PASRR LEVEL II PSYCHIATRIC EVALUATION
NEW JERSEY DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES

PLEASE PRINT AND DO NOT USE ABBREVIATIONS

CLIENT'S NAME: _____ _____ _____
LAST FIRST M.I.

INSTRUCTIONS:

1. **The Psychiatrist or Psychiatric Advanced Practice Nurse conducting the Evaluation shall not be directly involved in treating the client nor otherwise responsible for or involved in the person's care.**

2. **All Sections, except for Section 1, must be completed by the Psychiatrist or Psychiatric Advanced Practice Nurse conducting the Evaluation. Every Section and all questions must be answered.**

3. **The Examiner may record an N/A to indicate Not Applicable or an N/K to indicate Not Known.**

4. **Note that a completed LTC-26 Level I Screen must be submitted with this form. DMHAS will terminate the review if either form is incomplete or not provided.**

SECTION 1 Can be completed by person referring client for PASRR Level II Evaluation

REFERRING FACILITY INFO: ____Psych. Hospital (involuntary unit) ____Psych. Hospital (voluntary unit) ____General hospital

___Home ___Nursing Facility /Assisted Living ___ Other Residential Setting (RHCF, Group Home, Etc.) Describe: _____

IF FACILITY (Specify Facility Name/Complete Address) _____

Referring or Contact Person_____ Relationship to client. _____

Phone: _____ Fax: _____ Email: _____

CLIENT'S INFO: DATE OF BIRTH: _____/_____/_____ GENDER: ☐ Male ☐ Female _____ MARITIAL STATUS

RACE/ETHNICITY _____ EDUCATION (none, Elem. School, High School, College Graduate): _____

SOCIAL SECURITY NUMBER (9 DIGITS): _____

INSURANCE INFO: ☐ Medicare ☐ MEDICAID ☐ Applied For Medicaid ☐ Private Insurance ☐ Self-Pay

☐ Other (Identify) _____

MEDICAID NUMBER (12 DIGITS): _____

ADMISSION INFO: FACILITY ADMISSION DATE: _____/_____ /_____

RESIDENCE PRIOR TO ADMISSION: ☐ Private Home/Apt. ☐ Nursing Facility/Assisted Living ☐ Residential community setting

☐ Other (Describe): _____

FAMILY/Guardian: Does the client have family members and/or a guardian currently involved in his/her care? ☐ NO ☐ YES

If YES, specify Names, Relationships and describe family's Level of involvement in the client's care)

_____

_____

LEVEL II PYCHIATRIC EVAL. NEEDED FOR: ☐ Initial Nursing Facility Referral ☐ Rehab. ☐ Post 30 Day Rehab

☐ Residential Review/Change in status Explain: _____

Client's Name (Last, First) _____

SECTION 2 PSYCHIATRIC EVALUATION (Must be completed by psychiatrist / psychiatric APN conducting Evaluation)

SOURCES OF INFORMATION FOR EVALUATION (Check all that apply): ☐ INTERVIEW ☐ RECORD REVIEW ☐ STAFF

DESCRIBE COLLATEROL SOURCES (Family, Guardian, Treatment provider): _____

_____

DOES THE INDIVIDUAL SPEAK ENGLISH? ☐ NO ☐ YES If the CLIENT SPEAKS OTHER THAN ENGLISH, DESCRIBE HOW EVAL. WAS CONDUCTED**:** _____

DESCRIBE CLIENT'S PRESENTING BEHAVIORAL HEALTH PROBLEMS AND REASON FOR ANY RECENT HOSPITALIZATIONS_____

_____

_____

_____

_____

SUMMARIZE RELEVANT MENTAL HEALTH AND SUBSTANCE USE HISTORY (including current/ recent psychiatric hospitalizations and the pre-admission behavioral health care received in last 6-12 months, if known):_____

_____

_____

_____

_____

_____

_____

_____

PSYCHOSOCIAL/ HISTORY (Describe pertinent life events and changes in the past 12-24 months, such as living situation, family and social supports, including supports needed to maintain community living):

_____

_____

_____

EMPLOYMENT AND VOCATIONAL HISTORY:_____

_____

_____

CLIENT'S POSITIVE TRAITS AND STRENGTHS (Describe the client's experiences, abilities and interests as assets or resources in treatment planning) _____

