PASRR
Resident Review/MI

Section I: Identification

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