Washington State Department of Social & Health Services
Transforming lives

DIVISION OF BEHAVIORAL HEALTH AND RECOVERY

Level 2
Preadmission Screen and Resident Review (PASRR)
Follow-up or Significant Change
Psychiatric Evaluation Summary

ASSESSMENT CATEGORY (CHECK APPROPRIATE BOX)
☐ Follow-up
☐ Significant Change
☐ Medicaid Covered Individual

DATE OF PREVIOUS LEVEL 2 OR SIGNIFICANT CHANGE

DATE OF REFERRAL

DATE OF EVALUATION

The following psychiatric evaluation is required by OBRA 1987 for persons currently residing in a Medicaid certified nursing facility that since their last Level 2 evaluation have had a significant change in condition or are in need of a follow-up Level 2 evaluation. Based on the diagnosis and need for treatment, if any, a new determination will be made regarding the most appropriate placement and plan of care.

NAME: LAST FIRST MIDDLE

DATE OF BIRTH

NURSING FACILITY PLACEMENT AND MAILING ADDRESS:

REASON FOR REFERRAL: (CURRENT SYMPTOMS AND BEHAVIORS THAT HAVE CHANGED SINCE LAST PASRR LEVEL 2)

PASRR Rights reviewed with individual: ☐ Yes ☐ No
Individual agreed to evaluation: ☐ Yes ☐ No Comments:

SITE OF EVALUATION:
☐ Home ☐ Nursing facility ☐ Community facility ☐ Psychiatric inpatient setting ☐ General medical hospital setting
☐ Other (specify):

NAME OF SITE OF EVALUATION:

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 THE PAST 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:

PRINT NAME OF PERSON COMPLETING EVALUATION:

TITLE:

SIGNATURE OF PERSON COMPLETING EVALUATION:

DATE:

CONTRACTOR:

Comments / Recommendations of the Reviewing Psychiatrist

SIGNATURE OF REVIEWING PSYCHIATRIST:

DATE:

DEPARTMENT OF SOCIAL AND HEALTH SERVICES – DBHR DESIGNEE'S SIGNATURE:

DATE:

2. Recommendations for Plan of Care

☐ Follow-up Evaluation Date:

☐ No Follow-up Evaluation needed (Unless significant change in condition occurs while in nursing facility)

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:

3. Presenting Problem(s)

A. Current psychiatric problems and status:

B. Recent relevant events since previous PASRR Level 2 Evaluation: (list changes in condition, either improvement or decline)

C. Behavioral and emotional problems:

D. Interview and Impressions:

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:	**Total during lifetime:**
☐ None	☐ None
☐ 1 – 5 hospitalizations	☐ 1 – 5 hospitalizations
☐ More than 5 hospitalizations	☐ More than 5 hospitalizations
☐ Unknown	☐ 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:

NAME: LAST FIRST	DATE OF BIRTH

5. Substance Use History

A. Is there history or current use of alcohol or substances for this individual? ☐ Yes ☐ No ☐ Unknown

C. Substance use disorder questionnaire attached: ☐ Yes ☐ No Comments:

6. 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): Comments:

7. Current Medical Information and Medications

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 diagnoses**: 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(s), which are the basis for a NF placement, additional evaluation conducted by appropriate specialists.

B. Attach copies of medication use profile: for purposes of psychiatric review, record medication, copy of the current physicians orders. Specify additions / changes for all medications, including frequency of PRN medications, during the past 90 days.

C. List current psychotropic medications:

8. Psychological Test Instruments

Total Score:	Instruments:	Comments:
	Mini Mental Status Exam (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.

9. Behavioral Health Services

A. Has the individual requested behavioral health services? ☐ Yes ☐ No If yes, what type? Comment:

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

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

D. Where mental health services recommended in the previous Level 2? ☐ Yes ☐ No If yes, please describe:

E. If mental health services were received, describe outcome:

10. Additional Information

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

B. Individual's stated goals:

C. Have there been significant changes in their support network since the last PASRR? ☐ Yes ☐ No If yes, what kind? Comment:

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

NAME: LAST FIRST	DATE OF BIRTH