# PASRR/MI Modified
# For Special Admit and Out of State Evaluations

## For BOCK use only

RedCap _____ ☐ Pre-Admission Screening ☐ Resident Review

PASRR Outcome: ☐ SMI ☐ Unable to verify SMI ☐ Primary Dementia

Needs exceed NF Level of Services? ☐ No ☐ Yes/MI Additional Services? ☐ No ☐ Yes

Re-evaluation required? ☐ No ☐ 180 Days ☐ Other: _____

## SECTION I: Identification

1. Name (Last, First, MI) _____ 2. Date of Birth _____

3. Gender Male ☐ Female ☐ 4. DCN _____ 5. Evaluation Date _____

6. Current Location: NF ☐ Hospital ☐ Home ☐ RCF/ALF ☐ ISL ☐ Other ☐ _____

7. Facility Name _____ Admit Date _____

City _____

Contact person _____ Phone _____

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

Name _____ Phone _____

Address _____

City _____ State MO Zip Code _____

Relationship: [Select or type response] _____

## SECTION II: Modified Evaluation Type

1. Select reason for the modified evaluation.

☐ Special Admit (serious/terminal illness)

☐ Out of State

☐ Other (specify): _____

## SECTION III: Psychiatric Assessment/History

1. Please list all documented historical and current **psychiatric** and ID/DD **diagnoses** (include date of diagnosis if available).

## SECTION III: Psychiatric Assessment/History (continued)

2. Describe any **medical conditions** that could exacerbate, mimic, be related to mental illness symptoms, or considered a DD related condition.

3. Does the individual have a history of traumatic experiences which may include physical, emotional or sexual **abuse**, domestic violence, neglect, or exploitation? If Yes, specify: ☐ No

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

5. Describe any **previous psychiatric treatment** including hospitalizations, outpatient treatment, etc. Include services received through the Missouri Department of Mental Health.

6. **Current** psychiatric support/services. **Mark all that apply.**

- ☐ None
- ☐ Psychiatric follow-up/consultation
- ☐ Day program/partial hospital program
- ☐ Inpatient psychiatric treatment
- ☐ Individual therapy/counseling
- ☐ Medication administration/management/monitoring
- ☐ Sheltered workshop
- ☐ Supported community living/Independent supported living
- ☐ Group therapy/counseling
- ☐ Secured/behavioral unit
- ☐ ECT
- ☐ DMH Services (specify): ☐ CPS ☐ DD ☐ ADA
- ☐ Safety precautions (specify): _____
- ☐ Other (specify): _____

## SECTION III: Psychiatric Assessment/History (continued)

7. Any history OR current thoughts/plans/acts/ideation or intention of **suicide or self injury**? ☐ No ☐ Unknown If yes, describe:

8. Any history OR current thoughts/plans/acts/ideation or intention of **homicide, aggressive/assaultive or violent** behavior? ☐ No ☐ Unknown If yes, describe:

9. Does the individual have a history of **alcohol and/or drug use**? No ☐

If Yes, describe use and treatment/services including services received through the Missouri Department of Mental Health.

## SECTION IV: Behavioral Assessment

1. 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.

- ☐ Unsafe smoking behavior
- ☐ Refuses medications
- ☐ Refuses activities
- ☐ Refuses to eat
- ☐ Uncooperative with diet
- ☐ Uncooperative with hygiene
- ☐ Self induced vomiting
- ☐ Frequent/continuous yelling
- ☐ Intrusive/invades others space
- ☐ Impatient/demanding
- ☐ Wandering
- ☐ Alcohol/drug use
- ☐ Destroys property
- ☐ Exposes self
- ☐ Sexually aggressive
- ☐ Verbally abusive
- ☐ Verbally threatening
- ☐ Uncooperative with medical/nursing care or treatments
- ☐ Cursing/swearing
- ☐ Disturbs other residents
- ☐ Physically threatening
- ☐ Strikes others provoked
- ☐ Strikes others unprovoked
- ☐ Elope/leave facility
- ☐ Seclusiveness
- ☐ Injures self
- ☐ Suspicious of others
- ☐ Lies purposefully
- ☐ Steals deliberately
- ☐ Talks of suicide/ideation
- ☐ Passive death wish
- ☐ Suicide threats
- ☐ Suicide attempts
- ☐ Verbalizations or crying out
- ☐ Other (specify): _____

2. Describe frequency and intensity of behaviors and staff response to behaviors noted above. ☐ N/A

## SECTION IV: Behavioral Assessment (continued)

3. 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, describe:

## SECTION V: MI/IDD/RC Determination

1. Does the individual have a primary diagnosis of Dementia (Major Neurocognitive Disorder), including Alzheimer's disease or a related disorder OR a non-primary diagnosis of Dementia in the absence of a primary diagnosis of a major mental disorder?

