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

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 ☐ Paranoid Disorder
☐ Schizoaffective Disorder
☐ Major Depression
☐ Psychotic/Delusional Disorder
☐ Bipolar Disorder (manic depression)

2. Does the individual have any of the following mental disorders?
☐ No
☐ Suspected: One or more of the following diagnoses is suspected (check all that apply)
☐ Yes: (check all that apply)
☐ Personality Disorder
☐ Anxiety Disorder
☐ Panic Disorder
☐ 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 (Enter the diagnosis(es) below:)
☐ Diagnosis 1:
☐ Diagnosis 2:

Section II: SYMPTOMS

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]? ☐ No ☐ Yes
☐ Serious difficulty interacting with others
☐ Altercations, evictions, or unstable employment
☐ Frequently isolated or avoided others or exhibited signs suggesting severe anxiety or fear of strangers

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]? ☐ No ☐ Yes
☐ Serious difficulty completing tasks that she/he should be capable of completing
☐ Required assistance with tasks for which she/he should be capable of completing
☐ Substantial errors with tasks in which she/he completes

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

6. ☐ Self Injurious or self mutilation
☐ Suicidal Talk/Ideations
☐ History of suicide attempt or gestures
☐ Physical violence
☐ Physical threats (with potential for harm)

7. ☐ Severe appetite disturbance
☐ Hallucinations or delusions
☐ Serious loss of interest in things
☐ Excessive tearfulness
☐ Excessive irritability
☐ Physical threats (no potential for harm)

8. ☐ 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:
_____

Section III: HISTORY OF PSYCHIATRIC TREATMENT

9. Currently or within the <u>past 2 years,</u> has the individual received any of the following mental health services? ☐ No
☐ Yes (the individual has received the following service[s])
☐ Inpatient psychiatric hospitalizations. If yes, provide date:
☐ Partial hospitalization/day treatment. If yes, provide date:
☐ Residential treatment. If Yes, provide date:
☐ Other If Yes provide date:

10. Currently or within the <u>past 2 years,</u> has the individual experienced significant life disruption 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 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? ☐No ☐Yes
		Does dosage exceed Beer's List? ☐No ☐Yes
		Does dosage exceed Beer's List? ☐No ☐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:

Signature of QMHP

Qualification/Job Title Date

For Section VI only:

Signature of QIDP

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