

## 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/concentration, memory, intelligence, abstract reasoning, judgment, insight):

---

---

---

Thought and Perception (e.g., process, 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: \_\_\_\_\_  
(Street)

Telephone: \_\_\_\_\_

\_\_\_\_\_  
(City)                      (State/Zip Code)