State of Hawaii
Department of Health

Behavioral Health Administration
Adult Mental Health Division

Pre-Admission Screening / Resident Review

DETERMINATION OF NEED FOR SPECIALIZED PSYCHIATRIC TREATMENT FOR PERSONS WITH MENTAL ILLNESS

_____ _____ __/__/__ ____ ____
(Last Name) (First Name) (Middle) (Medicaid ID Number (Birthdate) (Age) (Sex)

_____ _____ _____ _____
(Home Address) (City) (State) (Zip)

_____ _____ _____
(Social Security Number) (Case Number) (Phone)

Need for Specialized Psychiatric Treatment (please answer all questions)	Yes	No	Describe Reasons for Conclusion
Experiencing an acute episode of serious mental illness.			
Requires implementation of an individualized plan of care developed, supervised and provided by a physician and other qualified mental health professionals for an acute episode of mental illness?			
Requires specific therapies and activities for the treatment of an acute episode of mental illness?			
Requires supervision by trained mental health personnel for an acute episode of mental illness?			

DETERMINATION FOR SPECIALIZED PSYCHIATRIC TREATMENT

A. ____ Client is not mentally ill (MI) but is in need of nursing facility services.
B. ____ Client is MI and in need of nursing facility services and in need of specialized psychiatric treatment for MI.
C. ____ Client is MI and in need of nursing facility services as well as specialized psychiatric treatment but is of advanced years and has made a competent independent decision for NF placement.
D. ____ Client is MI and in need of nursing facility services but not in need of specialized psychiatric treatment for MI.

[Include recommended services of lesser intensity while in the nursing facility]

_____

_____

E. ____ Client is MI and not in need of nursing facility services but in need of specialized psychiatric treatment for MI.
F. ____ Client is MI and not in need of nursing facility services or specialized psychiatric treatment for MI.
G. ____ Determination cannot be made at this time. The following information is needed:

_____ _____ __/__/__
(Print or Type) (Full Signature) (Date of Review)
(Full Name and Professional Acronym)

State of Hawaii
Department of Health

Behavioral Health Administration
Adult Mental Health Division

Pre-Admission Screening / Resident Review
Medical Evaluation for Persons with Mental Illness

_____ _____ __/__/__ ___
(Last Name) (First Name) (Middle) (Medicaid ID Number) (Birthdate) (Sex)

_____ _____ _____ _____
(Home Address) (City) (State) (Zip)

I HEREBY AUTHORIZE THE EXAMINING PHYSICIAN OR MEDICAL FACILITY TO RELEASE TO THE DHS AND ITS DESIGNEES ANY INFORMATION RELATED TO MY PAST: (A) MEDICAL CARE, (B) SUBSTANCE ABUSE OR PYSCHIATRIC AND/OR PSYCHOLOGICAL CARE AND HISTORY.

_____ _____
(Signature of Patient or Guardian) (Date)

Your patient's medical and psychiatric diagnosis and treatment regime as indicated on the 1147 Form necessitates a determination to be made by the Department of Heath/Adult Mental Health Division regarding your patient's need for nursing facility placement and psychiatric "active specialized treatment". A complete medical and psychiatric evaluation is needed to make this determination.

LICENSED PHYSICIAN: Please complete all subsequent items on this form or enclose copy of a recent medical history/physical record.

SIGNIFICANT HISTORY AND MAJOR ILLNESSESS			
Diagnosis/Illness/Problem	Date of Treatment	Medication and Treatment	Prognosis

Does the patient have any medication allergies? ___ Yes ___ No. If yes, list allergies

Medication and Allergic Reaction	
Medication	Reaction

Is patient currently receiving psychoactive medication? __ Yes __ No. If yes, list the drug, reason, potential side effects and date.

Name of Psychoactive Medication	Reason Drug is Prescribed	Start Date	Side Effects

What is this patient's ability to perform ADLs in the community and describe the level of support needed to perform activities in the community:

Physical Exam: Weight _____ Height _____ Temperature _____ Pulse _____ Blood Pressure _____

