PASRR
Resident Review/ID or DU

Section I: Identification

☐ PAS/ID/IDD ☐ PAS/DUAL (IMI and ID/IDD)

Name (Last, First, MI)

Gender Male ◯ Female ◯

Date of Birth

Age

SS# (last 4 digits)

Evaluation Date

Admit Date

Facility Name:

Address

City State AR Zip Code

Contact person

Phone Fax

Does the individual have a **LEGAL GUARDIAN?** No ☐ If Yes, complete the following:

Name Phone

Address

City State AR Zip Code

Relationship: [Select or type response]

Section II: Psychological Assessment

1. Please list all documented historical and current psychiatric diagnoses.

2. Describe historical symptoms or behaviors indicating a psychiatric disorder and time of onset.

Section II: Psychological Assessment (continued)

3. Describe any previous psychiatric treatment including hospitalizations, outpatient treatment, etc.

4. Describe current symptoms or behaviors indicating a psychiatric disorder.

5. Current psychiatric treatment (check all that apply)

- ☐ Medication therapy, administration, monitoring
- ☐ Individual therapy/counseling
- ☐ Outpatient psychiatric follow-up
- ☐ Day program/partial hospital program
- ☐ Inpatient psychiatric treatment
- ☐ Sheltered workshop
- ☐ Group therapy/counseling
- ☐ ECT
- ☐ Other (specify): _____
- ☐ Precautions (specify): _____

6. Does the client have a history of alcohol/drug abuse and/or treatment? No ☐

If yes, describe:

Last known use: _____

Section III: Behavioral Assessment

A. Problematic Behaviors: ☐ None

If yes, please indicate which of the following behaviors are problematic for the individual within the last 30 days based on the individual's medical record or staff comments.

- ☐ Dangerous smoking behavior
- ☐ Refuses medications
- ☐ Refuses activities
- ☐ Refuses to eat
- ☐ Uncooperative with diet
- ☐ Uncooperative with hygiene
- ☐ Self induced vomiting
- ☐ Impatient/demanding
- ☐ Frequent/continuous yelling
- ☐ Frequent/continuous whining
- ☐ Wandering
- ☐ Other (specify):
- ☐ Alcohol/drug use
- ☐ Destroys property
- ☐ Exposes self
- ☐ Sexually aggressive
- ☐ Verbally abusive
- ☐ Verbally threatening
- ☐ Cursing/swearing
- ☐ Disturbs other residents
- ☐ Physically threatening
- ☐ Strikes others provoked
- ☐ Strikes others unprovoked
- ☐ Pacing
- ☐ Tries to escape
- ☐ Seclusiveness
- ☐ Suspicious of others
- ☐ Lies purposefully
- ☐ Steals deliberately
- ☐ Talks of suicide/ideation
- ☐ Passive death wish
- ☐ Suicide threats
- ☐ Suicide attempts
- ☐ Injures self

B. Placement in Seclusion/Restraints

In the last 30 days has the individual been placed in seclusion or restraints to control dangerous behavior?

☐ No If Yes, complete the following:

Type of Restraint	Date	Duration	Behavior/precipitating event

C. Typical Daily Activities

Per client and/or staff report, describe how the individual spends most of her/his time:

Section IV: Medical History/Treatment

A. Medical Diagnoses. List all medical diagnosis as documented in the client's record.

B. Current Medications. Record medications, excluding convenience medications) ☐ Current MAR is attached

Drug Name	Dosage	Frequency	Start Date

C. STAT/PRN Medications.

In the last 30 days, has the individual received an emergency (STAT) or PRN administration of medications to control her/his behavior? ☐ No If Yes, complete the following:

Drug Name	Dosage	Date Given	Precipitating Event/Behavior

Section IV: Medical History/Treatment (continued)

D. Special Medical Treatments. Does the individual currently receive any special medical treatments? ☐ No

If yes, please indicate which of the following treatments the individual receives (check all that apply).

- ☐ Bowel and bladder
- ☐ Catheterization care
- ☐ Colostomy/illeostomy
- ☐ Decubitus care
- ☐ Diabetic monitoring
- ☐ Fracture care
- ☐ Gastrostomy
- ☐ Blood transfusions
- ☐ Tracheostomy care
- ☐ Posey/soft restraints
- ☐ Seizure precautions
- ☐ Formal behavior modification
- ☐ IV meds/antibiotics
- ☐ Inhalation therapy
- ☐ Intake and output
- ☐ IV fluids
- ☐ Medication monitoring
- ☐ Oral suction
- ☐ Tube feedings/TPN
- ☐ Geri chair
- ☐ Oxygen
- ☐ Prosthesis care
- ☐ Restraints
- ☐ Special skin care
- ☐ Sterile dressing
- ☐ Wound/incision care
- ☐ Symptom control (terminal illness)
- ☐ TPR/BP
- ☐ Dietary supplements
- ☐ Weight monitoring
- ☐ Therapeutic diet (specify): _____
- ☐ Ordered labs (specify): _____
- ☐ Other (specify): _____

E. Rehabilitative Services. Does the client receive any type of rehabilitative services? ☐ No

If yes, please indicate services received:

☐ Physical therapy ☐ Speech therapy ☐ Occupational therapy ☐ Restorative nursing

COMMENTS

Service Recommendations

Specialized Services: Defined as the implementation of an individualized program plan developed by an IDT & provided by a QDDP that represents areas that are relevant to identifying the individual's needs, directing them toward the acquisition of behaviors necessary to function with as much self-determination and independence as possible

Based on the individual's physical and mental condition and the above definition:

☐ Yes ☐ No 1. This person requires the level of care provided in a nursing facility

☐ Yes ☐ No 2. Specialized services recommended

These are services provided outside the NF setting - 6 hrs/day, 5 days/week **REGARDLESS** of physical limitations.
* Sheltered Workshop: Skill preparation for vocational opportunities
* Adult Education: Provide access to community by developing living skills

☐ Yes ☐ No 3. Health rehabilitative services recommended (In order to check Yes, you **MUST** recommend NF placement)

☐ Structured environment ☐ Formal behavior modification ☐ Individual psychotherapy
☐ Daily living skills training ☐ Community support ☐ Crisis intervention
☐ Develop support networks ☐ Pharmacologic management by Physician
☐ Other: _____

☐ Yes ☐ No 4. Other services are recommended for this person (specify):

_____

☐ Yes ☐ No 5. This person would not benefit from specialized services due to advanced age

☐ Yes ☐ No 6. This person would not benefit from specialized services due to severe illness

Development and Placement Recommendations

Recommendations are provided to assist the IDT in developing and individualized care plan

1. Adult Development

☐ 1. Personal Hygiene ☐ 5. Eating ☐ 9. Bed Mobility ☐ 13. Leisure
☐ 2. Toileting ☐ 6. Rehabilitative Therapy ☐ 10. Locomotion ☐ 14. Socialization
☐ 3. Bathing ☐ 7. Speech Therapy ☐ 11. Behavior Management
☐ 4. Dressing ☐ 8. Transferring ☐ 12. Pre-Vocational Training
☐ 15. Other: _____

2. Work Activity

☐ 1. Supported Employment ☐ 2. Competitive Employment

3. Community-Based Habilitative Training

☐ 1. Food preparation ☐ 4. Laundry ☐ 7. Medication administration
☐ 2. Household safety ☐ 5. Community integration ☐ 8. Money management
☐ 3. Sexuality ☐ 6. Transportation ☐ 9. Other: _____

4. Alternative Placement Options

☐ Residential Care Facility ☐ Group Home ☐ ICF/ID
☐ Supervised apartment ☐ Assisted Living Facility ☐ Own home or other residence
☐ Post Acute Head Injury Facility ☐ Residential Treatment Facility ☐ Dementia/Alzheimer's Unit (specify):
☐ DDS Group Home ☐ Medicaid Waiver Services ☐ Assisted Living Facility
☐ Human Development Center ☐ Other: _____

Assessor Signature: _____ Date: _____