

**Department of Mental Health  
TRANSMITTAL LETTER**

<b>SUBJECT</b> <b>DMH Guidelines on Nursing Facility Referrals and Required Reviews</b>		
<b>POLICY NUMBER</b> <b>DMH Policy 511.3B</b>	<b>DATE</b> MAY 22 2013	<b>TL#</b> 190

**Purpose.** The purpose of this policy is to describe the procedures by which consumers are screened for placement in a nursing facility (NF) using the Preadmission Screening and Resident Review (PASRR), the review of level of care and appropriateness of a NF for those already in NF, and the discharge and transition processes when NF is no longer indicated in the consumer's level of care. This amendment adds the Pre-Admissions Screen/Resident Review for Mental Illness and/or Intellectual Disability form (Exhibit 1), currently being used in practice but not included in the previous policy.

**Applicability.** Applies to any provider or entity participating in the Department of Mental Health's (DMH) Mental Health Rehabilitation Services' (MHRS) structure and/or has a contract for services with DMH, Saint Elizabeths Hospital (SEH) and other hospitals in the District of Columbia. This policy also applies to DMH consumers and sources of referrals for consumers to transfer from one type of facility in the community (e.g., CRF, private home) directly to a nursing facility.

**Policy Clearance.** This policy has been reviewed by affected responsible staff and cleared through appropriate MHA offices.

**Implementation Plans.** A plan of action to implement or adhere to a policy must be developed by designated responsible staff. If materials and/or training are required to implement the policy, these requirements must be part of the action plan. Specific staff should be designated to carry out the implementation and program managers are responsible to follow through to ensure compliance. Action plans and completion dates should be sent to the appropriate authority. Contracting Officer Technical Representatives (COTRs) must also ensure that contractors are informed of this policy if it is applicable or pertinent to their scope of work. Implementation of all DMH policies shall begin as soon as possible. Full implementation of this policy shall be completed within sixty (60) days after the date of this policy.

**Policy Dissemination and Filing Instructions.** Managers/supervisors of DMH and DMH contractors must ensure that staff are informed of this policy. Each staff person who maintains policy manuals must file this policy in the DMH Policy and Procedures Manual, and contractors must ensure that this policy is maintained in accordance with their internal procedures.

**ACTION**

**REMOVE AND DESTROY**

**DMH Policy 511.3A**

**INSERT**

**DMH Policy 511.3B**

  
\_\_\_\_\_  
Stephen T. Baron  
Director, DMH

GOVERNMENT OF THE DISTRICT OF COLUMBIA  <b>DEPARTMENT OF MENTAL HEALTH</b>	<b>Policy No.</b> <b>511.3B</b>	<b>Date</b> <b>MAY 22 2013</b>	<b>Page 1</b>
	<b>Supersedes</b> <b>DMH Policy 511.3A with the same title dated Aug. 10, 2012</b>		
<b>Subject: DMH Guidelines on Nursing Facility Referrals and Required Reviews</b>			

1. **Purpose.** The purpose of this policy is to establish the following: (a) procedures for admission in a nursing facility through the Preadmission Screening and Resident Review (PASRR), (b) review protocols in level of care determination and appropriateness of a nursing facility (NF) for those already in NF, and the (c) processes in discharge and transition when NF is no longer the consumer's level of care. This new revision includes the (a) addition of the Pre-Admissions Screen/Resident Review for Mental Illness and/or Intellectual Disability form (Exhibit 1), currently being used in practice but not included in the previous policy, and (b) clarification regarding the follow-up and services provided by CSAs when consumer is admitted in a NF to address mental health needs.

2. **Applicability.** Applies to any provider or entity participating in the Department of Mental Health's (DMH) Mental Health Rehabilitation Services' (MHRS) structure and/or has a contract for services with DMH, Saint Elizabeths Hospital (SEH) and other hospitals in the District of Columbia. This policy also applies to DMH consumers and sources of referrals for consumers to transfer from one type of facility in the community (e.g., CRF, private home) directly to a NF).

3. **Background.** Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not placed inappropriately in nursing homes for long term care. Under PASRR, applicants to Medicaid-certified nursing facilities (NF) must be screened to identify a diagnosis of serious mental illness (SMI) and/or developmental or intellectual disability (DD/ID)<sup>1</sup>.

DMH Mental Health Authority serves as State PASRR for the District, and performs the pre-admission screening for District citizens who are seeking nursing home placement and have a mental illness or a history of mental illness. DMH establishes the eligibility for admission in a nursing home, review continued stay for those who are already in a NF, and determine discharge and transition processes when the NF level of care no longer applies. DMH assesses if the individual has a (a) need for the level of services provided by a NF and (b) if he/she requires specialized services for SMI. Referrals can come from hospitals and organizations with which DMH has no formal relationship.

4. **Authority.** The Omnibus Reconciliation Act of 1987 (OBRA), P.L. 100-203, Section 4211(c)(7), OBRA 1990 and 1993, as amended by the Balanced Budget Amendment of 1996, P.L. 104-315; DMH Establishment Amendment Act of 2001, D.C. Code § 7 – 1131.01 *et seq.* (2001); and 42 CFR § 483.100 *et seq.* Olmstead Community Integration Initiative, District of Columbia, April 2012.

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<sup>1</sup> Referrals to NF for individuals with a primary diagnosis of intellectual and/or developmental disability are handled by the D.C. Department on Disability Services and are not the responsibility of the DMH PASRR system.

**5. Definitions/Abbreviations.**

5a. Change in condition. A change in status, either physical or mental, which results in a decline or improvement in the mental health or functional abilities of the resident while in NF which could prompt an evaluation of level of care, which recommends the type of services for the individual.

