Washington State Department of Social & Health Services
Transforming lives

DIVISION OF BEHAVIORAL HEALTH AND RECOVERY
WASHINGTON STATE PASRR PROGRAM
PREADMISSION SCREEN AND RESIDENT REVIEW (PASRR)

Level II PASRR
Initial Psychiatric Evaluation Summary

Assessment Category (Check appropriate box)
☐ Significant Change
☐ Medicaid
☐ Military Service

Date of Referral

Date of Evaluation

The following evaluation is required by OBRA 1987 to complete the Level II process for potentially mentally ill persons in a Medicaid certified nursing facility. Based on the diagnosis and need for treatment, a determination will be made regarding the most appropriate placement and plan of care.

Name: Last	First	Middle	Date of Birth

☐ Preadmission. If checked, name and address of site of evaluation:

Site of Evaluation
☐ Home ☐ Nursing facility ☐ Community facility ☐ Psychiatric inpatient setting ☐ General medical hospital setting
☐ Other (specify):

☐ Current nursing facility resident. If checked, nursing facility placement and mailing address:

Reason for Referral: Current Symptoms and Behaviors

			Comments
PASRR rights review with individual	☐ Yes	☐ No	
Individual agreed to evaluation	☐ Yes	☐ No	

Gender
☐ Male ☐ Female

Primary Language
☐ English ☐ Other (specify):

Race / Ethnicity
☐ American Indian/Alaska Native
☐ African American/Black
☐ Asian/Pacific Islander
☐ Hispanic
☐ White, not of Hispanic origin

Marital Status
☐ Married
☐ Single
☐ Widowed
☐ Divorced/separated
☐ Unknown

Primary Living Situation during Last Year
☐ Home
☐ Nursing facility
☐ Homeless
☐ State Hospital
☐ Other (specify):
☐ Other psychiatric inpatient
☐ Mental Health residential
☐ Developmental Disability facility
☐ Other residential program

1. Diagnosis Indicated by Present Evaluation

DSM:	
Medical:	
Psychiatric diagnoses of record:	

Signature of Person Completing Evaluation	Date	Contractor

Print Name of Person Completing Evaluation	Title	County

Comments / Recommendations of the Reviewing Psychiatrist *(leave space for comments)*

Signature of Reviewing Psychiatrist	Date
Signature of Department of Social and Health Services, DBHS Designee	Date

2. Recommendations for Plan of Care

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:

E. Recommendations for Follow-up Evaluation:

1. ☐ Yes, follow-up is needed.
2. ☐ Follow-up date (usually three months):
3. ☐ No follow-up evaluation needed (unless significant change in condition occurs while in nursing facility ☐)

3. Presenting Problem(s)

A. Current psychiatric, behavioral and emotional problems and status:

B. Recent relevant events (list reason(s) for hospitalization and/or SNF placement / referral):

C. List current psychotropic medications:

D. Psychosocial (education, work, family, military):

E. Interview, Impressions and summary:

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 (**excluding** tobacco) for this individual?

1. Is there a history as reported by individual? ☐ Yes ☐ No ☐ Unknown
2. Is there a history as reported by medical records? ☐ Yes ☐ No ☐ Unknown

B. Is there history or current use of **tobacco** (including vaporizer) for this individual?

1. Is there a history as reported by individual? ☐ Yes ☐ No ☐ Unknown
2. Is there a history as reported by medical records? ☐ Yes ☐ No ☐ Unknown

C. If yes, specify substance(s) used, dates, circumstances (current and past) and treatments received (location and date(s) of treatment:

D. Substance Use Disorder Questionnaire attached: ☐ Yes ☐ No

Comment:

6. 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.

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, 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.

8. 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):

9. Behavioral Health Services

A. Has the individual requested behavioral health services? ☐ Yes ☐ No ☐ Uncertain

Comment:

If yes, what type?

B. Agrees to recommended behavioral health services? ☐ Yes ☐ No ☐ Uncertain

Comment:

C. Does the individual perceive a need for mental health services? ☐ Yes ☐ No ☐ Uncertain

Comment:

10. Additional Information

A. Strengths and assets (according to evaluation findings):

B. Individual's stated goals:

C. Identify current support network and adult family situation (include names, relationship, potential support provided):

D. Individual's identified skills, strengths, and favorite activities with interests: