Department of Behavioral Health

TRANSMITTAL LETTER

SUBJECT Preadmission Screening and Resident Review (PASRR)		
POLICY NUMBER DBH Policy 511.3C	DATE SEP 2 8 2017	TL# 312

Purpose. This policy and procedures establish the Preadmission Screening and Resident Reviews (PASRR) for individuals referred for nursing facility (NF) placement and those who experience a change in condition in the District of Columbia. The only change in this revision is the inclusion of the new Exhibit 3 - Prescription Order Form (POF) for Long Term Care Services and Supports, which replaces the former Nursing Facility Level of Care Form 1728 per Department of Health Care Finance Transmittal #17-0.

Applicability. Applies to all Department of Behavioral Health (DBH)-certified providers, Saint Elizabeths Hospital (SEH), other hospitals in the District of Columbia (District), and entities which refer persons for transfers from one type of facility in the community (e.g., CRF, private home) directly to a NF. PASRR applies to anyone in the District entering a NF, regardless of payment source (Medicaid, Medicare or private pay).

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate Behavioral Health Authority (BHA) offices.

Effective Date. This policy is effective immediately.

Superseded Policy. DBH Policy 511.3B, DBH Guidelines on Nursing Facility Referrals and Required Reviews (PASRR), dated June 9, 2017.

Distribution. This policy will be posted on the DBH web site at www.dbh.dc.gov under Policies and Rules. Applicable entities are required to ensure that affected staff is familiar with the contents of this policy.

Tanya A. Royster, M. D.
Director, DBH

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF BEHAVIORAL HEALTH	Policy No. 511.3C	Date SEP 2 8 2017	Page 1
	Supersedes DBH Policy 511.3B, Preadmission Screening and Resident Review (PASRR), dated June 9, 2017		

Subject: Preadmission Screening and Resident Reviews (PASRR)

1. **Purpose**. This policy and procedures establish the Preadmission Screening and Resident Reviews (PASRR) for individuals referred for nursing facility (NF) placement and those who experience a change in condition in the District of Columbia. The only change in this revision is the inclusion of the new Exhibit 3 - Prescription Order Form (POF) for Long Term Care Services and Supports, which replaces the former Nursing Facility Level of Care Form 1728 per Department of Health Care Finance Transmittal #17-0.

2. **Applicability**. Applies to all Department of Behavioral Health (DBH)-certified providers, Saint Elizabeths Hospital (SEH), other hospitals in the District of Columbia (District), and entities which refer persons for transfers from a type of facility in the community (e.g., CRF, private home) to a NF. PASRR applies to anyone in the District entering a NF, regardless of payment source (Medicaid, Medicare or private pay).

3. **Background**. Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in NF for long term care. PASRR requirements[1]: (1) All applicants to a Medicaid-certified nursing NF be evaluated for mental illness (MI) and/or intellectual disability (ID) or related condition (RC); (2) Individuals be offered the most appropriate setting for their needs in the community, a NF, or acute care settings; and (3) That they receive the services they need in those settings.

DBH serves as the State PASRR agency for the District, and performs the Level II pre-admission screening for District citizens who are seeking nursing home placement and have a mental illness or a history of mental illness.

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; 42 CFR § 483.100 *et seq.*; the Department of Behavioral Health Establishment Act of 2013, D.C. Code § 7 – 1141.01 *et seq.*; and the District of Columbia's Olmstead Community Integration Plan, http://odr.dc.gov/page/olmstead-community-integration-plan-dc-one-community-all

5. **Definitions/Abbreviations.**

5a. Change in condition (see section 10). A change in status in the individual, either physical or mental, which results in decline or improvement in the mental health or functional abilities while in a NF which recommends the type of services.

[1] PASRR requirements are contained in Title 42, Code of Federal Regulations, and Section 483.100 138.

5b. Dementia. An overall decline in cognitive 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). One of many settings for long term care, including other services and supports outside of an institution, provided by Medicaid or other state agencies.

5d. Pre-admission Screening and Resident Review (PASRR) Level I Screening (Exhibit 1). The initial screening required for all individuals prior to admission to a Medicaid certified NF, regardless of payer source, to determine whether they might have MI or ID or RC.

5e. PASRR Level II: Psychiatric Evaluation Screening and Determination (Exhibit 2). A comprehensive evaluation that verifies the diagnosis of mental illness from Level I screening. Level II determines the individual's needs, appropriate setting, and recommendations for the plan of care including specialized services. Evaluations are of two types: those that occur prior to admission to a NF and those during NF stay whenever there is a significant change in the resident's physical and/or mental status.

5f. Quality Management Reviewer. Contractor hired by the District to serve as the quality management reviewer for PASRR.

5g. Specialized Services. Any service or support recommended by an individualized Level II determination that a particular NF resident requires due to SMI, ID or RC that supplements the scope of services that the facility must provide under reimbursement as nursing facility services.

6. **Policy**.

6a. Individuals referred for admission to a NF must be screened for evidence of MI and/or ID or RC. Entries are based on whether the individual has the following:

(1) Diagnosis of mental illness or a history of mental illness or a co-occurring mental illness and a substance use disorder; and

(2) Substantiated need for 24-hour nursing care and supervision due to chronic and/or acute somatic illness and/or impaired self-care ability.

6b. The referring provider must complete the PASRR Level I Screening (Exhibit 1). If the result is positive for mental illness, the provider must proceed in conducting Level II Screening. Both screenings shall be submitted to the DBH PASRR Coordinator due to detection of mental illness. 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 (SMI), the referral must be directly submitted to the Quality Management Reviewer without a Level II screening for individuals with Medicaid eligibility. It does not have to be sent to the DBH PASRR Coordinator.

6c. The DBH-certified providers or referring providers must conduct follow-up and transition

planning in addressing the individual's mental health needs when admitted to a NF.

6d. For residents enrolled with a DBH-certified provider, the DBH provider must be a part of the community re-integration planning team when an individual's discharge to the community setting has been determined to be appropriate.

7. **Referrals and Determinations on Eligibility for Admission to a NF.**

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

(1) Review and evaluate applications and referrals of individuals with mental illness who are considered for appropriate placement in a NF.

(2) Ensure that PASRR Level II determinations are based on physical and mental evaluation by a person or entity other than DBH which substantiates mental illness and need for a NF.

(3) Coordinate actions to obtain the services of an independent psychiatrist to perform the assessment of individuals getting treatment at Saint Elizabeths Hospital.

(4) Establish whether individuals with mental illness require the level of services provided by a NF and whether specialized services are needed. After review and analysis of all data, provide approval where appropriate.

(5) Identify the required services in comparison to what the NF provides:

a. If specialized services are recommended, identify the specific mental health services required to meet the individual'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 individual's needs;

c. Provide justification for the conclusions; and

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

(6) 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 or discharging hospital), unless the individual is exempt from preadmission screening.

NOTE: The PASRR must be done each time a person is admitted to a nursing home. **PASRR approval expires thirty (30) days from the date of the determination**; however, if the individual is not admitted during the thirty (30) days of approval, and no significant changes in condition occurred during that time, the PASRR Coordinator must be contacted to update the PASRR determination. Further, the Request for Medicaid

Nursing Facility Level of Care Form (Exhibit 3) must be resubmitted to DHCF for the Quality Management Reviewer's approval.

(7) Facilitate resident reviews for individuals already in a NF when an authorized representative notifies DBH of a significant change in the individual's physical or mental condition (see Section 10).

7b. The DBH PASRR Coordinator will:

(1) Work with the DBH Chief Clinical Officer/designee to coordinate review of referral packages.

(2) Coordinate the review of nursing referral packages sent to DBH. These referrals are sent for PASRR Level II screening and approval for individuals with mental illness who may or may not be DBH consumers who showed positive in Level I screening 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 individual has been observed to have signs of mental illness and is being referred to DBH for PASRR Level II screening for a NF (Exhibit 2).

(4) Complete a psychiatric evaluation of the individual for the DBH PASRR Level II Screening (The form in Exhibit 2 can be used. If a different form is utilized, all items in Exhibit 2 must be addressed).

a. Saint Elizabeths Hospital is required to obtain an evaluation of individuals by an independent psychiatrist for the DBH PASRR Level II screening. The psychiatrist must determine the appropriateness of referral in a NF and document in Exhibit 2.

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 DBH 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 8 below).

(6) Send all NF referral packages which include Pre-Admissions Screen/Resident Review for MI and/or ID or RC (Exhibit 1) to the DBH PASRR Coordinator except for referrals for individuals with a primary diagnosis of dementia; or for those with a primary diagnosis of ID or RC (also, see section 7c, 13 below).

(7) When the individual 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 DBH PASRR Level II screening to:

DBH PASRR Coordinator
Department of Behavioral Health
64 New York Ave., NE (3rd Floor)
Washington, DC 20002
Fax #: (202) 671-2972
Contact Telephone Number: (202) 673-6450

(9) Retain the original referral package so that copies can be made available later for the NF and Quality Management Reviewer.

(10) Obtain a Level II screening determination notice signed by the DBH Chief Clinical Officer from the DBH PASRR Coordinator. Ensure that all documentation is complete and the provider's working fax number is included (see section 8 below).

(11) Provide a copy of the PASRR Level II determination (Exhibit 2) to the individual being referred to NF and his or her legal representative, if any.

(12) For Medicaid eligible consumers, after obtaining DBH PASRR approval, the referral package and the Level II screening written approval must be submitted to the Quality Management Reviewer.

(13) After obtaining PASRR approval of the referral package for individuals 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; the referral must be directly submitted to the Quality Management Reviewer without a Level II screening for individuals with Medicaid eligibility. It does not have to be sent to the DBH PASRR coordinator.