5b. Dementia. The Diagnostic and Statistical Manual of Mental Disorders (also known as the DSM) define dementia as an overall decline in intellectual function, including difficulties with language, simple calculations, planning and judgment, and motor (muscular movement) skills as well as loss of memory.

5c. Nursing Facility (NF). Primarily provides residents with skilled nursing care and related services for the rehabilitation of injured, disabled or sick persons, or, on a regular basis, health related care services above the level of custodial care to other individuals with developmental disabilities.

5d. Pre-admission Screening and Resident Review (PASRR) Level I Screening. The initial screening required for all individuals prior to admission to a Medicaid certified nursing facility, regardless of payer source. The screening is conducted by hospitals, nursing facilities or DMH CSA providers for preadmission screenings.

5e. PASRR Level II Screening and Determination. A comprehensive evaluation that verifies the diagnosis of mental illness and determines the level of services by a NF including appropriateness of specialized services. It is required for all individuals identified as having possible mental illness. Evaluations are of two types: those that occur prior to admission to a NF and those that occur when a consumer is already residing in a NF and exhibits a significant change in their physical and/or mental status.

5f. Delmarva Foundation for Medical Care, Inc. (Delmarva). The current contract agency for the District that determines the type of level of care designation for Medicaid eligible consumers only of the District of Columbia and gives the final authorization for NF placement for those consumers. If Delmarva authorizes the NF placement (based on the referral package), Delmarva will provide a NF Services Level of Care designation representing this approval. This approval is valid for thirty (30) calendar days and therefore must be utilized within that period.

5g. Level of care (LOC). A utilization management tool used by Medicaid to determine an individual's level of disability and the appropriate level of care/services they require. A LOC assessment is required when a person is seeking Medicaid payment for certain services. In order for Medicaid to pay for NF services.

5h. Level of Care Utilization System (LOCUS). Refer to clinical evaluations tools that are utilized to determine level of care (LOC) and medical necessity for adults.

5i. Plan of Care. A written plan for those individuals found to have a serious mental illness and to be in need of Specialized Services. These individualized models of care include the identification of the needed specialized services, potential service CSA providers, and the approximate duration, frequency, and intensity of services needed.

5j. Specialized Services. Added to NF services toward the continuous and aggressive implementation of an individualized NF plan of care.

5k. Core Services Agency (CSA). DMH-certified community-based MHRS provider that has entered into a Human Care Agreement with DMH to provide specified MHRS. A CSA shall provide at least one core service directly and may provide up to three core services via contract with a sub-provider or subcontractor. A CSA may provide specialty services directly if certified by DMH as a specialty provider. However, a CSA shall also offer specialty services via an affiliation agreement with all specialty CSA providers.

## **6. Policy.**

6a. DMH will conduct the Preadmission Screening and Resident Review (PASRR) for District citizens who are seeking placement in a NF and have a mental illness or a history of mental illness.

6b. The criteria for a NF placement is the need of an individual for 24-hour nursing care and supervision due to chronic and/or acute somatic illness and/or impaired self-care ability.

6c. CSA providers will conduct follow-up and transition planning in addressing consumer's mental health needs when admitted in a NF.

6d. CSA providers will be part of the community re-integration planning team when discharge to a community setting has been determined to be appropriate.

## **7. Referrals and Determinations on Eligibility for admission in a NF.**

7a. The DMH Chief Clinical Officer/designee will:

- (1) Review and evaluate applications and referrals of individuals with mental illness who are deemed as appropriate for placement into NF.
- (2) Determine the appropriateness of the NF as the least restrictive setting for the consumer to receive the necessary medical care, psychiatric care, and assistance with activities of daily living.
- (3) Make PASRR Level II determinations based on an independent physical and mental evaluation performed by a person or entity other than the DMH Mental Health Authority.
- (4) Coordinate actions to obtain the services of an independent psychiatrist to perform the evaluation of consumers at Saint Elizabeths Hospital.
- (5) Establish whether consumers require the level of services provided by a nursing facility and whether specialized services are needed for those with mental illness while in the NF. After review and analysis of all data, provide approval where appropriate.
- (6) Identify the required services for the level of care in comparison to what the nursing facility provides:
  - a. If specialized services are recommended, identify the specific mental health services required to meet the consumer's needs;
  - b. If no specialized services are indicated, identify any specific mental health services of lesser intensity than specialized services that could meet the consumer's needs;

c. Include the bases for the conclusions; and

d. Facilitate the provision of specialized or specific services needed by the consumer while in the NF.

(7) Convey, within seven (7) work days, from receipt of a complete referral package, the determination in writing to the initiating party of the PASRR (e.g., provider, to the NF; and/or to the discharging hospital), unless the individual is exempt from preadmission screening. PASRR approval expires thirty (30) days from the date of the determination.<sup>2</sup>

(8) Conduct resident reviews of consumers already in a NF when an authorized representative notifies DMH of a significant change in the individual's physical or mental condition (see Section 11 below).

**7b. The DMH PASRR Coordinator will:**

(1) Work with the DMH Chief Clinical Officer/designee to coordinate review of referral packages for a NF.

(2) Coordinate the review of nursing referral packages sent to DMH. These referrals are sent for PASRR Level II screening and approval for individuals with mental illness who may or may not be DMH consumers who have had a Level I screening positive for mental illness and are recommended for NF.

Note: The PASRR Coordinator does not locate NF placements for consumers. This is accomplished at the provider level – see section 7c (2) below.

**7c. The provider will:**

(1) Have the referring clinician complete a Level I screening (Exhibit 1).

(2) Locate NF placements to refer consumers.

(3) For the Level I screening, at least in the case of first time identifications, issue a written notice to the consumer and his or her legal representative, if any, that the consumer has been observed to have signs of mental illness and is being referred to the DMH for PASRR Level II screening for a NF.

(4) Complete a psychiatric evaluation of the consumer for the DMH PASRR Level II Screening (The form in Exhibit 2 may be used or if a different format is used but must address all the items on the form).

a. Saint Elizabeths Hospital is required to obtain an evaluation of consumers by an independent psychiatrist for the DMH PASRR Level II screening. The psychiatrist will determine the appropriateness of the consumer for placement in a NF and will document it using the form shown in Exhibit 2.

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<sup>2</sup> The PASRR has to be done each time a person is admitted to a nursing home; however, if the consumer is not admitted during the thirty (30) days of approval, ONLY the PASRR Level of Care form (Exhibit 3) has to be completed – NOT the whole packet, unless there is a change in the individual's functioning.

b. The psychiatrist will also document physical findings that require NF care based on information in the clinical record current within the past thirty (30) days. Saint Elizabeths Hospital contacts the DMH Chief Clinical Officer/designee regarding the need for these evaluations by an independent psychiatrist.

- (5) Complete all the items required in the referral package (see Section 9 below).
- (6) Send all NF referral packages to the DMH PASRR Coordinator except for referrals for consumers with a primary diagnosis of dementia; or for consumers with a primary diagnosis of intellectual and/or developmental disability (also, see section 7c, 13)
- (7) When a consumer is hospitalized in a private community hospital and a NF placement is being considered, it is the hospital's responsibility to complete the NF referral package and coordinate for the PASRR screenings.
- (8) Forward a copy of the referral package for Mental Health Authority PASRR Level II screening to:

DMH PASRR Coordinator  
Department of Mental Health  
64 New York Ave., NE (3<sup>rd</sup> Floor)  
Washington, DC 20002  
Fax #: 202-671-2972
- (9) Retain the original referral package so that copies can be made available later for the NF and/or Delmarva.
- (10) Obtain a Level II screening determination notice signed by the DMH Chief Clinical Officer from the DMH PASRR Coordinator. Ensure all documentation is complete and the provider's working fax number is included (see section 9 below).
- (11) Provide a copy of the PASRR Level II determination to the consumer and his or her legal representative, if any.
- (12) For Medicaid eligible consumers, after obtaining DMH PASRR approval, fax the referral package and the Level II screening written approval to Delmarva Foundation for Medical Care, Inc.
- (13) After obtaining PASRR approval of the referral package for consumers eligible to use private funds; follow internal agency procedures and NF instructions for those consumers.
- (14) If there is a primary diagnosis of dementia (including Alzheimer's disease or a related disorder); or a non-primary diagnosis of dementia without a primary diagnosis that is a serious mental illness; forward the referral directly to Delmarva Foundation for Medical Care, Inc. without a Level II screening for consumers with Medicaid eligibility. It does not have to be sent to the DMH PASRR Coordinator.
- (15) Maintain a copy of the complete referral package and PASRR Level II determinations in the consumer's record in accordance with all federal and local laws and regulations.
- (16) Establish internal policies and procedures and NF instructions, as necessary, on the following:

- determination of NF eligibility,
- incompetency and consent issues,
- financial issues (Medicaid eligibility, spend down of income, use of private funds),
- burial funds, and
- transportation.

#### 9. Referral Package Requirements.

9a. Contents of the Referral Package. The CSA providers will complete a referral package and ensure that the following are included:

(1) **Pre-Admissions Screen/Resident Review for Mental Illness and/or Intellectual Disability** (Exhibit 1). The completed PASRR Level I screening form for referrals to Delmarva and direct referrals to nursing facilities for private pay consumers; signed by a licensed clinician within thirty (30) days of submission of the referral package to the DMH for Medicaid eligible consumers.

(2) **PASRR Level II: Psychiatric Evaluation** (Exhibit 2); signed by a psychiatrist within thirty (30) days of submission of the referral package to the DMH for Medicaid eligible consumers.

(3) **Request for Medicaid NF Level of Care** (Exhibit 3), DHCF 1728 Form revised 7/16/2009, signed by a psychiatrist within thirty (30) days of submission of the referral package to the DMH for Medicaid eligible consumers.

(4) **Psycho-social Assessment** (Exhibit 4) - current within ninety (90) days of submission of the referral package to DMH (*this is not the diagnostic assessment*); or a different format may be used but must include all of the same information; and

(5) **History and Physical Exam Form for PASRR Review** (Exhibit 5). This provides the medical history, including neurological and other relevant/pertinent examinations, and pertinent examination results - current within ninety (90) days of submission of the referral package to DMH.

NOTE: ALL documentation must be legible. Illegible documentation may delay or hinder processing. Any additional documentation requested by MHA from the provider must be provided promptly.

#### 10. Procedures upon consumer's acceptance in a NF.

10a. The CSA provider will:

(1) Follow the instructions of the NF admissions coordinator once the consumer has been accepted.

(2) Comply with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and the D.C. Mental Health Information Act. See DMH Policy 645.1, Privacy Policies and Procedures regarding release of information to outside agencies when making placement arrangements.

(3) Notify family members or significant others about consumer being admitted in a

NF if they were not previously involved. Provide them with the name, address, and phone number to the NF.

