



**Department of Health and Human Services
Office of Adult Mental Health Services
PNMI Service Review Tool
March 23, 2006**

I. Demographics

Consumer Name:

First : _____ Middle Initial: _____ Last Name: _____

Current Address: _____

Current Telephone Number: _____

Date of Birth: ____ - ____ - ____

Is the consumer a Class Member? Yes No

Is the Consumer a MaineCare Member Yes No

If yes, MaineCare Number: _____

Are there any underage children living with this Consumer?

<input type="checkbox"/> 1 Child	<input type="checkbox"/> 2 Children
<input type="checkbox"/> 3 or More	<input type="checkbox"/> None

Marital Status

<input type="checkbox"/> Divorced	<input type="checkbox"/> Married/Domestic Partner
<input type="checkbox"/> Separated	<input type="checkbox"/> Single
<input type="checkbox"/> Widow/Widower	

Educational Status:

<input type="checkbox"/> High School Diploma	<input type="checkbox"/> GED
<input type="checkbox"/> Certificate Program	<input type="checkbox"/> Associates Degree
<input type="checkbox"/> College Graduate	

II. Diagnoses & LOCUS

DSM IV Dx (all V Axes)

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

LOCUS Composite Score (7-35): _____

Level of Care: 1-6 _____

Date of LOCUS: ____/____/____



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III Other Service Areas

1. Is the consumer receiving other mental health services?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Unknown	

2. If yes, what type of service(s)?

<input type="checkbox"/> ACT	<input type="checkbox"/> ICI
<input type="checkbox"/> CI	<input type="checkbox"/> Outpatient
<input type="checkbox"/> Med Management	<input type="checkbox"/> Targeted CM
<input type="checkbox"/> Peer Support Services	<input type="checkbox"/> Day Treatment

3. If yes, who is providing the service? _____

Is the Consumer receiving any of the following:

- 4. General Assistance? Yes No Unknown
- 5. SSI/SSDI? Yes No Unknown
- 6. Section 8 housing? Yes No Unknown
- 7. Housing Choice Voucher? Yes No Unknown
- 8. BRAP? Yes No Unknown
- 9. Shelter Plus Care? Yes No Unknown

10. Admit Date to PNMI: _____

11. Type of PNMI:

<input type="checkbox"/> 1601 Residential Treatment	<input type="checkbox"/> 1602 Community Residential
<input type="checkbox"/> 1603 Supported Housing	

12. Were there any bed hold days during the past year? Yes No

13. If yes, how many days? _____

14. If yes, what was the reason for bed hold day(s)?

<input type="checkbox"/> Medical Hospitalization	<input type="checkbox"/> Psychiatric Hospitalization
<input type="checkbox"/> Crisis Stabilization Unit	<input type="checkbox"/> Family visit
<input type="checkbox"/> Other	



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IV. Risk of Harm

15. Suicidal:

<input type="checkbox"/> Has Hx	<input type="checkbox"/> Ideation
<input type="checkbox"/> Self-Injurious Behaviors	<input type="checkbox"/> Plans
<input type="checkbox"/> Not Present	

16. Homicidal:

<input type="checkbox"/> Has Hx	<input type="checkbox"/> Ideation
<input type="checkbox"/> Plans	<input type="checkbox"/> Not Present

17. Hallucinations:

<input type="checkbox"/> Auditory	<input type="checkbox"/> Tactile
<input type="checkbox"/> Visual	<input type="checkbox"/> Olfactory
<input type="checkbox"/> Other	<input type="checkbox"/> Not Present

18. Psychosis:

<input type="checkbox"/> Delusional	<input type="checkbox"/> Paranoid
<input type="checkbox"/> Has Hx	<input type="checkbox"/> Not Present

19. Risk:

<input type="checkbox"/> Assaultive	<input type="checkbox"/> Criminal Behavior
<input type="checkbox"/> Fire Setting	<input type="checkbox"/> Has Hx
<input type="checkbox"/> History of Arrest, Jail	<input type="checkbox"/> Not Criminally Responsible; Title 15
<input type="checkbox"/> Not Present	<input type="checkbox"/> Order of Protection against Consumer
<input type="checkbox"/> Other _____	<input type="checkbox"/> Repeated Disturbances in Community
<input type="checkbox"/> Sexual Predatory Behavior	

