

## **APPENDIX B. PRIORITY CRITERIA TOOLS**

APPENDIX B.1 CATARACT SURGERY

APPENDIX B.2 GENERAL SURGERY

APPENDIX B.3 HIP AND KNEE REPLACEMENT

APPENDIX B.4 MRI SCANNING

APPENDIX B.5 CHILDREN'S MENTAL HEALTH (version 1.0 and 1.1) and CHILDREN'S GLOBAL ASSESSMENT OF FUNCTIONING (GAF) SCALE



**APPENDIX B.1  
CATARACT SURGERY PRIORITY CRITERIA  
Version 1.0 revised October 2, 2000 – with weights**

**PLEASE PRINT CLEARLY**

Provincial Health Care Number: \_\_\_\_\_

Patient Age: \_\_\_\_\_ Sex: [circle one] **M** **F**

This form is being filled out for which eye?  
(circle one) Right Eye Left Eye

(circle one) First eye for surgery **OR** Second eye for surgery?

Has the other (second eye):  already been wait-listed for surgery? **OR**  
 already had surgery performed? If so, when? \_\_\_\_\_

If second eye, when was first eye done?: \_\_\_\_\_

Surgeon's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE CHECK THE BOX THAT MOST ACCURATELY DESCRIBES THE PATIENT'S CURRENT SITUATION.**

**1. Best corrected visual acuity:**

Points	
Operated Eye	Non-operated Eye
<b>0</b>	<b>0</b>
<b>3</b>	<b>0</b>
<b>5</b>	<b>9</b>
<b>8</b>	<b>11</b>
<b>11</b>	<b>13</b>
<b>11</b>	<b>15</b>
<b>11</b>	<b>17</b>

- | Right Eye:   | Left Eye:  |
|--|--|
| <input type="checkbox"/> 6/9 or better (20/30)                 | <input type="checkbox"/> 6/9 or better (20/30)                 |
| <input type="checkbox"/> 6/12 (20/40)                          | <input type="checkbox"/> 6/12 (20/40)                          |
| <input type="checkbox"/> 6/18 (20/60)                          | <input type="checkbox"/> 6/18 (20/60)                          |
| <input type="checkbox"/> 6/24 (20/80)                          | <input type="checkbox"/> 6/24 (20/80)                          |
| <input type="checkbox"/> 6/36 (20/120)                         | <input type="checkbox"/> 6/36 (20/120)                         |
| <input type="checkbox"/> 6/60 (20/200)                         | <input type="checkbox"/> 6/60 (20/200)                         |
| <input type="checkbox"/> Count fingers/hand movements or worse | <input type="checkbox"/> Count fingers/hand movements or worse |

**2. Glare:**

- |                               |                                   |
|-------------------------------|-----------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Mild | <input type="checkbox"/> Severe   |

**3. Ocular comorbidity (e.g. age-related macular degeneration, chronic simple glaucoma):**

	None	Mild	Moderate	Severe
Age-related macular degeneration.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>0</b>	<b>-2</b>	<b>-6</b>	<b>-15</b>
Other forms of comorbidity.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>0</b>	<b>0</b>	<b>1</b>	<b>2</b>

**If other form of comorbidity, what?**

- diabetic retinopathy                       other retinal disease                       chronic simple glaucoma  
 hypertensive retinopathy                       other \_\_\_\_\_

**4. Extent of impairment in visual function (e.g. reading, recognizing faces, seeing steps or curbs, watching TV, driving, and reading traffic signs):**

- 0**  No impairment  
**3**  Mild impairment  
**12**  Moderate impairment  
**23**  Severe impairment

**5. Other substantial disability (e.g. hearing loss, uses wheelchair, partially reversible dementia):**

- 0**  None/mild  
**4**  Moderate  
**10**  Severe

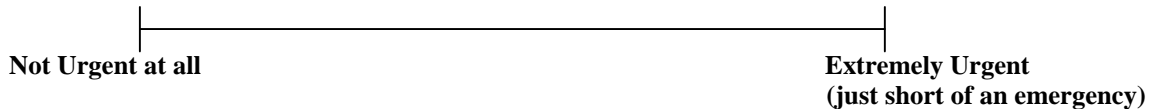
Please specify disability: \_\_\_\_\_

**6. Ability to work or live independently or care for dependants:**

- Not applicable  
**0**  Not threatened or no difficulties  
**2**  Not threatened but more difficult  
**10**  Threatened but not immediately  
**19**  Immediately threatened or unable

**7. All things considered, how would you rate the urgency of this patient?**

(Draw a line somewhere across the scale.)



**8. In your clinical judgment, what should be the maximum waiting time for this patient?**

Number of weeks \_\_\_\_\_ **OR** Number of months \_\_\_\_\_

**Comments on the form or process used to complete form:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**APPENDIX B.2**  
**GENERAL SURGERY PRIORITY CRITERIA**  
Version 1.0 revised December 19, 2000 – with weights

**PLEASE PRINT CLEARLY**

Patient Name \_\_\_\_\_ PATIENT ID \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_ Patient Age \_\_\_\_\_ Sex: [circle one] M F  
MM DD YYYY

Principal Diagnosis: 1. \_\_\_\_\_ Check if applicable:  
2. \_\_\_\_\_ Cancer Proven   
3. \_\_\_\_\_ Cancer Suspected

Proposed Procedure: 1. \_\_\_\_\_  
2. \_\_\_\_\_

Proposed Date of Surgery: \_\_\_\_\_ 2001  
MM DD YYYY

Surgeon's Name \_\_\_\_\_ ID \_\_\_\_\_ Date Form Completed: \_\_\_\_\_  
MM DD YYYY

**PLEASE CHECK THE BOX THAT MOST ACCURATELY DESCRIBES THE PATIENT'S CURRENT SITUATION.**

**1. Usual FREQUENCY of painful episodes/suffering:**

- 0  None
- 3  Occasional
- 6  Often
- 9  Constant

**2. How INTENSE is the pain at its worst?**

- 0  No pain
- 3  Mild
- 7  Moderate
- 11  Severe

**3. Usual INTENSITY of other forms of suffering. Please specify form of suffering – CIRCLE all that apply:**

Nausea or vomiting... Fatigue.... Itching.....Psychological stress such as anxiety or depression. List others: \_\_\_\_\_

- 0  None
- 4  Mild
- 8  Moderate
- 12  Severe

**4. Degree of impairment in usual activities due to surgical condition:**

- 0 Not impaired at all/mildly impaired
- 5 Able but difficult and/or somewhat impaired
- 10 Able but very difficult and at much reduced level
- 15 Totally dependent (Unable to perform any usual activities)

**5. Recent history of: Major complications of condition**

**OR significant physical exam results**  
**OR significant test results.**

- 0 No
- 8 Yes

**6. Life-expectancy implications of condition without procedure:**

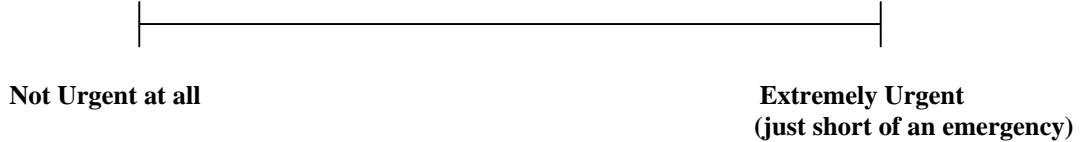
- 0 Minimal threat to life
- 10 Patient faces somewhat reduced life expectancy
- 15 Patient faces substantially reduced life expectancy
- 20 Patient has condition that is likely to be fatal between six months and two years
- 25 Patient has condition that is likely to be fatal within six months

**7. Expected improvement in life-expectancy with surgery:**

- 0 None
- 5 Minimal
- 10 Moderate
- 20 Major

**8. All things considered, how would you rate the urgency or relative priority of this patient?**

(Draw a line across the scale.)