(4) Request that the receiving NF initiate the change of representative payee if DMH is still the representative payee for the consumer. The change of payee must be initiated by the receiving NF immediately following placement. In all instances, financial planning must take place prior to placement.

(5) For individuals placed from Saint Elizabeths Hospital (SEH), SEH must notify the CSA responsible for the consumer of the of the nursing home placement.

(6) Conduct ongoing mental health services during and throughout transitions into and out of nursing facilities to include completion of LOCUS, when due, and participation in treatment team meetings.

(7) Request DMH to discharge/disenroll consumers from its services after 90 days of placement in NF, depending on the stability of the consumer during transition, complexity of the case, and/or completion of transition plan goals. The CSA shall consult with the PASRR Coordinator and the NF in this regard prior to discharge or disenrollment. The Director of Care Coordination in consult with the PASRR Coordinator must approve the discharge/disenrollment.

#### **11. Level of Care Review, Continued Stay and Community Re-Integration Processes.**

##### **11a. The PASRR Coordinator will:**

(1) Continue to review appropriateness of level of care (LOC) by ensuring that LOCUS is conducted for NF residents every one hundred eighty (180) days.

(2) Determine the following when a NF notifies<sup>3</sup> DMH that there has been a significant change(s) in condition in a resident's physical and/or mental health condition:

- a. The level of services provided by the NF, and
- b. Needed specialized services for individual with mental illness.

(3) Gather the following information about the individual:

- a. Demographic information (e.g., age, race, ethnicity, etc.);
- b. NF information: address, telephone number and contact person at NF of who will be facilitating the transition into the community;
- c. Information about family or other important stakeholders (e.g., guardians, partners, friends, etc.) who may participate in the process;
- d. Brief description of the circumstances that led to the NF placement;
- e. Brief description of circumstances that led the NF to admit the consumer as

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<sup>3</sup> To report significant changes that could prompt a less restrictive setting, and upon the desire of the individual, the NF can also call the DMH PASRR Coordinator.

having an AXIS I mental health diagnosis and the significant change in status; and

- (4) Refer the consumer to the DMH Chief of Continuity of Care upon completion of above.

NOTE: If the PASRR Coordinator assesses that the consumer does not need PASRR due to other medical conditions or lack of a mental health diagnosis, the inquiring agency will be referred to DELMARVA.

11b. The DMH Chief Continuity of Care will:

- (1) Contact the NF and arrange for an initial consultation upon receipt of referral from DMH PASRR Coordinator in order to

a. Determine eligibility for public mental health services which includes the current or past enrolment with a DMH network provider;

b. Determine likelihood that the individual is physically able to live in the community with necessary supports as supported by nursing consults from the DMH PASRR Liaison to determine physical capacity, and describe the specific supports and services for physical health conditions.

c. Complete a LOCUS to inform the assessment process.

- (2) If consumer is not affiliated with a core service agency in the community, assist the consumer, or through his legal representative, to enroll with the DMH network provider when assessed to be appropriate for community re-integration and eligible for public mental health services.

(3) Request for a complete a PASRR packet for review if the consumer may not be medically stable for re-integration to the community, and refer referral back to the PASRR Coordinator.

(4) Convene a treatment team meeting with all the identified members, including provider representative where consumer is already affiliated with, as applicable, to develop the initial transition plan.

(5) Monitor progress and facilitate the acquisition of resources needed for the consumer's transition.

(6) Turn over the responsibility for monitoring progress to the Integrated Care Manager once the consumer is in the community setting.<sup>4</sup>

12. **DMH Record Retention, Tracking System, Reports and Quality Improvement.**

12a. The PASRR Coordinator will:

- (1) The PASRR Coordinator will maintain records of evaluations and determinations, in order to support its determinations and actions and to protect the appeal rights of consumers subjected to PASRR.

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<sup>4</sup> Refer to DMH Policy 200.2A, Continuity of Care Practice Guidelines for Adult Mental Health CSA providers, for cross-reference to this section.

(2) Track the number of referrals for new admissions to NFs, the number of residents requiring LOCUS, and referrals for which clinical record reviews and/or Level II evaluations are not completed due to situations such as the death of the consumer, discharges/ transfers from nursing facilities, those never admitted to nursing facilities, and those admitted for hospitalizations.

**12b. The DMH Quality Improvement Director and Chief Clinical Officer/designee will:**

(1) Conduct periodic checks on completed referrals using specific protocols and guidelines to determine the accuracy of determinations and appropriateness of recommendations, if applicable and the quality of work related to the PASRR Level II evaluations.

(2) Develop recommendations toward quality improvement activities.

**13. Exhibits.**

Exhibit 1 – Pre-Admissions Screen/Resident Review for Mental Illness and/or Intellectual Disability

Exhibit 2 - PASRR Level II: Psychiatric Evaluation

Exhibit 3 – Request for Medicaid NF level of Care (Exhibit 3), DHCF 1728 Form, revised 7/16/2009

Exhibit 4 - Psycho-social Assessment

Exhibit 5 - History and Physical Exam Form for PASRR Review

**14. Related References.**

DMH Policy 300.1D Level of Care Utilization System (LOCUS/CALOCUS) Evaluation, 02/27/2012

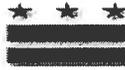
DMH Policy 645.1, Privacy Policies and Procedures, 07/16/2003

DMH Policy 200.2A Continuity of Care Practice Guidelines for Adult Mental Health CSA providers, 02/17/2012

**Approved By:**

**Stephen T. Baron  
Director, DMH**

  
(Signature) 5/22/13  
(Date)



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

**PASSR LEVEL II: PSYCHIATRIC EVALUATION**

**Section I**

Name: \_\_\_\_\_  
Last First M.I.

Gender: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Original Admission Date: \_\_\_\_\_

Is there a legal Guardian?  Yes  No If "Yes," please complete the following:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widowed  Unknown

Academic Skills:  Can read/write simple words  Can read/recognize 3 – 4 word sentences.  
 Can read at newspaper level  Can perform simple mathematics

Last full-time employment position held/day program type: \_\_\_\_\_

Reasons for this admission (Check all that apply):  Psychiatric  Medical  Other

DSM-IV Current AXIS I: Primary \_\_\_\_\_

Diagnoses:

AXIS I Secondary \_\_\_\_\_

AXIS II: Related Condition \_\_\_\_\_

AXIS III \_\_\_\_\_

AXIS IV \_\_\_\_\_



**GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF MENTAL HEALTH**

DMH Policy 511.3B  
Exhibit 2 – Sec. 9a (2)



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

**h. Socialization (Mark all that apply):**

- Appropriately responds to others' initiations
- Appropriately initiates contacts with others
- Inappropriate responses/interactions (Describe): \_\_\_\_\_
- Withdrawn

**i. Attitude (Mark one):**

- Cooperative
- Oppositional
- Agitated
- Guarded

**2. Chart of Behavior (Instructions: Complete the chart, based on all available information for the last three (03) months, including information from the individual's medical records and staff comments). Check Category and Rate Frequency from 1 to 5 (1 least frequent, 5 Most frequent)**

Category	Frequency	Category	Frequency
<input type="checkbox"/> Dangerous smoking behavior		<input type="checkbox"/> Destroys property	
<input type="checkbox"/> Refuses medications		<input type="checkbox"/> Exposes self	
<input type="checkbox"/> Uncooperative diet		<input type="checkbox"/> Is sexually aggressive	
<input type="checkbox"/> Uncooperative hygiene		<input type="checkbox"/> Abuses – verbally	
<input type="checkbox"/> Refuses activities		<input type="checkbox"/> Threatens – verbally	
<input type="checkbox"/> Refuses to eat		<input type="checkbox"/> Threatens – physically	
<input type="checkbox"/> Self-induces vomiting		<input type="checkbox"/> Strikes others – provoked	
<input type="checkbox"/> Impatient/demanding		<input type="checkbox"/> Strikes others – unprovoked	
<input type="checkbox"/> Frequent/continuous yelling		<input type="checkbox"/> Talk of suicide	
<input type="checkbox"/> Wanders		<input type="checkbox"/> Suicidal threats	
<input type="checkbox"/> Tries to escape		<input type="checkbox"/> Suicidal attempts	
<input type="checkbox"/> Seclusiveness		<input type="checkbox"/> Injures self	
<input type="checkbox"/> Suspicious of others		<input type="checkbox"/> Others (Specify)	
<input type="checkbox"/> Lies purposefully		<input type="checkbox"/> Others (Specify)	
<input type="checkbox"/> Steals deliberately		<input type="checkbox"/> None	

**3. Placement in Seclusion/Physical Restraints/Behavior Change (s)**

Instructions: In the last sixty (60) days, has the individual been placed in seclusion or other physical restraints to control dangerous behaviors?

- YES       NO

If "yes," describe the behavior changes and type of restraints, if applicable:

\_\_\_\_\_

\_\_\_\_\_

**4. Comments:**

\_\_\_\_\_

\_\_\_\_\_

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
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Exhibit 2 – Sec. 9a (2)



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

5. Functional Assessment Summary (Instructions: Describe current functional status-improvement or decline, etc. Identify any strengths or weaknesses which may impact the individual's participation in specialized services):

- a. Motor Skills (This domain assesses one's sensory and motor abilities. Visual and auditory abilities are examined, as are fine-motor and gross-motor skills).

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- b. Social & Communication Skills (This domain assesses receptive and expressive abilities and how one utilizes those skills to make needs and requests known. This area also assesses the individual's ability to interact with others).

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- c. Personal Living (Pertains to eating, toileting, maintaining a clean, neat appearance, taking care of clothing, dressing and undressing, etc.):

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- d. Community Living (Addresses skills to handling money, telling time, acting responsibly, preparing meals, doing laundry, etc.).

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- e. Broad Independence (Addresses the individual's overall ability to take care of him/herself and interact in his environment).

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- f. Problem Behaviors (Describe behaviors which are disconcerting or upsetting to others, such as inappropriate physical contact, stereotypical or being overly active. Included in this domain may be behaviors that relate to sexual activity in socially unacceptable ways and behaviors that can cause harm to oneself. Describe any behavior strategies that have been implemented and their impact on the behavior).

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GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF MENTAL HEALTH

DMH Policy 511.3B  
Exhibit 2 – Sec. 9a (2)



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

6. Psychiatric Impressions:

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7. Medical events contributing to this referral?