20. Symptoms:

<input type="checkbox"/> Aggression	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Appetite Change	<input type="checkbox"/> Energy Level Change
<input type="checkbox"/> Impulsive	<input type="checkbox"/> Isolation
<input type="checkbox"/> Mania or Hypomania	<input type="checkbox"/> Other _____
<input type="checkbox"/> Poor Judgment	<input type="checkbox"/> Sleep Difficulties
<input type="checkbox"/> Thought Disordered	<input type="checkbox"/> Hypervigilance
<input type="checkbox"/> Flashbacks	<input type="checkbox"/> Nightmares
<input type="checkbox"/> Intrusive Thoughts	

V. Functional Status

21. How well does the Consumer Function within interpersonal relationships?

<input type="checkbox"/> Excellent (Occasional Disputes, Resolved Quickly, Seeks Out Other People, Adequate, Social Skills)	<input type="checkbox"/> Good
<input type="checkbox"/> Fair	<input type="checkbox"/> Poor (Severely Argumentative/Provocative, Alienates Potential Friends, Can't Manage Roommates, Avoids Other People, Very Poor Social Skills)

22. Does the Consumer attend to his/her hygiene & Activities of Daily Living?

<input type="checkbox"/> All of the Time	<input type="checkbox"/> Most of the time
<input type="checkbox"/> None of the Time	<input type="checkbox"/> Some of the Time



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23. Does the Consumer manage his or her finances?

<input type="checkbox"/> All of the Time	<input type="checkbox"/> Most of the Time
<input type="checkbox"/> Some of the Time	<input type="checkbox"/> None of the Time
<input type="checkbox"/> HasGuardian/Representative Payee	<input type="checkbox"/> Other _____

24. Is the Consumer employed? Yes No

25. How does the Consumer spend his/her day?

<input type="checkbox"/> Goes to the Social Club	<input type="checkbox"/> Spends Time with Family or Friends
<input type="checkbox"/> Sleeps much of the day	<input type="checkbox"/> Attends treatment program
<input type="checkbox"/> Is Working at Sheltered Workshop	<input type="checkbox"/> Is Working with Job Coach
<input type="checkbox"/> Is seeking employment	<input type="checkbox"/> Attends Spiritual/Religious/Faith Based Activities
<input type="checkbox"/> Activities are Limited Due to Physical Health	<input type="checkbox"/> Attending classes, including Community Courses
<input type="checkbox"/> Homemaker/parenting	<input type="checkbox"/> Retired
<input type="checkbox"/> Volunteer Work	<input type="checkbox"/> Vocational Training Program

26. What kind of natural support network does the Consumer have?

<input type="checkbox"/> At Least One Friend	<input type="checkbox"/> Church/Spiritual Group
<input type="checkbox"/> Clubhouses/Social Club	<input type="checkbox"/> Community groups
<input type="checkbox"/> Friends/Family	<input type="checkbox"/> Other _____
<input type="checkbox"/> None	<input type="checkbox"/> Peer Support Worker
<input type="checkbox"/> Self-Help Group	

27. Does the Consumer Participate in Community Activities?

<input type="checkbox"/> Adult Education/Educational Opportunities	<input type="checkbox"/> Assisting Peers/Peer group
<input type="checkbox"/> Art/Craft/Music Activities	<input type="checkbox"/> Church/synagogue/mosque
<input type="checkbox"/> Nature/Outdoor Group	<input type="checkbox"/> None
<input type="checkbox"/> Other _____	<input type="checkbox"/> Recreational Activities/Sports
<input type="checkbox"/> Special Interest Group/Political Group	<input type="checkbox"/> Spiritual or Faith Based Activities

VI. Medical Information

28. What are the Consumer's current major medical/health issues?

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer
<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Cholesterol Issues
<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Chronic Pulmonary Disease	<input type="checkbox"/> Dementia
<input type="checkbox"/> Dental Needs	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Gastrointestinal Problems	<input type="checkbox"/> Head/Brain Injury/
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Obesity	<input type="checkbox"/> Smoking
<input type="checkbox"/> None	<input type="checkbox"/> Other _____



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29.. What is the Consumer's regular source of medical care?

