



## Level 2 PASRR Follow-Up or Significant Change in Condition Psychiatric Evaluation Summary

The following psychiatric evaluation is required by OBRA 1987 for persons currently residing in a Medicaid certified nursing facility that since their last Level 2 evaluation have had a significant change in condition or are in need of a follow-up Level 2 evaluation. Based on the diagnosis and need for treatment, if any, a new determination will be made regarding the most appropriate placement and plan of care.

ASSESSMENT CATEGORY (CHECK APPROPRIATE BOX) <input type="checkbox"/> Follow-Up <input type="checkbox"/> Significant Change in Condition <input type="checkbox"/> Medicaid covered Individual
DATE OF PREVIOUS LEVEL 2 OR SIGNIFICANT CHANGE OF CONDITION
DATE OF REFERRAL
DATE OF EVALUATION
DATE OF BIRTH

NAME: LAST	FIRST	MIDDLE	DATE OF BIRTH
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NURSING FACILITY PLACEMENT AND MAILING ADDRESS

REASON FOR REFERRAL: (CURRENT SYMPTOMS AND BEHAVIORS THAT HAVE CHANGED SINCE LAST PASRR LEVEL 2)

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

Home  
  Nursing facility  
  Community facility  
  Psychiatric inpatient setting  
  General medical hospital setting  
 Other (specify):

NAME OF SITE OF EVALUATION

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

DSM:	

Medical:	
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Psychiatric diagnoses of record:	
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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 since previous PASRR Level 2 Evaluation (list changes in condition, either improvement or decline):

**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. Substance Use Disorder Questionnaire attached:  Yes  No Comments:

#### 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(s), 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		
A.	Has the individual requested behavioral health services?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type? Comment:
B.	Agrees to recommended behavioral health services?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain Comment:
C.	Does the individual perceive a need for mental health services?	<input type="checkbox"/> Yes <input type="checkbox"/> No Comment:
D.	Were mental health services recommended in the previous Level 2?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:
E.	If mental health services were received, describe outcome:	
10. Additional Information		
A.	Strengths and assets (according to evaluation findings):	
B.	Individual's stated goals:	
C.	Have there been significant changes in their support network since the last PASRR? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type? Comment:	
D.	Individual's identified skills, strengths, and favorite activities with interests:	