☐ No

- ☐ No dementia diagnosis found in available documentation.
- ☐ Dementia diagnosis, but not primary or in the absence of a primary diagnosis of a major mental disorder.

☐ Yes (check all that apply)

- ☐ The individual has a diagnosis of dementia (major neurocognitive disorder) due to Alzheimer's, Lewy body, vascular dementia, Parkinson's, etc.
- ☐ Cognitive impairments interfere with the individual's ability to participate in, and benefit from traditional mental health services.
- ☐ Dementia related symptoms are the primary focus of concern and/or are more prominent than symptoms of a major mental disorder.

Comments:

**If you answered "Yes" to the above questions the individual DOES NOT meet criteria for a PASRR related mental health disability. Go to Question #6.**

## SECTION V: MI/IDD/RC Determination (continued)

2. Does the individual have a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders including schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability?

☐ No (check all that apply)

- ☐ Individual's current condition is such that assessment results may not be reflective of their typical behavior (due to acute medical illness, delirium, etc). SMI determination cannot be made at this time. Recommend re-evaluation at a later time.

  Describe: _____

- ☐ Current/historical symptoms are inconsistent with documented diagnosis.

  Describe: _____

☐ Yes (check all that apply)

- ☐ Anorexia Nervosa or other eating disorder
- ☐ Bi-polar Disorder
- ☐ Major Depressive Disorder
- ☐ Somatic Symptom Disorder/Conversion Disorder
- ☐ Delusional Disorder
- ☐ Schizophrenia
- ☐ Obsessive-Compulsive Disorder
- ☐ Panic Disorder
- ☐ Schizoaffective Disorder
- ☐ Dissociative identity Disorder
- ☐ Stressor-Related Disorder (PTSD)
- ☐ Mood Disorder
- ☐ Psychotic Disorder
- ☐ Dysthymic Disorder
- ☐ Personality Disorder (paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, etc)

  Specify: _____

- ☐ Severe Anxiety Disorder (agoraphobia, generalized anxiety disorder, etc)

  Specify: _____

- ☐ Other mental disorder in the DSM (specify): _____

**If you answered "NO", the individual DOES NOT meet criteria for a PASRR related mental health disability. Go to Question #6.**

3. Indicate specific symptoms to support the DSM-V criteria for the disorder indicated above. Summarize symptoms, precipitating factors, onset, duration and intensity that support the diagnosis.

## SECTION V: MI/IDD/RC Determination (continued)

4. **As a result of the previously indicated major mental disorder,** has the individual experienced functional impairment which has substantially affected one or more major life activities (including ADLs; instrumental ADLs; or functioning in social, family, and academic or vocational contexts), or would have caused functional impairment without the benefit of treatment or other support services?

☐ No ☐ Yes (check all that apply)

☐ **Interpersonal Functioning:** The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, unstable employment, fear of strangers, avoidance of interpersonal relationships, impairment of social/family relationships, or social isolation

☐ **Adaptation to Change:** The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interactions; agitation; exacerbated signs and symptoms associated with the illness or withdrawal from situations; self-injurious, self mutilation, suicidal (ideation, gestures, threats or attempts); physical violence or threats; appetite disturbance; delusions; hallucinations; serious loss of interest; tearfulness; irritability; or requires intervention by mental health or judicial system.

☐ **Concentration, Persistence and Pace:** The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings; difficulties in concentration; inability to complete simple tasks within an established time period; makes frequent errors or requires assistance in the completion of these tasks, or has impairment of ADLs/IADLs.

**If you answered "NO", the individual DOES NOT meet criteria for a PASRR related mental health disability. Go to Question #6.**

5. As a result of the previously indicated major mental disorder, has the individual required intensive mental health services (more intensive than routine follow up care) provided by mental health professionals to stabilize or maintain a person experiencing a significant disruption of their major mental disorder in the last 2 years.

