

PRE-ADMISSION SCREENING/RESIDENT REVIEW SUMMARY Level II for MR

Instructions: Please type or print in legible manner to ensure accurate review.

Date Referral Received: _____

Name: _____ DOB: _____ Sex: _____

SSN: _____ Medicaid ID #: _____ Medicare ID #: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Type of Level II Evaluation: Initial _____ Subsequent _____ NF Resident? Yes ___ No ___

Designated Rep (name and address): _____

Admitting Diagnosis:

Significant Medical Problems:

Primary: _____

Secondary: _____

Level I Provider: Name: _____

Level II Provider: Name: _____ Medicaid Provider ID: _____

	Evaluator Name	Credential	Assessment Date	Time Spent
Social History				
Adaptive Behavior Assessment				
Medical/Nursing Summary				
Psychological Evaluation				
Interdisciplinary (ID) Summary				
Travel				
Recommendations				

Screening terminated? Yes ___ No ___ Reason: _____

Signature: _____ Date: _____

Does this individual pose any danger to self or others? YES NO

If yes, explain _____

The following strengths and needs were identified from this evaluation process:

<u>Strengths</u>	<u>Needs</u>

Recommendations

Nursing Facility Recommendations:

- Appropriate for NF Placement
- Not Appropriate for NF Placement

Treatment Recommendations:

Specialized Services: (To be provided by RC)

- _____
- _____
- _____
- _____

Mental Health Rehabilitation Services: (To be provided by NF):

- | | |
|----------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Crisis Intervention | <input type="checkbox"/> Sensory Stimulation |
| <input type="checkbox"/> Behavior Management | <input type="checkbox"/> Adaptive Equipment Evaluation |
| <input type="checkbox"/> Environmental Structuring | <input type="checkbox"/> Behavior Management |
| <input type="checkbox"/> Sensory-motor Program | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Mobility Training | <input type="checkbox"/> Other _____ |
-
- | | |
|------------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Structured Therapeutic Activities | <input type="checkbox"/> Community living skills |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Pre-vocational skills |
| <input type="checkbox"/> Eating skills | <input type="checkbox"/> Education services |
| <input type="checkbox"/> Toileting skills | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Re-socialization skills | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Independent living skills | |

RC Contact Person _____ Phone # _____

ATTACH H&P AND COMPLETED MR EVALUATION REPORT