



DIVISION OF BEHAVIORAL HEALTH AND RECOVERY
Level 2
Preadmission Screen and Resident Review (PASRR)
Invalidation
Interrupted Evaluation

DATE OF REFERRAL:
DATE OF INTERRUPTED INVALIDATION:
DATE OF BIRTH:

INSTRUCTIONS: This form is to be used **only** when a Level 2 Evaluation is terminated (see criteria below). **An Invalidation must be completed and filed in the patient record.** If the evaluation is terminated after fifteen minutes or more, (not to exceed 60 minutes) this Interrupted Evaluation form should be completed, attached to a copy of the Invalidation, and submitted to DBHR with an A19 voucher.

NAME: LAST:	FIRST:	MIDDLE:
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NURSING FACILITY:

Criteria

The evaluation was terminated after _____ minutes (use 15 minute increments, not to exceed 60 min.)
 Check one of the following

- did not meet the criteria for serious mental illness; **or**
- did meet the criteria for major neurocognitive disorder; **or**
- did meet criteria for severe medical illness

Evaluator Information

SIGNATURE:	DATE:
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PRINT NAME:	TITLE:
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CONTRACTOR:	COUNTY:
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