(15) Maintain a copy of the complete referral package and PASRR Level II determinations (Exhibit 2) in the individual'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: (1) determination of NF eligibility, (2) incompetency and consent issues, (3) financial issues (Medicaid eligibility, spend down of income, use of private funds), (4) burial funds, and (4) transportation.

8. **NF Referral Package Requirements.** The DBH providers must complete a NF referral packet that includes the following:

(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 the Quality Management Reviewer and direct referrals to NF for private pay consumers; signed by a licensed clinician within thirty (30) days of submission of the referral package to the DBH 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 DBH for Medicaid eligible consumers.

(3) Prescription Order Form (POF) - Exhibit 3, signed by a psychiatrist within thirty (30) days of submission of the referral package to the DBH for Medicaid eligible consumers.

(4) Psycho-social Assessment (Exhibit 4) - current within ninety (90) days of submission of the referral package to DBH (this is not the diagnostic assessment); or a different form that include 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 DBH.

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

9. **Procedures upon consumer's acceptance in a NF**.

9a. The referring 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 DBH 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 DBH 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 referred from Saint Elizabeths Hospital (SEH), SEH must notify the DBH provider responsible for the consumer of the nursing home placement. On the other hand, if the consumer is not connected to a provider, the SEH social worker will facilitate the referral of the person to the NF in coordination with the PASRR Coordinator.

(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 DBH 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 DBH Community Services Administrator/designee, in consult with the PASRR Coordinator, must approve the discharge/disenrollment.

10. **Resident Review when there is a significant change**

10a. If there is a significant change in status, the NF will contact DBH PASRR Coordinator for a level II evaluation and that is done by an independent psychiatrist. Consumers with positive screen for intellectual disability or a related condition will be referred to the DC Department on Disability Services for a Level II comprehensive screening (see section 7b above).

10b. When DBH is notified by a NF, a referral source or through its outreach efforts, the PASRR Coordinator will:

(1) Collect 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; and

e. Brief description of circumstances that led the NF to admit the consumer as having mental health diagnosis and the significant change in status.

(2) Inform the NF of the DBH requirement to complete the PASRR referral for Level II Review (see Sec. 8 above) to ensure a full assessment and evaluation of the person's needs.

(3) Facilitate the enrollment of the person with a DBH provider upon completion of the PASRR Level II when discharge to a community setting has been recommended.

(4) Refer the person to the DBH Community Services Administrator.

(5) Nothing in this policy prohibits a resident from leaving a NF according to his or her wishes; however, discharge prior to the completion of a PASRR may result in the lack of information necessary to develop and implement a safe and effective community discharge plan.

10c. The DBH Community Services Administrator/designee will:

(1) Ensure that the individual has been referred to the D.C. Office on Aging/Aging and Disability Resource Center (DCOA/ADRC), if the NF has not previously done so.

(2) Convene a treatment team meeting with all the identified members, including the core service agency (CSA) representative, as applicable, to develop the initial transition plan.

(3) Monitor progress and with the assigned DBH provider, facilitate the acquisition of resources needed for the consumer's transition.

(4) Monitor progress when the consumer is in the community setting.

11. **DBH Record Retention, Tracking System, Reports and Quality Improvement.**

11a. The PASRR Coordinator will:

(1) 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.

(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.

11b. The DBH Office of Accountability/designee will:

(1) Conduct periodic checks related to provider certification.

(2) Develop recommendations toward quality improvement activities.

12. **Exhibits.**

Exhibit 1 – Level 1 Pre-Admission Screen/Resident Review for Serious Mental Illness (SMI) and/or Related Conditions Form Version, DHCF, May, 2017)

Exhibit 2 - PASRR Level II: Psychiatric Evaluation

Exhibit 3 – Prescription Order Form (POF) for Long Term Care Services and Supports, version February 21, 2017

Exhibit 4 - Psycho-social Assessment

Exhibit 5 - History and Physical Exam Form for PASRR Review

Approved By:

Tanya A. Royster, MD
Director, DBH

(Signature) 9/28/2017 **(Date)**

Government of the District of Columbia

Level I Pre-Admission Screen/Resident Review for SMI, ID, or Related Conditions

BENEFICIARY INFORMATION

Last Name:	First:	M.I.:	Gender: ☐ M ☐ F	Medicaid ID:	Social Security Number:
Date of Birth:	Assessment Type: ☐ Preadmission ☐ Significant Physical Change ☐ Significant Mental Change ☐ Suspicion of SMI or ID				

LEGAL STATUS

☐ Commitment ☐ Legal Guardian-Conservator ☐ Legal Representative/POA | Location: ☐ Home ☐ Hospital ☐ Nursing Facility ☐ Other

Applicant agrees to legal guardian and/or family participation? ☐ Yes ☐ No	Interpreter Required? ☐ Yes ☐ No ☐ Spanish ☐ Amharic ☐ Chinese ☐ Korean ☐ Other	Interpreter Name:

