

IDAHO Preadmission Screening and Resident Review (PASRR)

Level 1 HW00087

First Name: _____ Middle Initial: _____ Last Name: _____
 Mailing Address: _____ City: _____ State: _____ Zip: _____ Phone: _____
 Social Security #: XXX - XX - _____ Medicaid #: _____ Gender Male Female Date of Birth: _____
 Current Location: Medical Facility Psychiatric Facility Nursing Facility Community/Home Other _____
 Primary Care Physician _____ Phone: _____
 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 <input type="checkbox"/> Suspected: One or more of the following diagnosis is suspected (check all that apply) <input type="checkbox"/> Yes: (check all that apply) <ul style="list-style-type: none"> <input type="checkbox"/> Schizophrenia Spectrum and Other Psychotic Disorders <input type="checkbox"/> Depressive Disorders <input type="checkbox"/> Bipolar Disorders <input type="checkbox"/> Anxiety Disorders <input type="checkbox"/> Somatoform Disorders <input type="checkbox"/> Personality Disorders <input type="checkbox"/> Post-Traumatic Stress Disorder <input type="checkbox"/> Obsessive Compulsive-Related Disorders 	<p>2. Does the individual have any of the following mental disorders?</p> <input type="checkbox"/> No <input type="checkbox"/> Suspected <input type="checkbox"/> Yes: (check all that apply) <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety <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 not list dementia here)</p> <input type="checkbox"/> No <input type="checkbox"/> Yes <ul style="list-style-type: none"> <input type="checkbox"/> Diagnosis 1: _____ <input type="checkbox"/> Diagnosis 2: _____ 	<p>4. Does the individual have a substance related disorder?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes (complete remaining questions in this section) 4a. List substance abuse diagnosis(es) <ul style="list-style-type: none"> <input type="checkbox"/> Diagnosis 1: _____ <input type="checkbox"/> Diagnosis 2: _____ <input type="checkbox"/> Diagnosis 3: _____ <input type="checkbox"/> Diagnosis 4: _____ 4b. Is the NF need associated with this diagnosis? <input type="checkbox"/> No <input type="checkbox"/> Yes

Section II: CURRENT PSYCHIATRIC MEDICATIONS

5. Do not list medications used for a medical diagnosis or treatment of behaviors related to Dementia diagnosis

Medication	Dosage	Diagnosis	Started

Section III: SYMPTOMS

<p>6. Interpersonal Has the individual exhibited interpersonal symptoms or behaviors (not due to a medical condition)?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes - Provide date if available <ul style="list-style-type: none"> <input type="checkbox"/> Serious difficulty interacting with others Date: _____ <input type="checkbox"/> Altercations, evictions, or unstable employment Date: _____ <input type="checkbox"/> Frequently isolating or avoiding others Date: _____ 	<p>7. Concentration/Task related symptoms Has the individual exhibited any of the following symptoms or behaviors (not due to medical condition)?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes - Provide date if available <ul style="list-style-type: none"> <input type="checkbox"/> Serious difficulty completing age related tasks Date: _____ <input type="checkbox"/> Substantial errors with tasks in which she/he completes Date: _____ <input type="checkbox"/> Difficulty with concentration, persistence, pace Date: _____
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8. Adaptation to change

Has the individual exhibited any symptoms related to adapting to change:

- No
- Yes (check all that apply and provide date if known)
- | | | |
|--|--|--|
| <input type="checkbox"/> Self-injurious or self-mutilation - Date: _____ | <input type="checkbox"/> Suicidal talk/ideations - Date: _____ | <input type="checkbox"/> Physical violence - Date: _____ |
| <input type="checkbox"/> History of suicide attempt or gesture - Date: _____ | <input type="checkbox"/> Physical threats - Date: _____ | <input type="checkbox"/> Hallucinations or delusions - Date: _____ |
| <input type="checkbox"/> Severe appetite disturbance - Date: _____ | <input type="checkbox"/> Excessive tearfulness - Date: _____ | <input type="checkbox"/> Excessive Irritability - Date: _____ |
| <input type="checkbox"/> Serious loss of interest in things - Date: _____ | <input type="checkbox"/> Withdrawal due to adaptation difficulties – Date: _____ | |
- 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:
- _____
- _____
- _____

Date: _____

Section IV: HISTORY OF PSYCHIATRIC TREATMENT

9. Has the individual received any of the following mental health services?

- No
- Yes (the individual has received the following service[s])
- Inpatient psychiatric hospitalizations
Date: _____
- Partial hospitalization/day treatment
Date: _____
- Residential treatment
Date: _____
- Other: _____
Date: _____

10. Has the individual experienced significant life disruptions because of mental health symptoms?

- No
- Yes (check all that 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 V: 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 antipsychotic medications for the symptoms related to dementia and/or Alzheimers

Medication	Dosage MG/Day	
		If meds are listed, this is a <i>Positive PASRR</i> and must be forwarded to BLTC

Section VI: INTELLECTUAL DISABILITIES & DEVELOPMENTAL DISABILITIES

15. Does the individual have a diagnosis of intellectual disability (ID) - An intellectual disability is evidenced by an IQ of less than 70 based on standardized, reliable tests; onset before age 18?

- No
- Yes specify type/diagnosis
- _____
- _____
- _____

16. Does the individual have presenting evidence of intellectual disability (ID) that has not been diagnosed?

- No
- Yes

17. Does the individual have documented evidence of a related condition? –Related condition refers to severe, chronic disability that is attributable to condition related closely to intellectual disability, resulting in impairment of general intellectual functioning or adaptive behavior similar to ID and requiring similar treatment or services, onset before age 22; duration likely to last lifelong.

- No
 Yes (check all that apply)
- | | | |
|---|---|---|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Blindness | <input type="checkbox"/> Closed head injury |
| <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Deafness |
| <input type="checkbox"/> Other: _____ | | |

18. Has the individual received services from, or been referred to, an agency or facility that serves individuals with intellectual disability?

- No
 Yes

19. Are there substantial functional limitations in any of the following?

- No
 Yes (check all that apply)
- | | |
|--|--|
| <input type="checkbox"/> Mobility | <input type="checkbox"/> Self care |
| <input type="checkbox"/> Learning | <input type="checkbox"/> Capacity for living independently |
| <input type="checkbox"/> Understanding/Use of language | <input type="checkbox"/> Self direction |

Signature Of Physician, Physician’s Extender
or Hospital Discharge Planner (RN or LSW)

Date

Phone Number

If not completed by Physician, Physician’s Extender or Hospital 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 the Bureau of Long Term Care (BLTC) if ANY of the following are marked Yes:

- 1 3 4 5 8 9 10 14 15 16 17 18 19 **AND complete notification below**

- Attach the following if available:** History & Physical Updating Documentation
Level of Care 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’s Name: _____ Date _____

Signature of Individual: _____ Date _____

Signature of Legal Representative/Guardian: _____ Date _____

Fax Numbers

- Region 1 – Coeur d’ Alene (208) 666-6856
- Region 2 – Lewiston (208) 799-5167
- Region 3 – Caldwell (208) 454-7625
- Region 4 – Boise (208) 334-0953

- Region 5 – Twin Falls (208) 736-2116
- Region 6 – Pocatello (208) 239-6269
- Region 7 – Idaho Falls (208) 528-5756