Form Instructions

Pre-Admission Screening Level II/Resident Review Data Summary

IDENTIFICATION DATA

1 NAME (USE UPPER CASE BLOCK LETTERS)
LAST FIRST

2 DATE OF BIRTH
MONTH DAY YEAR

3 SOCIAL SECURITY NUMEER

COUNTY CODE

SEE MANUAL

5 PROVIDER CODE
3 DIGIT CODE

NURSING HOME

ACUTE CARE

CLINICAL STATUS

7 DATE OF RESIDENT REVIEW/LEVEL I I REFERRAL
MONTH DAY YEAR

8 PRIMARY DIAGNOSIS
DSM CODE

9 SPECIALIZED SERVICES

DOES THIS CLIENT REQUIRE PSYCHIATRIC INPATIENT HOSPITALIZATION?

1 = YES (enter either a "1" or a "2" in the box)
2 = NO

10 SPECIALIZED SERVICES (CONTINUED)
NAME OF HOSPITAL OR AGENCY PROVIDING SPECIALIZED SERVICES

11 MENTAL HEALTH SERVICES (BASED ON LEVEL II TREATMENT RECOMMENDATIONS)

INDICATE WHO WILL PROVIDE EACH OF THE FOLLOWING MENTAL HEALTH SERVICES: PLEASE CODE EACH BOX

- BEHAVIOR MANAGEMENT
- CRISIS SERVICES
- CONSULTATION
- MEDICATION MANAGEMENT
- THERAPY-INDIVIDUAL/GROUP
- DAY TREATMENT
- SKILLS TRAINING-INDIVIDUAL/GROUP
- CASE MANAGEMENT

1 – NURSING FACILITY (NF)
2 – COMMUNITY MENTAL HEALTH PROGRAM (CMHP)
3 – NF AND CMHP
4 – PRIVATE SECTOR PRACTITIONER
5 – NO PROVIDER AVAILABLE
6 – SERVICE IS NOT NEEDED

12 MENTAL HEALTH SERVICES

ESTIMATE NUMBER OF HOURS FOR MENTAL HEALTH SERVICES REQUIRED BY CLIENT PER YEAR

Office date stamp

SIGNATURES

13 QUALIFIED MENTAL HEALTH PROFESSIONAL (QMHP)
LAST NAME FIRST NAME

14 QMHP SIGNATURE

15 QMHP PHONE NUMBERS
AREA CODE PHONE NUMBER

16 LICENSED MEDICAL PROFESSIONAL (LMP)
LAST NAME FIRST NAME

17 LMP SIGNATURE

18 LMP LICENSE

1- MD/DO 4 – PA
2 – NP
3 - RN

19 COMPLETION DATE
MONTH DAY YEAR

A COPY OF THE LEVEL II EVALUATION MUST BE ATTACHED TO THIS LEVEL II SUMMARY AND SUBMITTED TO: AMHContract.Administrator@dhsoha.state.or.us

A COPY OF THE LEVEL II EVALUATION MUST ALSO BE SENT TO THE RESIDENTS NURSING FACILITY WITHIN 30 DAYS OF THE RESIDENT REVIEW REFERRAL