Legal Guardian/Family Member:	Street Address:		
Telephone:	City:	ST:	ZIP Code:
Power of Attorney:	Street Address:		
Telephone:	City:	ST:	Zip Code:

SECTION A: EXEMPTING CRITERIA*

Beneficiary admitted to nursing facility directly from hospital after receiving acute inpatient care? ☐ Yes ☐ No
Beneficiary requires nursing facility services for the condition he/she received acute inpatient care? ☐ Yes ☐ No
Beneficiary is likely to require less than 30 days nursing facility services? ☐ Yes ☐ No

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud

Print Physician Name:	SIGN HERE Physician Signature	Date:
Title:		

**Further completion of this form IS NOT NECESSARY if the beneficiary meets all of the exemptions listed in Section A. If exempting criteria is not met, proceed to Section B. Beneficiary is being admitted under the 30-day hospital discharge exemption. If the beneficiary's length of stay exceeds 30 days , the Level II evaluation must be completed no later than the 40th day of admission, on or before the date.*

SECTION B: EVALUATION CRITERIA FOR SERIOUS MENTAL ILLNESS (SMI)♦

1. Does the beneficiary have a known diagnosis of a major mental disorder? If yes, list diagnosis and DSM Code_____ ☐ Yes ☐ No ☐ Unknown
2. Does the beneficiary have a diagnosis or evidence of a major mental illness limited to the following disorders: schizophrenia, schizoaffective, mood (bipolar and major depressive type), paranoid or delusional, panic or other severe anxiety disorder; Somatoform or paranoid disorder; personality disorder; atypical psychosis or other psychotic disorder (not otherwise specified); or another mental disorder that may lead to chronic disability? ☐ Yes ☐ No ☐ Unknown. Specify diagnosis based on DSM-5 or current ICD criteria. →
3. Does the beneficiary have a history of any substance-related disorder diagnosis? ☐ Yes ☐ No ☐ Unknown Specify diagnosis →

SMI Determination Based Upon: ☐ Documented History ☐ Behavioral Observation ☐ Medications ☐ Individual/Legal Guardian/Family Report

♦*The beneficiary is considered to have a positive serious mental illness (SMI) if (1) questions 1 or 2 in Section B are answered "Yes".* With a positive screen for SMI the beneficiary must be referred to the District of Columbia Department of Behavioral Health for a Level II evaluation.

Government of the District of Columbia

Level I Pre-Admission Screen/Resident Review for SMI, ID, or Related Conditions

SECTION C: SYMPTOMS

1. Does the beneficiary have any current or historical significant impairment in functioning related to a suspected or known diagnosis of mental illness? ☐ Yes (☐ Current ☐ Past: When) ☐ No

   Check box preceding description if any subcategories below are applicable:

   ☐ ***Interpersonal functioning***. The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, unstable employment, fear of strangers, avoidance of interpersonal relationships and social isolation.

   ☐ ***Concentration, persistence, and pace***. The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these task.

   ☐ ***Adaptation to change***. The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family or social interactions, agitation, exacerbated signs and symptoms associated with the illness or withdrawal from situations, , self-injurious, self-mutilation, suicidal, physical violence or threats, appetite disturbance, delusions, hallucinations, serious loss of interest, tearfulness, irritability or requires intervention by mental health or judicial system.

2. Within the last two years has the beneficiary (check either and/or both if applicable).

   ☐ experienced one psychiatric treatment episode that was more intensive than routine follow-up care (e.g., had inpatient psychiatric care; was referred to a mental health crisis/screening center; has attended partial care/hospitalization; or has received Program of Assertive Community Treatment (PACT) or integrated Case Management Services); and/or:

   ☐ due to mental illness, experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community, or intervention by housing or law enforcement officials?

   Narrative information including dates: _____

   _____

   _____

   _____

   The beneficiary's behaviors/symptoms are stable and not presenting a risk to self or others? ☐ Yes ☐ No

If questions 1 and 2 In Section B are checked "No", but question 1 in Section C is "Yes" and a box is checked in question 2, the Level 1 form must be sent to the District of Columbia Department of Behavioral Health to determine if a Level II evaluation is needed.

SECTION D: INTELLECTUAL DISABILITY** (ID) RELATED CONDITIONS (RC)

1. Does the beneficiary have a diagnosis of ID or related condition (mild, moderate, severe, or profound)? ☐ Yes ☐ No
   List diagnosis (es) or evidence: _____
2. Beneficiary diagnosed with ID prior to age 18? ☐ Yes ☐ No
3. Presenting evidence (cognitive or behavior functions) indicating beneficiary has ID or related condition that has not been diagnosed? ☐ Yes ☐ No
4. Is the beneficiary registered for services with an agency which serves individuals with ID or related conditions? ☐ Yes ☐ No
   a. If Yes, describe the services the beneficiary is receiving: _____
   b. Name of service provider and contact information: _____
   c. If No, is the beneficiary interested in receiving services? ☐ Yes ☐ No
5. Has the beneficiary ever been a resident of a state facility including a state hospital, a state school, or other state facility? ☐ Yes ☐ No ☐ Unknown
   If Yes, indicate the name of the facility and the date(s): _____
6. Does the beneficiary have a current diagnosis, history or evidence of a related condition that may include a severe, chronic disability that is attributable to a condition other than mental illness that results in impairment of general intellectual functioning or adaptive behavior? ☐ Yes ☐ No
   Condition: ☐ autism ☐ seizure disorder ☐ cerebral palsy☐ spina bifida ☐ fetal alcohol syndrome ☐ muscular dystrophy ☐ deaf ☐ blindness ☐ closed head injury ☐ other: _____
   Impairment: ☐ mobility ☐ self-care ☐ self-direction ☐ learning ☐ understanding/use of language ☐ capacity for independent living.
   Was the date of onset prior to age 22? ☐ Yes ☐ No If yes, explain: _____

Government of the District of Columbia

Level I Pre-Admission Screen/Resident Review for SMI, ID, or Related Conditions

Beneficiary is considered to have a positive screen for ID or related condition if one or more of the above questions in the above section are answered Yes. As a result, the beneficiary must be referred to the District of Columbia Department of Disability Services for Level II evaluation. If all of the questions are answered no, the beneficiary has a negative screen for ID or related condition.

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud.

Print Name:	SIGN HERE	Date:
Title:		

SECTION E: DEMENTIA*

- ☐ The beneficiary has a diagnosis of dementia (including Alzheimer's disease or related disorder) based on criteria in the DSM-5 or current version of the ICD. (If checked specify DSM-5 or ICD codes: _____
- ☐ The following criteria were used to establish the basis for a dementia diagnosis: ☐ Mental Status Exam ☐ Neurological ☐ History Symptoms ☐ Other Diagnostics (specify): _____
- ☐ The physician documented dementia as the primary diagnosis **OR** that dementia is more progressed than a co-occurring mental illness diagnosis. Explain documentation and verification: _____

**A primary diagnosis of dementia, including Alzheimer's disease or related disorder IS NOT considered a major mental illness. Dementia applies to beneficiaries with a confirmed diagnosis of dementia that has been documented as a primary diagnosis more progressed than a co-occurring mental illness. If there is no confirmed diagnosis of dementia, check N/A☐. Only if the boxes in front of ALL THREE statements above are checked, is the beneficiary designated as having primary mental illness dementia exclusion. If none of the statements above are checked, then the beneficiary is not designated as having primary mental illness dementia exclusion.*

SECTION F: ADVANCE GROUP DETERMINATION°

1. Is the beneficiary 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 Section A)? ☐ Yes ☐ No
2. Does the beneficiary have a terminal illness (life expectancy of less than six months) as certified by a physician? ☐ Yes ☐ No
3. Does the beneficiary have a severe physical illness, such as coma, ventilator dependence, functioning at a brain stem level or other diagnoses which result in a level of impairment so severe that the beneficiary could not be expected to benefit from specialized services? ☐ Yes ☐ No
3. Is this beneficiary being provisionally admitted pending further assessment due to an emergency situation requiring protective services? The stay will not exceed 7 days. ☐ Yes ☐ No
4. Provisional Delirium: The presence of delirium in people with known or suspected MI and/or ID precludes the ability to make an accurate diagnosis. The person's Level I Screen and LOC will be updated no greater than 7 calendar days following admission to the NF (a physician signed statement certifying the delirium state must accompany this screen).
5. Is the beneficiary being admitted for a stay not to exceed 14 days to provide respite? ☐ Yes ☐ No

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud.

Print Name:	SIGN HERE	Date:

°*If the beneficiary is considered to have SMI, ID or RC, complete this section. Otherwise, skip this section and complete Section G. If any questions in this section are checked yes, there is no need for a Level II referral.* ↑

Government of the District of Columbia

Level I Pre-Admission Screen/Resident Review for SMI, ID, or Related Conditions

SECTION G: RESULTS OF SMI/ID (CHECK ALL THAT APPLY)

- ☐ Beneficiary has negative screen for serious mental illness and no further action is necessary.
- ☐ Beneficiary has negative screen for ID or related conditions and no further action is necessary.
- ☐ Beneficiary has a positive screen for serious mental illness and a PASRR referral Level II evaluation, psycho-social assessment, history and physical and Level of Care (LOC) has been forwarded to DBH for review. Date:
- ☐ Beneficiary has a possible positive screen and the Level I form has been forwarded to DBH for review. Date:
- ☐ Beneficiary has a positive screen for intellectual disability and has been referred to DDS for a Level II evaluation. Date:
- ☐ Notice of referral for Level II, if applicable, distributed to Beneficiary/Representative ☐ Yes ☐ No Date :

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud

Print Name:	SIGN HERE	Date:

The District of Columbia Department on Disability Services is the contact agency for a **Level II** evaluation.