☐ Yes ☐ No If Yes, specify the type of services (check all that apply):

☐ Inpatient psychiatric hospitalization, partial hospitalization program, psychiatric residential treatment center
(Specify date/provider): _____

☐ Referral to mental health crisis/screening center or program, or hospital emergency department
(Specify date/provider): _____

☐ Intervention by housing or law enforcement officials (Specify): _____

☐ Psychiatric consultation or other services by MH professionals, DMH/CPS community mental health services, or MH primary reason for NF/RCF/ALF admission or continued stay
(Specify date/provider): _____

☐ Treatment history for the past two years is unknown or treatment was unavailable but otherwise appropriate to consider the person positive for serious mental illness

**If you answered "NO", the individual DOES NOT meet criteria for a PASRR related mental health disability.**

6. Does the individual need further evaluation for possible mental illness, dementia, and/or intellectual/developmental disability? ☐ No If yes, describe:

**If the individual DOES NOT meet criteria for a PASRR related mental health disability proceed to Section: Conclusions.**

## SECTION VI: Psychosocial Assessment

1. Is English the individual's primary language? Yes ☐ No ☐ If No, primary language is: _____

2. Highest level of education attained: [Select or Type Response]

3. Previous employment/position held: _____

   Current employment status: _____

4. Marital Status: [Select or Type Response]

5. Describe current **family** state. What kind of support system/resource is the family? Who are the primary contacts? Where do they live?

6. Describe historical/past and most recent **living situation.**

7. Prior medical and **support systems (check all that apply):**

- ☐ None
- ☐ Home health
- ☐ Family assistance
- ☐ Medication supervision/set-up/administration
- ☐ Personal care/ADL assistance
- ☐ Housekeeping
- ☐ Meal preparation/home delivered meals
- ☐ Shopping assistance
- ☐ Respite services
- ☐ Adult day care program
- ☐ Financial management
- ☐ Other (church, friends etc): _____

8. Specify reason for **NF application, admission or continued stay(check all that apply)**

- ☐ A. Assistance needed to complete ADLs (eating, dressing, grooming, bathing, incontinence care)
- ☐ B. Assistance needed for transfers, ambulation, fall prevention
- ☐ C. Rehabilitation services needed (physical, occupational, speech therapy)
- ☐ D. Medical treatment and/or monitoring for acute condition. Treatment needed due to new/recent diagnosis or condition, short term medical care needs.
- ☐ E. Medical treatment and/or monitoring for chronic conditions with treatment services needed on regular basis in NF setting.
- ☐ F. 24 hour protective oversight needed due to severity of behaviors or mental illness symptoms. Individual cannot be without supervision at any time.
- ☐ G. Physical care needs exceed what can be managed in previous/current living situation
- ☐ H. Alternative care options are unavailable due to lack of funding or availability/wait list for RCF/ALF, low income housing, no DD waiver, or no available slots or providers, etc.
- ☐ I. Housing instability/homeless
- ☐ J. Mental health care needs exceed what can be managed in previous/current living situation due to aggression, substance use or medication noncompliance leading to exacerbation of symptoms.
- ☐ K. Other: _____

## SECTION VI: Psychosocial Assessment (continued)

9. Typical **Daily Activities**. Per individual and/or staff report describe how the individual spends most of her/his time (important activities, hobbies, interests, etc).

## SECTION VII: Level of Functioning

Coding: I = Independent V = Verbal assist, supervision, or set up P = Physical assist

1. Personal care and independent living skills:

| | | |
|---|---|---|
| ____Toileting | ____Bathing | ____Scheduling of medical treatments |
| ____Personal hygiene | ____Eating | ____Monitoring of health status |
| ____Brushing teeth/oral care | ____Meal preparation | ____Maintaining personal safety |
| ____Laundry/Care of clothing | ____Housekeeping | ____Budgeting and personal finance |
| ____Selects appropriate clothes | ____Shopping | ____Handling money |
| ____Dressing/undressing | | |

