

# VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Dates: Screen \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Assessment \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Reassessment \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## 1 IDENTIFICATION/BACKGROUND

### Name & Vital Information

Client Name: \_\_\_\_\_ Client SSN: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Phone: ( ) \_\_\_\_\_ City/County Code: \_\_\_\_\_

Directions to House:

Pets?

### Demographics

Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Male 0 \_\_\_\_\_ Female 1  
(Month) (Day) (Year)

Marital Status: \_\_\_\_\_ Married 0 \_\_\_\_\_ Widowed 1 \_\_\_\_\_ Separated 2 \_\_\_\_\_ Divorced 3 \_\_\_\_\_ Single 4 \_\_\_\_\_ Unknown 9

Race:

- \_\_\_\_\_ White 0
- \_\_\_\_\_ Black/African American 1
- \_\_\_\_\_ American Indian 2
- \_\_\_\_\_ Oriental/Asian 3
- \_\_\_\_\_ Alaskan Native 4
- \_\_\_\_\_ Unknown 9

Education:

- \_\_\_\_\_ Less than High School 0
- \_\_\_\_\_ Some High School 1
- \_\_\_\_\_ High School Graduate 2
- \_\_\_\_\_ Some College 3
- \_\_\_\_\_ College Graduate 4
- \_\_\_\_\_ Unknown 9

Communication of Needs:

- \_\_\_\_\_ Verbally, English 0
- \_\_\_\_\_ Verbally, Other Language 1
- Specify \_\_\_\_\_
- \_\_\_\_\_ Sign Language/Gestures/Device 2
- \_\_\_\_\_ Does Not Communicate 3
- Hearing Impaired? \_\_\_\_\_

Ethnic Origin \_\_\_\_\_ Specify \_\_\_\_\_

### Primary Caregiver/Emergency Contact/Primary Physician

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Name of Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

### Initial Contact

Who called: \_\_\_\_\_  
(Name) (Relation to Client) (Phone)

Presenting Problem/Diagnosis:



CLIENT NAME:

Client SSN: - -

## Physical Environment

Where do you usually live? Does anyone live with you?

	Alone 1	Spouse 2	Other 3	Names of Persons in Household	
<input type="checkbox"/> House Own 0					
<input type="checkbox"/> House Rent 1					
<input type="checkbox"/> House Other 2					
<input type="checkbox"/> Apartment 3					
<input type="checkbox"/> Rented Room 4					
	Name of Provider (Place)			Admission Date	Provider Number (If Applicable)
<input type="checkbox"/> Adult Care Residence 50					
<input type="checkbox"/> Adult Foster 60					
<input type="checkbox"/> Nursing Facility 70					
<input type="checkbox"/> Mental Health/ Retardation Facility 80					
<input type="checkbox"/> Other 90					

Where you usually live, are there any problems?

No 0	Yes 1	Check All Problems That Apply	Describe Problems:
<input type="checkbox"/>	<input type="checkbox"/>	Barriers to Access	
<input type="checkbox"/>	<input type="checkbox"/>	Electrical Hazards	
<input type="checkbox"/>	<input type="checkbox"/>	Fire Hazards/No Smoke Alarm	
<input type="checkbox"/>	<input type="checkbox"/>	Insufficient Heat/Air Conditioning	
<input type="checkbox"/>	<input type="checkbox"/>	Insufficient Hot Water/Water	
<input type="checkbox"/>	<input type="checkbox"/>	Lack of/Poor Toilet Facilities (Inside/Outside)	
<input type="checkbox"/>	<input type="checkbox"/>	Lack of/Defective Stove, Refrigerator, Freezer	
<input type="checkbox"/>	<input type="checkbox"/>	Lack of/Defective Washer/Dryer	
<input type="checkbox"/>	<input type="checkbox"/>	Lack of/Poor Bathing Facilities	
<input type="checkbox"/>	<input type="checkbox"/>	Structural Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Telephone Not Accessible	
<input type="checkbox"/>	<input type="checkbox"/>	Unsafe Neighborhood	
<input type="checkbox"/>	<input type="checkbox"/>	Unsafe/Poor Lighting	
<input type="checkbox"/>	<input type="checkbox"/>	Unsanitary Conditions	
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	

**2 FUNCTIONAL STATUS** (Check only one block for each level of functioning)

ADLS	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40			Is Not Performed 50
	No 0	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2	Spoon Fed 1	Syringe/Tube Fed 2	Fed by IV 3	
Bathing											
Dressing											
Toileting											
Transferring											
Eating/Feeding											

Continence	Needs Help?		Incontinent Less than weekly 1	External Device/ Indwelling/ Ostomy Self care 2	Incontinent Weekly or more 3	External Device Not self care 4	Indwelling Catheter Not self care 5	Ostomy Not self care 6
	No 0	Yes						
Bowel								
Bladder								

Comments:

Ambulation	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40		Is Not Performed 50
	No 0	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2	Confined Moves About	Confined Does Not Move About	
Walking										
Wheeling										
Stairclimbing										
Mobility										

IADLS	Needs Help?	
	No 0	Yes 1
Meal Preparation		
Housekeeping		
Laundry		
Money Management		
Transportation		
Shopping		
Using Phone		
Home Maintenance		

Comments:

**Outcome: Is this a short assessment?**

\_\_\_\_\_ No, Continue with Section 0 \_\_\_\_\_ Yes, Service Referrals 1 \_\_\_\_\_ Yes, No Service Referrals 2

Screener: \_\_\_\_\_ Agency: \_\_\_\_\_

CLIENT NAME:

Client SSN: - - -

### 3 PHYSICAL HEALTH ASSESSMENT

#### Professional Visits/Medical Admissions

Doctor's Name(s) (List all)	Phone	Date of Last Visit	Reason for Last Visit

Admissions: In the past 12 months, have you been admitted to a ... for medical or rehabilitation reasons?

No 0	Yes 1	Name of Place	Admit Date	Length of Stay/Reason
		Hospital		
		Nursing Facility		
		Adult Care Residence		

Do you have any advanced directives such as ... (Who has it ... Where is it ...)?

No 0	Yes 1	Location
		Living Will, _____
		Durable Power of Attorney for Health Care, _____
		Other, _____

#### Diagnoses & Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as ... (Refer to the list of diagnoses)?

Current Diagnoses	Date of Onset

Enter Codes for 3 Major, Active Diagnoses: \_\_\_\_\_ None 00 \_\_\_\_\_ DX1 \_\_\_\_\_ DX2 \_\_\_\_\_ DX3

Current Medications (Include Over-the-Counter)	Dose, Frequency, Route	Reason(s) Prescribed
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		
10. _____		

Total No. of Medications: \_\_\_\_\_ (If 0, skip to Sensory Function) Total No. of Tranquilizer/Psychotropic Drugs: \_\_\_\_\_

Do you have any problems with medicine(s) ... ?

No 0	Yes 1

How do you take your medicine(s)?

	Without assistance 0
	Administered/monitored by lay person 1
	Administered/monitored by professional nursing staff 2
	Describe help _____
	Name of helper _____

- Diagnoses:**
- Alcoholism/Substance Abuse (01)
  - Blood-Related Problems (02)
  - Cancer (03)
  - Cardiovascular Problems
    - Circulation (04)
    - Heart Trouble (05)
    - High Blood Pressure (06)
    - Other Cardiovascular Problems (07)
  - Dementia
    - Alzheimer's (08)
    - Non-Alzheimer's (09)
  - Developmental Disabilities
    - Mental Retardation (10)
  - Related Conditions
    - Autism (11)
    - Cerebral Palsy (12)
    - Epilepsy (13)
    - Friedreich's Ataxia (14)
    - Multiple Sclerosis (15)
    - Muscular Dystrophy (16)
    - Spina Bifida (17)
  - Digestive/Liver/Gall Bladder (18)
  - Endocrine (Gland) Problems
    - Diabetes (19)
    - Other Endocrine Problems (20)
  - Eye Disorders (21)
  - Immune System Disorders (22)
  - Muscular/Skeletal
    - Arthritis/Rheumatoid Arthritis (23)
    - Osteoporosis (24)
    - Other Muscular/Skeletal Problems (25)
  - Neurological Problems
    - Brain Trauma/Injury (26)
    - Spinal Cord Injury (27)
    - Stroke (28)
    - Other Neurological Problems (29)
  - Psychiatric Problems
    - Anxiety Disorders (30)
    - Bipolar (31)
    - Major Depression (32)
    - Personality Disorder (33)
    - Schizophrenia (34)
    - Other Psychiatric Problems (35)
  - Respiratory Problems
    - Black Lung (36)
    - COFD (37)
    - Pneumonia (38)
    - Other Respiratory Problems (39)
  - Urinary/Reproductive Problems
    - Renal Failure (40)
    - Other Urinary/Reproductive Problems (41)
  - All Other Problems (42)

CLIENT NAME:

Client SSN:

## Sensory Functions

How is your vision, hearing, and speech?

	No Impairment 0	Impairment		Complete Loss 3	Date of Last Exam
		Record Date of Onset/Type of Impairment			
		Compensation 1	No Compensation 2		
Vision					
Hearing					
Speech					

## Physical Status

Joint Motion: How is your ability to move your arms, fingers and legs?

- Within normal limits or instability corrected 0
- Limited motion 1
- Instability uncorrected or immobile 2

Have you ever broken or dislocated any bones... Ever had an amputation or lost any limbs... Lost voluntary movement of any part of your body?

Fractures/Dislocations	Missing Limbs	Paralysis/Paresis
<input type="checkbox"/> None 000 <input type="checkbox"/> Hip Fracture 1 <input type="checkbox"/> Other Broken Bone(s) 2 <input type="checkbox"/> Dislocation(s) 3 <input type="checkbox"/> Combination 4 Previous Rehab Program? <input type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 Date of Fracture/Dislocation? <input type="checkbox"/> 1 Year or Less 1 <input type="checkbox"/> More than 1 Year 2	<input type="checkbox"/> None 000 <input type="checkbox"/> Finger(s)/Toe(s) 1 <input type="checkbox"/> Arm(s) 2 <input type="checkbox"/> Leg(s) 3 <input type="checkbox"/> Combination 4 Previous Rehab Program? <input type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 Date of Amputation? <input type="checkbox"/> 1 Year or Less 1 <input type="checkbox"/> More than 1 Year 2	<input type="checkbox"/> None 000 <input type="checkbox"/> Partial 1 <input type="checkbox"/> Total 2 Describe: _____ _____ Previous Rehab Program? <input type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 Onset of Paralysis? <input type="checkbox"/> 1 Year or Less 1 <input type="checkbox"/> More than 1 Year 2

## Nutrition

Height: \_\_\_\_\_ (inches)

Weight: \_\_\_\_\_ (lbs)

Recent Weight Gain/Loss:  No 0  Yes 1

Describe: \_\_\_\_\_

<p><b>Are you on any special diet(s) for medical reasons?</b></p> <input type="checkbox"/> None 0 <input type="checkbox"/> Low Fat/Cholesterol 1 <input type="checkbox"/> No/Low Salt 2 <input type="checkbox"/> No/Low Sugar 3 <input type="checkbox"/> Combination/Other 4 <p><b>Do you take dietary supplements?</b></p> <input type="checkbox"/> None 0 <input type="checkbox"/> Occasionally 1 <input type="checkbox"/> Daily, Not Primary Source 2 <input type="checkbox"/> Daily, Primary Source 3 <input type="checkbox"/> Daily, Sole Source 4	<p><b>Do you have any problems that make it hard to eat?</b></p> <p>No 0 Yes 1</p> <input type="checkbox"/> <input type="checkbox"/> Food Allergies <input type="checkbox"/> <input type="checkbox"/> Inadequate Food/Fluid Intake <input type="checkbox"/> <input type="checkbox"/> Nausea/Vomiting/Diarrhea <input type="checkbox"/> <input type="checkbox"/> Problems Eating Certain Foods <input type="checkbox"/> <input type="checkbox"/> Problems Following Special Diets <input type="checkbox"/> <input type="checkbox"/> Problems Swallowing <input type="checkbox"/> <input type="checkbox"/> Taste Problems <input type="checkbox"/> <input type="checkbox"/> Tooth or Mouth Problems <input type="checkbox"/> <input type="checkbox"/> Other: _____
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CLIENT NAME:

Client SSN: - - -

## Current Medical Services

**Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as ... ?**

No	Yes	Frequency
___	___	Occupational _____
___	___	Physical _____
___	___	Reality/Remotivation _____
___	___	Respiratory _____
___	___	Speech _____
___	___	Other _____

**Special Medical Procedures: Do you receive any special nursing care, such as ... ?**

No	Yes	Site, Type, Frequency
___	___	Bowel/Bladder Training _____
___	___	Dialysis _____
___	___	Dressing/Wound Care _____
___	___	Eyecare _____
___	___	Glucose/Blood Sugar _____
___	___	Injections/IV Therapy _____
___	___	Oxygen _____
___	___	Radiation/Chemotherapy _____
___	___	Restraints (Physical/Chemical) _____
___	___	ROM Exercise _____
___	___	Trach Care/Suctioning _____
___	___	Ventilator _____
___	___	Other: _____

