# EXHIBIT 1220-2 LEVEL II PASRR PSYCHIATRIC EVALUATION

| | |
|---|---|
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## Nursing Facility Appropriate and/or Specialized Services

**Location** _____

**Initial Review** ○ Yes ○ No

1. Does the member have a PRINCIPAL diagnosis of dementia? ○ Yes ○ No
**If yes**, STOP AND PROCEED TO History and Examination.
**If no**, proceed to question 2.

2. Does the member have a Serious Mental Illness qualifying diagnosis per Policy Attachment 106.1, SMI Qualifying Diagnosis? ○ Yes ○ No
**If yes**, proceed to question 3
**If no**, do not complete the rest of the page, DOCUMENT FINDINGS ON NEXT PAGE

3. Does this member require Nursing Facility (NF) level of care? If yes, please explain why: ○ Yes ○ No

**If no**, identify appropriate community placement needs (i.e. therapeutic group home, assisted living, in-home/out patient care, etc.):

4. Does this member require Specialized Services (Psychiatric care beyond that available in the current/proposed placement)? ○ Yes ○ No

**If yes**, please explain why:

5. Does this member require any additional psychiatric care to be provided in this facility? If yes, what services: ○ Yes ○ No

**Signature**_____ **Date** _____ Board Certified ○ Yes ○ No

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## HISTORY AND EXAMINATION

### IDENTIFYING DATA

**Examination Date** _____ **Gender** _____

**Examination Time** _____ **Marital Status** _____

**Race/Ethnicity** _____ **Actual Age** _____

**Level of Education** _____ **Occupation** _____

**CHIEF COMPLAINT OR REASON FOR REFERRAL**
(Pertinent findings from Level I Screening or Resident Review):

**HISTORY OF PSYCHIATRIC SYMPTOMATOLOGY AND TREATMENT**
(including past psychotropic medications and hospitalizations):

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## HISTORY AND EXAMINATION Continued

**DEVELOPMENTAL HISTORY:**

**PAST MEDICAL/SURGICAL HISTORY (include the following):**

Childhood Illnesses:

Significant acute and chronic illness (including hospitalizations):

Surgeries:

Injuries and Fractures:

Pertinent Family Medical History:

Allergies:

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**History of Substance Abuse/Dependence and Treatment:**

**Current medications (psychiatric and non-psychiatric):**

| Drug Name | Dosage | Frequency | Allergies | Side Effects | Is there a potential to mimic/mask mental illness |
|---|---|---|---|---|---|
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### REVIEW OF BODY SYSTEMS (Pertinent Positives Only):

### SUMMARY OF RECENT PHYSICAL EXAMINATION FINDINGS (Pertinent Positives Only):

### DATE OF MOST RECENT PHYSICAL EXAMINATION: _____

### MUSCULOSKELETAL-SKELETAL SYSTEM (Abnormal Findings Only):

**1. Spine:**

**2. Back:**

3.**Joints:**

**4. Upper extremities:**

**5. Lower extremities:**

## NEUROLOGIC SYSTEM (Abnormal Findings Only):

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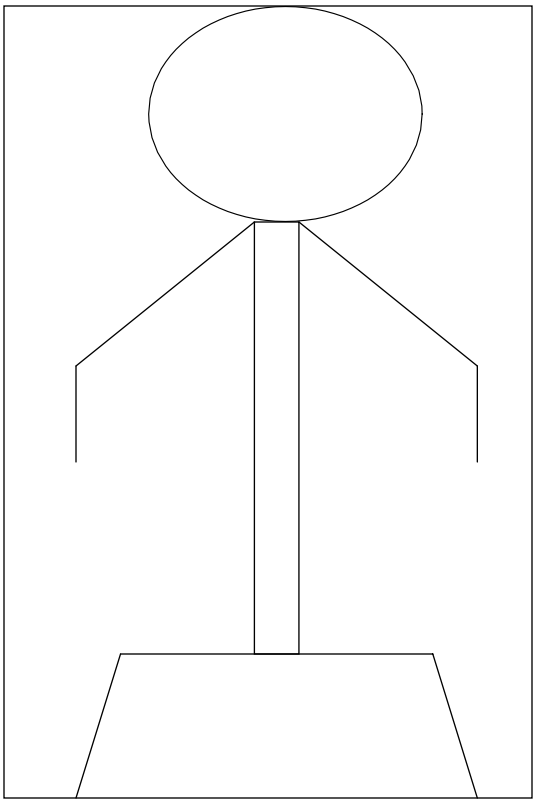
**1. Cranial nerves:**

