STATE OF RHODE ISLAND
LEVEL II PASRR-MI

SECTION I: Identification

1. Name (Last, first, MI):_____2. Date of Birth:_____3. Age_____
4. Gender: □ Male □ Female 5. Ethnicity: _____ 6. Primary Language: _____7. Marital Status:_____
8. Military Service: □ Yes □ No 9. SSN:_____ 10. Evaluation Date:_____
11. Evaluation Location: □ NF □ Home □ Group Home □ Assisted Living □ Other _____
12. Primary Care Physician: _____ Phone: _____
13. Family Support: _____ Phone: _____
14. Mental Health Community Service: _____ Phone: _____
15. Does this individual have a legal guardian? □ Yes □ No If yes, **attach guardian papers**.
Name:_____ Address: _____
Phone: _____ Relationship: _____

SECTION II: Psychosocial Assessment

1. Highest Level of education attained: _____ 2. Employment History:_____
_____
3. Describe the individual's primary living arrangement in the last year: _____
4. State if the living arrangement is insufficient and the reason(s):_____
_____
5. Reason's for Nursing Facility admission: □ Illness/disease □ Unsafe behavior
□ Cannot manage household □ Isolation □ No primary caregiver □ Fear for safety
□ Financial problems □ Decline in ADL's Additional reasons/comments:_____
_____

6. List all documented historical and current psychiatric diagnosis and date/age of onset.

Diagnosis	Date/Age of Onset

7. List any previous psychiatric treatment including hospitalizations, outpatient services, and Community Mental Health Services.

	Dates

8. Describe current symptoms or behaviors indicating a psychiatric disorder:_____
_____
_____

9. Current psychiatric support/services (**check all that apply**): □ Medication administration and monitoring
□ Individual counseling □ Outpatient psychiatric follow up □ Inpatient psychiatric treatment □ ECT
□ Day program/partial hospitalization □ Secured/behavioral unit □ Group counseling □ Behavior therapy
□ Diagnosis review/update □ On-going psych evaluation/consultation □ Intense monitoring of mental status
□ Case management follow-up □ Psychiatric consultative services

SECTION II: Psychosocial Assessment Continued

10. Does this individual have a history of drug and/or alcohol abuse? □ Yes □ No If yes, please describe:
_____
11. What is this individual's stated preference of living arrangement?_____
12. Is this living arrangement feasible? _____
13. Does this individual have support?_____
14. How extensive is the support system? _____
15. Where do the supporters live?_____
16. List the individual's activities, hobbies and interests. Describe the level of participation in activities:_____
_____
17. Summarize the reason(s) the individual and/or family state the need for nursing facility care, use quotes when possible:
_____
18. List all practitioners who have treated this individual in the past 12 months:_____
_____

SECTION III: Level of Functioning

Level of support needed:	**Independent**	**Prompts**	**Assistance**	**Dependant**
Self Care				
Eating	□	□	□	□
Dressing/Grooming	□	□	□	□
Toileting/Hygiene	□	□	□	□
Communication				
Ability to express needs	□	□	□	□
Understands clearly	□	□	□	□
Mobility				
In the home	□	□	□	□
Community	□	□	□	□
Stairs	□	□	□	□
Transfer skills	□	□	□	□
Independent Living				
Cooking	□	□	□	□
Laundry	□	□	□	□
Cleaning	□	□	□	□
Shopping	□	□	□	□
Money management	□	□	□	□
Transportation	□	□	□	□
Access community resources	□	□	□	□
Health Monitoring				
Schedule medical appointments	□	□	□	□
Appointment reliability	□	□	□	□
Take prescribed medications	□	□	□	□
Recognize health issues	□	□	□	□
Self-direction				
Responds to emergencies	□	□	□	□
Self preservation	□	□	□	□
Daily decisions	□	□	□	□
Occupy time	□	□	□	□
Problem solve	□	□	□	□

SECTION IV: Medical History

1. List all medical diagnosis as documented in the individual's record.

Diagnosis	Active/Inactive Status	Date of Onset

2. Does the individual have any medication allergies? □ Yes □ No If Yes, list allergies:

_____

3. Current medication. Record current medication or attach MAR. □ Current MAR is attached

Name	Dosage	Frequency	Start Date

4. Comment on concerns regarding medications:

□ Frequently refuses medication
□ Experiences adverse effects (specify):_____
□ Review recommended (describe):_____
□ Lab monitoring (specify):_____

5. Have any medications been discontinued or dose changed in the last 30 days? □ Yes □ No If Yes, please complete the following:

Drug Name	Dosage	Frequency	Start Date	Stop Date	Change

SECTION V: Medical Assessment

1. Does the individual currently have any medical treatments? □ Yes □ No

If Yes, please indicate **(check all that apply):**

□ Bowel and bladder
□ Catheterization care
□ Colostomy/ileostomy care
□ Decubitus care
□ Diabetic monitoring
□ Blood transfusions
□ Cane/Walker to ambulate
□ Tracheostomy care
□ Restraints
□ Seizure precautions
□ IV meds/antibiotics
□ Intake and output
□ Sterile dressings
□ Oral suction
□ Tube feed/TPN
□ Wheelchair dependant
□ Oxygen therapy
□ Prosthesis care
□ Special skin care
□ Wound care
□ Dietary Supplements
□ Weight monitoring
□ Terminal illness
□ Fracture care
□ IV fluids
□ Ordered labs(specify)_____
□ Therapeutic Diet(specify)_____

SECTION V: Medical Assessment Continued

2. Does this client receive any ***rehabilitative services***? □ Yes □ No If Yes, please indicate services received*:*
□ Physical therapy □ Speech therapy □ Occupational therapy □ Restorative nursing

As indicated by staff, chart review, physical examination and/or individual's report, please specify whether the individual is experiencing problems in the following areas:

3. ***Neurological Problems:*** □ Yes □ No If Yes, please specify:
□ Parkinson's □ Huntington's Disease □ Traumatic brain injury □ Multiple Sclerosis
□ Headaches □ Tardive Dyskinesia □ Numbness □ Parasthesia □ Tremors
□ Unsteady gait/balance □ Fainting □ Blackouts
□ Seizures (last occurrence)_____

4. ***Sleep Disturbances:*** □ Yes □ No If Yes, please specify (check all that apply):
□ Difficulty falling asleep □ Early wakening □ Erratic sleep pattern

5. ***Hearing Problems:*** □ Yes □ No If Yes, please specify: □ Hearing others □ In groups □ Pain in ears
□ Correct with aid device

6. ***Vision Problems:*** □ Yes □ No If yes, please specify: □ Blurred vision □ Field cut
□ Lights/spots □ Vision loss □ Unequal pupils □ Reading small print

7. ***Cardiovascular Problems:*** □ Yes □ No If Yes, please specify: □ CHF □ Hypertension □ Irregular beat
□ Hypotension □ ASHD □ Pain on exertion □ Non-exertion pain □ Previous CVA (date):_____□ By-pass (date):_____ □ Circulatory problems (specify):_____

8. ***Pulmonary Problems:*** □ Yes □ No If Yes, please specify: □ SOB on exertion □ Productive cough □ Non-productive cough □ SOB lying flat □ SOB at rest □ COPD □ Lung cancer □ Smoking currently

9. ***Upper GI Problems:*** □ Yes □ No If Yes, please specify: □ Nausea/vomiting □ GERD
□ Stomach ulcer □ Loss of appetite □ Belching/gas □ Intermittent pain □ Occult blood in stool
□ Indigestion

10. ***Lower GI Problems:*** □ Yes □ No If Yes, please specify: □ Diarrhea □ Impactions □ Rectal pain
□ Constipation □ Hemorrhoids □ Fecal incontinence □ Bloody/tarry stools □ Diminished bowel sounds

11. ***Urological Problems:*** □ Yes □ No If Yes, please specify: □ Incontinence □ Nocturia
□ Frequency/urgency □ TURP/prostate problems □ Neurogenic bladder □ Recurrent UTI

12. ***Musculoskeletal Problems:*** □ Yes □ No If Yes, please specify: □ Paralysis □ Joint pain
□ Obesity □ Fractures □ Contractures □ Generalized weakness □ Rheumatiod arthritis □ Osteoporosis
□ Amputee □ Osteoarthritis □ Sprain/strain

13. ***Endocrine Problems:*** □ Yes □ No If Yes, please specify: □ Diabetic □ Hypothyroidism
□ Hyperthyroidism □ Hormone therapy

14. ***Skin Problems:*** □ Yes □ No If Yes, please specify: □ Rash □ Dry skin □ Pressure sore
□ Stasis ulcer □ Fragile skin □ Contusion/bruising □ Skin cancer □ Other:_____

15. ***Throat/neck Problems:*** □ Yes □ No If yes, please specify: □ Difficulty swallowing □ Choking episodes
□ Frequent sore throats □ Lump in throat

16. ***Nose Problems:*** □ Yes □ No If Yes, please specify: □ Nasal congestion □ Nose bleeds □ Decreased ability to smell □ Frequent runny nose

17. ***Physical/Nutrition:*** Height in inches_____ Current weight_____(lbs) Frame size_____ Is weight stable?
□ Yes □ No How is individual's appetite? □ Good □ Fair □ Poor

SECTION VI: Neurological Assessment

Complete or attach current neurological report. Coding Y=yes N=no U=uncooperative. □Attached

Motor Functioning	Y	N	U
Can reach for and lift object			
Can brush/comb own hair			
Can stand up straight			
Abnormal voluntary movements			

Fine motor skills	Y	N	U
Can pick up pencil/pen			
Can button shirt			
Can touch nose with finger			
Can touch assessor's extended finger			
Can copy circle or square			

Cranial Nerves	Y	N	U
Masseters tighten with jaw clenched			
Able to feel touch on face			
Able to smile and say "E"			
Mouth deviates to the L/R when smiling			

Normal Reflexes – Right Side	Y	N	U
Tricep joint			
Bicep joint			
Wrist joint			
Knee joint			
Achilles joint			
Plantars			

Oral Sensory Functioning	Y	N	U
Tongue deviates to the L/R			
Stridor/horseness/dysarthia present			
Uvula is central			
Abnormal Voluntary Movements			
Pharyngeal muscles contract			

Visual Sensory Functioning	Y	N	U
Pupils equal and reactive to light			
Pupils follow lateral movement			
Nystagmus present			

Spine and Peripheral Nerves	Y	N	U
Neck is supple			
Spinal curvatures are normal			
Able to shrug shoulders against resistance			
Able to turn neck against resistance			

Normal Reflexes – Left Side	Y	N	U
Tricep joint			
Bicep joint			
Wrist joint			
Knee joint			
Achilles joint			
Plantars			

SECTION VII: Maladaptive/Inappropriate Behaviors

1. Please indicate the presence/absence of Problematic Behaviors for the individual based on medical records or staff comments using the key provided: 0= None 1= Less than 5 times a week 2= Greater than 5 times a week

__Dangerous smoking
__Injures self
__Refuses to eat/uncooperative
__Destroys property
__Verbally abusive
__Uncooperative with hygiene
__Demanding/impatient
__Frequent whining
__Provokes others
__Wandering
__Physically threatening
__Alcohol/drug use
__Exposes self
__Sexually aggressive
__Verbally threatening
__Boundary violation
__Cursing yelling
__Steals deliberately
__Disturbs others
__Suspicious of others
__Strikes others provoked
__Strikes others unprovoked
__Trespasses
__Pacing
__Suicide threats
__Tries to escape
__Refuses medication
__Isolative
__Refuses activities
__Lies intentionally
__Self-induced vomiting
__Talks suicide ideation
__Passive death wish
__Frequent yelling
__Suicide attempts
__Other; specify:_____

SECTION VII: Maladaptive/Inappropriate Behaviors Continued

2. In the last 30 days has the individual been placed in seclusion or restraints to control dangerous behavior? □ Yes □ No If Yes please complete the following:

Type of restraint	Date	Duration	Behavior/precipitating event

SECTION VIII: Mental Status Exam

Cognitive Capacities

1. ***Orientation:*** Mark all that apply. □ Person □ Place □ Date/time □ Forgetful □ Confused □ Disoriented □ Oriented to situation
2. ***Intellectual functioning:*** □ Above average □ Average □ Below average □ Impaired abstract thinking □ Impaired calculation ability
3. Memory: □ Normal □ Impaired immediate recall □ Impaired remote memory □ Other, specify:_____
4. ***Attention/concentration:*** □ Good □ Fair □ Poor
5. ***Overall appearance:*** □ Neat and appropriate □ Careless/disheveled □ Unusual clothing
6. ***Posture:*** □ Appropriate □ Slumped □ Rigid/tense □ Atypical □ Inappropriate
7. ***Facial expression:*** □ Appropriate □ Anxious/fearful □ Depressed/sad □ Angry/hostile □ flat □ Bizarre
8. ***General body movement:*** □ Appropriate □ Accelerated speed □ Decreased, slow □ Atypical, peculiar □ Restless, fidgety □ Other, specify:_____
9. ***Attitude:*** □ Cooperative □ Domineering □ Submissive □ Suspicious □ Provocative □ Uncooperative
10. ***Affect:*** □ Appropriate □ Blunted □ Tearful □ Inappropriate □ Labile □ Other, specify:_____
11. ***Mood:*** □ Appropriate □ Apathetic □ Euphoric, elated □ Angered □ Fearful, anxious □ Depressed □ Other, specify:_____
12. ***Manner:*** Mark all that apply. □ Warm/pleasant □ Cooperative □ Sense of humor □ Childlike □ Sincere □ Shy □ Concerned about others □ Outgoing □ Apathetic □ Suspicious □ Guarded □ Threatening □ Grandiose □ Silly □ Aggressive □ Easily frustrated □ Agitated □ Easily distracted □ Irritable □ Dismissive □ Uncooperative □ Nervous/restless □ Non-responsive □
13. ***Speech:*** □ Appropriate □ Mute □ Incoherent □ Pressured □ Slowed □ Slurred □ Disorganized □ Inappropriate content □ Other:_____
14. ***Thought process/cognitive status:*** Mark all that apply. □ Coherent □ Relevant □ Logical □ Irrelevant □ Poor concentration □ Poor judgment □ Incoherent □ Illogical □ Loose associations □ Blocking □ Tangential □ Preservation □ Disorganized □ Circumstantial □ Poor insight □ Impoverished □ Short term memory deficit □ Long term memory deficit □ Problems with abstract
15. ***Threat to self/others:*** Mark all that apply. Specify severity where applicable.
□ No threat to self or others □ Imminent danger to self □ Imminent danger to others
Suicidal plan: □ Specific □ Non-specific Homicidal plan: □ Specific □ Non-specific
16. ***Psychotic features:*** Mark all that apply. Specify severity and type where applicable.

Auditory hallucinations	□ Mild	□ Moderate	□ Severe	□ None
Visual hallucinations	□ Mild	□ Moderate	□ Severe	□ None
Olfactory hallucinations	□ Mild	□ Moderate	□ Severe	□ None
Tactile hallucinations	□ Mild	□ Moderate	□ Severe	□ None
Delusions	□ Mild	□ Moderate	□ Severe	□ None

□ Paranoid □ Grandiose □ Referential □ Somatic □ Religious

SECTION IX: Placement Recommendations

1. Does this individual meet the minimum standards for admission to the Nursing Facility? □ Yes □ No
2. Is a Nursing Facility recommended for this individual? □ Yes □ No If the answer is "No", check the services recommended:

□ Home with individuals psychiatrist
□ Home with community mental health services
□ Group Home with community mental health services
□ Assisted living with community mental health services or other psychiatric services
□ Psychiatric In-patient hospitalization
□ Psychiatric Out-patient partial hospitalization

3. Check the services recommended to be provided to the individual in the nursing facility: Check all that apply

□ Assist with adjustment to the nursing facility
□ Assist with transition back to community placement
□ Assist with independence training
□ Assist with decision making
□ Specialized behavior program
□ Social activity/day program

4. The individual would not benefit from the above services due to advanced age or illness: □ Yes □ No
5. Does this individual require services to improve function above what the nursing facility can provide?
□ Yes □ No If Yes, please specify:_____

SECTION X: Conclusion

Source of information used in completing evaluation: **Check all that apply**.

□ Chart review of current facility
□ Client interview
□ Staff interview (specify):_____
□ Family/Guardian (specify):_____
□ Case Manager (specify):_____
□ Other (specify):_____

Assessor Name (print):_____ Date:_____
Assessor Signature:_____ Title:_____

Contact Person:
The individual and address to which the results of the PASRR determinations should be mailed:
Name:_____
Facility:_____
Address:_____
Phone:_____

The contact person is responsible for insuring that the determination letters and all materials with this assessment are:

1. Forwarded to the admitting or Retaining Nursing Facility:
   Name:_____
   Address:_____
2. Forwarded to the Individual's Physician:
   Name:_____
   Address:_____

In addition, the contact person is responsible for:

3. Notifying the Individual or Legal Guardian:
   Name (if other than individual):_____
   Address:_____
   Relationship:_____

Please include a copy of the individuals ID Screen with this assessment to:

PASRR-MI Assessment Coordinator
Division of Behavioral Healthcare Services, Barry Hall
14 Harrington Rd
Cranston, RI 02920-3080
Phone: (401) 462-1717, 3291: Fax: 462-6078