<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Primary Care Physician
<input type="checkbox"/> Clinic	<input type="checkbox"/> None
<input type="checkbox"/> Other _____	

30. Who currently prescribes the consumer's psychotropic medications?

<input type="checkbox"/> None	<input type="checkbox"/> Other _____
<input type="checkbox"/> Problems with Finding/Accessing a Psychiatrist/Prescriber	<input type="checkbox"/> Psychiatrist/Prescriber at Same Agency
<input type="checkbox"/> Psychiatrist/Prescriber at Other Agency	<input type="checkbox"/> Private Sector Prescriber
<input type="checkbox"/> PCP	

31. Does the residential staff have contact with the prescriber of psychotropic medications?

<input type="checkbox"/> Consumer Refused Release of Information	<input type="checkbox"/> Difficult to Connect by Phone
<input type="checkbox"/> Face to Face Contact Available	<input type="checkbox"/> None
<input type="checkbox"/> Other _____	<input type="checkbox"/> Telephone Contact
<input type="checkbox"/> Treatment Team Meetings	

32. Consumer's medication concerns:

<input type="checkbox"/> Consumer Takes Medications All of the Time Engages in Substance Abuse While Taking Medications	<input type="checkbox"/> Consumer Does Not Take Medications
<input type="checkbox"/> Consumer has Problems with Side Effects	<input type="checkbox"/> Consumer has a Stable Medication Regimen
<input type="checkbox"/> Consumer Opposed/Reluctant to Take Medications	<input type="checkbox"/> Medication Costs Problematic
<input type="checkbox"/> CM Does Not Know	<input type="checkbox"/> Consumer takes medications more that prescribed
<input type="checkbox"/> Consumer takes medications less than prescribed	<input type="checkbox"/> Consumer seeks multiple prescribers
<input type="checkbox"/> Consumer is on more than 5 medications	<input type="checkbox"/> No concerns at this time

33. List medications and list dosages, if known:

34. Coordination between your agency and the Consumer's PCP:

<input type="checkbox"/> CM/Resident Staff Accompanies Consumer to Medical Appointments	<input type="checkbox"/> Consumer Could Benefit from Assistance with Healthcare Needs but Refuses
<input type="checkbox"/> Consumer is Able to Effectively Manage His/Her Own Coordination of Health Care	<input type="checkbox"/> Consumer Refused Permission for Any Contact/Involvement
<input type="checkbox"/> Family/Natural Support System Coordinate/Assists with Healthcare Need	<input type="checkbox"/> Phone Contact with Medical Practice
<input type="checkbox"/> Other _____	<input type="checkbox"/> None
<input type="checkbox"/> Not applicable – does not have a PCP	

35. Does the Consumer have a history of Substance Abuse or Dependence Issues? *If no skip to number 44.*

<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Do Not Know	

36. If yes, please check all that apply:

<input type="checkbox"/> Alcohol	<input type="checkbox"/> Cocaine/Crack
<input type="checkbox"/> Marijuana	<input type="checkbox"/> Opiates/Pain Killers (Heroin, Methadone, Oxycontin, Oxcodone, Hydrocodone, etc.)
<input type="checkbox"/> Ecstasy	<input type="checkbox"/> Ritalin/Stratera
<input type="checkbox"/> Sedative/Hypnotics	<input type="checkbox"/> Other Street Drugs
<input type="checkbox"/> Other _____	



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37. Does the Consumer have current Substance Abuse or Dependence Issues? If No, skip to number 50.