**Do you have any pressure ulcers?**

None	Location/Size
___	Stage I 1 _____
___	Stage II 2 _____
___	Stage III 3 _____
___	Stage IV 4 _____

## Medical/Nursing Needs

*Based on client's overall condition, assessor should evaluate medical and/or nursing needs.*

**Are there ongoing medical/nursing needs?**    \_\_\_ No 0    \_\_\_ Yes 1

**If yes, describe ongoing medical/nursing needs:**

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis

**Comments:**

Optional: Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Others: \_\_\_\_\_ Date: \_\_\_\_\_

(Signature/Title)

# 4 PSYCHO-SOCIAL ASSESSMENT

## Cognitive Function

**Orientation** (Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right )

**Person:** Please tell me your full name (so that I can make sure our record is correct).

**Place:** Where are we now (state, county, town, street/route number, street name/box number)?  
Give the client 1 point for each correct response.

**Time:** Would you tell me the date today (year, season, date, day, month)?

- Oriented 0
- Disoriented - Some spheres, some of the time 1
- Disoriented - Some spheres, all the time 2
- Disoriented - All spheres, some of the time 3
- Disoriented - All spheres, all of the time 4
- Comatose 5

Spheres affected: \_\_\_\_\_

Optional: MMSE Score

(5)

(5)

(3)

(5)

Total: \_\_\_\_\_

Note: Score of 14 or below implies cognitive impairment

## Recall/Memory/Judgement

**Recall:** I am going to say three words, and I want you to repeat them after I am done (House, Bus, Dog). Ask the client to repeat them. Give the client 1 point for each correct response on the first trial. Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

**Attention/Concentration:** Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).

**Short-Term:** Ask the client to recall the 3 words he was to remember.

**Long-Term:** When were you born (What is your date of birth)?

**Judgement:** If you needed help at night, what would you do?

No 0 Yes 1

- Short -Term Memory Loss?
- Long-Term Memory Loss?
- Judgement Problem?

## Behavior Pattern

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc.) or become agitated and abusive?

- Appropriate 0
- Wandering/Passive - Less than weekly 1
- Wandering/Passive - Weekly or more 2
- Abusive/Aggressive/Disruptive - Less than weekly 3
- Abusive/Aggressive/Disruptive - Weekly or more 4
- Comatose 5

Type of inappropriate behavior: \_\_\_\_\_ Source of Information: \_\_\_\_\_

## Life Stressors

Are there any stressful events that currently affect your life, such as...?

- |   |   |   |
|---|---|---|
| No 0 Yes 1  | No 0 Yes 1  | No 0 Yes 1  |
| <input type="checkbox"/> <input type="checkbox"/> Change in work/employment | <input type="checkbox"/> <input type="checkbox"/> Financial problems            | <input type="checkbox"/> <input type="checkbox"/> Victim of a crime |
| <input type="checkbox"/> <input type="checkbox"/> Death of someone close    | <input type="checkbox"/> <input type="checkbox"/> Major illness - family/friend | <input type="checkbox"/> <input type="checkbox"/> Failing health    |
| <input type="checkbox"/> <input type="checkbox"/> Family conflict           | <input type="checkbox"/> <input type="checkbox"/> Recent move/relocation        | <input type="checkbox"/> <input type="checkbox"/> Other: _____      |



CLIENT NAME:

Client SSN: - -

### Emotional Status

In the past month, how often did you ... ?	Rarely/ Never 0	Some of the Time 1	Often 2	Most of the Time 3	Unable to Assess 9
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you didn't have anyone to talk to?					
Feel like you didn't want to be around other people?					
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?					
Feel sad or hopeless?					
Feel that life is not worth living or think of taking your life?					
See or hear things that other people did not see or hear?					
Believe that you have special powers that others do not have?					
Have problems falling or staying asleep?					
Have problems with your appetite that is, eat too much or too little?					

Comments:

### Social Status

Are there some things that you do that you especially enjoy?

No 0 Yes 1

Describe

- Solitary Activities, \_\_\_\_\_
- With Friends/Family, \_\_\_\_\_
- With Groups/Clubs, \_\_\_\_\_
- Religious Activities, \_\_\_\_\_

How often do you talk with your children, family or friends, either during a visit or over the phone?

Children

Other Family

Friends/Neighbors

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> No Children 0       | <input type="checkbox"/> No Other Family 0   | <input type="checkbox"/> No Friends/Neighbors 0 |
| <input type="checkbox"/> Daily 1             | <input type="checkbox"/> Daily 1             | <input type="checkbox"/> Daily 1                |
| <input type="checkbox"/> Weekly 2            | <input type="checkbox"/> Weekly 2            | <input type="checkbox"/> Weekly 2               |
| <input type="checkbox"/> Monthly 3           | <input type="checkbox"/> Monthly 3           | <input type="checkbox"/> Monthly 3              |
| <input type="checkbox"/> Less than Monthly 4 | <input type="checkbox"/> Less than Monthly 4 | <input type="checkbox"/> Less than Monthly 4    |
| <input type="checkbox"/> Never 5             | <input type="checkbox"/> Never 5             | <input type="checkbox"/> Never 5                |

Are you satisfied with how often you see or hear from your children, other family and/or friends?

No 0  Yes 1

CLIENT NAME:

Client SSN: - -

### Hospitalization/Alcohol - Drug Use

**Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, alcohol or substance abuse problems?**

No 0  Yes 1

Name of Place	Admit Date	Length of Stay/Reason

**Do (did) you ever drink alcoholic beverages?**

Never 0

At one time, but no longer 1

Currently 2

How much: \_\_\_\_\_

How often: \_\_\_\_\_

**Do (did) you ever use non-prescription, mood altering substances?**

Never 0

At one time, but no longer 1

Currently 2

How much: \_\_\_\_\_

How often: \_\_\_\_\_

*If the client has never used alcohol or other non-prescription, mood altering substances, skip to the tobacco question.*

<b>Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?</b>	<b>Do (did) you ever use alcohol/other mood-altering substances with...</b>	<b>Do (did) you ever use alcohol/other mood-altering substances to help you...</b>
<p><input type="checkbox"/> No 0 <input type="checkbox"/> Yes 1</p> <p>Describe concerns: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>No 0 Yes 1</p> <p><input type="checkbox"/> Prescription drugs?</p> <p><input type="checkbox"/> OTC medicine?</p> <p><input type="checkbox"/> Other substances?</p> <p>Describe what and how often:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>No 0 Yes 1</p> <p><input type="checkbox"/> Sleep?</p> <p><input type="checkbox"/> Relax?</p> <p><input type="checkbox"/> Get more energy?</p> <p><input type="checkbox"/> Relieve worries?</p> <p><input type="checkbox"/> Relieve physical pain?</p> <p>Describe what and how often:</p> <p>_____</p>

**Do (did) you ever smoke or use tobacco products?**

Never 0

At one time, but no longer 1

Currently 2

How much: \_\_\_\_\_

How often: \_\_\_\_\_

**Is there anything we have not talked about that you would like to discuss?**

CLIENT NAME:

Client SSN: - -

## 5 ASSESSMENT SUMMARY

*Indicators of Adult Abuse and Neglect: While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1 - 55.3 to report this to the local Department of Social Services, Adult Protective Services.*

### Caregiver Assessment

**Does the client have an informal caregiver?**

No 0 (Skip to Section on Preferences)     Yes 1

**Where does the caregiver live?**

With client 0  
 Separate residence, close proximity 1  
 Separate residence, over 1 hour away 2

**Is the caregiver's help**

Adequate to meet the client's needs? 0  
 Not adequate to meet the client's needs? 1

**Has providing care to the client become a burden for the caregiver?**

Not at all 0  
 Somewhat 1  
 Very much 2

**Describe any problems with continued caregiving:**

### Preferences

Client's preferences for receiving needed care: \_\_\_\_\_

Family/Representative's preferences for client's care: \_\_\_\_\_

Physician's comments (if applicable): \_\_\_\_\_

CLIENT NAME:

Client SSN: - -

### Client Case Summary

### Unmet Needs

No 0 Yes 1 (Check All That Apply)

- Finances
- Home/Physical Environment
- ADLS
- IADLS

No 0 Yes 1 (Check All That Apply)

- Assistive Devices/Medical Equipment
- Medical Care/Health
- Nutrition
- Cognitive/Emotional
- Caregiver Support

### Assessment Completed By:

Assessor's Name	Signature	Agency/Provider Name	Provider#	Section(s) Completed

Optional: Case assigned to: \_\_\_\_\_ Code #: \_\_\_\_\_