



DIVISION OF BEHAVIORAL HEALTH AND RECOVERY  
 PREADMISSION SCREEN AND RESIDENT REVIEW (PASRR)

**Level 2 PASRR Initial Psychiatric  
 Evaluation Summary**

ASSESSMENT CATEGORY (CHECK APPROPRIATE BOX)
<input type="checkbox"/> Preadmission
<input type="checkbox"/> Initial Nursing Facility
<input type="checkbox"/> Significant Change
<input type="checkbox"/> Medicaid covered Individual

The following evaluation is required by OBRA 1987 to complete the Level 2 process for potentially mentally ill persons in a Medicaid certified nursing facility. Based on the diagnosis and need for treatment, a determination will be made regarding the most appropriate placement and plan of care.

NAME: LAST	FIRST	MIDDLE	DATE OF REFERRAL
			DATE OF EVALUATION
			DATE OF BIRTH

NURSING FACILITY PLACEMENT AND MAILING ADDRESS

REASON FOR REFERRAL: CURRENT SYMPTOMS AND BEHAVIORS

PASRR rights review with individual	<input type="checkbox"/> Yes <input type="checkbox"/> No	COMMENTS
Individual agreed to evaluation	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SITE OF EVALUATION

Home  Nursing facility  Community facility  Psychiatric inpatient setting  General medical hospital setting

Other (specify):

NAME OF SITE OF EVALUATION

GENDER	PRIMARY LANGUAGE
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> English <input type="checkbox"/> Other (specify):

RACE / ETHNICITY	MARITAL STATUS	PRIMARY LIVING SITUATION DURING THE PAST YEAR
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Married	<input type="checkbox"/> Home <input type="checkbox"/> Other psychiatric inpatient
<input type="checkbox"/> African American/Black	<input type="checkbox"/> Single	<input type="checkbox"/> Nursing facility <input type="checkbox"/> Mental Health residential
<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Widowed	<input type="checkbox"/> Homeless <input type="checkbox"/> Developmental Disability facility
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Divorced/separated	<input type="checkbox"/> State Hospital <input type="checkbox"/> Other residential program
<input type="checkbox"/> White, not of Hispanic origin	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other (specify):

**1. Diagnosis Indicated by Present Evaluation**

DSM:	

Medical:	
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Psychiatric diagnoses of record:

SIGNATURE OF PERSON COMPLETING EVALUATION	DATE
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PRINT NAME OF PERSON COMPLETING EVALUATION	TITLE
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CONTRACTOR

**Comments / Recommendations of the Reviewing Psychiatrist**

SIGNATURE OF REVIEWING PSYCHIATRIST	DATE
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SIGNATURE OF DEPARTMENT OF SOCIAL AND HEALTH SERVICES, DBHR DESIGNEE'S SIGNATURE	DATE
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## 2. Recommendations for Plan of Care

- Follow-up Evaluation Date:
- No follow-up Evaluation Needed (Unless significant change in condition occurs while in nursing facility)
- A. Mental Health Services:** provide explanation for recommended service(s):
  - 1. Acute psychiatric hospitalization (The mental health needs of the individual cannot be met at the skilled nursing facility):
  
  - 2. Specialized services can be provided in a skilled nursing facility by a licensed mental health professional or mental health agency for:
    - a. Individual Services, i.e., case management, therapy, case consultation for:
  
    - b. Psychiatric assessment and medication evaluation / management for:
  
  - 3. No mental health services are recommended at this time (explain below):

- B. Recommendations for Nursing Facility** (include likes and dislikes about people, and community environments, what helps keep them calm):
  - 1. Environmental:
  
  - 2. Staff approaches / training:
  
  - 3. Behavioral supports:
  
  - 4. Activities:
  
  - 5. Other:

- C. Other Medical Services:**
  - 1. Psychiatric medication management as currently provided by the individual's primary physician (non-psychiatrist):
  
  - 2. Medical assessment to address the following physical health symptoms:
  
  - 3. Ancillary services (podiatry, PT, dental, etc.):

- D. Recommendations for Community Transition:**
  - 1. Is it possible for this individual to reside in the community and have their needs met?
  
  - 2. Individual's stated preference of living situation in community:
  
  - 3. Evaluator recommendations for community transition:

## 3. Presenting Problem(s)

**A.** Current psychiatric problems and status:

**B.** Recent relevant events (list reason(s) for hospitalization and/or SNF placement / referral):

**C.** Behavioral and emotional problems:

**D.** Interview and Impressions:

#### 4. Psychiatric History

A. Psychiatric history (include history of suicide attempts and risk of harm to self or others):

B. Date of onset of psychiatric symptoms:  Less than 1 year  1 – 5 years  More than 5 years  Unknown

C. Psychiatric hospitalizations:

**Within past two years:**

- None  
 1 – 5 hospitalizations.  
 More than 5 hospitalizations  
 Unknown

**Total during lifetime:**

- None  
 1 – 5 hospitalizations.  
 More than 5 hospitalizations  
 Unknown

D. Provide information of psychiatric hospitalizations (reason, location, dates, course of treatment) with emphasis on most recent hospitalization:

E. History of previous medications with response / lack of response (if known):

F. Current mental health services provider / Behavioral Health Organization (BHO) / agency name and telephone number:

#### 5. Substance Use History

A. Is there history or current use of alcohol or substances for this individual?  Yes  No  Unknown

B. If yes, specify substance(s) used, dates, circumstances (current and past) and treatments received (location and date(s) of treatment):

C. Substance Use Disorder Questionnaire attached:  Yes  No Comment:

#### 6. Family History

A. Family history of mental illness (note relationship):

B. Family history of suicide (note relationship):

C. Family history of alcohol / substance abuse (note relationship):

#### 7. Medical and Medication History

A. Attach copies of laboratory reports, consultations, recent medical notes and the comprehensive history and physical examination and medical diagnoses list for psychiatric review.

\* **Required contents as necessary to determine diagnosis:** complete medical history; review of all systems; specific evaluation of the individual's neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves, and abnormal reflexes; and in case of abnormal finding, which are the basis for a NF placement, additional evaluation conducted by appropriate specialists.

B. Attach copies of medication use profile: for purpose of psychiatric review, record medication, copy of the current physician's orders. Specify additions / changes for all medications including frequency of PRN medications, during the past 90 days.

C. List current psychotropic medications:

8. Psychological Test Instruments		
TOTAL SCORE	INSTRUMENTS	COMMENTS
	Mini-Mental Status Examination (MMSE)	
	Geriatric Depression Scale (GDS)	
	Brief Psychiatric Rating Scale (BPRS)	
	Mood Disorder Questionnaire (MDQ)	
Functional assessment (include review of MDS, any OT, PT, speech therapy documentation): See attachments for complete information.		
9. Behavioral Health Services		
<b>A.</b> Has the individual requested behavioral health services? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, what type? Comment:		
<b>B.</b> Agrees to recommended behavioral health services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain    Comment:		
<b>C.</b> Does the individual perceive a need for mental health services? <input type="checkbox"/> Yes <input type="checkbox"/> No    Comment:		
10. Additional Information		
<b>A.</b> Strengths and assets (according to evaluation findings):		
<b>B.</b> Individual's stated goals:		
<b>C.</b> Identify current support network and adult family situation (include names, relationship, potential support provided):		
<b>D.</b> Individual's identified skills, strengths, and favorite activities with interests:		