_____

Client's Name (Last, First) _____

CURRENT PSYCHIATRIC MEDICATIONS (Include indications, recent medication changes, and all PRNS needed in last 30 days)

MEDICATION	*DOSAGE*	*INDICATIONS*

_____

_____

_____

PSYCHIATRIC OR COGNITIVE TESTING (i.e., MINI MENTAL STATUS EXAM) PERFORMED: ☐ NO ☐ YES

IF YES, DESCRIBE TEST(S), DATE(S) COMPLETED, AND FINDINGS: _____

_____

MENTAL STATUS EXAMINATION

APPEARANCE AND ATTIRE: _____

_____

ATTITUDE AND BEHAVIORS: (Describe disruptive, assaultive, self-injurious, inappropriate sexual behavior, etc.) _____

_____

_____

SPEECH:_____

_____

AFFECT AND MOOD: _____

_____

THOUGHT CONTENT: _____

_____

_____

PRESENCE OF SUICIDAL OR HOMICIDAL IDEATION/ BEHAVIOR (Give specifics, such as dates and details of any attempts, and current ideation):

_____

PERCEPTIONS, HALLUCINATIONS/DELUSIONS: _____

_____

SENSORIUM, MEMORY, AND ORIENTATION: _____

_____

INSIGHT AND JUDGEMENT: _____

_____

DIAGNOSES: MENTAL HEALTH, SUBSTANCE USE DISORDERS, DEVELOPMENTAL DISORDERS (Provide ICD-9 OR DSM-5 CODES):

_____

_____

_____

CLIENT'S NAME (First, Last)_____

SECTION 3 MEDICAL AND FUNCTIONING ASSESSMENT (NOTE: Examiner may provide copy of client's medical reports and progress notes to **supplement** parts of this section)

CURRENT MEDICAL DIAGNOSES AND APPROX. YEARS OF EACH ILLNESS (IF KNOWN):_____

_____

_____

_____

SIGNIFICANT RESULTS OF LABORATORY TESTS/SPECIAL NEUROLOGICAL DIAGNOSTIC STUDIES: _____

_____

LIST ALL CURRENT MEDICATIONS AND THEIR DOSAGES (exclude psychotropic medications already listed above):

NAME OF MEDICATIONS ***DOSAGE*** ***INDICATIONS***

_____

_____

_____

_____

RECENT MEDICAL/SURGICAL TREATMENT AND REHABILITATION SERVICES PROVIDED_____

_____

_____

NEED FOR SPECIALIZED MEDICAL, NURSING AND/OR REHAB SERVICES: ☐ YES, SEE BELOW ☐ NONE

☐BOWEL AND BLADDER CARE ☐TRACH CARE ☐CATH. CARE ☐ TUBE FEEDING ☐COLOSTOMY/ILEOSTOMY

☐ SEIZURE PREC. ☐ MODIFIED DIET ☐DIABETIC MONITORING ☐BLOOD TRANSFUSION ☐ OXYGEN ☐PROSTHETICS CARE

☐ DECUBITI/WOUND CARE ☐IV MEDS/FLUIDS ☐ INHALATION THERAPY ☐ INTAKE/OUTPUT

☐ REHAB THERAPY (PT, OT) ☐ SPEECH/LANGUAGE THERAPY ☐PHARMACIST CONSULT. ☐ LAB TEST MONITORING

INDICATE IF PRESENT: ☐ ABNORMAL MOVEMENTS ☐DYSPHAGIA ☐VISION LOSS ☐HEARING DEFICIT ☐SPEECH PROBLEMS

DESCRIBE CLIENT'S GAIT AND NEED FOR WHEEL CHAIR/WALKER OR GERICHAIR_____

DESCRIBE OTHER CORRECTIVE AND ADAPTIVE EQUIPMENT OR INTERVENTIONS THAT WILL BE PROVIDED: _____

_____

CLIENT'S SELF-MANAGEMENT OF MEDICATIONS OR OTHER NECESSARY MEDICAL TREATMENT:

☐Unable to Perform/Refuses ☐Needs supervision ☐ Only needs occasional prompting or reminders ☐Independent

DESCRIBE:_____

CLIENT'S CAPABILITY TO PERFORM ADLS/IADLs (Use the rating scale below to describe current functioning in each area):

1 – Unable to Perform at all 2 – Often needs assistance 3 – Needs occasional prompting/reminders 4 – Independent

Activities of Daily Living	Rating	Instrumental Activities of Daily Living	Rating
DRESSING		HOUSEKEEPING	
BATHING		MANAGING MONEY	
TOILETING		SHOPPING	
GROOMING		USING TRANSPORTATION	
TRANSFERRING FROM BED/CHAIR		MEAL PREPARATION	
EATING		USING TELEPHONE	

CLIENT'S NAME (Last, First) _____

SECTION 4 SUMMARY OF PLACEMENT AND TREATMENT RECOMMENDATIONS

MOST APPROPRIATE/ LEAST RESTRICTIVE SETTING TO MANAGE THE INDIVIDUAL'S CURRENT MEDICAL AND BEHAVIORAL HEALTH CARE NEEDS:

☐NURSING FACILITY ☐ HOME OR INDEPENDENT LIVING

☐ COMMUNITY SETTING (e.g., ASSISTED LIVING, SUPPORTED HOUSING, SUPERVISED GROUP HOME, RESIDENTIAL HEALTH CARE FACILITY) SPECIFY: _____

☐ OTHER: _____

SUMMARIZE THE RATIONALE FOR THE ABOVE RECOMMENDATION:

_____

_____

_____

_____

_____

_____

WOULD THIS INDIVIDUAL POSSIBLY BE APPROPRIATE FOR PLACEMENT IN AN ALTERNATIVE COMMUNITY SETTING (OTHER THAN A NURSING FACILITY)?

☐NO ☐ YES, DESCRIBE/EXPLAIN: _____

_____

_____

_____

_____

_____

IF THE INDIVIDUAL REQUIRES NURSING FACILITY PLACEMENT AT THIS TIME, WHAT BEHAVIORAL TREATMENT OR SUPPORT SERVICES ARE NEEDED TO MAINTAIN OR IMPROVE THE INDIVIDUAL'S RECOVERY?

☐ Person-centered Treatment/Service Plan
☐ Psychotropic Medication Monitoring
☐ Structured socialization activities
☐ Therapeutic group interventions
☐ Supportive counseling
☐ Individual therapy
☐ Behavioral management program
☐ Family Counseling
☐ Substance Use Counseling or treatment
☐ Attendance in Self Help Center or other recovery activities outside nursing facility
☐ S-COPE Consultation
☐ Other_____

DESCRIBE/ EXPLAIN: _____

_____

_____

_____

_____

_____

_____

CLIENT'S NAME (Last, First) _____

SECTION 5. CERTIFICATION OF NEED FOR SPECIALIZED SERVICES FOR SERIOUS MENTAL ILLNESS

THIS SECTION MUST BE COMPLETED IN FULL

I, _____ (Print Name), having no direct treatment relationship with the client, do hereby certify that I have personally assessed this client, spoken with current caregivers, and have reviewed the available clinical records. I also certify that it is my professional opinion that the client:

☐NO ☐ YES HAS AN ACTIVE PSYCHOSIS

☐NO ☐ YES HAS A SERIOUS MENTAL ILLNESS

☐NO ☐ YES HAS MENTAL HEALTH TREATMENT NEEDS THAT CAN BE MET IN A NURSING FACILITY

☐NO ☐ YES NEEDS SPECIALIZED SERVICES (e.g., inpatient psychiatric hospitalization)

Signature below also certifies the following: For current NF residents who no longer require NF services but require mental health services the individual or legally responsible person (legally responsible guardian) has been offered the choice of receiving services in an appropriate alternative setting. This person has been informed of all alternatives offered under the NJ State Medicaid Plan for the resident. This person has been informed of all alternatives covered under the NJ State Medicaid Plan for the resident. Furthermore, this person has been told of 1) the effect on eligibility for Medicaid services under the State Plan, 2) the effects on readmission to the facility, and 3) has been referred to the DMHAS for assistance in finding mental health (behavioral health) services and/or specialized services.

SIGNATURE OF EXAMINER _____ **DATE:** _____/_____/_____

NAME / TITLE _____

SPECIALTY AND AFFILIATION: _____

FAX THIS EVALUATION TO THE DMHAS PASRR COORDINATOR AT (609) 341-2307 OR CONTACT THE DMHAS PASRR COORDINATOR AT 609-438-4146 OR 609-438-4152