PASRR MH EVALUATION Name: _____

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
PREADMISSION SCREENING AND RESIDENT REVIEW
MENTAL HEALTH EVALUATION

Physician's Name:

Address:

Information is required to complete Preadmission Screening and Resident Review process for persons requesting admission to or wishing to continue residency in a nursing facility. Based on mental health diagnosis and need for treatment, determination will be made regarding most appropriate plan of care.

Please complete all items requested providing date each item was administered and completed. Attach supportive material. Please type or print. Incomplete or illegible forms may delay payment.

Person's Name:

Date: DOB: Sex:

Social Security Number: Medicaid Number:

1. _____ Physical Examination (Attach copy and include following):
(DATE COMPLETED)

A. COMPLETE MEDICAL HISTORY:

B. REVIEW OF ALL BODY SYSTEMS:

C. SPECIFIC EVALUATION(S) OF NEUROLOGICAL SYSTEM in areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves and abnormal reflexes;

D. ABNORMAL FINDINGS basis for nursing facility placement, additional evaluations that have been conducted by appropriate specialists.

PASRRMH EVALUATION NAME:

2. _____ COMPREHENSIVE DRUG HISTORY including current or immediate past use of medications that could mask symptoms or mimic mental illness.
(DATE COMPLETED)

3. _____ PSYCHOSOCIAL EVALUATION including current living arrangements, and medical and support systems.
(DATE COMPLETED)

4. _____ FUNCTIONAL ASSESSMENT Ability to engage in activities of daily living and level of support needed to assist individual to perform these activities while living in community. Assessment must determine whether level of support can be provided to individual in alternative community setting or whether level of support needed is such that nursing facility placement is required. Functional assessment must address following areas:
(DATE COMPLETE)

A. SELF-MONITORING OF HEALTH STATUS:

PASRR MH EVALUATION NAME:

B. SELF-ADMINISTERING OF MEDICAL TREATMENT:

C. SCHEDULING OF MEDICAL TREATMENT, INCLUDING MEDICATION COMPLIANCE:

D. SELF-MONITORING OF NUTRITIONAL STATUS:

E. MANAGING MONEY:

F. DRESSING APPROPRIATELY:

G. GROOMING:

PASRR MH EVALUATION NAME:

5. _____ (DATE COMPLETED) COMPREHENSIVE PSYCHIATRIC EVALUATION including complete psychiatric history, evaluation of intellectual functioning, , memory functioning, orientation, description of current attitudes and overt behaviors, affect, suicidal or homicidal ideation, paranoia and degree of reality testing (presence and content of delusions) and hallucinations.

6. Does individual have current primary or secondary diagnosis of major mental disorder (as defined in DSM III R) and that mental disorder is schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; or another mental disorder that may lead to chronic disability; but not primary diagnosis of dementia, including Alzheimer's Disease or related disorder, or non-primary diagnosis of dementia unless primary diagnosis is major mental disorder as defined above?

Yes: _____ No: _____

Psychiatric Diagnostic Impression:

Axis I: (000.00) Axis II: (000.00)

(000.00)

7. In your opinion, is this person a danger to self or others (as per s. 394.463(1), F.S.)?

Yes: _____ No: _____ If yes, explain:

8. In your opinion, is this person capable of making decisions about his/her treatment?

Yes: _____ No: _____ Questionable: _____