



# NorthSTAR

## Uniform Assessment Diagnosis Form

**Principal Diagnosis Axis:** \_\_\_ (1=AXIS I; 2=AXIS II)

Description		DSM Code
<b>AXIS I</b>	Level 1	_____
	Level 2	_____
	Level 3	_____
		_____
<b>AXIS II</b>	Level 1	_____
	Level 2	_____
	Level 3	_____

**OPTIONAL (AXIS III & IV)**

		ICD Code
<b>AXIS III</b>	Level 1	_____
	Level 2	_____
	Level 3	_____
	Level 4	_____
	Level 5	_____
	Level 6	_____
<b>AXIS III Date:</b> ____ - ____ - ____		

**AXIS IV:** (Check all that apply) \_\_\_A \_\_\_B \_\_\_C \_\_\_D \_\_\_E \_\_\_F \_\_\_G \_\_\_H \_\_\_I

**AXIS V:** Current: \_\_\_\_ Past Year: \_\_\_\_

**Authorized Level Of Care (LOC-A):**

**Please Check the Box to Indicate Request:**

- Med Management Only
- Service Package 1
- Service Package 1S (full state package)
- Service Package 2
- Service Package 3
- Service Package 4
- Service Package 5

**Information Box**

**Provider Number:** \_\_\_\_\_

**Vendor Number Location:** \_\_\_\_\_

**Form Completion Date:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Member NorthSTAR ID:** \_\_\_\_\_

Field Name	Type	Contents
NORTHSTAR ID	R	NorthSTAR Member Number.
LAST NAME	R	Consumer's last name.
FIRST NAME	R	Consumer's first name.
MIDDLE NAME	O	Consumer's middle name.
NPI NUMBER	R	National Provider Identifier
PROVIDER NUMBER	R	BHO 6 digit Assigned Provider Number.
VENDOR NUMBER LOCATION COMPONENT	R	BHO 7 DIGIT ASSIGNED VENDOR NUMBER (WHERE SERVICE IS PROVIDED SPECIFIC TO LOCATION)
ASSESSMENT TYPE: CRISIS	O/R	Check this box if the purpose of the assessment is to record that the consumer is receiving crisis services and not currently enrolled in a service package. <b>Note:</b> Crisis is no longer an Intake assessment type.
ASSESSMENT TYPE: INTAKE	O/R	Check this box if the purpose of the assessment is the consumer's intake to services.
ASSESSMENT TYPE: INTAKE NON-ADMISSION	---	This option will be automatically entered by the WebCARE screens if the purpose of the assessment is a non-admission due to ineligibility or refusal of services.
ASSESSMENT TYPE: UPDATE	O/R	Check this box if the purpose of the assessment is to update the consumer's care.
ASSESSMENT TYPE: DISCHARGE	O/R	Check this box if the purpose of the assessment is the consumer's discharge.
REASON FOR DISCHARGE	O/R	If discharge, indicate the code that best describes the discharge reason. (C = Level of Care Services Complete, J = Incarcerated in Jail or Prison, M = Moved out of Local Service Area, N = Never Returned for Services within Authorized Service Period, not to exceed 6 months, T = Transferred to Other Community Provider in Local Service Area, P = Elected a new provider, E = Change in NorthSTAR eligibility Z = Other).
DISCHARGE DATE	O/R	If the assessment purpose is discharge, indicate the date of discharge
ACTION TYPE: ADD	O/R	Check this line to add a new Uniform Assessment for the first time.
ACTION TYPE: CORRECT/MODIFY	O/R	Check this line to correct or modify information that has been previously submitted.
ACTION TYPE: DELETE	O/R	Check this line to delete a previously submitted form that was incorrect.

**Section 1: Adult TRAG & Recommended Level of Care – Completed by Provider QMHP.**

A. ADULT-TRAG DIMENSION RATINGS		
1-8	R	Indicate the individual rating for each of the Adult-TRAG dimensions 1 through 8.
9 DEPRESSIVE SYMPTOMATOLOGY	O/R	If MDD, indicate the rating for this dimension.
B. CALCULATED LEVEL OF CARE RECOMMENDED	D	Indicates the Adult-TRAG Level of Care recommendation (LOC-R), automatically calculated from responses to Section 1, A.
C. TCOOMMI CONSUMER?	O	Check this box if the consumer receives services through a Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) contract.
D. ASSESSMENT DATE	R	Date of the Adult TRAG completion in MMDDYYYY format.
ASSESSED BY	R	Name of the person completing Section 1.
CREDENTIALS	R	Highest credentials of the person completing Section 1 (QMHP-CS, RN, LCSW, LMSW-ACP, LMFT, LPC, LPHD-PSY, RN-APN, PA, MD, DO). LVN is <i>not</i> approved to complete Section 1.
NOTES	O	Used for provider/authority communication and clinical notes. Limited to 6 lines or less

**Section 3: Diagnosis-Specific Clinical Symptom Rating Scales – [Also known as the TIMA scales] Completed by Provider LVN or QMHP staff.**

**Choose one algorithm and complete all items for that algorithm (based on current principle diagnosis).**

A. SCHIZOPHRENIA ALGORITHM		Total Positive Symptom Rating Scale (PSRS) and the Total Brief Negative Symptom Assessment (BNSA).
B. BIPOLAR ALGORITHM		Total Brief Bipolar Disorder Symptom Scale (BDSS).
C. MAJOR DEPRESSION ALGORITHM		Total Quick Inventory of Depressive Symptomatology (QIDS) and the QIDS version.
D. ASSESSMENT DATE	R	Date of the rating scales assessment completion in MMDDYYYY format
E. EXTENDED REVIEW PERIOD REQUESTED	O/R	Complete this field for members in package 1 who are eligible for an extended review period. You <i>can not</i> complete this field for consumers receiving their first Uniform Assessment at Intake.
ASSESSED BY	R	Name of the person completing Section 3.
CREDENTIALS	R	Highest credentials of the person completing Section 3 (QMHP-CS, RN, LCSW, LMSW-ACP, LMFT, LPC, LPHD-PSY, RN-APN, PA, MD, DO, LVN).
NOTES	O	Used for provider/authority communication and clinical notes. Limited to 6 lines or less

**Section 4: Community Data** – Completed by Provider QMHP staff.

A. RESIDENCE TYPE (CURRENT)	R	Consumer's current type of residence.
B. PAID EMPLOYMENT TYPE (CURRENT)	R	Consumer's current employment status.
C. MAIN REASON FOR BEING OUT OF THE LABOR FORCE	O/R	Main reason that the consumer is not in the labor force. Required if Section B is 4=Not in the labor force.
D. ASSESSMENT DATE	R	Date the community data was collected in MMDDYYYY format.
NOTES	O	Used for the name and credentials of the staff responsible for completion of this section or for provider/authority communication. Limited to 6 lines or less
FORM MARKED AS COMPLETED BY:	R	Signature of the person indicating the form is complete ("Complete" or "Provider Complete").

**PAGE 2: DIAGNOSIS FORM** – COMPLETED BY LVN OR QMHP STAFF.

FOR NON-SUBSTANCE RELATED MENTAL HEALTH DIAGNOSIS

* PRINCIPAL DIAGNOSIS AXIS	R	CONSUMER'S PRINCIPAL DIAGNOSIS
* AXIS I	O/R	PSYCHIATRIC SYNDROME
* AXIS II	O/R	PERSONALITY AND SPECIFIC DEVELOPMENTAL DISORDER OR MENTAL RETARDATION (SEE THE CURRENT OFFICIAL DSM-IV MANUAL FOR DIAGNOSTIC CODES)
* AXIS I DIAGNOSIS	O/R	LEVEL 1 IS REQUIRED IF THE PRINCIPAL DIAGNOSIS AXIS FIELD IS MARKED. LEVEL 1 IS MOST SIGNIFICANT. PLEASE PRINT THE NARRATIVE DESCRIPTIONS FOR EACH LEVEL IN BLOCK CAPITAL LETTERS. (ALL THREE DO NOT HAVE TO BE COMPLETED.)
* AXIS II DIAGNOSIS	O/R	LEVEL 1 IS REQUIRED IF THE PRINCIPAL DIAGNOSIS AXIS FIELD IS MARKED. LEVEL 1 IS MOST SIGNIFICANT. PLEASE PRINT THE NARRATIVE DESCRIPTIONS FOR EACH LEVEL IN BLOCK CAPITAL LETTERS. (ALL THREE DO NOT HAVE TO BE COMPLETED.)
* AXIS III	O/R	THERE ARE SIX FIELDS FOR RECORDING ICD-9 CODES REPRESENTING THE CONSUMER'S PHYSICAL DIAGNOSES. LEVEL 1 IS MOST SIGNIFICANT. DOCUMENT ANY IDENTIFIED PHYSICAL DIAGNOSIS. PLEASE PRINT THE NARRATIVE DESCRIPTIONS FOR EACH LEVEL IN BLOCK CAPITAL LETTERS. (SEE THE CURRENT OFFICIAL ICD-9 MANUAL FOR DIAGNOSTIC CODES.)
* AXIS III DATE	R	DATE OF THE PHYSICIAN'S EXAMINATION IN WHICH THE AXIS III
* AXIS IV	O/R	Indicate the individual rating for each of the psychosocial and environment problems A through I. (No selection will indicate no perceived problem.)
* AXIS V	O/R	Indicates consumer's psychological, social, and occupational functioning. (Do not include impairment in functioning due to physical or environmental limitations.)
* AXIS V Current		Write in two-digit code to identify the consumer's current level of adaptive functioning.
* AXIS V Past Year		Write in two-digit code to identify the consumer's highest level of adaptive functioning in the past year.