Shirley Quarles-Owens, RN MSN
Supervisory Community Health Nurse
DC Department on Disability Services
Developmental Disabilities Administration
Health and Wellness Unit
Independence Square Building
250 E Street, SW
Washington, DC 20024
202-730-1708 (office)
202-730-1841 (fax)
202-615-8268 (mobile)
shirley.quarles-owens@dc.gov

The District of Columbia Department of Behavioral Health is the contact agency for **Level II** evaluations:

Chaka A. Curtis, RN
Psychiatric Nurse / PASRR Coordinator
Division of Integrated Care
DC Department of Behavioral Health
64 New York Ave NE - Room 310
Washington, DC 20002
202-673-6450 (office)
202-671-7626 (fax)
202-439-1143 (mobile)
chaka.curtis@dc.gov

For individuals who wish to be enrolled in a Medicaid-certified nursing facility, please fax this form along with the Prescription Order Form to the Delmarva Foundation. The fax # is (202) 698-2075.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

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

_____

_____

_____

_____

ICD-I0-CM Diagnosis:

Section II Behavioral/Psychiatric Assessment

1. Affective Behavior Observations

a. Physical Features (mark all that apply):

☐ Clean/Tidy ☐ Poor hygiene/Unwashed ☐ Well groomed
☐ Careless/Disheveled/Sloppy ☐ Normal street dress ☐ Wearing bedclothes
☐ Makeup or jewelry ☐ No apparent effort at personal appearance
☐ Non-seasonal clothing ☐ Other (Specify) _____

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Name: _____

b. Level of Consciousness (mark all that apply):
☐ Alert ☐ Drowsy ☐ Attentive ☐ Inattentive ☐ Lethargic ☐ Other (Specify: _____)

c. Manner (Mark all that apply):

☐ Warm	☐ Shy	☐ Threatening	☐ Concerned about others
☐ Outgoing nature	☐ Silly	☐ Sincere	☐ Apathetic
☐ Aggressive	☐ Sense of humor	☐ Suspicious	☐ Easily frustrated
☐ Childlike	☐ Reluctant to Respond		
☐ Others (Specify) _____			

d. Mood and Affect (Mark all that apply):
☐ Appropriate in quality and intensity to stated themes ☐ Flat or blunted

	Mild	Moderate	Severe
Depressed			
Anxious, fearful or worried			
Angry, belligerent or hostile			
Delusional			
Suicidal			
Homicidal			
Other (Specify)			

e. Form of Thought (Mark all that apply):

☐ Coherent	☐ Incoherent/Illogical	☐ Blocking	☐ Tangentiality
☐ Relevant	☐ Irrelevant/Rambling	☐ Impoverished	☐ Circumstantiality
☐ Logical	☐ Loose Associations	☐ Perseveration	☐ Pressured

f. Orientation

☐ Orientated X3; clear at al times	☐ Orientated X3; forgetful at times
☐ Oriented to person and place	☐ Oriented to person
☐ Oriented to bathroom/bed	☐ Confused at times in day
☐ Confused at times at night	☐ Disoriented X3
☐ Nonresponsive	☐ Unable to Determine

g. Communication Ability (Mark all that apply):

☐ No problems	☐ Reads ☐ Writes	☐ Speech unclear/slurred
☐ Gestures/aids	☐ Inappropriate content	☐ Stammer/stutter/impediment
☐ Eye contact	☐ Unresponsive	

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

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Name: _____

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
☐ Dangerous smoking behavior		☐ Destroys property	
☐ Refuses medications		☐ Exposes self	
☐ Uncooperative diet		☐ Is sexually aggressive	
☐ Uncooperative hygiene		☐ Abuses – verbally	
☐ Refuses activities		☐ Threatens – verbally	
☐ Refuses to eat		☐ Threatens – physically	
☐ Self-induces vomiting		☐ Strikes others – provoked	
☐ Impatient/demanding		☐ Strikes others – unprovoked	
☐ Frequent/continuous yelling		☐ Talk of suicide	
☐ Wanders		☐ Suicidal threats	
☐ Tries to escape		☐ Suicidal attempts	
☐ Seclusiveness		☐ Injures self	
☐ Suspicious of others		☐ Others (Specify)	
☐ Lies purposefully		☐ Others (Specify)	
☐ Steals deliberately		☐ 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:

_____

_____

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).

_____

_____

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Name: _____

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).

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

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

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

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).

6. Psychiatric Impressions:

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Name: _____

7. Medical events contributing to this referral?

_____

_____

_____

8. Recommendations:

_____

_____

_____

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

_____

_____

_____

Printed Name: _____ Title: _____

Signature: _____ Date: _____

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE
PRESCRIPTION ORDER FORM (POF)
FOR LONG TERM CARE SERVICES AND SUPPORTS

This completed form must be faxed to the Delmarva Foundation at 202-698-2075.

SECTION I: PATIENT INFORMATION

A. **PATIENT D.C. MEDICAID NUMBER (*8 digits*)[1]	B. **NAME (*LAST, FIRST*)	C. **DATE OF BIRTH: _____/_____/_____
Di. **TELEPHONE NUMBER _____-_____-_____ Dii. SECONDARY TELEPHONE NUMBER _____-_____-_____		E. CURRENT ADDRESS
Fi. EMERGENCY CONTACT, NAME _____ Fii. TELEPHONE NUMBER _____-_____-_____		G. PERMANENT ADDRESS (if different than above)
SPECIAL INSTRUCTIONS/NOTES		

SECTION II: PHYSICIAN/APRN INFORMATION

A. **PROVIDER NAME (*LAST, FIRST*)	B. **DC MEDICAID PROVIDER NUMBER (*8 digits*)
C. **TELEPHONE NUMBER _____-_____-_____	D. NATIONAL PROVIDER IDENTIFIER NUMBER
E. PROVIDER ADDRESS	F. FAX NUMBER _____-_____-_____

SECTION III: DETERMINING NEED FOR SERVICES

A. **This patient has the following chronic medical condition(s)/ICD-10 diagnosis(es):	B. **This patient is unable to independently perform the following (*check all that apply*): ☐ Bathing ☐ Dressing ☐ Overall Mobility ☐ Eating ☐ Medication Management ☐ Using Telephone ☐ Housekeeping ☐ Meal Preparation ☐ Toilet Use
C. This patient's condition has changed significantly, as follows:	D. The reason for this referral to services is: (eg. ADHP, PCA, EPD, NH, etc.)

I have personally examined this patient. Based upon my professional opinion, long term care services and supports are medically necessary.

**Signature of Ordering Physician/APRN: _____ Date: _____/_____/_____

**These fields are required for the Department of Health Care Finance to process this form.
[1] If the individual is new to DC Medicaid and does not yet have a Medicaid number, please note "N/A."

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE

PRESCRIPTION ORDER FORM (POF) GUIDE

This cover sheet provides guidance to physicians and advanced practice registered nurses (APRNs) on how to complete the attached Prescription Order Form (POF), which is required by the District of Columbia's Department of Health Care Finance (DHCF) to receive Medicaid-funded long term care services and supports.

Section I: Patient Information

This section provides information on the individual seeking Medicaid-funded long term care services and supports. The following is REQUIRED for the Department of Health Care Finance to process this form:

- Patient DC Medicaid Number (*8 digits*) (if available)
- Name (*First, Last*)
- Date of Birth
- Telephone Number

If there are special instructions for contacting this patient, please include these in this section.

Section II: Physician/APRN Information

This section provides information on the physician/APRN ordering Medicaid-funded long term care services and supports for the individual referenced in Section 1. Please note that all referring providers must be enrolled as a DC Medicaid Provider. DHCF has a streamlined application process for ordering/referring providers which can be obtained at www.dcpdms.com by clicking, "Create an account." Providers can then follow the instructions to set up an expedited enrollment package. Please note that providers who enroll as ordering/referring providers only will not receive payment for any claims submitted, and will not be part of the Medicaid-eligible providers' directory.

The following is REQUIRED for the Department of Health Care Finance to process this form:

- Provider Name (*First, Last*)
- DC Medicaid Provider Number (*8 digits*) (if applicable)
- Telephone Number

Section III: Determining Need for Services

This section provides information on the individual's need for long term care services and supports, which include:

- case management,
- personal care aide (PCA),
- homemaker,
- chore aide,
- personal emergency response,
- assisted living,
- occupational therapy,
- physical therapy,
- adult day health program (ADHP),
- environmental accessibility adaptation, and
- nursing home (NH).

Parts A and B of this section are REQUIRED for DHCF to process this form. Part C allows the provider to note any changes in the patient's medical condition. Part D allows the provider to detail the reason for the referral (e.g., patient is being discharged and needs assistance at home, patient could benefit from day activities, ongoing ADHP or PCA, interest in enrolling in the Persons who are Elderly and Individuals with Physical Disabilities Waiver (EPD), NH, etc.). The ordering physician/APRN's signature on this POF certifies the individual's need for long term care services and supports.

Please ensure that all mandatory fields noted with ** are filled out—this will prevent delays in your patient's connection to services. The completed form must be faxed to the Delmarva Foundation at 202-698-2075.

****These fields are required for the Department of Health Care Finance to process this form.**
[1] If the individual is new to DC Medicaid and does not yet have a Medicaid number, please note "N/A."

