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

Instructions for Evaluators

Assessment Category

Significant Change: If evaluation was requested due to an individual showing a significant change in condition, check this box.
Medicaid: If an individual is covered by Medicaid, check this box.
Military Service: If an individual served in the military, check this box.

Date Boxes

Date of Referral: Type in the date the Level I referral was made.
Date of Evaluation: Type in the date the evaluation was completed.
Date of Birth: Type in the date of birth of the individual.

Name

Type in the last name of the individual; check correct spelling.
Type in the first name of the individual; check correct spelling.
Type in the middle name / initial of the individual; check correct spelling. If the individual does not have a middle name, leave it blank.

Preadmission

If checked, name and address of site of evaluation.

Site of Evaluation

Check appropriate box indicating the location of where the evaluation was completed. If other, write in location site.

Nursing Facility Placement and Mailing Address

Type in the name and address of skilled nursing facility where the individual is going to be placed. Make every effort to identify the facility of discharge. If unknown, continue to follow-up with referring party to find out placement and notify DBHR.

Reason for Referral

List all current symptoms and behaviors that lead to the referral.

PASRR Rights

Review PASRR rights with the individual and check the box.
Did the individual agree to the PASRR evaluation? Check the appropriate box. If no, indicate reasons why in the comment box.

Gender

Check appropriate box - what gender the individual self identifies as.

Primary Language

Check appropriate box. Specify other primary language.

Race / Ethnicity

Check appropriate box.

Marital Status

Check appropriate box.

Primary Living Situation during the Past Year

Check the appropriate box. If other, specify other living situation.

1. Diagnosis Indicated by Present Evaluation

- List all diagnoses indicated by the present evaluation using the most current DSM (include code)
- List all applicable medical diagnoses.
- List all psychiatric diagnoses of record.

Sign and type in the date form was completed of the person completing the assessment.
Print name and title of the person completing the assessment.
If you are working for a contractor, type in the name of the contractor.

Comments / Recommendations of the Reviewing Psychiatrist

Write recommendations or comments related to the completed evaluation here. **To be completed only by the reviewing psychiatrist.** This is the portion to be reviewed by the SNF staff for implementation of any identified specialized services for incorporation into the individual plan of care.

Reviewing Psychiatrist: Sign and write in the date upon completion of psychiatric review.

Department of Social and Health Services / DBHR Designee: Sign and date upon completion.

2. Recommendations for Plan of Care

A. Mental Health: Check the appropriate box. Provide a specific explanation.

1. **Acute psychiatric hospitalization**. If checked, the MH needs of the individual cannot be met at the SNF. Notify staff as appropriate.
2. **Specialized services**. Check the appropriate box (a and/or b) and provide specific examples.
3. **No mental health services** are needed. Explain why.

B. Recommendations for Nursing facility: This section is to provide the nursing facility staff with information to help them meet the mental health needs of the individual while they are in the nursing facility.

Check applicable boxes (1 - 5).

Write your recommendations in a manner that is appropriate for all levels of nursing facility staff. Be descriptive. Ask **"person centered"** questions that include likes and dislikes about people, and community environments, and what helps to keep them calm. Recommendations **must** be specific to the individual.

C. Other Medical Services: Check appropriate boxes (1 - 3).

1. Note any physical health symptoms that may impact their psychiatric condition.
2. Note any ancillary services that will benefit the individual during their nursing facility stay.
3. Note any substance use treatment (tobacco, alcohol, or other).

D. Recommendations for Community Transition

1. Note if the individual's current needs could be met in the community.
2. Note individual's stated preference of living situation in community.
3. Note specific recommendations that will help to facilitate a potentially successful transition into the community.

E. Follow-up Evaluation Date:
Check the appropriate box. If a follow-up evaluation is needed, indicate a date to follow-up.

3. Presenting Problem(s)

A. List current symptoms and behaviors as exhibited during interview, conversations with staff and medical record information as noted in the chart.

B. List reasons for hospitalization and/or nursing facility placement.

C. List all current psychotropic medications. **This documentation must accompany the evaluation for psychiatric review.**

D. This is where you would document information about childhood, education, employment, family life, and significant problems or losses. Shows how an individual was functioning prior to their present condition.

E. This is where information you observed and gathered during the interview is written and interpreted. Write your conclusions in a manner that is appropriate for all levels of nursing facility staff. Note any discrepancies between what is documented as opposed to what is observed.

4. Psychiatric History

A. List all psychiatric history. Include inpatient treatment, outpatient treatment, any suicide attempts, or risk of harm to self or others.

B. Onset of Psychiatric Symptoms: Check appropriate box

C. Psychiatric Hospitalizations: Check appropriate boxes

D. List reasons and course of treatment during psychiatric hospitalization(s) with emphasis on most recent.

E. History of previous medications: List any known history or adverse reactions or failed trials to any psychiatric medications.

F. Current MH services: List current mental health provider and frequency of services if known and Behavioral Health Organization.

5. Substance Use History

A. Is there a history or current use of alcohol or substances (**excluding** tobacco) for this individual? Check appropriate box.

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

C. If yes, specify substances, dates and circumstances on form.

D. If yes, complete substance use disorder questionnaire and attach it with the evaluation.

6. Psychological Test Instruments

Testing Instruments

Complete all appropriate tests as needed documenting score and particular findings in the comment section. If the test is not performed or does not apply, write N/A in score box for each test.

Functional assessment

Include a review of the MDS, or any OT, PT, and Speech Therapy consults. This documentation ***must*** accompany the evaluation.

7. Medical and Medication History

A. Attach copies of all supporting medical documentation as listed on the form.
This documentation must accompany the evaluation for psychiatric review.

B. Attach copies of medication use profile as listed on the form. Attach a copy of the current physician orders. Specify additions or changes for all medications, including frequency of PRN medications, during the past 90 days. **This documentation *must* accompany the evaluation for psychiatric review.**

8. Family History

A. Is there a family history of mental illness for the individual? If yes, note relationship.

B. Is there a family history of suicide for the individual? If yes, note relationship.

C. Is there a family history of substance use for the individual? If yes, note relationship.

9. Behavioral Health Services

A. Indicate if the individual has requested behavioral health services.

B. Indicate if the individual agrees to any recommended behavioral health services or if they are uncertain.

C. Indicate if the individual perceives a need for behavioral health services.

10. Additional Information

A. List the individual's strengths and assets.

B. List the individual's goals.

C. Identify and list the individual's current support network and adult family situation – List names, relationship, any potential support provided.

D. List the individual's identified skills, strengths and favorite activities with interests.

Distribution of this document

Upon completion of Level II Psychiatric Evaluation Summary, immediately send two (2) copies of the form and any pertinent medical documentation to the Psychiatrist for psychiatric, quality assessor review, and for DBHR processing.