**2. Finger to Nose:**

**3. Heel to Shin:**

**4. Motor Bulk:**



**5. Motor Strength:**

**6. Motor Tone:**

**7. Reflexes:**

**8. Coordination:**

**9. Movements:**

**10. Sensory:**

**11. Gait:**

**12. Romberg:**

**13. Other:**

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## PSYCHOSOCIAL HISTORY

1.Does the member currently have family/friends in the community adequate to meet their needs for care and support? If yes, please describe:

2. Evaluation of member's current living arrangements ( Select ):

☐ Independent Living ☐ Family - Supported Living ☐ Supervised/Assisted Living ☐ Nursing Facility

Describe any recent changes:

3. Describe member's current medical and psychiatric support systems (Insurances, Care Providers, Caretakers):

Describe any recent changes:

4. Does the member have a legal guardian or representative? ○ Yes ○ No

Name _____ Relationship _____

Contact Information: _____

5. Evaluation of member's ability to perform activities of daily living (Select):

| | Needs Assistance | Independent |
|---|---|---|
| a) Bathing | ○ Yes ○ No | ○ Yes ○ No |
| b) Dressing | ○ Yes ○ No | ○ Yes ○ No |
| c) Eating | ○ Yes ○ No | ○ Yes ○ No |
| d) Walking/Ambulation/Mobility | ○ Yes ○ No | ○ Yes ○ No |
| e) Managing Money | ○ Yes ○ No | ○ Yes ○ No |
| f) Medication Administration | ○ Yes ○ No | ○ Yes ○ No |

Describe, including any assistive devices needed:

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## MENTAL STATUS EXAMINATION

1. Actual Age _____ Apparent Age: ☐ As Stated ☐ Older ☐ Younger

2. Race/Ethnicity ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian/Pacific Islander ☐ American Indian ☐ Other/Mixed

3. Gender ☐ Male ☐ Female ☐ Other

4. Height ☐ Tall ☐ Medium ☐ Short

5. Build ☐ Cachectic ☐ Thin ☐ Medium ☐ Heavy ☐ Very obese

6. Hygienic state ☐ Clean ☐ Disheveled ☐ Unshaven ☐ Odorous

7. Clothing ☐ Appropriate ☐ Untidy ☐ Peculiar (describe): _____

8. Other:

## BEHAVIOR/ATTITUDE:

1. Alertness ☐ Normal/Responsive ☐ Hyper-vigilant ☐ Sleepy ☐ Confused ☐ Stuporous ☐ Comatose
   1. Other _____

2. Posture ☐ Normal ☐ Slumped ☐ Rigid ☐ Relaxed 2. Other _____

3. Gait ☐ Normal ☐ Abnormal ☐ Not Observed 3. Other _____

4. Facial Expression ☐ Normal/Unremarkable ☐ Flat/Immobile ☐ Sad ☐ Worried ☐ Angry ☐ Variable ☐ Happy
   4. Other _____

5. Eye Contact ☐ Good ☐ Avoided ☐ Stared into space ☐ Staring 5. Other _____

6. Attention Span ☐ Poor ☐ Satisfactory ☐ Distractable 6. Other _____

7. Motor Level ☐ Normal ☐ Hypoactive ☐ Hyperactive 7. Other _____

8. Mannerisms ☐ None ☐ Posturing ☐ Stereotypy ☐ Pacing ☐ Tongue movements/Thrusting ☐ Tics
   ☐ Hand wringing ☐ Echopraxia ☐ Buccolingual-masticator (chewing) 8. Other _____