<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Do Not Know	

38. If yes, please check all that apply:

<input type="checkbox"/> Alcohol	<input type="checkbox"/> Cocaine/Crack
<input type="checkbox"/> Marijuana	<input type="checkbox"/> Opiates/Pain Killers (Heroin, Methadone, Oxycontin, Oxycodone, Hydrocodone, etc.)
<input type="checkbox"/> Ecstasy	<input type="checkbox"/> Ritalin/Stratera
<input type="checkbox"/> Sedative/Hypnotic	<input type="checkbox"/> Other Street Drugs
<input type="checkbox"/> Other _____	

39. Has a referral Been made for treatment?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Consumer Refused	

40. If Yes, where?

<input type="checkbox"/> AA/NA/Other Self-Help Group	<input type="checkbox"/> Inpatient Detox
<input type="checkbox"/> Intensive Outpatient Treatment (IOP)	<input type="checkbox"/> Partial Hospitalization Program (PHP)
<input type="checkbox"/> Residential Program	<input type="checkbox"/> Substance Abuse Counseling (Individual/Group)
<input type="checkbox"/> On Wait List	<input type="checkbox"/> Other _____

41. Is the Consumer engaged/involved in a Substance Abuse Recovery Program?

<input type="checkbox"/> AA/NA/Other Self-help group	<input type="checkbox"/> Outpatient Individual Therapy
<input type="checkbox"/> Outpatient Group Therapy	<input type="checkbox"/> Other _____

42. Barriers to the Consumer's involvement in Substance Abuse Programming:

<input type="checkbox"/> Appropriate Program does not exist in Consumer's Community	<input type="checkbox"/> Denies substance abuse as a problem
<input type="checkbox"/> Distance to Programming	<input type="checkbox"/> Local Programs are Full
<input type="checkbox"/> Refuses Treatment	<input type="checkbox"/> Transportation
<input type="checkbox"/> Variable Attendance at Substance Abuse Program	

VII. Treatment and Recovery History

43. Is the Consumer experiencing other life stressors?

<input type="checkbox"/> Financial	<input type="checkbox"/> DHHS Involvement
<input type="checkbox"/> Significant change in overall health	<input type="checkbox"/> Significant Losses
<input type="checkbox"/> Legal Involvement	<input type="checkbox"/> New Immigrant to US
<input type="checkbox"/> Communication Difficulties	

44. Does the Consumer have a reported trauma history?

<input type="checkbox"/> Accident with Severe Physical Injury	<input type="checkbox"/> Active Duty Combat
<input type="checkbox"/> Criminal Victimization	<input type="checkbox"/> Disaster (Fire/Flood/Tsunami/Earthquake)
<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Emotional Abuse
<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Sexual Abuse
<input type="checkbox"/> Terrorism	<input type="checkbox"/> None



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45. Has the Consumer been involved with any crisis services within the past six months? If none, skip to # 55.

<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> None	<input type="checkbox"/> Unknown

46. Cause of crisis?

<input type="checkbox"/> Death/Loss	<input type="checkbox"/> Deterioration of Self-Care
<input type="checkbox"/> Drug/Alcohol Relapse from Period of Sobriety	<input type="checkbox"/> Financial
<input type="checkbox"/> Mental Health/Deterioration	<input type="checkbox"/> Other _____
<input type="checkbox"/> Physical Health/Deterioration	<input type="checkbox"/> Suicidal
<input type="checkbox"/> Homicidal	<input type="checkbox"/> Trauma

47. Where was the Consumer assessed?

<input type="checkbox"/> Call/Involve Crisis Team	<input type="checkbox"/> Call/Involve Police
<input type="checkbox"/> Call/Involve Psychiatrist/Therapist	<input type="checkbox"/> Consumer Brought to ER
<input type="checkbox"/> Face to Face in CSW/Professional Office	<input type="checkbox"/> Face to Face in Home or Community Location
<input type="checkbox"/> Face to Face in Jail	<input type="checkbox"/> Consumer Managed it Alone or with Natural Supports
<input type="checkbox"/> None	<input type="checkbox"/> Other _____
<input type="checkbox"/> Telephone Only	

