Form Instructions

HEALTH SYSTEMS DIVISION
PASRR Level II

RESIDENT REVIEW

Screening for Mental Illness

PART A B SYMPTOMATIC CHANGE IN MENTAL HEALTH CONDITION (NURSING FACILITY)

RESIDENT: BIRTHDATE: REFERRAL DATE:

FACILITY: SS #: MEDICAID #:

CONTACT PERSON: PHONE #: MEDICARE ONLY? (NOT MEDICAID) ☐ YES ☐ NO

Resident exhibits indicators of mental illness, and/or behaviors which:
(Note: Behaviors listed are examples only and are not definitions of the categories below. Any behavior, depending on many factors, may give cause for specialized services. If behavior is not listed, indicate it after Other.

☐ Are self-endangering. Examples: cutting self, refusing to eat or take medications, throwing self out of wheelchair, persistently leaves NF, wanders along road or highway, Other:

☐ Are dangerous to others. Examples: Striking, hitting, shoving, and kicking other residents or staff, throwing objects, ramming wheelchair or walker into others. Other:

☐ Jeopardize the current nursing facility placement. Examples: Sexually inappropriate behaviors, violent property destruction, persistent loud yelling. Other:

☐ Indicate a need for specialized services (psychiatric hospitalization). Examples: Appears to hear or see things that others do not (hallucinations) and is quite distressed by the imaginary voices/individuals; expresses bizarre fixed ideas (delusions) that do or may motivate potentially harmful behaviors; severe depression; severe anxiety. Other:

☐ Other:

Documentation supporting review. (Note: All documents to be attached.)

☐ Current psychiatric and relevant medical diagnoses

☐ Brief narrative describing history of behaviors or symptoms in detail

☐ Mental health/psychiatric interventions attempted (care plans; behavior plans completed in past 3 months; evaluations completed in past 12 months)

☐ List of medications including psychotropic

☐ Lab work: Complete ☐ In process ☐

M.D. notified? ☐ Yes ☐ No Name of M.D.:

Resident notified of referral? Yes ☐ No ☐ Informed by:

PART B MENTAL HEALTH REVIEW (CMHP)

☐ **A mental health evaluation is indicated for this client. This evaluation has been scheduled for:** (Evaluation must be scheduled within 14 days of receipt of referral in Part A.)

☐ **A mental health evaluation is <u>not</u> indicated for this resident**. (Check reason below.)

☐ Client requires immediate psychiatric hospitalization (specialized services) and will be evaluated as an inpatient at: (facility).

☐ Resident's physical status has recently deteriorated. Reassessment of situation may be indicated when physical health is stable. Follow up telephone call scheduled for:

☐ Resident has stabilized and does not appear to need mental health services.

☐ Resident is receiving mental health services including evaluation services from another mental health provider. Provider Name:

☐ Brief consultation sufficient (T2010). Other:

QMHP SIGNATURE: DATE:

COUNTY PHONE NO.

Part B must be completed within 7 working days of receipt of resident referral from nursing facility staff.