Normal	Check each item in the appropriate Column. Enter "NE" if not evaluated	Abnormal	Findings
	Head, Face, Neck, and Scalp		
	Nose, Throat, and Mouth		
	Sinuses		
	Ears, General		
	Hearing: Right ____ Left ____		
	Ophthalmoscopic		
	Pupils		
	Vision: Far _____ Near _____		
	Lungs and Chest		
	Heart		
	Vascular System		
	Abdomen and Viscera		
	Anus and Rectum		
	Endocrine System		
	G-U System		
	Upper Extremities		
	Lower Extremities		
	Feet		
	Spine, Other Musculoskeletal		
	Identifying Body Marks, Tatoos, Scars		
	Skin, Lymphatics		
	NEUROLOGICAL		
	Motor (station, gait, power, coordination)		
	Sensory (pain, temperature, touch, deep pain and vibratory sense)		
	Reflexes (superficial)		
	(deep)		
	(pathological)		
	Cranial Nerves:		
	I		
	II		
	III, IV, VI		
	V		
	VII		
	VIII		
	IX, X, XI		

Level of Care SNF _____ ICF _____ HOSPICE _____ DEFERRED _____ OTHER (Specify) _____
Physical Diagnosis: _____

_____ MD _____ MD _____
Examining Physician (Print or Type) Signature of Physician Date

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Pre-Admission Screening / Resident Review
Psychiatric Evaluation Part I

_____ _____ __/__/__ ____ ____
(Last Name) (First Name) (Middle) (Medicaid ID Number) (Birthdate) (Age) (Sex)

_____ _____ _____ _____
(Home Address) (City) (State) (Zip)

I HEREBY AUTHORIZE THE EXAMINING PHYSICIAN OR MEDICAL FACILITY TO RELEASE TO THE DHS AND ITS DESIGNEE ANY INFORMATION RELATED TO MY PAST: (A) MEDICAL CARE, (B) SUBSTANCE ABUSE OR PYSCHIATRIC AND/OR PSYCHOLOGICAL CARE AND HISTORY.

_____ _____
(Signature of Patient or Guardian) (Date)

The psychiatric evaluation consists of two forms including: PSYCHIATRIC EVAUATION, PART I AND PART II: SERIOUS MENTAL ILLNESS CRITERIA. All forms must be completed before a final determination shall be made. Please provide sufficient information to determine the patient's need for "active treatment/specialized services". Use the back of Part II form if additional space is needed to record your response.

1. Psychiatric History (including Drug History): Provide dates if known.

2. Current Psychiatric Condition:
   a. Is the patient a harm to self or others, i.e. suicidal or homicidal ideation, and/or exhibit externalizing and/or internalizing behaviors, i.e. physical violence, damage to property, sexually inappropriate, self abusive, or abuses unauthorized substances?

   b. Is patient delusional and/or has hallucinations?

3. Mental Status (appearance, orientation, affect and mood, thought, insight, organicity, etc.):

4. Describe Patient's Strengths and Weaknesses:

5. Estimated IQ Level:

6. Psychosocial Evaluation: Include current living arrangements, medical and support systems:

7. Recommendations / Plans of Service / Appropriate Placement:

8. Diagnosis: (A listing of applicable diagnoses is available on back of this form)

DSM – III – R	Axis I	Axis II	Axis IV	Axis V
Primary	___.__	___.__	_____	__/__

_____ _____ _____
Psychiatrist/Psychologist Name and Title Signature Date

PASRR APPLICABLE DSM-III-R DIAGNOSES*

SCHIZOPHRENIA

Code in fifth digit: 1=subchronic, 2=chronic, 3=chronic with exacerbation, 4= in remission, 0=unspecified

295.1x disorganized
295.2x catatonic
295.3x paranoid, specify if stable
295.9x undifferentiated
295.6x residual, specify if late onset

DELUSIONAL (PARANOID) DISORDER

297.10 Delusional Paranoid Disorder. Specify ertomanic, grandose, jealous, persecutory, unspecified

PSYCHOTIC DISORDERS NOT ELSEWHERE CLASSIFIED

295.40 Schizophreniform disorder, specify without good prognosis or without good prognostic features
295.70 Schizoaffective disorder, specify bipolar or depressive type
297.30 Induced Psychotic Disorder
298.80 Brief Reactive Psychosis
298.90 Psychotic Disorder NOS (Atypical psychosis)

MOOD DISORDERS

Code current state of Major Depression and Bipolar Disorder In fifth digit:

1= mild
2= moderate
3= severe without psychotic features
4= with psychotic features (Specify mood congruent or mood incongruent)
5= in partial remission
6= in full remission
0= unspecified

For major depressive episodes, specify if chronic and specify melancholic type.

For Bipolar Disorders, Bipolar Disorders NOS, recurrent Major Depression and Depressive Disorders NOS, specify if seasonal pattern.

BIPOLAR

296.4x manic
296.5x depressive
296.6x mixed
296.70 Bipolar disorder NOS
301.13 Cyclothymia

DEPRESSIVE DISORDERS
Major Depression

296.2x single episode
296.3x recurrent
300.40 Dysthymia or depressive neurosis, specify primary or secondary, early or late onset
311.00 Depressive disorder NOS

ANXIETY DISORDERS (for Anxiety and Phobia neuroses)

Panic Disorders

300.01 Without agoraphobia specify current severity of panic attacks
300.21 With agoraphobia specify current severity of agoraphobia avoidance specify current severity of panic attacks
300.22 Agoraphobia without history of panic attacks. Specify with or without limited symptom attacks.
300.23 Social Phobia specify if generalized type
300.29 Simple Phobia
300.30 Obsessive compulsive disorder (or Obsessive compulsive neurosis)
309.89 Post traumatic stress disorder specify if delayed onset
300.00 Anxiety disorder NOS
300.02 Generalized anxiety disorder

SOMATOFORM DISORDERS

300.11 Conversion Disorder (or hysteria neurosis, conversion type)
300.701 Body dysmorphic disorder
300.702 Hypochondriasis (or Hypochondrical neurosis)
300.703 Somatoform disorder NOS
300.704 Undifferentiated somatoform disorder
307.80 Somatoform pain disorder
300.81 Somatization disorder

PERSONALITY DISORDERS (Coded on Axis II)

Cluster A
301.00 Paranoid
301.20 Schizoid
301.22 Schizotypal

Cluster B
301.50 Histronic
301.70 Antisocial
301.81 Narcissistic
303.81 Borderline

Cluster C
301.40 Obsessive/Compulsive
301.60 Dependent
301.82 Avoidant
301.84 Passive Aggressive
301.90 Personality Disorder NOS

*Federal Register Vol. 57 No. 230 11/30/92 Page 56507 (483.102)

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Pre-Admission Screening / Resident Review
PSYCHIATRIC EVALAUTION PART II
SERIOUS MENTAL ILLNESS (SMI) CRITERIA

_____ ____/____/____
(Last Name) (First Name) (Middle Initial) Birthdate

An individual is considered to have a serious mental illness (SMI) if the individual meets the following requirements on <u>diagnosis, level of impairment, and duration of illness</u>:

1. DIAGNOSIS
The patient is 18 years or older and has a possible diagnosis within the following DSM-III-R disorders: "a schizophrenic, mood, paranoid, panic or other severe anxiety disorder, somatoform disorder personality disorder, other psychotic disorder, or another mental disorder that may lead to a chronic disability." (See Part I or Psychiatric Evaluation) ___YES ___NO

2. LEVEL OF FUNCTIONAL IMPAIRMENT
On a continuing or intermittent basis for the past 3 to 6 months, the patient's mental disorder has resulted in one or more functional limitations in major life activities characterized by:

a. Problems in interpersonal functioning: ___YES ___NO
- Has serious difficulty interacting appropriately and communicating effectively; or
- Has a history of altercations, evictions, being fired from a job, fear of strangers, avoidance of interpersonal relationships and social isolation.

b. Problems in concentration, persistence and pace: ___YES ___NO
- Has serious difficulty in sustaining attention to permit completion of tasks in work or work like settings, or in school and home settings; or
- Manifests difficulties in concentration; or
- Unable to complete simple tasks within an established time period, makes frequent errors or requires assistance in completing simple tasks.

c. Problems in adaptation to change: ___YES ___NO
- Has serious difficulty in adapting to changes associated with work, school, family or social interaction; or
- Requires mental health or judicial interventions due to exacerbated signs and symptoms associated with the illness or withdrawal from the situation.

3. RECENT TREATMENT OR HISTORY INDICATES THE INDIVIDUAL HAS EXPERIENCED AT LEAST ONE OF THE FOLLOWING IN THE LAST TWO YEARS.

a. Psychiatric treatment more intensive than outpatient care more than once; or ___YES ___NO
b. Required supportive services to maintain functioning at home or in a residential treatment environment; or ___YES ___NO
c. Required intervention by housing or law enforcement officials. ___YES ___NO

IS THE INDIVIDUAL SERIOUSLY MENTALLY ILL (SMI)? ____ YES ____ NO
An individual is considered to be seriously mentally ill if the following criteria are met: Yes to diagnostic classification; Yes to either 2a or 2b or 2c AND Yes to either 3a, 3b, or 3c.