

Providers are asked to complete and fax this form to Maximus (1.877.431.9568) when a quality study is requested.

Resident Name _____

Date of Birth _____

SSN _____

NF Name _____

NF City _____

Admit Date _____

A. Diagnosis (Complete all of A)

Current psychiatric and/or MR/DD diagnosis:

Medical Diagnoses:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical rehabilitative prognosis: good poor unknown

B. Psychotropic and Antidepressant Medications (including psychiatric medications, meds for dementia, seizures, and sleep disorders) Also Attach MDS

Medication	Dose MG/Day	Date Started	Response Y/N + any description
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

For the following Sections C-G, check symptoms present now or in the past 6 months. If present now or within the past 6 months, identify whether the behavior or symptom is typically present for that resident (whether the symptom represents the person's baseline)

C. Are Interpersonal and/or Personality Disorder Symptoms Present? N Y (if yes, complete below; if no, proceed to Section D)

Behavior present currently?	Present within the past 6 Months?	If present now or in the past 6 months, is this typical for the resident?		Behavior present currently?	Present within the past 6 Months?	If present now or in the past 6 months, is this typical for the resident?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Hostile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Inappropriate
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Refuses Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety/Fear of Others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Resists Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Extreme hypersensitivity
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Expresses feelings of extreme jealousy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent Conflicts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety/Fear of Others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Avoids social situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Unstable relationships with others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent conflicts with others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Suspicious without reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Believes others are exploiting, harming, deceiving, or betraying;
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Disruptive (yelling, throwing, hitting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Other:

D. Are Concentration or Cognition Issues Present? N Y (if yes, complete below; if no, proceed to Section E)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Requires more assistance than s/he should with tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Unable to complete tasks s/he should medically be able to complete
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Problems finding/using right words
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Disoriented to person
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Confused	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Disoriented to place
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Fluctuating orientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Disoriented to time
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Short term memory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Long term memory loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Short term memory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Long term memory loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Other: _____

If yes to any questions within this section, does the individual have a **diagnosis of dementia**? No Yes, If yes:

- A) Was dementia diagnosis by: Attending MD Psychiatrist
 B) Are symptoms worse in the late afternoon or evening? No Yes
 C) Dementia diagnosis date: _____ D) Diagnostic Tests: _____

E. Are Mood Issues Present? N Y (if yes, complete below; if no, proceed to Section F)

Behavior present currently	Present within the past 6 Months?	If present now or in the past 6 months, is this typical for the resident?		Behavior present currently	Present within the past 6	If present now or in the past 6 months, is this typical for the resident?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Changes in sleep patterns
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Loss of interest in previously enjoyed activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Feelings of worthlessness, helplessness, or guilt
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Weight gain or loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Difficulty concentrating
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Changeable, unpredictable, and rapidly switching emotions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Mania (persistently elevated or irritable moods, reduced sleep, increased talkativeness, or inflated self-esteem)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Fatigue and loss of energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Suicidal thoughts or feelings
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Expresses hopelessness or helplessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent refusal to eat (or significant weight loss) and/or refuses medications
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Personality Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Homicidal behaviors or history
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Other: _____

F. Are Anxiety/Stress Symptoms Present? N Y (if yes, complete below; if no, proceed to Section G)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive anxiety, worry, or apprehension (not due to a medical condition)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Persistent thoughts or memories prompting re-experiencing of a traumatic event.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Extreme and irrational fear of things
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Persistent and unpleasant thoughts or ideas (obsessions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Repetitive actions (compulsions) believed to prevent a threatening event
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Intense terror/fear that strikes without warning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Other: _____

G. Are Psychotic Symptoms Present? N Y (if yes, complete below; if no, proceed to Section H)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Behaviors or speech which may appear eccentric, silly, or unusual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Incoherent, nonsensical, or loosely associated speech
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Delusions - Erroneous beliefs or misinterpretations (e.g., that s/he has certain powers or someone is attempting to cause harm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Hallucinations - seeing, hearing, or sensing presence of others not there; may mumble or speak to no one in particular or become upset without reason
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Paranoia, such as feeling that others are trying to cause harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Other: _____

Please complete and fax to the Maximus Mississippi Team at 877.431.9568

840 Crescent Centre Drive / Suite 400 / Franklin, TN 37067 /

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H. provider Treatments and Services (please respond to all questions in this section)

If no, explain: _____

1. How do symptoms affect the individual's ability to complete Activities of Daily Living?
- Psychiatric symptoms do not impact patient's ability to participate in ADLs
 - Psychiatric symptoms marginally impact patient's ability to participate in ADLs
 - Psychiatric symptoms significantly impair patient's ability to participate in ADLs

2. What services are being provided to (or planned for) the individual by an outside provider not on staff or a consultant of the facility (such as a community mental health center provider)?