Comments: _____

2. Mobility/Gait **(mark all that apply)**

☐ Normal/Fully independent ☐ Aids (cane/walker) ☐ Unsteady ☐ Staff assist

☐ Wheelchair unassisted ☐ Wheelchair assisted ☐ Bedfast ☐ Other: _____

Comments: _____

3. Describe the individual's **communication** and interaction with others.

## SECTION VIII: Medical History

1. Does the individual have any medication allergies? ☐ No

If Yes, specify: _____

2. Describe **previous medications** used to treat mental illness symptoms, including current or recent use of medications that could mask or mimic mental illness symptoms. ☐ Unknown

3. Has the client been compliant with medication instructions in the past? ☐ No ☐ Yes ☐ Unknown

## SECTION VIII: Medical History (continued)

4. Current Medications. Record current meds (include drug name, dosage, frequency, and start date), excluding convenience meds or attach current MAR/Physician Orders/POS.

☐ Current MAR /Physician Orders/POS attached Date: _____

5. Describe individual's response to hypnotics, anti-psychotics, mood stabilizers and anti-depressants, anti-anxiety/sedative agents, and anti-Parkinson agents. ☐ N/A

6. Describe the individual's ability to self-administer physician-prescribed medications: _____

7. Has the individual received an emergency (STAT) or PRN administration of medications to control behavior in the last 30 days?

☐ No If Yes, describe:

8. List all current and historical medical diagnoses and status as documented in the individual's record

☐ Current Diagnosis List/History & Physical Attached Date: _____

9. Level of Impact medical/physical health conditions and treatments have on individual's independent functioning

☐ None ☐ Mild ☐ Moderate ☐ Severe

## SECTION IX: Physical Assessment

1. Appetite: _____

2. Sleep Pattern **(mark all that apply)**

- ☐ Normal
- ☐ Problems falling asleep
- ☐ Problems staying asleep
- ☐ Receives medication
- ☐ Severely disturbed pattern
- ☐ Hypersomnia/daytime sedation
- ☐ Other: _____

3. Does the individual currently receive any special **medical treatments**/supports?

☐ No If Yes, please indicate which of the following treatments the individual receives **(mark all that apply)**

- ☐ Blood transfusions
- ☐ Bowel and bladder/Incontinence care
- ☐ Catheterization care
- ☐ Choking/Aspiration precautions
- ☐ Colostomy/Illeostomy/Ureterostomy
- ☐ CPAP/BIPAP
- ☐ Diabetic monitoring
- ☐ Dietary supplements
- ☐ Decubitus care
- ☐ Dialysis
- ☐ Fall precautions
- ☐ Foot care
- ☐ Fracture care
- ☐ Hemodialysis
- ☐ Hospice Services
- ☐ Inhalation therapy/Respiratory care
- ☐ Injections
- ☐ Intake and output
- ☐ IV fluids
- ☐ IV meds/antibiotics
- ☐ Medication monitoring
- ☐ Therapeutic diet (specify): _____
- ☐ Monitoring of Vital Signs
- ☐ Oral suction
- ☐ Oxygen
- ☐ Prosthesis care
- ☐ Seizure precautions
- ☐ Special skin care/monitoring
- ☐ Tracheostomy care
- ☐ Tube feedings/TPN
- ☐ Weight monitoring
- ☐ Wound/incision care
- ☐ Ordered labs (specify): _____
- ☐ Other (specify): _____

4. Rehabilitation services. Does the individual receive any type of rehabilitative services?

☐ None ☐ Physical therapy ☐ Occupational therapy ☐ Speech therapy ☐ Restorative nursing services

## SECTION X: Affective Behavioral Observations

1. Orientation ☐ Person ☐ Place ☐ Circumstance ☐ Time ☐ Unable to assess

2. Memory
- Immediate _____
- Short term _____
- Long term _____

3. Affect. **Mark all that apply.**

- ☐ Appropriate in quality and intensity to stated themes
- ☐ Flat or blunted
- ☐ Labile
- ☐ Unable to determine
- ☐ Angry
- ☐ Constricted
- ☐ Other (specify): _____
- ☐ Mood congruent
- ☐ Mood incongruent

## SECTION XI: PASRR Level II Evaluation Report

Client Name: _____

1. **Mental Health disability.** Based on this Level II evaluation the individual:

   ☐ Has a mental health disability as defined by PASRR

2. (Reserved)

3. Provide a **summary** of the client's medical and social history

4. Individual's **limitations** (developmental needs, physical, communication, memory, needs, etc.)

5. Individual's **strengths** (positive traits and developmental strengths, abilities, accomplishments, personal traits, etc.)

6. Has a prospective Nursing Facility been identified? No ☐ N/A (Currently in NF) ☐

   If Yes, please indicate facility name: _____

## SECTION XI: PASRR Level II Evaluation Report (continued)

7. Nursing Facility Level of Services? (check all that apply)

- ☐ The individual's needs could be met in a nursing facility at this time.
- ☐ Community alternatives to nursing facility should also be considered, if available, with supports listed in #9.
- ☐ The individual's mental health and/or intellectual disability service needs cannot be met in a nursing facility at this time.
  - ☐ Requires 1:1 supervision to maintain safety due to behavioral/mental health symptoms
  - ☐ Recent/current aggressive/violent behavior requiring seclusion, restraints, PRN medications etc.
  - ☐ Current/active homicidal ideation
  - ☐ Current/active suicidal ideation/self harm
  - ☐ Medication refusal leading to acute exacerbation/continuation/instability of psychiatric symptoms
  - ☐ Other (specify): _____

Provide discussion/supporting documentation for the recommendations listed above.

**If the individual requires services beyond the capabilities of a nursing facility contact Bock before proceeding and skip to Section: Conclusions.**

8. The individual needs, or continues to need, the following specialized mental health services?

- ☐ Psychiatric diagnostic evaluation
- ☐ Individual, family, or group psychotherapy
- ☐ Psychotherapy for crisis
- ☐ Health behavior assessment and intervention
- ☐ Tobacco cessation counseling
- ☐ None

## SECTION XI: PASRR Level II Evaluation Report (continued)

9. The individual needs or continues to need the following supports and services.

☐ A. Provision of specific services to address the individual's **mental health and behavioral needs**.

- ☐ Obtain Individual Support Plan (ISP), Individualized Treatment Plan (ITP), Behavioral Support Plan (BSP) from DMH Community Mental Health Center and/or Developmental Disability Regional Office.
- ☐ Monitoring of behavioral symptoms
- ☐ Trauma informed services
- ☐ Tools of choice or other Positive Behavioral Support services

☐ B. **Medication** therapy and monitoring services

- ☐ Psychiatric follow up to prescribe and manage medications
- ☐ Medication set up/administration by staff and monitoring for compliance with prescribed medication
- ☐ Monitoring of therapeutic effect in managing mental health symptoms, including therapeutic levels, and/or interaction or adverse effects
- ☐ Provide education/training in drug therapy management
- ☐ Other: _____

☐ C. Provision of a **structured environment**.

- ☐ Maintain environment with low stimulation, minimum of visual/auditory distractions, and/or sensory supports
- ☐ Provide instructions at the individual's level of understanding
- ☐ Environmental supports to prevent elopement
- ☐ Assess and plan for the level of supervision required to prevent harm to self or others
- ☐ Provide for individual personal space
- ☐ Establish consistent routines, providing a schedule of daily tasks/activities, etc.

☐ D. **Crisis Intervention** Services. Assess and plan for Crisis Intervention that provides emotional support, education, safety planning and case management to handle an immediate crisis. A crisis plan should developed to create clear steps that are to be taken to support client during a behavioral health crisis including who to contact for assistance, how to work together with client during the crisis, and how to determine when the crisis is over. The plan should also identify a physician and emergency medical services that should be contacted. Facility may also wish to utilize DMH Behavioral Health Crisis Hotline: https://dmh.mo.gov/behavioral-health/treatment-services/specialized-programs/behavioral-health-crisis-hotline

☐ Suicidal precautions ☐ Assault precautions ☐ Elopement precautions

## SECTION XI: PASRR Level II Evaluation Report (continued)

☐ E. Implementation of **ADL program** to increase independence and self determination.

Assess and plan a program for the development and maintenance of necessary living skills including **(mark all that apply)**:

☐ Grooming/dressing ☐ Nutrition needs ☐ Bathing

☐ Personal Hygiene ☐ Money Management ☐ Maintenance of own living environment

☐ Toileting/bowel/bladder ☐ Other: _____

By providing the following services **(mark all that apply)**

☐ Physical therapy evaluation and/or treatment

☐ Occupational therapy evaluation and/or treatment

☐ Speech-language pathology evaluation and/or treatment

☐ Restorative services (for turning/positioning, transferring, ambulation, ADLs, range of motion, bowel/bladder program

☐ Provision of, training or assistance in use of adaptive equipment or assistive devices

☐ Dietary or nutritional services

☐ Provide cueing, reminders, education and/or modeling of daily living skills

☐ F. Development of **Personal Supports**

☐ Assess and plan for meaningful socialization and recreational activities to diminish tendencies toward isolation, withdrawal, etc.

☐ Assess, plan, and develop appropriate personal support network through community and social connections.

Provide comments regarding any Support and Services previously selected.

## SECTION XI: PASRR Level II Evaluation Report (continued)

☐ G. Assess and plan for **discharge**, transition to less restrictive environment by application/referral to appropriate community resources. Facility/staff to make referral and assist with application for resources and/or services. Describe and specify:

Identify what supports/services may be needed for the individual to live successfully in a **less restrictive/community setting**.

**Substance use services:**

☐ 1. Community based substance use treatment

☐ 2. 12 step/substance use program

☐ 3. Residential/Intensive substance use treatment/Rehabilitation services

**DD Support Services**

☐ 1. Referral to DMH/DD Regional Office for intake/eligibility evaluation

☐ 2. Application for DD/Waiver Services

**Housing assistance:**

☐ 1. Intensive Residential Treatment Services (IRTS)/Psychiatric Individualized Supported Living (PISL)

☐ 2. Cluster apartment services

☐ 3. Residential Services (RCF/ALF)

☐ 4. Permanent supported housing

☐ 5. DD Residential/Independent Supported Living (ISL)

## SECTION XI: PASRR Level II Evaluation Report (continued)

**Community based psychiatric treatment and supports:**

- ☐ 1. Group counseling/psychotherapy/support group
- ☐ 2. Individual counseling/psychotherapy
- ☐ 3. Medication education/counseling/set-up/administration
- ☐ 4. Skills training/vocation rehabilitation/supported employment
- ☐ 5. Community Psychiatric Rehabilitation/Case Management
- ☐ 6. Psychiatric follow-up/Physician services
- ☐ 7. Intensive Community Psychiatric Rehabilitation (ICPR)
- ☐ 8. Peer Support Services
- ☐ 9. Crisis Stabilization Services/Mobile Crisis Response
- ☐ 10. Behavioral analysis/monitoring/development of behavioral support plan
- ☐ 11. Integrated Treatment for Co-Occurring Disorders (ITCD)

**Home and Community Based Services:**

- ☐ 1. Day programming/Adult day care
- ☐ 2. Housekeeping/homemaker/chore services
- ☐ 3. Nutritional/dietary evaluation/delivered meals or shopping assistance
- ☐ 4. Personal care/ADL assistance
- ☐ 5. Respite care
- ☐ 6. Adaptive equipment evaluation/Environmental accessibility adaptations
- ☐ 7. Financial assistance/financial management services
- ☐ 8. Family support/education
- ☐ 9. Supported decision making
- ☐ 10. Hospice services
- ☐ 11. Medical follow-up/Physician services
- ☐ 12. Home health/nursing care services/nurse visits
- ☐ 13. Physical therapy evaluation
- ☐ 14. Occupational therapy evaluation
- ☐ 15. Speech/Language therapy evaluation
- ☐ 16. Other (describe): _____

Comments regarding Supports/Services

## SECTION XI: PASRR Level II Evaluation Report (continued)

10. Describe any additional information to be utilized by the nursing facility for care planning purposes.

## SECTION: Conclusions

Source of information used in completing evaluation:

- ☐ Client interview
- ☐ Previous PASRR (date): _____
- ☐ Record review - previous facility (specify): _____
- ☐ Record review - Regional Office (specify): _____
- ☐ Record review - Community Mental Health Provider (specify): _____
- ☐ Staff interview (specify): _____
- ☐ Family/guardian (specify): _____
- ☐ Case Manager (specify): _____
- ☐ Other (specify): _____
- ☐ Record review - current facility
- ☐ CIMOR

Assessor Name: _____ Date: _____

Signature: *** Signature on File *** Title _____

**For BOCK USE ONLY:**

Reviewed/Edited by: _____ Date: _____