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

PSYCHOSOCIAL ASSESSMENT
SAMPLE FORMAT

PART 1 BASIC INFORMATION			
Consumer Name:			Date of Assessment:
Date of Birth:	Gender: ☐ Male ☐ Female		Date(s) of Interview:
iCAMS ID#:	Social Security Number:		
Primary Language:			
English Proficiency: ☐ Not at all ☐ Limited ☐ Proficient		*Translator Need? ☐ Yes ☐ No	
Homeless ☐ Yes ☐ No			
Living Arrangements/Type of Housing Prior to Nursing Care Facility Placement (describe):			
Street address:	City:	State:	Zip Code:
Phone:			
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ 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? ☐ Yes ☐ No			
If yes, what type of insurance?			
☐ Medicaid #: Effective Date: Expiration Date:	☐ Medicare #: Effective Date: Expiration Date:	☐ Medicare-D #: Provider Name: Effective Date: Expiration Date:	☐ Other Type of Insurance (explain)
Does the Consumer receive disability benefits? ☐ Yes ☐ No			
If yes, what type of benefits? ☐ SSI ☐ SSDI ☐ Other (explain)			
Amount of benefit:			
Does the Consumer have a representative payee? ☐ Yes ☐ No			

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

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:		

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

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

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral 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? ☐ Yes ☐ No If yes, describe		
Is there a history of psychiatric hospitalizations? ☐ Yes ☐ No If yes, describe		
Is there a history of medical hospitalizations? ☐ Yes ☐ No If yes, describe		
Is there a legal history? ☐ Yes ☐ 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 ☐ Yes ☐ No ☐ N/A
History of Substance Abuse ☐ Yes ☐ No ☐ N/A

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

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
ICD 10 CM
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)		
Community Support Agency:	Community Support Worker:	Phone:

Consumer Name: *iCAMS Identification #:*

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

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	

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OFBEHAVIORAL HEALTH

CLINICAL RECORD	History and Physical Exam Form For PASRR Reviews

Patient Name:	Hospital No:	Unit:
Date of assessment:		

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:
Injuries (head):

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OFBEHAVIORAL HEALTH

Family history:				
IMMUNIZATIONS				
Influenza:	☐ Yes	☐ No	☐ Refused	☐ N/A
Pneumovax:	☐ Yes	☐ No	☐ Refused	☐ N/A
Tetanus:	☐ Yes	☐ No	☐ Refused	☐ N/A

PART III: REVIEW OF SYSTEMS		
Constitutional symptoms:		
ENT (Ear, Nose and Throat): If abnormal, describe:	☐ Normal	☐ Abnormal
Respiratory: If abnormal, describe:	☐ Normal	☐ Abnormal
Cardiovascular: If abnormal, describe:	☐ Normal	☐ Abnormal
Gastrointestinal: If abnormal, describe:	☐ Normal	☐ Abnormal
Genito-Urinary: If abnormal, describe:	☐ Normal	☐ Abnormal
Gynecological: If abnormal, describe:	☐ Normal	☐ Abnormal
Lymphadenopathy: If abnormal, describe:	☐ Normal	☐ Abnormal
Musculo-Skeletal: If abnormal, describe:	☐ Normal	☐ Abnormal
Neurological: If abnormal, describe:	☐ Normal	☐ Abnormal
Psychiatric: If abnormal, describe:	☐ Normal	☐ Abnormal

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OFBEHAVIORAL HEALTH

PART IV: PHYSICAL EXAMINATION					
Height:	**Weight:**	**Temperature:**	**Pulse:**	**Blood Pressure:**	
General Appearance:					
Orientated (time, place, person): ☐ Yes ☐ No If no, describe:					
Affect: ☐ Full range ☐ Expansive ☐ Labile ☐ Flat ☐ Constricted ☐ Blunted Describe:					
Eyes: ☐ WNL ☐ Abnormal If abnormal, describe:					
Nose: ☐ WNL ☐ Abnormal If abnormal, describe:					
Mouth: ☐ WNL ☐ Abnormal If abnormal, describe:					
Throat: ☐ WNL ☐ Abnormal If abnormal, describe:					
Teeth: ☐ WNL ☐ Abnormal If abnormal, describe:					
Chest: ☐ WNL ☐ Abnormal If abnormal, describe:					
Cardiovascular: ☐ WNL ☐ Abnormal If abnormal, describe:					
Abdominal: ☐ WNL ☐ Abnormal If abnormal, describe:					
Prostate: ☐ WNL ☐ Abnormal If abnormal, describe:					
Musculoskeletal: ☐ WNL ☐ Abnormal If abnormal, describe:					
Extremities/Nails: ☐ WNL ☐ Abnormal If abnormal, describe:					
Skin: ☐ WNL ☐ Abnormal If abnormal, describe:					

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OFBEHAVIORAL HEALTH

Lymphatics: If abnormal, describe:	☐ WNL	☐ Abnormal

PART V: NEUROLOGICAL EXAM

Sensory: If abnormal, describe:	☐ WNL	☐ Abnormal
Motor: If abnormal, describe:	☐ WNL	☐ Abnormal
Reflexes: If abnormal, describe:	☐ WNL	☐ Abnormal
Strength: If abnormal, describe:	☐ WNL	☐ Abnormal
Romberg: If abnormal, describe:	☐ WNL	☐ Abnormal
Gait: If abnormal, describe:	☐ WNL	☐ Abnormal

Cranial Nerves

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

Assessment:

Plan:

SIGNATURE

Physician	Signature	
	Name	Date: