

Dual Diagnosis Management

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North Dakota Preadmission
Screening and Resident Review
Mental Health Evaluation (05/03)

General Information

Evaluation type Pre-admission Status Change

Applicant/Resident Name: (Last) (First) (MI) Assessment Date:

SSN: Date of Birth: Age:

Address: City: State: Zip:

Legal Representative: Phone: ()

Address: City: State: Zip:

Race: African American Asian Caucasian Hispanic Native American

Other:

Gender: Female Male

Marital Status: Never Married Married/Cohabiting Divorced Separated Widowed

Education (Circle Highest Grade Completed)

1 2 3 4 5 6 7 8 9 10 11 12 GED

College (number of years or highest degree): Special Education (# of years):

Employment History:

Does Applicant/Resident have children? No Yes, how many: Number Living:

Current Living Arrangements: Home/Alone Home/Caregiver Group Home

Medical Hospital Psychiatric Hospital Nursing Home

Other (specify):

Source(s) of information: Chart Family Patient/Client

Caregiver Legal Guardian Staff (specify):

Other (specify):

**Psychiatric
Treatment History**

Name:

SSN:

DSM-IV-TR Diagnosis of Record or Diagnosis per Report:

Axis I:

Axis II:

Axis III:

Describe applicant/resident's current family situation & involvement:

Describe applicant/resident's current social/recreation/community supports:

Describe applicant/resident's current professional/medical support system:

Psychiatric Hospitalization/s: None known (consumer denied & no evidence in record or by other sources)

Date: Reason/Diagnosis:

Date: Reason/Diagnosis:

Date: Reason/Diagnosis:

Date: Reason/Diagnosis:

Partial Hospitalization/Day Program: None known (consumer denied & no evidence in record or by other sources)

Date: 7/1/03 Reason/Diagnosis:

Date: Reason/Diagnosis:

Date: Reason/Diagnosis:

Outpatient Treatment/Therapy (ECT, AA, etc): None known (consumer denied & no evidence in record or by other sources)

Date: Reason/Diagnosis:

Date: Reason/Diagnosis:

Date: Reason/Diagnosis:

Is There a Family History of Mental Illness or Substance Abuse? No Yes (specify) :

**Behavioral/Mental
Status
Observations**

Name:

SSN:

MENTAL STATUS OBSERVATIONS:

- Behavior:** Appropriate Inappropriate Compulsive
- Attention:** Adequate Short Distractible
- Affect:** Appropriate Flat Blunt Incongruent Shallow
- Attitude:** Cooperative Oppositional Agitated Guarded
- Mood Level:** Level Depressed Euphoric Labile
- Thought Content:** Appropriate Somatic Preoccupied Obsessive
 Ruminations
- Associations:** Intact Loose Circumstantial Fragmented
 Confabulation
- Hallucinations:** None Visual Auditory Tactile
 Olfactory

Describe if present:

- Delusions:** None Persecutory Paranoid Grandeur Sexual

Describe:

- Ideation:** Appropriate Suicidal (describe in detail) Homicidal (describe in detail)
 History of suicide attempts, violence, or aggression (describe in detail)

Describe:

- Speech Content:** Appropriate Disorganized Fragmented Vague Superficial

- Speech Form:** Appropriate Pressured Slurred Stutters Blocking
 Other:

Continued
Behavioral/Mental
Status

Name:

SSN:

Behavioral Assessment (check all that apply and indicate frequency):

- No mental health symptoms or other behavior problems identified (consumer denied & no evidence in record or by other sources)
- Self-injurious: Verbally Aggressive:
- Physically Aggressive: Sexually Aggressive:
- Sexually Inappropriate: Excessive Tearfulness:
- Hypersomnia: Insomnia:
- Excessive Complaints: Anxious:
- Angry: Abrasive, Irritable:
- Uncooperative: Refuses Medications:
- Destructive: Requires Restraints:
- Hoarding: Stealing:
- Weight Loss: Bowel Incontinence:
- Bladder Incontinence: Wandering:
- Confused: Suspicious:
- Reclusive: Social Withdrawal:
- Suicidal Ideations: Suicidal Attempts:
- Restlessness: Other:

- Wanders/runs away:

Observations/Impressions (based on chart review, staff, family & applicant/resident interaction):

4 Physical Assessment

Name:

SSN:

Date of Last Physical Examination:

Immunizations current: Yes No

Hepatitis B Tetanus

PPD date:

PPD Positive PPD Negative

Childhood Illnesses:

Measles

Rubella

Rheumatic fever

Mumps

Polio

Encephalitis

Chicken Pox

Other (Specify):

Serious Illness/Accidents:

Hospitalizations (Medical):

Surgeries:

Medical Evaluations, dates, significant findings

Current meds/frequency/dosage (prescription, inhalers, over the counter meds e.g., vitamins, herbs). Attach copy of Medication list if needed: None known (consumer denied & no evidence in record or by other sources)

Medication	Frequency	Dosage

**Continued
Physical
Assessment**

Name:

SSN:

Nutritional Status:

Dietary restrictions/Special Diet No Yes:

Appetite: Good Fair Poor Difficulties: None Gagging Chewing Swallowing Choking

Tube feedings: No Yes, (if yes specify):

SKIN: (*✓ all that apply*) Warm Pink Dry Bruises (specify): Rash (specify):
 Wounds/Scars (specify): Other (specify):

EYES/NOSE: Visual Aids: None Glasses/Contacts Cataracts

ORAL: Normal Glaucoma Dentures Edentulous (no teeth)

Disturbance in smell/taste? N Y (Describe):

Other (specify): Other (Specify):

HEARING/COMMUNICATION: No known problems

Hearing Impaired Hearing Loss Hearing Aids Other (Specify):

Does client understand verbal communication? Yes No **Speech Impairment:** Yes No

What is client's primary means of communication? Verbal Signing Writing Gestures
 None Other (Specify):

RESPIRATORY SYSTEM: No known problems

Chronic URI Chronic cough Asthma SOB Wheezing Bronchitis Emphysema
 TB Oxygen needs Other(Specify):

CARDIOVASCULAR SYSTEM: No known problems

Heart disease Palpitations Murmur Anemia Stroke/TIA Edema
 High Blood Pressure Blood clots/phlebitis Other Specify):

GASTROINTESTINAL SYSTEM: No known problems

Bowel incontinence Ileostomy Colostomy Ulcers Other (Specify):

GENITOURINARY SYSTEM: No known problems

Urinary incontinence Frequent UTI's Kidney stones Diapers/Depends Catheter (Specify type):
 Other (Specify):

MUSCULOSKELETAL SYSTEM: No known problems

Kyphosis Scoliosis Spastic Flaccid Ataxia Gout
 Contractures Paralysis Hemiplegi Paraplegia Quadriplegia Arthritis

Gait: Normal Shuffling Limp Unsteady Assistive Device (specify):

Deformities (specify):

Limb Loss (specify):

Prosthesis (specify):

5 Current Functioning Abilities

Name:

SSN:

Rank applicant/resident's current functional ability to perform independently in the following day-to-day living activities:

- ❶ Total assistance/unable assistance of one
- ❷ Performs with assistance of greater than one
- ❸ Performs with assistance of one
- ❹ Performs with adaptive equipment
- ❺ Performs with verbal prompts
- ❻ Independent

FUNCTIONAL SKILLS:

- _____ Eating
- _____ Dressing/Undressing
- _____ Bathing
- _____ Toileting
- _____ Grooming
- _____ Ambulation
- _____ Transfer
- _____ Self-Medication
- _____ Personal Hygiene
- _____ Brushing Teeth
- _____ Selecting Appropriate Clothes
- _____ Household Tasks
- _____ Care of Clothing
- _____ Meal Preparation
- _____ Use Telephone
- _____ Use Transportation
- _____ Shopping
- _____ Understand time
- _____ Use Money
- _____ Manage Finances
- _____ Use Leisure time
- _____ Respond to Emergencies
- _____ Treat Minor Ailments
- _____ Monitor Health Status
- _____ Attend Medical Appointments

To what extent has the applicant/resident engaged in the following activities:

- ❶ Almost never (<1x/mo)
- ❷ Seldom (<1x/wk)
- ❸ Sometimes (1-2x/wk)
- ❹ Often (3-4x/wk)
- ❺ Almost always (5x/wk or more)
- ❻ Unsure or not applicable
- ❼ Not applicable

Appropriately responds to others
Can understand 1 step instructions
Complete Assignments

Appropriately initiates contact with others
Can understand multi-step instructions
Stay on task

Mini Mental Status Examination:	Score:	Is Score Valid?	Invalid?
If Invalid check reason	Education below 7th Grade	Unable to Read or Write	Applicant/Resident Refuses any portion.

To what extent can prosthetic/orthotic/corrective/mechanical supportive devices improve the individual's functional capacity?

To what extent can non-oral communication systems improve individual's functional capacity?

To what extent can amplification devices (for example, hearing aid) or a program of amplification improve individual's functional capacity?

6 Summary/ Overview

Name:

SSN:

Identify Strengths:

Identify Weaknesses:

Summary (treatment plan needs, recommendations and/or concerns):

Evaluation performed by (signature):

Date:

Printed Name and Credentials:

Reviewed by:

(MD) Date: