

Pre-Admission Screening Level II/Resident Review Data Summary

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| Office Use only |
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IDENTIFICATION DATA

| | |
|---------------------------------------|--|
| 1 NAME (USE UPPER CASE BLOCK LETTERS) | |
| LAST | FIRST |
| 2 DATE OF BIRTH MONTH DAY YEAR | 3 SOCIAL SECURITY NUMEER |
| 4 COUNTY CODE | 5 PROVIDER CODE 3 DIGIT CODE |
| 6 SEE MANUAL | <input type="checkbox"/> NURSING HOME <input type="checkbox"/> ACUTE CARE |

CLINICAL STATUS

| | | |
|---|---|------------------------|
| 7 DATE OF RESIDENT REVIEW/LEVEL II REFERRAL MONTH DAY YEAR | 8 PRIMARY DIAGNOSIS DSM CODE | 9 SPECIALIZED SERVICES |
| DOES THIS CLIENT REQUIRE PSYCHIATRIC INPATIENT HOSPITALIZATION? | | |
| <input type="checkbox"/> 1 = YES (enter either a "1" or a "2" in the box) <input type="checkbox"/> 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 | | |
| <input type="checkbox"/> - BEHAVIOR MANAGEMENT <input type="checkbox"/> - CRISIS SERVICES <input type="checkbox"/> - CONSULTATION <input type="checkbox"/> - MEDICATION MANAGEMENT <input type="checkbox"/> - THERAPY-INDIVIDUAL/GROUP <input type="checkbox"/> - DAY TREATMENT <input type="checkbox"/> - SKILLS TRAINING-INDIVIDUAL/GROUP <input type="checkbox"/> - 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 | Office date stamp |
| 12 MENTAL HEALTH SERVICES | | |
| ESTIMATE NUMBER OF HOURS FOR MENTAL HEALTH SERVICES REQUIRED BY CLIENT PER YEAR | | |

SIGNATURES

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|--|---|
| 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 |
| | 19 COMPLETION DATE MONTH DAY YEAR |
| | 1 - MD/DO 4 - PA 2 - NP 3 - RN |

A COPY OF THE LEVEL II EVALUATION MUST BE ATTACHED TO THE BACK OF THIS LEVEL II SUMMARY (AMH #04400 AND SENT TO AMH, DHS, PASRR, E-86) 500 SUMMER ST NE, SALEM, OR 97310

A COPY OF THE LEVEL II EVALUATION MUST ALSO BE SENT TO THE RESIDENTS NURSING FACILITY WITHIN 30 DAYS OF THE RESIDENT REVIEW REFERRAL (AMH, #048) FOR FURTHER INFORMATION REGARDING LEVEL II EVALUATIONS SEE REVERSE SIDE OF THIS FORM.