**9. In your clinical judgment, what should be the maximum waiting time for this patient?**

Number of weeks \_\_\_\_\_ **OR** Number of months \_\_\_\_\_

**Comments on the form or process used to complete form:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**APPENDIX B.3**  
**HIP AND KNEE REPLACEMENT PRIORITY CRITERIA**  
**Version 1.0 revised October 3, 2000 – with weights**

<b>PLEASE PRINT CLEARLY</b>	
Provincial Health Care Number: _____	
Patient Age: _____	Sex: [circle one] <b>M</b> <b>F</b>
[Tick one box] <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Hip <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Knee	
[Tick one box] <input type="checkbox"/> Primary <input type="checkbox"/> Revision	
Diagnosis: _____ _____	
Surgeon's Name: _____	Phone: _____
Date: _____	

**Patients must be on appropriate non-surgical treatment prior to evaluation (e.g. medications, walking aids, shoe inserts)**

**PLEASE CHECK THE BOX THAT MOST ACCURATELY DESCRIBES THE PATIENT'S CURRENT SITUATION**

**1. Pain on motion (e.g. walking, bending): \***

- 0 None/mild
- 6 Moderate
- 13 Severe

\* Take into account usual duration, intensity, and frequency of pain, including need for narcotic vs. non-narcotic medication.

**2. Pain at rest (e.g. while sitting, lying down, or causing sleep disturbance): \***

- 0 None
- 3 Mild
- 8 Moderate
- 11 Severe

\* Take into account usual duration, intensity, and frequency of pain, including need for narcotic vs. non-narcotic medication.

**3. Ability to walk without significant pain :**

- 0 Over 5 blocks
- 0 1-5 blocks
- 4 Less than 1 block
- 7 Household ambulator

4. **Other functional limitations (e.g. putting on shoes, managing stairs, sitting to standing, sexual activity, bathing, cooking, recreation or hobbies):**

- 0  No limitations
- 4  Mild limitations (able to do most activities with minor modifications or difficulty)
- 11  Moderate limitations (able to do most activities but with modification or assistance)
- 19  Severe limitations (unable to perform most activities)

5. **Abnormal findings on physical exam related to affected joint (e.g. deformity, instability, leg length difference, restriction of range of motion on examination):**

- 0  None/mild
- 5  Moderate
- 10  Severe

6. **Potential for progression of disease documented by radiographic findings (e.g. recurrent dislocation, x-ray evidence of protrusion, significant bone loss, component wear, impending fracture):\*\***

- 0  None
- 4  Mild
- 11  Moderate
- 20  Severe

\*\* Predominantly applies to revisions, use in primary cases only in special circumstances (e.g. ligament instability, bone loss)

7. **Threat to patient role and independence in society (i.e. ability to work, give care to dependants, live independently (difficulty must be related to affected joint)):**

- 0  Not threatened but more difficult
- 10  Threatened but not immediately
- 20  Immediately threatened or unable

8. **All things considered, how would you rate the urgency or relative priority of this patient? (Draw a line across the scale.)**



9. **In your clinical judgement, what should be the maximum waiting time for this patient?**

Number of weeks \_\_\_\_\_ OR Number of months \_\_\_\_\_

10. **In your practice how long would it take this patient to have the surgery done from the time you first see the patient?**

Number of weeks \_\_\_\_\_ OR Number of months \_\_\_\_\_

**Comments on the form or process used to complete form:** \_\_\_\_\_

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**APPENDIX B.4  
MRI SCANNING PRIORITY CRITERIA  
Version 1.0 revised June 22, 2000 – with weights**

**PLEASE PRINT CLEARLY**

Provincial Health Care Number: \_\_\_\_\_

Patient Age: \_\_\_\_\_ Sex: [circle one] **M** **F**

Body Part:

<input type="checkbox"/> Brain	<input type="checkbox"/> Neck (soft tissue)	<input type="checkbox"/> Spine (cervical)	<input type="checkbox"/> Spine (thoracic)	<input type="checkbox"/> Spine (lumbar)
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Chest	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Knee	<input type="checkbox"/> Other _____

Diagnosis: \_\_\_\_\_  
\_\_\_\_\_

Specialist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE CHECK THE BOX THAT MOST ACCURATELY DESCRIBES THE PATIENT'S CURRENT SITUATION.**

- 1. Usual duration/frequency/intensity of pain &/or suffering:**
  - 0 None/mild
  - 10 Moderate
  - 20 Severe
- 2. Severity of illness/impairment:**
  - 5 Low
  - 10 Medium
  - 20 High
- 3. Probable time course of clinical deterioration:**
  - 5 Long-term (> 6 months)
  - 10 Mid-term (1 – 6 months)
  - 20 Short-term (< 1 month)
- 4. Probability of MRI providing clinically significant diagnostic information:**
  - 5 Low
  - 10 Medium
  - 20 High
- 5. Probability of successful treatment resulting from the diagnostic information:**
  - 5 Low
  - 10 Medium
  - 20 High





**APPENDIX B.5**  
**CHILDREN'S MENTAL HEALTH PRIORITY CRITERIA**  
**Version 1.0 revised October 16, 2000 – with weights**

**PLEASE PRINT CLEARLY**

Provincial Health Care Number: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Age: \_\_\_\_\_ Sex: [circle one] **M** **F**

Reason for referral: \_\_\_\_\_

Clinician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Clinician's Profession: \_\_\_\_\_

Facility: \_\_\_\_\_ Program: \_\_\_\_\_

Referral Source: \_\_\_\_\_

**PLEASE CHECK THE BOX THAT MOST ACCURATELY DESCRIBES THE PATIENT'S CURRENT SITUATION**

**1. Danger to self**

- |                                |                                   |
|--------------------------------|-----------------------------------|
| <input type="checkbox"/> None  | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Minor | <input type="checkbox"/> Severe   |

**2. Danger to others**

- |                                |                                   |
|--------------------------------|-----------------------------------|
| <input type="checkbox"/> None  | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Minor | <input type="checkbox"/> Severe   |

**3. Psychotic symptoms**

- |                               |                                   |
|-------------------------------|-----------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Mild | <input type="checkbox"/> Severe   |

**4. Global age-appropriate developmental progress**

- |   |   |
|---|---|
| <input type="checkbox"/> No delay and/or no risk of delay       | <input type="checkbox"/> Moderate delay and/or moderate risk of delay |
| <input type="checkbox"/> Minor delay and/or minor risk of delay | <input type="checkbox"/> Severe delay and/or high risk of delay       |

**5. Children's GAF score (see Attachment, Children's Global Assessment of Functioning—higher is healthier)**

- |                                     |                                       |
|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> 40 or less | <input type="checkbox"/> 51 to 60     |
| <input type="checkbox"/> 41 to 50   | <input type="checkbox"/> More than 60 |

**6. Internalized symptoms**

- |                                |                                   |
|--------------------------------|-----------------------------------|
| <input type="checkbox"/> None  | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Minor | <input type="checkbox"/> Severe   |

**7. Externalized/disruptive behaviour**

- |   |  |
|---|--|
| <input type="checkbox"/> No problems    | <input type="checkbox"/> Moderate problems |
| <input type="checkbox"/> Minor problems | <input type="checkbox"/> Severe problems   |

**8. Comorbid medical conditions**

- |                                |                                   |
|--------------------------------|-----------------------------------|
| <input type="checkbox"/> None  | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Minor | <input type="checkbox"/> Severe   |

**9. Comorbid psychiatric conditions**

- None  Moderate  
 Minor  Severe

Please specify: \_\_\_\_\_

**10. Harmful substance use/misuse**

- No problems  Moderate problems  
 Minor problems  Severe problems

**11. Significant biological family history of mental illness**

- Yes  No  Unknown

**12. School and/or work**

- No problems  Moderate problems  
 Minor problems  Severe problems

**13. Social/friendships/community functioning**

- No problems  Moderate problems  
 Minor problems  Severe problems

**14. Does the patient have problems in the context of the home?**

- No problems  Moderate problems  
 Minor problems  Severe problems

**15. Family functioning or factors affecting child**

- No problems  Moderate problems  
 Minor problems  Severe problems

**16. Prognosis without further intervention**

- Good  Guarded  
 Moderate  Poor

**17. Degree of likely benefit with further intervention**

- Very High  Moderate  
 High  Low

**18. All things considered, how would you rate the urgency or relative priority of this patient?  
(Draw a line across the scale)**



**19. What is the ideal and maximum waiting time that this patient/client should have to wait for an initial assessment by a clinician?**

Ideal \_\_\_\_\_ Maximum \_\_\_\_\_

**20. Following this assessment how long should the patient/client have to wait for treatment?**

Ideal \_\_\_\_\_ Maximum \_\_\_\_\_

**Comments on the form or process used to complete form:**

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The following version of the Children's Mental Health Priority Criteria tool (version 1.1) was revised on the recommendation of the panel co-chair and participants in the reliability focus group session (December 4, 2000) and is being used in Phase II pilot-testing.



**APPENDIX B.5**  
**CHILDREN'S MENTAL HEALTH PRIORITY CRITERIA**  
**Version 1.1 revised January 11, 2001 – no weights**

**PLEASE PRINT CLEARLY**

Provincial Health Care Number: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Age: \_\_\_\_\_ Sex: [circle one] **M** **F**

Reason for referral: \_\_\_\_\_

Clinician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Clinician's Profession: \_\_\_\_\_

Facility: \_\_\_\_\_ Program: \_\_\_\_\_

Referral Source: \_\_\_\_\_

**PLEASE CHECK THE BOX THAT MOST ACCURATELY DESCRIBES THE CHILD/YOUTH'S CURRENT SITUATION**

**1. Danger to self**

- |                                |                                   |
|--------------------------------|-----------------------------------|
| <input type="checkbox"/> None  | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Minor | <input type="checkbox"/> Severe   |

**2. Danger to others**

- |                                |                                   |
|--------------------------------|-----------------------------------|
| <input type="checkbox"/> None  | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Minor | <input type="checkbox"/> Severe   |

**3. Psychotic symptoms**

- |                               |                                   |
|-------------------------------|-----------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Mild | <input type="checkbox"/> Severe   |

**4. Global age-appropriate developmental progress**

- |   |   |
|---|---|
| <input type="checkbox"/> No delay and/or no risk of delay       | <input type="checkbox"/> Moderate delay and/or moderate risk of delay |
| <input type="checkbox"/> Minor delay and/or minor risk of delay | <input type="checkbox"/> Severe delay and/or high risk of delay       |

**5. Children's GAF score (see Attachment, Children's Global Assessment of Functioning—higher is healthier)**

- |                                     |                                       |
|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> 40 or less | <input type="checkbox"/> 51 to 60     |
| <input type="checkbox"/> 41 to 50   | <input type="checkbox"/> More than 60 |

**6. Internalized symptoms**

- |                                |                                   |
|--------------------------------|-----------------------------------|
| <input type="checkbox"/> None  | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Minor | <input type="checkbox"/> Severe   |

**7. Externalized/disruptive behaviour**

- |   |  |
|---|--|
| <input type="checkbox"/> No problems    | <input type="checkbox"/> Moderate problems |
| <input type="checkbox"/> Minor problems | <input type="checkbox"/> Severe problems   |

**8. Comorbid medical conditions**

- |                                |                                   |
|--------------------------------|-----------------------------------|
| <input type="checkbox"/> None  | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Minor | <input type="checkbox"/> Severe   |

**9. Harmful substance use/misuse**

- No problems
- Minor problems
- Moderate problems
- Severe problems

**10. Significant biological family history of mental illness or substance abuse**

- Yes
- No
- Unknown

**11. School and/or work**

- No problems
- Minor problems
- Moderate problems
- Severe problems

**12. Social/friendships/community functioning**

- No problems
- Minor problems
- Moderate problems
- Severe problems

**13. Does the child/youth have problems in the context of the home?**

- No problems
- Minor problems
- Moderate problems
- Severe problems

**14. Negative impact of family functioning on child or youth**

- No problem
- Minor effect on child or youth
- Moderate effect on child or youth
- Severe effect on child or youth

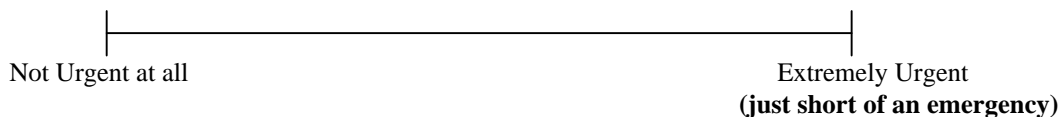
**15. Prognosis without further intervention**

- Good
- Moderate
- Poor

**16. Likelihood of substantial improvement as a result of treatment. "Substantial improvement" means a significant improvement in GAF as a result of treatment.**

- Very High
- High
- Moderate
- Low

**17. All things considered, how would you rate the urgency or relative priority of this patient?  
(Draw a line across the scale)**



**18. What is the maximum waiting time that this child/youth should have to wait for an initial assessment by a mental health specialist?**

Maximum \_\_\_\_\_

**19. Following this assessment how long should the child/youth have to wait for treatment?**

Maximum \_\_\_\_\_

**Comments on the form, or process used to complete form:**

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## Children's Global Assessment of Functioning (GAF) Scale (revised)

Rate the subject's most impaired level of general functioning for the specified time period by selecting the lowest level which describes his/her functioning on a hypothetical continuum of health-illness. Use intermediary levels (e.g. 35, 58, 62). Rate actual functioning regardless of treatment or prognosis. The examples of behaviour provided are only illustrative and are not required for a particular rating.

Specified Time Period: 1 month

- 91-100** Superior functioning in all areas (at home, at school, and with peers); involved in a wide range of activities and has many interests (e.g. has hobbies or participates in extracurricular activities or belongs to an organized group such as Scouts, etc): likeable, confident; "everyday" worries never get out of hand; doing well in school; no symptoms
- 81-90** Good functioning in all areas; secure in family, school, and with peers; there may be transient difficulties and "everyday" worries that occasionally get out of hand (e.g. mild anxiety associated with an important exam. occasionally "blowups" with siblings parents, or peers)
- 71-80** No more than slight impairment In functioning at home, at school; or with peers; some disturbance of behaviour or emotional distress may be present in response to life stresses (e.g. parental separations, deaths, birth of a sib), but these are brief and interference with functioning is transient; such children are only minimally disturbing to others and are not considered deviant by those who know them
- 61-70** Some difficulty in a single area, but generally functioning pretty well (e.g. sporadic or isolated antisocial acts, such as occasionally playing hooky or petty theft; consistent minor difficulties with school work; mood changes of brief duration; fears and anxieties which do not lead to gross avoidance behaviour; self-doubts); has some meaningful interpersonal relationships; most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern
- 51-60** Variable functioning with sporadic difficulties or symptoms in several but not all social areas; disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings
- 41-50** Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor or inappropriate social skills, frequent episodes of aggressive or other antisocial behaviour with some preservation of meaningful social relationships
- 31-40** Major impairment in functioning in several areas and unable to function in one of these areas, e.g. disturbed at home, at school, with peers or in society at large, e.g., persistent aggression without clear instigation; markedly withdrawn and isolated behaviour due to either mood or thought disturbance, suicidal attempts with clear lethal intent: such children are likely to require special schooling and/or hospitalization or withdrawal from school (but this is not a sufficient criterion for inclusion in this category)
- 21-30** Unable to function in almost all areas, e.g., stays at home, in ward, or in bed all day without taking part in social activities or severe impairment in reality testing or serious impairment in communication (e.g., sometimes incoherent or inappropriate)
- 11-20** Needs considerable supervision to prevent hurting others or self (e.g. frequently violent, repeated suicide attempts) or to maintain personal hygiene or gross impairment in all forms of communication, e.g. severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.
- 0-10** Needs Constant supervision (24-hr care) due to severely aggressive or destructive behavior or gross impairment in reality testing, communication, cognition, affect, or personal hygiene

Children's Global Assessment Scale was adapted from the Global Assessment Scale for Adults  
Children's Global Assessment Scale- Shaffer et al 1229.