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8. Recommendations:

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9. Findings/Summary - Appropriate for Nursing Facility placement?  YES  NO

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Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

MAY 22 2013

GOVERNMENT OF THE DISTRICT OF COLUMBIA



Pre-Admission Screen/Resident Review for Mental Illness and/or Mental Retardation

CLIENT IDENTIFYING INFORMATION		
Name: (Last)	(First)	(M.I.)
Home Address:		
Social Security Number:		
Date of Birth:	Sex: Male Female (Circle)	
Current Location: <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Other _____		

Part A. EXEMPTING CRITERIA		
Further completion of this form IS NOT NECESSARY if the client meets <u>all</u> of the exemptions listed below. Place a check mark next to each criterion met by the client. Sign and date where indicated. No further action is required. If exempting criteria is not met, proceed to Part B.		
<input type="checkbox"/> The individual is admitted to nursing facility directly from a hospital after receiving acute inpatient care. <input type="checkbox"/> The individual requires nursing facility services for the condition for which he/she received acute inpatient care. <input type="checkbox"/> The attending physician certifies that the individual is likely to require less than 30 days nursing facility services. <input type="checkbox"/> I certify that the client does meet <u>all</u> of the exempting criteria and that the information is true and accurate to the best of my knowledge.		
Signature _____	Title _____	Date _____

Part B. EVALUATION CRITERIA FOR MENTAL ILLNESS/ MENTAL RETARDATION	
MENTAL ILLNESS	
(Please check off the appropriate answers to the following three questions)	
The client is considered to have a positive screen for mental illness if <u>all</u> of the three questions below are answered yes. If any of the questions below are answered no, the client has a negative screen. With a positive screen for mental illness, the client needs to be referred to the District of Columbia Department of Mental Health for a Level II evaluation.	
<b>*** Please note: A primary diagnosis of Dementia, including Alzheimer's disease or related disorder is NOT considered a major mental illness.</b>	
1. Does the client have a major mental illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, list diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM): _____	
2. Has the above diagnosis resulted in serious functional limitations in major life activities within the past 3 to 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. In the past 2 years has the client had psychiatric treatment more intensive than outpatient care more than once? <input type="checkbox"/> Yes <input type="checkbox"/> No	

MAY 22 2013

(Part B Continued)

**MENTAL RETARDATION**

(Please check off the appropriate answers to the following four questions)

The client is considered to have a **positive screen for mental retardation or a related condition** if one or more of the four questions below are answered **'yes'**. If **all** of the questions are answered **'no'**, the client has a negative screen for mental retardation or a related condition. With a positive screen, the client needs to be referred to the DC Developmental Disabilities Administration for a Level II evaluation.

1. Does client have a diagnosis of mental retardation or a related condition? \_\_\_Yes \_\_\_No
2. Was client diagnosed with mental retardation or a similar related condition prior to age 18?  
\_\_\_Yes \_\_\_No
3. Is there any presenting evidence (cognitive or behavior functions) that indicate that the client has mental retardation or a related condition? \_\_\_Yes \_\_\_No
4. Is the client being referred by and deemed eligible for services by an agency, which serves individuals with mental retardation or a related condition? \_\_\_Yes \_\_\_No

**Part C: EXEMPTING CRITERIA FOR POSITIVE SCREENS  
(CATEGORICAL ADVANCE GROUP DETERMINATION)**

Please Answer ALL questions if Individual is Positive for MI or ID

Based upon Part B, if the individual is considered to have MI or ID, complete Part C of this form. Otherwise skip Part C and complete Part D. **If any questions are checked "yes" there is no need for referral for Level II evaluation**

1. Is the individual being admitted for convalescent care not to exceed 120 days due to an acute physical illness, which required hospitalization and does not meet **all** criteria for an exempt hospital discharge? (Described in Part A) \_\_\_Yes \_\_\_No
2. Does the individual have a terminal illness (life expectancy less than 6 months) as certified by a physician? \_\_\_Yes \_\_\_No
3. Does the individual have a severe physical illness, which results in a level of impairment so severe that the individual cannot be expected to benefit from specialized services?  
\_\_\_Yes \_\_\_No
4. Is this individual being provisionally admitted pending further assessment due to an emergency situation requiring protective services? The stay will not exceed 7 days.  
\_\_\_Yes \_\_\_No
5. Is the individual being admitted for a stay not to exceed 14 days to provide respite?  
\_\_\_Yes \_\_\_No

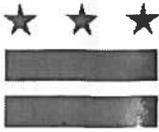
**Part D. RESULTS OF MENTAL ILLNESS/MENTAL RETARDATION SCREENING**

(Please check all that apply)

- \_\_\_ Client has a negative screen for mental illness and no further action is necessary.
- \_\_\_ Client has a negative screen for mental retardation and no further action is necessary.
- \_\_\_ Client has a positive screen for mental illness and has been referred to the District of Columbia Department of Mental Health for a Level II evaluation.
- \_\_\_ Client has a positive screen for mental retardation and has been referred to the DC Developmental Disabilities Administration for a Level II evaluation.
- \_\_\_ I certify that the information is true and accurate to the best of my knowledge.

Signature of the licensed health professional completing this form \_\_\_\_\_

Title \_\_\_\_\_ Date \_\_\_\_\_



**Government of the District of Columbia  
Department of Health Care Finance  
Request for Medicaid Nursing Facility Level of Care**



**Please Print Clearly and Be Sure to Complete All Sections**

<b>Level of Care Requested:</b>	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Adult Day Treatment	<input type="checkbox"/> Elderly and Individuals with Physical Disabilities (EPD) Waiver
---------------------------------	-------------------------------------------	----------------------------------------------	------------------------------------------------------------------------------------------

Reason for Request for Nursing Facility (NF) Services:	Reason for Request for Adult Day Treatment Services:	Reason for Request for EPD Waiver Services:
<input type="checkbox"/> Return from Hospital within Medicaid Bedhold Days (Number of Bedhold Days Left _____) <input type="checkbox"/> Return from Hospital after Medicaid Bedhold has Expired <input type="checkbox"/> Transfer from EPD Waiver to NF	<input type="checkbox"/> Initial NF Placement <input type="checkbox"/> Conversion from Any Other Pay Source to Medicaid (Start On ____/____/____) <input type="checkbox"/> Transfer from NF to NF	<input type="checkbox"/> Initial Assessment <input type="checkbox"/> Annual Reassessment <input type="checkbox"/> Transfer from NF to EPD Waiver

**Part A**

Date of Request \_\_\_\_/\_\_\_\_/\_\_\_\_ Name \_\_\_\_\_

Last First Middle Initial

SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Medicaid # (if not available, state if pending) \_\_\_\_\_

Permanent Address (include name of NF, if applicable)

\_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_

Legal Representative (Power of Attorney or Legal Guardian). Indicate N/A, if applicable.

