MENTAL HEALTH DIVISION

LEVEL II

INITIAL PSYCHIATRIC EVALUATION

SUMMARY INFORMATION

	YES	NO	DATE
Medicaid pending	☐	☐	
Medicaid	☐	☐	

ASSESSMENT CATEGORY
(CHECK APPROPRIATE BOX)

☐ Preadmission

☐ Initial Nursing Facility

The following information is required by OBRA 1987 to complete the Level II screening process for mentally ill persons in a nursing facility. Based on the diagnosis and need for treatment, a determination will be made regarding the most appropriate plan of care.

1. NAME LAST FIRST MIDDLE	2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH
4. NURSING FACILITY PLACEMENT	5. IF PREADMISSION, SITE OF EVALUATION	
6. MAILING ADDRESS		

I. DSM-IV DIAGNOSIS INDICATED BY PRESENT EVALUATION

Axis I: 1) ____________________ 2) ____________________

____

Axis II: ____________________

Axis III: ____________________

____

Axis IV: psychosocial stressors:

Axis V: current GAF:

II. COMMENTS/RECOMMENDATIONS OF THE REVIEWING PSYCHIATRIST

(SEE COMPLETE EVALUATION SUMMARY AND CONCLUSIONS ON PAGE 2 AND 3)

SIGNATURE OF REVIEWING PSYCHIATRIST	DATE

III. RECOMMENDATIONS FOR SERVICES

A. **Follow-up Review Evaluations:**

Next date for Level II Follow-Up Resident Review Evaluation, DSHS 14-339: ☐ date: ______ or

Explanation: ☐ None, unless significant change in physical or mental conditions occurs

B. **Mental Health Services** (should be receiving); give explanation for service(s) recommended:

☐ 1. Acute psychiatric hospitalization (Specialized Mental Health Services); give explanation for service(s) recommended:

☐ 2. Services provided by a licensed mental health professional or agency for:

☐ a. Case management

☐ b. Full assessment/evaluation

☐ c. Individual/group therapy

☐ d. Case consultation (occasional/as needed)

☐ e. Psychiatric medication evaluation/management for:

☐ 3. No Mental Health Services are needed (explain):

III. RECOMMENDATIONS FOR SERVICES (CONTINUED)

C. Other **Medical** Services**:**

☐ 1. Psychiatric medications management as currently provided by the person's primary physician (non psychiatrist).

☐ 2. Medical assessment to address the following symptoms (non psychiatric):

☐ 3. Ancillary services (podiatry, PT, dental, etc.):

D. **Nursing Facility intervention:**

☐ 1. Environmental:

☐ 2. Staff approaches/training:

☐ 3. Behavioral plan:

☐ 4. Activities:

IV. RECOMMENDATIONS FOR RESIDENTIAL PLACEMENT (PERSONS NOT REQUIRING PSYCHIATRIC HOSPITALIZATION)

☐ Nursing facility WAC 388-97-225 ☐ Geriatric long term rehabilitation services ☐ Other (specify):

☐ Long-term rehabilitative services ☐ Supervised or Supported Living

V. EVALUATION SUMMARY

A. Test instruments (see attachments for complete information)

TOTAL SCORE	INSTRUMENTS NAME	VALIDITY		IF NOT VALID, WHY?
		YES	NO	
	Folstein Mini-Mental Status Examination	☐	☐	
	Geriatric Depression Scale (short)	☐	☐	
	Sandoz Cognitive Assessment Geriatric (SCAG)	☐	☐	
	Brief Psychiatric Rating Scale (BPRS)	☐	☐	

B. Prominent behavioral and emotional problems and needs as determined by this evaluation:

C. Evaluation summary and conclusions (person's psychiatric history; psychiatric diagnosis; current level of function; strengths and deficits; recent relevant events; recommendations for residential placement; and types of mental health services needed):

V. EVALUATION SUMMARY (CONTINUED)
Evaluation summary and conclusions (continued):

EVALUATOR CERTIFICATION/INFORMATION		
PRINT NAME OF PERSON COMPLETING EVALUATION		TELEPHONE NUMBER
SIGNATURE OF PERSON COMPLETING ASSESSMENT	DATE	TITLE OF PERSON COMPLETING ASSESSMENT
AGENCY NAME		

LEVEL II
INITIAL PSYCHIATRIC EVALUATION
SUPPORTING INFORMATION

I. IDENTIFICATION INFORMATION

1. ASSESSMENT PERFORMED AT (NAME)

☐ Home ☐ Nursing facility ☐ Community facility ☐ Psychiatric inpatient setting ☐ General medical hospital setting
☐ Other (specify):

2. GENDER
☐ Male ☐ Female

3. PRIMARY LANGUAGE
☐ English ☐ Other (specify):

4. RACE/ETHNICITY
- ☐ American Indian/Alaska Native
- ☐ African American/Black
- ☐ Asian/Pacific Islander
- ☐ Hispanic
- ☐ White, not of Hispanic origin

5. MARITAL STATUS
- ☐ Married
- ☐ Single
- ☐ Widowed
- ☐ Divorced/separated
- ☐ Unknown

6. PRIMARY LIVING SITUATION DURING THE PAST YEAR
- ☐ Home
- ☐ Nursing facility
- ☐ Streets
- ☐ State hospital
- ☐ Other (specify):
- ☐ Other psychiatric inpatient
- ☐ Mental Health residential
- ☐ Developmental Disability facility
- ☐ Other residential program

II. PSYCHOSOCIAL HISTORY

A. Family of origin/childhood (parents, siblings, issues):

B. Education (highest grade completed): ☐ Elementary ☐ Junior high ☐ High school ☐ College ☐ Unknown

C. Employment status and history: ☐ Unknown
If known, describe:

D. Identify significant life events (marriages, children, geographical moves, health problems, deaths, and other significant losses occurring in adulthood):

II. PSYCHOSOCIAL HISTORY (CONTINUED)

E. Recent events (past 1 - 3 years) leading to current hospitalization and/or nursing facility placement. If currently hospitalized, give admission date, course of treatment and reason for nursing facility placement; and indicate why nursing facility placement is needed:

F. Identify current support network and adult family situation (include names, relationship, potential support provided):

G. Skills, strengths and favorite activities with interests (include type and frequency):

III. PSYCHIATRIC HISTORY

A. Current psychiatric diagnoses:

B. Date on onset of psychiatric symptomatology: ☐ Less than 1 year ☐ 1 - 5 years ☐ More than 5 years ☐ Unknown

C. Psychiatric hospitalizations

Within past two years:
- ☐ None
- ☐ 1 - 5 hospitalizations.
- ☐ More than 5 hospitalizations

Total during lifetime:
- ☐ None
- ☐ 1 - 5 hospitalizations.
- ☐ More than 5 hospitalizations

D. Provide information of psychiatric hospitalizations in past two years (reason, location, dates, course of treatment) with emphasis on most recent hospitalization: ☐ See attached documents for this information

E. Psychiatric medications treatment in the past 2 years (give information not included in attached records, e.g., “multiple trials of “x” with or without improvement: ☐ See attached documents for this information

F. Current mental health services provider/agency name and telephone number:

G. Willingness to accept mental health services: ☐ Willing ☐ Partially willing ☐ Unwilling

H. Is there family history (blood relatives) of mental illness: ☐ Yes ☐ No ☐ Unknown
If yes, give relationship and diagnoses:

IV. SUBSTANCE ABUSE

A. Is there evidence of alcohol or substance abuse for this person? ☐ Yes ☐ No ☐ Unknown

B. If yes: ☐ By history ☐ Current

C. Specify substance(s) abused, circumstances and treatments received (location of treatment):

D. Is there a family history of alcohol/substance abuse? ☐ Yes ☐ No ☐ Unknown
If yes, specify family member(s) and substances:

V. MEDICAL AND MEDICATION HISTORY

A. Attach copies of laboratory reports, consultations, recent medical notes and the Comprehensive History and Physical Examination and medical diagnoses list for psychiatric review.

* Required contents as necessary to determine diagnosis: complete medical history; review of all systems; specific evaluation of the person's neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves, and abnormal reflexes; and in case of abnormal finding which are the basis for a NF placement, additional evaluations conducted by appropriate specialists.

B. Medication use profile: for purposes of psychiatric review, record medication use below or attach a copy of the current physicians orders. Specify additions/changes for all medications, including frequency of PRN medications, during the past 90 days.
* For any medication changes prior to the current month and back to the past 90 days, Medication Administration Records may be attached or changes may be listed below or ☐ see attached documents:

START DATE	STOP DATE	MEDICATIONS	START DATE	STOP DATE	MEDICATIONS

C. After psychiatric review is completed, the copies of medical and medication information will be returned to and will be available from the agency performing this evaluation (for agency information, see page 3, end of Section V.

VI. FUNCTIONAL ASSESSMENT/COMMUNITY PLACEMENT POTENTIAL

A. Indicate the level of assistance this person would require to do the following activities by checking the appropriate code number for each item:

KEY: 1 None, independent with/without assistive devices
2 Minimal cueing or supervision
3 Moderate assistance/supervision
4 Total dependence on others

		1	2	3	4
a.	Take medications as prescribed	☐	☐	☐	☐
b.	Treat own minor physical problems	☐	☐	☐	☐
c.	Keep medical/mental health appointments	☐	☐	☐	☐
d.	Maintain an adequate diet	☐	☐	☐	☐
e.	Manage financial affairs	☐	☐	☐	☐
f.	Use money correctly to purchase whatever is needed	☐	☐	☐	☐
g.	Use transportation	☐	☐	☐	☐
h.	Enter/leave building including stairs/steps	☐	☐	☐	☐
i.	Perform self care and grooming activities	☐	☐	☐	☐
j.	Perform activities necessary to maintain a home or apartment	☐	☐	☐	☐
k.	Able to respond to emergencies/ask for assistance	☐	☐	☐	☐

B. Residential Placement issues:

1. Is the person willing to live in a community residential setting? ☐ Yes ☐ No ☐ Maybe
2. Do you believe a residential placement can be obtained? ☐ Yes ☐ No ☐ Maybe

C. Identify the person's residential placement preference:

D. Are there any problems with residential placement? ☐ Yes ☐ No
If yes, describe:

DEPARTMENT OF SOCIAL AND HEALTH SERVICES - AAFS/MHD DESIGNEE'S SIGNATURE	DATE