Service provided by an outside provider that is not on staff or a consultant of the facility (such as a mental health center)	Currently receiving	Frequency (approximate); Legend: A= Every 4-6 months as needed B= Every 2-3 months as needed C= Every month as needed D= 2-3 times monthly E= Once weekly F= 2-3 times weekly G= 4-5 times weekly	Most recent date of service; Legend: A= Within the last week B= >1 week but < 1 mo C= > 1 mo but <2 mos D= > 2 mos but <3 mos E= >3 mos but <4 mos F= > 4 mos but <5 mos G= >5 mos but <6 mos H= >6 months	Received over the past 6 months but not currently	Name of mental health provider agency (or community mental health center)	Services are planned but have not begun
Psychiatric medication monitoring	<input type="checkbox"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> H	<input type="checkbox"/>	_____	<input type="checkbox"/>
Individual therapy	<input type="checkbox"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> H	<input type="checkbox"/>	_____	<input type="checkbox"/>
Family Therapy	<input type="checkbox"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> H	<input type="checkbox"/>	_____	<input type="checkbox"/>
Group Therapy by non-NF entity	<input type="checkbox"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> H	<input type="checkbox"/>	_____	<input type="checkbox"/>
Psychosocial Rehabilitation Services	<input type="checkbox"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> H	<input type="checkbox"/>	_____	<input type="checkbox"/>
Other (identify):	<input type="checkbox"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> H	<input type="checkbox"/>	_____	<input type="checkbox"/>

3. What behavioral health services is the NF providing currently or within the past 6 months:

Service provided by an NF provider or consultant	Currently receiving	Received over the past 6 months but not currently	Services are planned but have not begun	Are these services provided by an employee of the agency?	If services are being provided by an outside provider that provides consulting to the NF, name the outside provider agency
Psychiatric medication monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Supportive counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Behavior plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Other (identify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	_____

4. Is the prior PASRR evaluation in the patient's record (floor record)? Yes No, but I was able to locate a copy No, it could not be located.
5. Are PASRR recommendations incorporated in Care Plan? Yes, they are currently incorporated Yes, they were initially incorporated, but service needs have since changed No Unknown because the document could not be located

Comments: _____

I. Psychiatric Services (please respond to all questions in this section)

1. List any inpatient psychiatric admissions. If the individual has been a long-term resident, limit the responses to the past 2 years:

Date	Circumstances, if known:
Date	Circumstances, if known:
Date	Circumstances, if known:
Date	Circumstances, if known:

J. Guardianship and Physician Information

Does the individual have a legal guardian? No Yes, **legal guardian information is below:**

Legal Representative Last Name: _____ First Name: _____ Phone: _____

Street: _____ City: _____ State: _____ Zip: _____

Primary Physician's Name: _____ Phone: _____ Fax: _____

Street: _____ City: _____ State: _____ Zip: _____

Section K: Check all applicable information and attach records to this submission

Provide copies of any consultations or evaluations that support and/or substantiate the mental health, physical and/or behavioral change(s) noted on this form. Select attachments included

Required Documents if NF resident:

MAR Plan of Care MDS

Preferred Documents if available and/or applicable:

Physician's Notes Nursing Notes/Summary Medical Consultation(s) Psychiatric Evaluation(s)

Intellectual Assessment(s) Other (List): _____

Signature: _____ **Printed Name:** _____

Position: _____ **Facility:** _____

Phone: _____ **Date form was submitted to Maximus:** _____

Maximus use Only

Purpose:

Quality Study Service Monitoring Approved NF Requires onsite Level II evaluation

Quality Reviewer Name: _____
Quality Reviewer Comments: _____

Date: _____

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