

## Level 1 Pre-Admission Screening and Resident Review (PASRR)

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Social Security #: - - - - MID: \_\_\_\_\_ Gender  Male  Female Date of Birth: \_\_\_\_\_  
 Current Location:  Medical Facility  Psychiatric Facility  Nursing Facility  Community/Home  Other  
 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

- |  |   |   |
|--|---|---|
| <p>1. Does the individual have any of the following Major Mental Illnesses (MMI)?</p> <input type="checkbox"/> No<br><input type="checkbox"/> Suspected: One or more of the following diagnosis is suspected (check all that apply)<br><input type="checkbox"/> Yes: (check all that apply)<br><input type="checkbox"/> Schizophrenia <input type="checkbox"/> Paranoid Disorder<br><input type="checkbox"/> Schizoaffective Disorder<br><input type="checkbox"/> Major Depression<br><input type="checkbox"/> Psychotic/Delusional Disorder<br><input type="checkbox"/> Bipolar Disorder (manic depression) | <p>2. Does the individual have any of the following mental disorders?</p> <input type="checkbox"/> No<br><input type="checkbox"/> Suspected: One or more of the following diagnoses is suspected (check all that apply)<br><input type="checkbox"/> Yes: (check all that apply)<br><input type="checkbox"/> Personality Disorder<br><input type="checkbox"/> Anxiety Disorder<br><input type="checkbox"/> Panic Disorder<br><input type="checkbox"/> Depression (mild or situational) | <p>3. Does the individual have a diagnosis of a mental disorder that is not listed in #1 or #2? (do <b>NOT</b> list dementia here)</p> <input type="checkbox"/> No<br><input type="checkbox"/> Yes (Enter the diagnosis(es) below:)<br><br><input type="checkbox"/> Diagnosis 1:<br><br><input type="checkbox"/> Diagnosis 2: |
|--|---|---|

### Section II: SYMPTOMS

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| <p>4. Interpersonal – Currently or within the <u>past 6 months</u>, has the Individual exhibited interpersonal symptoms or behaviors [not due to a medical condition]? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <input type="checkbox"/> Serious difficulty interacting with others<br><input type="checkbox"/> Altercations, evictions, or unstable employment<br><input type="checkbox"/> Frequently isolated or avoided others or exhibited signs suggesting severe anxiety or fear of strangers | <p>5. Concentration/Task related symptoms – Currently or within the <u>past 6 months</u>, has the individual exhibited any of the following symptoms or behaviors [not due to a medical condition]? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <input type="checkbox"/> Serious difficulty completing tasks that she/he should be capable of completing<br><input type="checkbox"/> Required assistance with tasks for which she/he should be capable of completing<br><input type="checkbox"/> Substantial errors with tasks in which she/he completes |
|---|---|

Adaptation to change – Currently or within the past 6 months, has the individual exhibited any symptoms in #6, 7, or 8 related to adapting to change?  No  Yes

- |  |   |   |
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| <p>6. <input type="checkbox"/> Self Injurious or self mutilation<br/> <input type="checkbox"/> Suicidal Talk/Ideations<br/> <input type="checkbox"/> History of suicide attempt or gestures<br/> <input type="checkbox"/> Physical violence<br/> <input type="checkbox"/> Physical threats (with potential for harm)</p> | <p>7. <input type="checkbox"/> Severe appetite disturbance<br/> <input type="checkbox"/> Hallucinations or delusions<br/> <input type="checkbox"/> Serious loss of interest in things<br/> <input type="checkbox"/> Excessive tearfulness<br/> <input type="checkbox"/> Excessive irritability<br/> <input type="checkbox"/> Physical threats (no potential for harm)</p> | <p>8. <input type="checkbox"/> 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: _____)</p> |
|--|---|---|

### Section III: HISTORY OF PSYCHIATRIC TREATMENT

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|---|--|
| <p>9. Currently or within the <u>past 2 years</u>, has the individual received any of the following mental health services? <input type="checkbox"/> No</p> <input type="checkbox"/> Yes ( the individual has received the following service[s])<br><input type="checkbox"/> Inpatient psychiatric hospitalizations. If yes, provide date:<br><input type="checkbox"/> Partial hospitalization/day treatment. If yes, provide date:<br><input type="checkbox"/> Residential treatment. If Yes, provide date:<br><input type="checkbox"/> Other If Yes provide date: | <p>10. Currently or within the <u>past 2 years</u>, has the individual experienced significant life disruption because of mental health symptoms? <input type="checkbox"/> No <input type="checkbox"/> Yes (check all the apply)</p> <input type="checkbox"/> Legal intervention due to mental health symptoms. Date:<br><input type="checkbox"/> Housing change because of mental illness date:<br><input type="checkbox"/> Suicide attempt or ideation. Date(s):<br><input type="checkbox"/> Other Date: |
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11. Has the individual had a recent psychiatric/behavioral evaluation?  No  Yes Date: \_\_\_\_\_

**Section IV: 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. If yes to 12, list currently prescribed antidepressant or antipsychotic medications listed on the Beer's List.

Medication	Dosage MG/Day	Refer to Beer's List
		Does dosage exceed Beer's List? <input type="checkbox"/> No <input type="checkbox"/> Yes
		Does dosage exceed Beer's List? <input type="checkbox"/> No <input type="checkbox"/> Yes
		Does dosage exceed Beer's List? <input type="checkbox"/> No <input type="checkbox"/> Yes

**Section V: PSYCHOTROPIC MEDICATIONS**

15. Has the individual been prescribed psychoactive (mental health) medications other than those listed in question 14?  No  Yes  
 \*Do not list medications if used for a medical diagnosis or medications used for the treatment of behaviors r/t a medical condition i.e. Dementia.  
 List any medications used that resulted in an adverse reaction.

Medication	Dosage MG/Day	Diagnosis	Started	Ended

**Section VI: INTELLECTUAL DISABILITIES & DEVELOPMENTAL DISABILITIES**

16. Does the individual have a diagnosis of intellectual disability (ID) or developmental disability (DD) or related condition?  No  Yes  
 Related Condition diagnosis which impairs intellectual functioning or adaptive behavior:  
 Down Syndrome  Cerebral Palsy  Autism  Epilepsy  
 Fetal Alcohol Syndrome  Closed Head Injury  Other:  
 Substantial functional limitations in 3 or more of the following secondary to Related Condition  
 Mobility  Learning  Capability of independent living  
 Understanding use of language  Self Care  Self Direction  
 Did the condition manifest prior to age 22?  No  Yes

17. Does the individual have any history of ID or DD?  No  Yes

18. Is there presenting evidence of a cognitive or behavioral impairment prior to age 22 or suspicion of ID condition that occurred prior to age 22?  No  Yes

19. Has the individual ever received services from an agency that serves people affected by ID/DD?  No  Yes Agency:

Signature of Physician or Hospital Discharge Planner (RN or LSW)

Date

If not completed by Physician or Discharge Planner, this form must be completed by **both** of the following:

For Section I-V only:

For Section VI only:

Signature of QMHP

Signature of QIDP

Qualification/Job Title

Date

Qualification/Job Title

Date

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

1 6 7 9 10 14 15 16 17 18 19 **AND complete notification below**

**Attach the following:** History & Physical Updating Documentation Level of Care Certification  
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 Name

Signature of Individual:

Date

Signature of Legal representative/Guardian

Date