Last First

Address \_\_\_\_\_

Present Location of Individual (Name and Address of Hospital/NF/Community if Different From Above)

\_\_\_\_\_

**Part B**

(Please check one box in each row below)

Activities	Only Independent (Needs no help)	Supervision or Limited Assistance (Needs oversight, encouragement or cueing OR highly involved in activity but needs assistance)	Extensive Assistance or Totally Dependent (May help but cannot perform without help from staff OR cannot do for self at all)
<b>Activities of Daily Living (ADLs)</b>			
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Instrumental Activities of Daily Living (IADLs)</b>			
Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Money Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name \_\_\_\_\_ Medicaid # \_\_\_\_\_

Is the individual ventilator-dependent?  Yes  No

If additional supporting documents are included please list them here: \_\_\_\_\_

Name of Person Completing Form \_\_\_\_\_ Title \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Signature of Person Completing Form \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Part C - Must be Completed by a Physician, Physician Assistant, or Nurse Practitioner Responsible for Patient Care**

The information presented above appropriately reflects the patient's functional status.

		<b>Please check appropriate box:</b>	
Name	_____	<input type="checkbox"/>	Physician
		<input type="checkbox"/>	Physician Assistant
		<input type="checkbox"/>	Nurse Practitioner
Address	_____	Phone	(____) _____ - _____
	_____	NPI *	_____
Signature	_____	Date	____/____/____

\*Physician assistants should include their supervising physician's NPI number

**Part D - To be completed by the Quality Improvement Organization (if needed)**

Level of Care	_____	Certification Period	_____
		(for EPD Only)	
Authorized Signature	_____	Date	____/____/____
Comments	_____		
	_____		

Delmarva Foundation, Inc.  
9240 Centreville Rd.  
Easton, MD 21601  
Telephone: (800) 999-3362

**ALL FORMS ARE TO BE FAXED TO THE FOLLOWING NUMBER:  
1-800-971-8101**

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF MENTAL HEALTH



PSYCHOSOCIAL ASSESSMENT  
SAMPLE FORMAT

PART 1 BASIC INFORMATION			
Consumer Name:		Date of Assessment:	
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date(s) of Interview:
eCura #:	Social Security Number:		
Primary Language:			
English Proficiency: <input type="checkbox"/> Not at all <input type="checkbox"/> Limited <input type="checkbox"/> Proficient *Translator Need? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Homeless <input type="checkbox"/> Yes <input type="checkbox"/> No			
Living Arrangements/Type of Housing Prior to Nursing Care Facility Placement (describe):			
Street address:		City:	State: Zip Code:
Phone:			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Emergency Contact/Guardian/Conservator			
Name	Relationship	Address	Phone
Family Members and/or Significant Others			
Name	Relationship	Address	Phone
Reason for Admission to Nursing Care Facility:			

PART 2 CURRENT RESOURCES			
Does the Consumer have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, what type of insurance?			
<input type="checkbox"/> Medicaid #: Effective Date: Expiration Date:	<input type="checkbox"/> Medicare #: Effective Date: Expiration Date:	<input type="checkbox"/> Medicare-D #: Provider Name: Effective Date: Expiration Date:	<input type="checkbox"/> Other Type of Insurance (explain)
Does the Consumer receive disability benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, what type of benefits? <input type="checkbox"/> SSI <input type="checkbox"/> SSDI <input type="checkbox"/> Other (explain)			
Amount of benefit:			

Consumer Name:

eCura#

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF MENTAL HEALTH



Does the Consumer have a representative payee? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, record the following for the representative payee:			
Name:			
Street address:	City:	State:	Zip Code:
Does the Consumer have any other sources of income?			
Source:		Amount:	

<b>PART 3 CONSUMER PERSPECTIVE (in Consumer's own words)</b>
Reason for the referral/Presenting Problem:
Consumer's strengths:
Consumer's attitude toward placement:
Goals for treatment:
Goals for discharge:

<b>PART 4 CULTURAL CONSIDERATIONS</b>
Race/Ethnicity:
Religious Preferences/Involvement in Spiritual Activities:
Cultural Identification and Involvement:
Community Involvement and Activities:
Interests/Hobbies:

Consumer Name:

eCura#

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF MENTAL HEALTH



PART 5 DEVELOPMENTAL HISTORY
Family of Origin:
History of Relationships:
History of Any Trauma:
Medical History:
Psychiatric History:
Significant Events:

PART 6 SOCIAL HISTORY
Educational History:
Employment History:
Military History:
Sexual History: (e.g. sexual orientation, sexual abuse)
Is there a history of physical/emotional abuse and neglect? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe
Is there a history of psychiatric hospitalizations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe
Is there a history of medical hospitalizations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe
Is there a legal history? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe.
Case(s) pending:
Attorney
Name: _____ Address: _____ Phone: _____
Describe daily activities prior to placement in nursing care facility:
PART 7 DRUG AND ALCOHOL ABUSE HISTORY
Current Substance Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

Consumer Name:

eCura#

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF MENTAL HEALTH



History of Substance Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A								
Substance Name	Amount & Frequency of Use	Route of Administration	Date of first use	Date of last use	Length of use	Longest Abstinence	Attempts to stop using	Effect on Life and Relationships

Describe Prior Substance Treatment History (e.g. detox, rehab etc.)

