ASSESSMENT OF SERIOUS COGNITIVE IMPAIRMENT

Standards for Licensed Assisted Living Facilities **requires:**

Prior to admission to a safe, secure environment, a resident shall have been assessed by an independent clinical psychologist licensed to practice in the Commonwealth or by an independent physician as having a serious cognitive impairment due to a primary psychiatric diagnosis of dementia with an inability to recognize danger or protect his/her own safety and welfare. The physician shall be board certified or board eligible in a specialty or subspecialty relevant to the diagnosis and treatment of serious cognitive impairments.

The regulation defines "serious cognitive impairment" as severe deficit in mental capability of a chronic, enduring or long-term nature that affects areas such as thought processes, problem-solving, judgment, memory, and comprehension and that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, and impulse control. Such cognitive impairment is not due to acute or episodic conditions, nor conditions arising from treatable metabolic or chemical imbalances or caused by reactions to medication or toxic substances.

Name of Prospective Resident: _____

Birth Date: _____/_____/_____

Address: _____
(Street)

_____
(City) **(State/Zip Code)**

Cognitive Functions (e.g., orientation, comprehension, problem-solving, attention and concentration, memory, intelligence, abstract reasoning, judgment, and insight):

_____

_____

_____

Thought and Perception (e.g., process and content): _____

_____

_____

_____

Mood/Affect: _____

_____

_____

Name of Prospective Resident: _____

Behavior/Psychomotor: _____

_____

_____

Speech/Language: _____

_____

_____

Appearance: _____

_____

_____

Additional Comments: _____

_____

_____

DOES THE INDIVIDUAL NAMED ABOVE HAVE A SERIOUS COGNITIVE IMPAIRMENT DUE TO A PRIMARY PSYCHIATRIC DIAGNOSIS OF DEMENTIA?

☐ **YES** ☐ **NO**

IS THE INDIVIDUAL NAMED ABOVE UNABLE TO RECOGNIZE DANGER OR PROTECT HIS/HER OWN SAFETY AND WELFARE?

☐ **YES** ☐ **NO**

_____ _____/_____/_____

Signature of Licensed Physician or Virginia-Licensed Clinical Psychologist **Date**

_____

(Please print or type physician's or psychologist's name here)

Address: _____ **Telephone**: _____

(Street)

_____

(City) **(State/Zip Code)**