48. What was the resolution?

<input type="checkbox"/> Crisis Stabilization Unit	<input type="checkbox"/> Check-in Calls by Crisis Team
<input type="checkbox"/> Jail	<input type="checkbox"/> Inpatient Hospitalization
<input type="checkbox"/> Natural Supports to Stay with Consumer	<input type="checkbox"/> Other _____
<input type="checkbox"/> Stayed in Emergency Room Until Crisis Passed/Discharged	<input type="checkbox"/> Observation Bed

49. Consumer's Crisis Plan:

<input type="checkbox"/> Advanced Stage of Crisis Symptoms Identified	<input type="checkbox"/> Consumer Refused a Crisis Plan
<input type="checkbox"/> Contingency Plan for Children/Pets	<input type="checkbox"/> Early Warning Signs/Symptoms Identified
<input type="checkbox"/> Family, Friends, Peers are Identified to be Involved/Not Involved	<input type="checkbox"/> Has Not Been Offered a Crisis Plan
<input type="checkbox"/> Notification of Other Person or Professionals, Agencies to Notify	<input type="checkbox"/> None

50. Number of Consumer psychiatric hospitalizations in the past year:

<input type="checkbox"/> 1	<input type="checkbox"/> 2
<input type="checkbox"/> 3 or more	<input type="checkbox"/> None

51. Number of Consumer inpatient treatment for SA including detox in the past year:

<input type="checkbox"/> 1	<input type="checkbox"/> 2
<input type="checkbox"/> 3 or more	<input type="checkbox"/> None



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VIII. CURRENT TREATMENT

52. Consumer's Treatment Plan/ ISP Goal Areas:

- 1. Housing
- 2. Financial
- 3. Education
- 4a. Social/Recreation/Peer: Family
- 4b. Social/Recreation/Peer: Cultural/Gender
- 4c. Social/Recreation/Peer: Recreational/Social
- 4d. Social/Recreation/Peer: Peer Support:
- 5. Transportation
- 6. Health Care:
 - a. Dental b. Eye Care c. Hearing Health d. Medical
- 7. Vocational
- 8. Legal
- 9. Living Skills
- 10. Substance Abuse
- 11. Mental Health:
 - a. Trauma b. Emotional/Psychological c. Psych/Medications d. Crisis
- 12. Spiritual
- 13. Outreach
- 14. Other _____

53. What is the targeted discharge date?

<input type="checkbox"/> 3 months	<input type="checkbox"/> 6 months
<input type="checkbox"/> 1 year	<input type="checkbox"/> No discharge plans at this time
<input type="checkbox"/> Unknown	

54. What are the consumer's goals to move to independent living?



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IX. CLINICAL ADVISOR REVIEW SUMMARY

a. Does Consumer Meet Clinical Criteria for Eligibility Regardless of Class Member Status?

Yes No

b. Are the Symptoms/Behaviors Consistent with Diagnosis?

Yes No

c. Does the Consumer Exhibit Symptoms/Behaviors that Indicate a Need for a Medication Assessment?

Yes No Already receiving MD services

d. Do the Areas of Need Identified in This Review Match the Goals in the Consumer's ISP?

Yes No Partially

e. Has there been Progress made Towards Goals Since the Last Review?

- No
- Mild
- Moderate
- Good
- Excellent

f. LOCUS Summary

Clinical Advisor Total LOCUS Score I (7-35)	# _____
Clinical Advisor Assessed Level of Care	# _____
Provider Total LOCUS Score	# _____
Provider Assessed Level of Care	# _____

g. Is the appropriate Level of Care being provided to the consumer at this time?

- No- a Higher Level is Appropriate
- No- a Lower Level is Appropriate
- No- Less Frequent Intervention is Appropriate
- No- a More Frequent Intervention is Appropriate
- Yes
- No – Consumer prefers to be served at a lower level of care
- No – Higher Level of Care does not exist in the consumer's community

Comments: _____

Other Interventions Needed? Yes No (Diabetes education, HIV)

Clinical Advisor Case Summary:

Case Referred to Supervisor? Yes No

Reason: _____

Case Referred to Mental Health Team Leader? Yes No