gender:** Enter the child’s gender.
  1 Male
  2 Female

• **Who is filling out this form?** Enter the information source for the assessment.
  a Mother
  b Father
  c Caregiver
  d Therapist
  e Teacher
  f Other
  g Combination

**Instructions for Pages 2–4**

Use the column headers and item descriptions to rate the child. Most items, but not all, employ the “rarely, sometimes, usually” rating system.
## Appendix G: The 0–3 Module

<table>
<thead>
<tr>
<th>Age Group (Months)</th>
<th>Mean +2 SD</th>
<th>Mean +1.5 SD</th>
<th>Mean +1 SD</th>
<th>Mean</th>
<th>Mean −1 SD</th>
<th>Mean −1.5 SD</th>
<th>Mean −2 SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–2.9</td>
<td>29.2</td>
<td>27.7</td>
<td>26.1</td>
<td>23.0</td>
<td>19.9</td>
<td>19.0</td>
<td>16.8</td>
</tr>
<tr>
<td>3.0–5.9</td>
<td>34.6</td>
<td>33.0</td>
<td>31.3</td>
<td>28.0</td>
<td>24.7</td>
<td>23.1</td>
<td>21.4</td>
</tr>
<tr>
<td>6.0–8.9</td>
<td>37.0</td>
<td>35.0</td>
<td>33.0</td>
<td>29.0</td>
<td>25.0</td>
<td>23.0</td>
<td>21.0</td>
</tr>
<tr>
<td>9.0–11.9</td>
<td>41.5</td>
<td>40.2</td>
<td>38.8</td>
<td>36.1</td>
<td>33.4</td>
<td>32.1</td>
<td>30.7</td>
</tr>
<tr>
<td>12.0–14.9</td>
<td>42.0</td>
<td>42.0</td>
<td>41.5</td>
<td>38.3</td>
<td>35.1</td>
<td>33.5</td>
<td>31.9</td>
</tr>
<tr>
<td>15.0–17.9</td>
<td>42.0</td>
<td>41.9</td>
<td>40.6</td>
<td>38.1</td>
<td>36.5</td>
<td>34.4</td>
<td>33.1</td>
</tr>
<tr>
<td>18.0–20.9</td>
<td>42.0</td>
<td>42.0</td>
<td>41.8</td>
<td>39.5</td>
<td>37.2</td>
<td>36.1</td>
<td>34.9</td>
</tr>
<tr>
<td>21.0–23.9</td>
<td>42.0</td>
<td>42.0</td>
<td>42.6</td>
<td>40.8</td>
<td>39.0</td>
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*Table 3. 0–3 module: description of normative values for cognitive domain by age group*
Appendix G: The 0–3 Module

Figure 29. Cognitive normative values for the 0–3 module
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<th>Age Group (Months)</th>
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<th>Mean +1.5 SD</th>
<th>Mean +1 SD</th>
<th>Mean</th>
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Table 4. 0–3 module: description of normative values for motor domain by age group
Figure 30. Motor normative values for the 0–3 module