

Name:

Part 1: Comprehensive Evaluation - Mental Illness

Mental Status / Psychiatric Assessment

1. Treatment Review

Psychiatric Hospitalization: Prior admission to state or private psychiatric facilities (give dates, facility and reason for admission)

Community-Based Treatment Involvement with community mental health center, private psychiatric or other treatment facilities (include outpatient and community support services)

History of cooperation with recommended treatment.

2. Referral Diagnosis:

3. Mental Status Assessment (other Mental Status Assessment tools may be utilized)

Mental Status Assessment

Present	Yes	No	Present	Yes	No
Physically Unkempt, Unclean Clothing Disheveled, Dirty Clothing Atypical, Unusual, Bizarre Unusual Physical Characteristics	<input type="checkbox"/>	<input type="checkbox"/>	Orientation	<input type="checkbox"/>	<input type="checkbox"/>
Slumped Rigid, Tense Atypical, Inappropriate	<input type="checkbox"/>	<input type="checkbox"/>	Disoriented to Person Disoriented to Place Disoriented to Time	<input type="checkbox"/>	<input type="checkbox"/>
Accelerated, Increased Speed Decreased, Slow Atypical, Peculiar, Inappropriate Restless, Fidgety	<input type="checkbox"/>	<input type="checkbox"/>	Memory	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety, Fear, Apprehension Depression, Sadness/Anger, Hostility Decreased Variability of Expression, Bizarreness, Inappropriateness	<input type="checkbox"/>	<input type="checkbox"/>	Impaired Immediate Recall Impaired Recent Memory Impaired Remote Memory	<input type="checkbox"/>	<input type="checkbox"/>
Increased, Loud Decreased, Slowed Atypical Quality, Slurring Stammering	<input type="checkbox"/>	<input type="checkbox"/>	Perception	<input type="checkbox"/>	<input type="checkbox"/>
Domineering Submissive, Overly Compliant Provocative Suspicious Uncooperative	<input type="checkbox"/>	<input type="checkbox"/>	Thought Content	<input type="checkbox"/>	<input type="checkbox"/>
Impaired Level of Consciousness Impaired Attention Span Impaired Abstract Thinking Impaired Calculation Ability Impaired Intelligence	<input type="checkbox"/>	<input type="checkbox"/>	Stream Thought (As manifested by speech) Feeling (Affect and mood)	<input type="checkbox"/>	<input type="checkbox"/>
			Obsessions Compulsions Phobias De-realization, Depersonalization Suicidal Ideation Homicidal Ideation Delusions Paranoia Ideas of Reference Ideas of Influence	<input type="checkbox"/>	<input type="checkbox"/>
			Associational Disturbance Thought Flow Decreased, Slow Thought Flow Increased Inappropriate to Thought Content Increased Liability of Affect Predominate Mood is: - Blunted, Absent, Unvarying - Euphoric, Elated - Angry, Hostile - Fearful, Anxious, Apprehensive - Depressed, Sad	<input type="checkbox"/>	<input type="checkbox"/>
			Overt Behaviors	<input type="checkbox"/>	<input type="checkbox"/>
			Abuses Substances Verbally Abuses Others Physically Abuses Others Destroys Property Physically Abuses Self Fearful, Crying, Clinging Takes Property from others without Permission Performs Repetitive Behaviors (Pacing, Rocking, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
			Comments: (Diagnostic history, recent improvement or decline of SMI, describe current psychiatric symptoms (mood, orientation, cognition, thought content, etc...))		

Name: _____

Please list tools used for mental status/psychiatric assessment:

Mini Folstein (Score) _____ Other, Please Specify: _____

Is organicity/dementia present? Yes No How was this substantiated? _____

4. DSM IV TR Diagnostic Code & Label Impression based on clinical Data gathered. (CMHMRC staff):

AXIS I	AXIS IV
AXIS II	AXIS V
AXIS III	

5. IQ Level: _____ Date Obtained: _____

6. Other Comments: *(Explain if there is a disparity in the current diagnosis versus the referral diagnosis)*

**IF THE PERSON HAS A PRIMARY DIAGNOSIS OF ORGANIC MENTAL DISORDER
*****PASRR PROCESS STOPS HERE*******

(For the purposes of a PASRR evaluation, when a person has more than one diagnosis, the primary diagnosis is the one with the most pervasive symptoms or the condition that is chiefly responsible for the need for treatment. The primary diagnosis may not necessarily be listed first in a chronological listing of problems/conditions.)

Medication History (This section must be completed thoroughly)

1. Documentation of all medications individual has taken in the last year: (Identify below or attach medication list)

a. Currently prescribed

Medication	Dosage	Frequency	Reason

b. Previous psychotropic medications (Please include dosage, frequency and reason):

c. Comment on any medications that could mask or mimic mental illness symptoms.

2. Self-Management of medications (Please complete for new admission)

<input type="checkbox"/> Without Supervision	<input type="checkbox"/> Complies Only if Given Choice
<input type="checkbox"/> With Some Prompting and Supervision	<input type="checkbox"/> Hoards Medication
<input type="checkbox"/> Only With Prompting and Supervision	<input type="checkbox"/> Refuses Medication

3. Does client complain of side effects of medication or are there visible signs of side effects?

4. List all allergies including medication (prescribed or over the counter) allergies and food allergies.

5. Does the client use alcohol or other non-prescribed drugs? Is there a history of alcohol/drug abuse? If yes, identify TYPE, FREQUENCY, AMOUNT AND LENGTH OF USE/ABUSE.

Name:

Psychosocial Evaluation

1. Reason for Placement: Identify changes in the individual's status and/or living situation that contributed to the request for nursing facility placement.

2. Family/Friends/Support System (list names & phone numbers:

3. Current Functioning Level (ability of person to function in a less restrictive setting):

a. Is the person's ability to communicate and verbalize in expressive/receptive skill areas impaired?
 Yes No. If yes, please **describe** the Impairment and what action the evaluator took to overcome this?

b. Please rank person's ability to perform following areas and/or identify current supports provided to assist with activity:

Rank current functioning 1 – 4:				
1 - Unable to Perform		3 - Needs Minimum Assistance		
2 - Needs Moderate Assistance		4 - Independent		
Activities of Daily Living		Instrumental Activities of Daily Living		
Eating		Meal Preparation	Laundry	
Dressing		Light Housekeeping	Shoppin	
Bathing		Heavy Housework	Mobility	
Toileting		Money Management	Travel	
Grooming		Nutritional Habits		
Ambulation		Health Monitoring & Medication Management		
Transfer				

c. Comments::

Base (Low intensity) Medicaid Nursing Facility Level of Care

In order to meet minimal level of care criteria for admission to a nursing facility, an applicant **must** meet two (2) criteria listed below. **(Check the box(s) that apply)**

- Assistance with wheelchair
- Physical or environmental management for confusion and mild agitation
- Must be fed
- Assistance with going to bathroom or using bedpan for elimination
- Old colostomy care
- In-dwelling catheter for dry care
- Changes in bed position
- Administration of stabilized dosages of medication
- Restorative and supportive nursing care to maintain the individual and prevent deterioration of his condition
- Administration of injections during time licensed personnel is available
- Services that could ordinarily be provided or administered by the individual but due to physical or mental condition is not capable of self-care
- Routine administration of medical gases after a regimen of therapy has been established.

The following criteria must also be considered...

An individual with a mental illness or mental retardation or a developmental disability meeting the health status and care needs specified above shall meet patient status and still be excluded from coverage in the following situations;
If the department determines that in the individual case the combination of care needs are beyond the capability of the facility and that placement in the facility is inappropriate due to potential danger to the health and welfare of the individual, other patients in the facility or staff of the facility or
The individual does not meet the PASRR criteria for entering or remaining in a facility

Patient Status: (Previously level of care)

A patient status decision shall be based on medical diagnosis, care needs, services and health personnel required to meet these needs and the feasibility of meeting the needs through alternative institutional or non-institutional services.

Name:

Medical History / Physical Examination

1. The following is Comprehensive History and Physical Data which Includes complete history and review of all body systems, specific evaluation of neurological system in area of motor and sensory functioning, gait, and deep tendon reflexes. Nursing home admission cannot occur until after this requirement has been met. The examination must be performed by a physician, registered nurse or a physician assistant. If not performed by a physician, a physician must review and concur with the conditions.

	a.	Source of Data:			
		**Date Performed:		**Performed By:	
		Major physical / medical needs:			
		Abnormal finding that requires additional information:			
		Finding	Evaluation Recommended	Date of Referral	To Agency / Person
		Comments:			

	b.	<u>If information is not available</u> , evaluator or CMHC must either conduct the examination and complete the Comprehensive History and Physical Examination Form or refer the applicant to another office for the evaluation. If referred for evaluation, give:			
		Date of referral:		To Agency / Person:	
		Date findings Returned:			
		Summary of Major Physical / Medical Needs:			

3.	Date of Last Minimum Data Set (MDS) Conducted at Facility (if appropriate):	
	Note Major Physical Medical Needs:	

4.	Date of Last Level of Care Certification Performed by Peer Review (if appropriate):	
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5.	Other Comments:
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Name:

The examination must be performed by a physician, registered nurse or a physician assistant. If not performed by a physician, he / she must review and concur with the conclusions. Information from a history / physical performed within the last year may be used if there has been no significant change in the individual's medical condition.

I	Medical History	
	1. History of Present Symptoms or Illness (include last date seen by physician, if applicable)	
	2. Past Medical History (include physical or developmental disabilities and, if appropriate, pertinent family history)	
	3. Allergies or Drug/Food Sensitivities	4. History of Substance Use/Abuse, Frequency, Amount (include alcohol)

II	Review of Body Systems - Assess all variables and explain all abnormal findings.					
	Vital signs:	T:	P:	R:	B/P:	WT:

	General Appearance and Behavior:
	Skin:
	Head:
	Face (include Eyes, Ears, Nose):
	Mouth, Throat, Neck:
	Cardiovascular:
	Pulmonary:

Name:

	Breast:
	Gastrointestinal:
	Genitourinary:
	Rectal:
	Musculoskeletal:
	Neurological (include Motor Functioning, Sensory Functioning, Gait, Deep Tendon Reflexes, Cranial Nerves and abnormal reflexes):

III Abnormal Findings - In case of abnormal findings, which are the basis for the individual's nursing home placement, include recommendations for additional information.

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IV Summary of Major Medical/Physical Needs.

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	Signature and Professional Title (RN or PA) if not performed by a physician	Date
	Physician Signature (A physician must sign here in order to complete the form)	Date

Name:

Part II: Findings and Recommendations

Review of Findings

Positive Traits/Developmental Strengths and Weaknesses:

Medication History:

Mental Status/Psychiatric Assessment (include dangerousness to self or others):

Psychosocial Evaluation:

Medical History/Physical Examination:

Impact of Physical/Medical Diagnosis on person's ability to function:

Nursing Facility Care Needs:

Recommended Services through PASRR to be included in resident's treatment plan (Clearly describe mental health services needed and how they will benefit the resident):

Name:

Recommendations	
1	Does person need nursing facility care? <input type="checkbox"/> Yes <input type="checkbox"/> No
2	Are Specialized Services recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No
(If yes, Specialized Services Identification Form, this complete evaluation and the Computer Summary Form must be sent to the Division of Mental Health.)	
Specialized Services (Active treatment) Definition for Mental Illness: Specialized Services is the implementation of an individualized plan of care developed under and supervised by a physician, and provided by an interdisciplinary team of qualified mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of serious mental illness, which necessitates continuous supervision by trained mental health personnel. An applicant with mental illness who requires specialized services shall be considered to be eligible for the level of services provided in an institution for mental disease (IMD) or an inpatient psychiatric hospital.	

Disposition - Check one only. This information must be consistent with the disposition on the PASRR Computer Summary. For assistance, refer to the PASRR Manual.

Admission To or Continued Stay in Nursing Facility	
<input type="checkbox"/>	No specialized services recommended
<input type="checkbox"/>	Specialized services recommended
<input type="checkbox"/>	Client declined specialized services
Not Admitted to Nursing Facility	
<input type="checkbox"/>	Recommended to state treatment facility / CMHMRC program
<input type="checkbox"/>	Recommended to private treatment facility / community program
<input type="checkbox"/>	No action taken
<input type="checkbox"/>	Admitted to or continued stay in State IMD
<input type="checkbox"/>	Inappropriate PASRR Referral; Meets Exemption -- Process Stops

Name:

Evaluation Time Frames:

Date of Referral: _____

Date Verbal Given: _____

Date Report Sent: _____

Signature of Evaluator:

Title: _____

Date: _____

Counter Signature:

Title: _____

Date: _____

Signature of Evaluator:

Title: _____

Date: _____

Counter Signature:

Title: _____

Date: _____

If other evaluators were responsible for particular sections, please include below:

- Mental Status/Psychiatric Assessment

Name, Title, Date: _____

- Psychological Evaluation

Name, Title, Date: _____

- Medication History

Name, Title, Date: _____

- Medical History / Physical Examination

Name, Title, Date: _____

Name: _____

INTERPRETATION OF PASRR FINDINGS:

The Center for Medicare and Medicaid Services (CMS) Regulations mandate that the findings of this evaluation be interpreted to: the individual; the legal guardian; or, for a legally competent person who is incapable of understanding the findings, to his/her designated family member or representative.

The findings of this evaluation have been explained to (check one):

- Individual
- Legal Guardian
- Representative

I understand that my signature does not represent my consent or agreement with the findings. I also understand that I have the right to contest the findings if I receive a determination that I do not require nursing facility level of care or that I do not need specialized services. A cover letter accompanying this evaluation explains my appeal rights

Individual / Representative

(Relationship, if appropriate)

Community Mental Health Center Staff

Title

NOTE: If signature was not obtained, please document steps taken to obtain signature and note the date the Interpretation of Findings was sent to the individual/representative.