PART 8 DIAGNOSTIC IMPRESSION
Axis I
Axis II
Axis III
Axis IV
Axis V GAF
Overall Summary/Recommendations:
Medications:
Level of Functioning: (e.g. ambulation, ADL skill level, requires durable medical equipment, etc.)

**PART 9 COMMUNITY SUPPORT NEEDS** (applicable for step down from nursing care facility)

Consumer Name: \_\_\_\_\_ eCura# \_\_\_\_\_

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF MENTAL HEALTH



Community Support Agency:	Community Support Worker:	Phone:
Benefits/Financial Entitlement:		
Housing Level of Care Needed: (include appropriateness to return to previous living arrangements)		
Day Activity Recommendation(s): (day program, education, volunteer, employment etc.)		
Religious Spiritual Preferences Recommendations: (if desired)		
Substance Abuse Program: (as applicable)		
Medical Follow Up: (as applicable)		
Psychiatric Follow Up: (as applicable)		
Other:		

SIGNATURES	
Social Work	Signature _____ Date _____
	Print Name _____
Other Discipline	Signature _____ Date _____
	Print Name _____

Consumer Name:

eCura#

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF MENTAL HEALTH



**CLINICAL RECORD**

**History and Physical Exam Form For PASRR Reviews**

<b>Patient Name:</b>	<b>Hospital No:</b>	<b>Unit:</b>
<b>Date of assessment:</b>		

**PART I: HISTORY OF PRESENT ILLNESS**

**Most recent diagnosis:**

**Current medications:**

**Substance abuse history:**

**ALLERGIES/ADVERSE REACTIONS:**

**Current PPD status:**

**Chest x-ray:**

**PART II: PAST MEDICAL HISTORY**

**Childhood illnesses (including developmental issues):**

**Adult illnesses (resolved), past hospital admissions:**

**Surgeries:**

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DEPARTMENT OF MENTAL HEALTH



<b>Injuries (head):</b>				
<b>Family history:</b>				
<b>IMMUNIZATIONS</b>				
<b>Influenza:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused	<input type="checkbox"/> N/A
<b>Pneumovax:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused	<input type="checkbox"/> N/A
<b>Tetanus:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused	<input type="checkbox"/> N/A

**PART III: REVIEW OF SYSTEMS**

<b>Constitutional symptoms:</b>		
<b>ENT (Ear, Nose and Throat):</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
If abnormal, describe:		
<b>Respiratory:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
If abnormal, describe:		
<b>Cardiovascular:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
If abnormal, describe:		
<b>Gastrointestinal:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
If abnormal, describe:		
<b>Genito-Urinary:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
If abnormal, describe:		
<b>Gynecological:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
If abnormal, describe:		
<b>Lymphadenopathy:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
If abnormal, describe:		
<b>Musculo-Skeletal:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
If abnormal, describe:		
<b>Neurological:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
If abnormal, describe:		
<b>Psychiatric:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
If abnormal, describe:		

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**PART IV: PHYSICAL EXAMINATION**

Height:	Weight:	Temperature:	Pulse:	Blood Pressure:
<b>General Appearance:</b>				
<b>Orientated (time, place, person):</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If no, describe:				
<b>Affect:</b> <input type="checkbox"/> Full range <input type="checkbox"/> Expansive <input type="checkbox"/> Labile <input type="checkbox"/> Flat <input type="checkbox"/> Constricted <input type="checkbox"/> Blunted Describe:				
<b>Eyes:</b> If abnormal, describe:	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnormal		
<b>Nose:</b> If abnormal, describe:	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnormal		
<b>Mouth:</b> If abnormal, describe:	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnormal		
<b>Throat:</b> If abnormal, describe:	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnormal		
<b>Teeth:</b> If abnormal, describe:	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnormal		
<b>Chest:</b> If abnormal, describe:	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnormal		
<b>Cardiovascular:</b> If abnormal, describe:	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnormal		
<b>Abdominal:</b> If abnormal, describe:	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnormal		
<b>Prostate:</b> If abnormal, describe:	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnormal		
<b>Musculoskeletal:</b> If abnormal, describe:	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnormal		
<b>Extremities/Nails:</b> If abnormal, describe:	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnormal		
<b>Skin:</b> If abnormal, describe:	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnormal		

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 DEPARTMENT OF MENTAL HEALTH



<b>Lymphatics:</b>	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnormal
If abnormal, describe:		

**PART V: NEUROLOGICAL EXAM**

<b>Sensory:</b>	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnormal
If abnormal, describe:		

<b>Motor:</b>	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnormal
If abnormal, describe:		

<b>Reflexes:</b>	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnormal
If abnormal, describe:		

<b>Strength:</b>	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnormal
If abnormal, describe:		

<b>Romberg:</b>	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnormal
If abnormal, describe:		

<b>Gait:</b>	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnormal
If abnormal, describe:		

**Cranial Nerves**

I:	II:	III:	IV:
V:	VI:	VII:	VIII:
IV:	X:	XI:	XII:

<b>Assessment:</b>			
--------------------	--	--	--

<b>Plan:</b>			
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**SIGNATURE**

<b>Physician</b>	<b>Signature</b>		
	<b>Name</b>	<b>Date:</b>	