IDAHO Preadmission Screening and Resident Review (PASRR)

Level 1 HW00087

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Social Security #: XXX - XX - _____ Medicaid #: _____ Gender ☐ Male ☐ Female Date of Birth: _____

Current Location: ☐ Medical Facility ☐ Psychiatric Facility ☐ Nursing Facility ☐ Community/Home ☐ Other _____

Primary Care Physician _____ Phone: _____

Proposed NF Admission Date: _____ Receiving Nursing Facility: _____

Receiving Nursing Facility Address: _____ City: _____ State: _____ Zip: _____

Legal Representative _____ Phone _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Section I: MENTAL ILLNESS

1. Does the individual have any of the following Major Mental Illnesses (MMI)?

☐ No

☐ Suspected: One or more of the following diagnosis is suspected (check all that apply)

☐ Yes: (check all that apply)

- ☐ Schizophrenia Spectrum and Other Psychotic Disorders
- ☐ Depressive Disorders ☐ Bipolar Disorders
- ☐ Anxiety Disorders ☐ Somatoform Disorders
- ☐ Personality Disorders ☐ Post-Traumatic Stress Disorder
- ☐ Obsessive Compulsive-Related Disorders

2. Does the individual have any of the following mental disorders?

☐ No

☐ Suspected

☐ Yes: (check all that apply)

- ☐ Anxiety
- ☐ Depression (mild or situational)

3. Does the individual have a diagnosis of a mental disorder that is not listed in #1 or #2? (do not list dementia here)

☐ No

☐ Yes

- ☐ Diagnosis 1: _____
- ☐ Diagnosis 2: _____

4. Does the individual have a substance related disorder?

☐ No

☐ Yes (complete remaining questions in this section)

4a. List substance abuse diagnosis(es)

- ☐ Diagnosis 1: _____
- ☐ Diagnosis 2: _____
- ☐ Diagnosis 3: _____
- ☐ Diagnosis 4: _____

4b. Is the NF need associated with this diagnosis?

- ☐ No
- ☐ Yes

Section II: CURRENT PSYCHIATRIC MEDICATIONS

5. Do not list medications used for a medical diagnosis or treatment of behaviors related to Dementia diagnosis

Medication	Dosage	Diagnosis	Started

Section III: SYMPTOMS

6. Interpersonal

Has the individual exhibited interpersonal symptoms or behaviors (not due to a medical condition)?

☐ No

☐ Yes - *Provide date if available*

- ☐ Serious difficulty interacting with others
  Date: _____
- ☐ Altercations, evictions, or unstable employment
  Date: _____
- ☐ Frequently isolating or avoiding others
  Date: _____

7. Concentration/Task related symptoms

Has the individual exhibited any of the following symptoms or behaviors (not due to medical condition)?

☐ No

☐ Yes - *Provide date if available*

- ☐ Serious difficulty completing age related tasks
  Date: _____
- ☐ Substantial errors with tasks in which she/he completes
  Date: _____
- ☐ Difficulty with concentration, persistence, pace
  Date: _____

8. Adaptation to change

Has the individual exhibited any symptoms related to adapting to change?

☐ No

☐ Yes (check all that apply and provide date if known)

☐ Self-injurious or self-mutilation - Date:_____ ☐ Suicidal talk/ideations - Date:_____ ☐ Physical violence - Date:_____

☐ History of suicide attempt or gesture - Date:_____ ☐ Physical threats - Date:_____ ☐ Hallucinations or delusions - Date:_____

☐ Severe appetite disturbance - Date:_____ ☐ Excessive tearfulness - Date:_____ ☐ Excessive Irritability - Date:_____

☐ Serious loss of interest in things - Date:_____ ☐ Withdrawal due to adaptation difficulties – Date: _____

☐ Other major mental health symptoms, this may include recent symptoms that have emerged or worsened as a result of recent life changes as well as ongoing symptoms. Describe Symptoms:

_____

_____

_____

Date: _____

Section IV: HISTORY OF PSYCHIATRIC TREATMENT

9. Has the individual received any of the following mental health services?

☐ No

☐ Yes (the individual has received the following service[s])

☐ Inpatient psychiatric hospitalizations
Date: _____

☐ Partial hospitalization/day treatment
Date: _____

☐ Residential treatment
Date: _____

☐ Other: _____
Date: _____

10. Has the individual experienced significant life disruptions because of mental health symptoms?

☐ No

☐ Yes (check all the apply)

☐ Legal intervention due to mental health symptoms
Date: _____

☐ Housing change because of mental illness
Date: _____

☐ Suicide attempt or ideation
Date(s): _____

☐ Other _____
Date: _____

11. Has the individual had a recent psychiatric/ behavioral evaluation?

☐ No

☐ Yes
Date: _____

Section V: DEMENTIA

12. Does the individual have a *PRIMARY* diagnosis of dementia or Alzheimer's disease?

☐ No (proceed to 15)

☐ Yes (proceed to 13)

13. If yes to #12, attach corroborative testing or other information available to verify the presence or progression of the dementia?

☐ No

☐ Yes (check all that apply)

☐ Dementia work up

☐ Mental Status Exam

☐ Other (specify)_____

14. <u>If yes to 12, list</u> currently prescribed antipsychotic medications for the symptoms related to dementia and/or Alzheimer's

Medication	Dosage MG/Day	
		If meds are listed, this is a *Positive PASRR* and must be forwarded to BLTC

Section VI: INTELLECTUAL DISABILITIES & DEVELOPMENTAL DISABILITIES

15. Does the individual have a diagnosis of intellectual disability (ID) - An intellectual disability is evidenced by an IQ of less than 70 based on standardized, reliable tests; onset before age 18?

☐ No

☐ Yes, *specify type/diagnosis*

16. Does the individual have presenting evidence of intellectual disability (ID) that has not been diagnosed?

☐ No

☐ Yes

17. Does the individual have documented evidence of a related condition? –Related condition refers to severe, chronic disability that is attributable to condition related closely to intellectual disability, resulting in impairment of general intellectual functioning or adaptive behavior similar to ID and requiring similar treatment or services, onset before age 22; duration likely to last lifelong.

☐ No
☐ Yes *(check all that apply)*
- ☐ Autism ☐ Blindness ☐ Closed head injury
- ☐ Seizure disorder ☐ Cerebral Palsy ☐ Deafness
- ☐ Other: _____

18. Has the individual received services from, or been referred to, an agency or facility that serves individuals with intellectual disability?

☐ No
☐ Yes

19. Are there substantial functional limitations in any of the following?

☐ No
☐ Yes *(check all that apply)*
- ☐ Mobility ☐ Self care
- ☐ Learning ☐ Capacity for living independently
- ☐ Understanding/Use of language ☐ Self direction

Signature Of Physician, Physician's Extender, Hospital Discharge Planner (RN or LSW) or Community Care Manager (RN) | Date | Phone Number

If not completed by Physician, Physician's Extender, Hospital Discharge Planner or Community Care Manager, this form must be completed by *both* of the following:

For Section I-V only:

Signature of QMHP

Qualification/Job Title | Date

For Section VI only:

Signature of QIDP

Qualification/Job Title | Date

Forward to the Bureau of Long Term Care (BLTC) if ANY of the following are marked Yes:

☐*1* ☐*3* ☐*4* ☐*5* ☐*8* ☐*9* ☐*10* ☐*14* ☐*15* ☐*16* ☐*17* ☐18 ☐19 *AND* ***complete notification below***

Attach ***the following if available:*** ☐***History & Physical*** ☐***Updating Documentation*** ☐***Level of Care*** ☐***Discharge Orders/Summary*** ☐***Functional/ADL Assessment***

Notification of MH/DD review:

_____ has been identified with possible indicators of mental illness and/or intellectual disabilities/developmental disabilities and requires further screening.

This is mandated by Omnibus Budget Reconciliation Act of 1987, per Section 1919 (b)(3)(F).

You may be contacted by a representative of the Department of Health and Welfare concerning further screening and results of the screening when it is completed.

Print Individual's Name: _____ Date _____

Signature of Individual: _____ Date _____

Signature of Legal Representative/Guardian: _____ Date _____

Fax Numbers

Region 1 – Coeur d' Alene (208) 666-6856
Region 2 – Lewiston (208) 799-5167
Region 3 – Caldwell (208) 454-7625
Region 4 – Boise (208) 334-0953
Region 5 – Twin Falls (208) 736-2116
Region 6 – Pocatello (208) 239-6269
Region 7 – Idaho Falls (208) 528-5756