9. Physiological ☐ None ☐ Tearful ☐ Crying ☐ Blushing ☐ Sweating ☐ Tremulous 9. Other _____

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## BEHAVIOR/ATTITUDE Continued:

10. Manner of relating to interviewer:

a. Warmth ☐ Seductive ☐ Friendly ☐ Indifferent ☐ Cold ☐ Variable a. Other _____

b. Trust ☐ Trustful ☐ Somewhat Trustful ☐ Mildly Suspicious ☐ Openly Distrustful b. Other _____

c. Gender ☐ Appropriate ☐ Effeminate ☐ Masculine c. Other _____

d. Cooperativeness ☐ Active Cooperation ☐ Passive Cooperation ☐ Structure-Seeking ☐ Demanding ☐ Antagonistic ☐ Passively Uncooperative ☐ Argumentative ☐ Bargaining ☐ Sarcastic ☐ Vague ☐ Evasive ☐ Hostile d. Other _____

e. Style ☐ Unremarkable ☐ Dramatic ☐ Apathetic ☐ Worried ☐ Boastful ☐ Self-Deprecatory e. Other _____

11. Was there a significant change in relating manner during the session? If yes, describe: ○ Yes ○ No

## AFFECT AND MOOD:

**Affect:** ☐ Appropriate to content ☐ Blunted ☐ Flat ☐ Inappropriate ☐ Labile Other _____

**Mood:** ☐ Suspicious ☐ Euphoric ☐ Shame ☐ Guilt ☐ Indifference ☐ Relaxed ☐ Anxious ☐ Fearful ☐ Angry ☐ Depressed ☐ Agitated Other _____

## SPEECH:

1. Language: ☐ English ☐ Spanish 1. Other _____

2. Quantity: ☐ Mute ☐ Answers only questions ☐ Normal/Fluent ☐ Verbose 2. Other _____

3. Amplitude: ☐ Soft ☐ Normal ☐ Loud ☐ Screaming ☐ Monotone 3. Other _____

4. Impediments: ☐ None ☐ Stutter ☐ Lisp ☐ Slurring 4. Other _____

5. Speed: ☐ Normal ☐ Slow ☐ Rapid ☐ Pressured 5. Other _____

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## THOUGHT PROCESSES:

1. Association: ☐ Tight ☐ Logical ☐ Blocking ☐ Loose ☐ Incoherent
☐ Clang ☐ Rhyming 1. Other _____

2. Stream of Thought: ☐ Unremarkable ☐ Over Inclusive ☐ Concrete ☐ Echollic ☐ Joking ☐ Neologistic
☐ Flight of Ideas ☐ Precise ☐ Circumstantial ☐ Tangential ☐ Non Spontaneous
2. Other _____

## THOUGHT CONTENT:

1. Delusions: ◯ Yes ◯ No If yes, describe:

2. Feelings of Influences: ◯ Yes ◯ No If yes, describe:

3. Ideas of Reference: ◯ Yes ◯ No If yes, describe:

4. Depression: ◯ Yes ◯ No If yes, describe:

5. Obsessions/Compulsions: ◯ Yes ◯ No If yes, describe:

6. Phobic Thoughts: ◯ Yes ◯ No If yes, describe:

7. Anxieties: ◯ Yes ◯ No If yes, describe:

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## THOUGHT CONTENT Continued:

8. Depersonalization/Derealization: ○ Yes ○ No If yes, describe:

9. Illusions: ○ Yes ○ No If yes, describe:

10. Hallucinations: ○ Yes ○ No If yes, describe: ☐ Auditory ☐ Visual ☐ Gustatory ☐ Olfactory ☐ Tactile

11. Suicidal Ideation: ○ Yes ○ No If yes, describe:

12. Homicidal Ideation: ○ Yes ○ No If yes, describe:

## INTELLECTUAL FUNCTION: (ALL ITEMS IN THIS SECTION MUST BE COMPLETED)

1. ORIENTATION:

a. Person ○ Yes ○ No

b. Place (Specific) ☐ Full/Exact ☐ Partial ☐ Disoriented Describe:_____

c) Time (Specific):

i. Date/Day of week: ○ Yes ○ No

ii. Month: ○ Yes ○ No

iii. Season of year: ○ Yes ○ No

iv. Year: ○ Yes ○ No

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## INTELLECTUAL FUNCTION Continued:

2. FUND OF KNOWLEDGE: (e.g., Current Events, Geography, Current and Past Presidents, Comparisons/Differences)

☐ Superior ☐ Above Average ☐ Average ☐ Below Average ☐ Poor

Describe Abnormal Findings:

3. CALCULATIONS: Serial 3s ○ Yes ○ No

Serial 7s ○ Yes ○ No

Other: _____

4. MEMORY:

Three object recall memory: Immediate: ☐ 0/3 ☐ 1/3 ☐ 2/3 ☐ 3/3

3-5 minutes: ☐ 0/3 ☐ 1/3 ☐ 2/3 ☐ 3/3

10 minutes: ☐ 0/3 ☐ 1/3 ☐ 2/3 ☐ 3/3

Digit Span Memory (Record actual results):

| Digit Span Forward: | Digit Span Backward: |
|---|---|
| **6, 1, 2** _____ | **2, 5** _____ |
| **3, 4, 1, 7** _____ | **2, 7, 4** _____ |
| **6, 3, 8, 8, 4** _____ | **8, 4, 1, 3** _____ |
| **9, 7, 2, 4, 6, 3** _____ | **4, 5, 2, 9, 3** _____ |

Can the member name a pencil/pen and watch correctly? ○ Yes ○ No

Can the member repeat "No, ifs, ands, or buts" correctly? ○ Yes ○ No

Can the member follow a three-step command? ("Take a paper in your right hand, fold it in half and put it on the floor") ○ Yes ○ No

Other _____

Can the member name the current US President ? ○ Yes ○ No Other _____

Can the member name the prior US President? ○ Yes ○ No Other _____

5. INTELLIGENCE ESTIMATE: ☐ Superior ☐ Above Average ☐ Average ☐ Borderline IQ ☐ Mental Retardation

7. JUDGEMENT: ☐ Excellent ☐ Good ☐ Average ☐ Significantly Limited ☐ Poor

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## MENTAL STATUS EXAMINATION Continued:

7. INSIGHT:

Insight into problem: ○ Yes ○ No

General Insight: ☐ Full/Complete ☐ Partial ☐ Significantly Limited ☐ Poor ☐ None

**TARDIVE DYSKINESIA EXAMINATION:** ☐ Negative ☐ Positive

Describe abnormal findings:

**Assets** (Personal and other strengths exhibited by member despite presence of any illness e.g., supportive family, sense of honor, motivation for treatment)

Describe:

**DSM IV Diagnosis**

| DSM IV | Diagnostic Code | Diagnosis | Date of Onset |
|---|---|---|---|
| Axis I | | | |
| Axis II | | | |
| Axis III | | | |
| Axis IV | | | |
| Axis V | GAF Score | | |

This Psychiatric and Medical History, Report of Physical Examination, and Mental Status Examination was completed by:

**Psychiatrist´s Name (Print)** _____

**Psychiatrist Signature** _____ Date _____

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**Additional Current Medical list if needed:**

Current medications (psychiatric and non-psychiatric):

| Drug Name | Dosage | Frequency | Allergies | Side Effects | Is there a potential to mimic/mask mental illness |
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Any other Additional Remarks: