

DATE: _____

NAME: _____

II. MEDICAL ASSESSMENT

20. Health Assessment - Include infectious diseases, nutritional needs, prior treatments, degenerative conditions, recent hospitalization(s), and/or surgery(ies) with dates - Date of most recent office visit. (Attach most recent Hospital Discharge Summary and Physical, if available)

21. Normal Vital Signs for the individual:

a. Height	b. Weight	c. Blood Pressure	d. Temperature	e. Pulse	f. Respiratory Rate
------------------	------------------	--------------------------	-----------------------	-----------------	----------------------------

22. Check if Abnormal:

- | | | | |
|------------------------------------|--|--|--|
| a. <input type="checkbox"/> Eyes | g. <input type="checkbox"/> Breasts | m. <input type="checkbox"/> Extremities | s. <input type="checkbox"/> Musculo-Skeletal |
| b. <input type="checkbox"/> Ears | h. <input type="checkbox"/> Lungs | n. <input type="checkbox"/> Abdomen | t. <input type="checkbox"/> Skin |
| c. <input type="checkbox"/> Nose | i. <input type="checkbox"/> Heart | o. <input type="checkbox"/> Hernia(s) | u. <input type="checkbox"/> Nervous System |
| d. <input type="checkbox"/> Throat | j. <input type="checkbox"/> Arteries | p. <input type="checkbox"/> Genitalia-male | v. <input type="checkbox"/> Allergies (Specify) _____ e. |
| <input type="checkbox"/> Mouth | k. <input type="checkbox"/> Veins | q. <input type="checkbox"/> Gynecological | |
| f. <input type="checkbox"/> Neck | l. <input type="checkbox"/> Lymph System | r. <input type="checkbox"/> Ano-Rectal | |

Describe abnormalities and treatment:

23. Medical Conditions/Symptoms: [Please Grade as : (1) - Mild, (2) - Moderate, (3) - Severe]

- | | | |
|---|---|--|
| a. <input type="checkbox"/> Angina-rest _____ | e. <input type="checkbox"/> Paralysis _____ | i. <input type="checkbox"/> Diabetes _____ |
| b. <input type="checkbox"/> Angina-exertion _____ | f. <input type="checkbox"/> Dysphagia _____ | j. <input type="checkbox"/> Contracture(s) _____ |
| c. <input type="checkbox"/> Dyspnea _____ | g. <input type="checkbox"/> Aphasia _____ | k. <input type="checkbox"/> Mental Disorder(s) _____ |
| d. <input type="checkbox"/> Significant Arthritis _____ | h. <input type="checkbox"/> Pain _____ | l. <input type="checkbox"/> Other (Specify) _____ |

24. Decubitus a. Yes b. No If yes, check the following:

A. Stage _____ **B. Size** _____ **C. Treatment** _____

Location:

a. <input type="checkbox"/> Left Leg	c. <input type="checkbox"/> Right Leg	e. <input type="checkbox"/> Left Hip	g. <input type="checkbox"/> Right Hip
b. <input type="checkbox"/> Left Arm	d. <input type="checkbox"/> Right Arm	f. <input type="checkbox"/> Left Buttock	h. <input type="checkbox"/> Right Buttock

Other _____ **Developed at:** a. Home b. Hospital c. Facility

25. In the event of an emergency, the individual can vacate the building: (check only one)

- a. Independently b. With Supervision c. Mentally Unable d. Physically Unable

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26. Indicate individual's functional ability in the home for each item with the level number 1, 2, 3, 4, or 5. Nursing care plan must reflect functional abilities of the client in the home.

Item	Level 1	Level 2	Level 3	Level 4
a. __ Eating (not a meal Prep)	Self/Prompting	Physical Assistance	Total Feed	Tube Fed
b. __ Bathing	Self/Prompting	Physical Assistance	Total Care	
c. __ Dressing	Self/Prompting	Physical Assistance	Total Care	
d. __ Grooming	Self/Prompting	Physical Assistance	Total Care	
e. __ Cont./Bladder	Continent	Occas. Incontinent*	Incontinent	Catheter
f. __ Cont./Bowel	Continent	Occas. Incontinent* *less than 3 per wk.	Incontinent	Colostomy
g. __ Orientation	Oriented	Intermittent Disoriented	Totally Disoriented	Comatose (Level 5)
h. __ Transferring	Independent	Supervised/Assistive Devise	One Person Assistance	Two Person Assist.
i. __ Walking	Independent	Supervised/Assistive Devise	One Person Assistance	Two Person Assist.
j. __ Wheeling	No Wheelchair	Wheels Independently	Situational Assistance (Doors, etc.)	Total Assistance
k. __ Vision	Not Impaired	Impaired /Correctable	Impaired/Not Correctable	Blind
l. __ Hearing	Not Impaired	Impaired/Correctable	Impaired/Not Correctable	Deaf
m. __ Communication	Not Impaired	Impaired/Understandable	Understandable with Aids	Inappropriate/None

27. Professional and technical care needs (check all that apply).

- | | | |
|--|--|---|
| a. <input type="checkbox"/> Physical Therapy | f. <input type="checkbox"/> Ostomy | k. <input type="checkbox"/> Parenteral Fluids |
| b. <input type="checkbox"/> Speech Therapy | g. <input type="checkbox"/> Suctioning | l. <input type="checkbox"/> Sterile Dressings |
| c. <input type="checkbox"/> Occupational Therapy | h. <input type="checkbox"/> Tracheostomy | m. <input type="checkbox"/> Irrigations |
| d. <input type="checkbox"/> Inhalation Therapy | i. <input type="checkbox"/> Ventilator | n. <input type="checkbox"/> Special Skin Care |
| e. <input type="checkbox"/> Continuous Oxygen | j. <input type="checkbox"/> Dialysis | o. <input type="checkbox"/> Other _____ |

28. Individual is capable of administering his/her own medications (check only one).

- a. Yes b. With Prompting/Supervision c. No Comment: _____

29. Current Medications	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

DATE: _____

III. MI/MR ASSESSMENT

NAME: _____

30. Current Diagnoses (Check all that apply)

- a. None
- b. Mental Retardation
- c. Autism
- d. Seizure Disorder (Age at onset: _____)
- e. Cerebral Palsy
- f. Other Developmental Disabilities (Specify: _____)
- g. Schizophrenic Disorder
- h. Paranoid Disorder
- i. Major Affective Disorder
- j. Schizoaffective Disorder
- k. Affective Bipolar Disorder
- l. Tardive Dyskinesia
- m. Major Depression
- n. Other related conditions (Specify: _____)

Date of last PASARR Level II Evaluation _____

31. Has an individual ever received services from an agency serving persons with mental retardation/developmental disability and/or mental illness? Yes No If yes, specify agency

Name _____ Address _____
 Admission Date _____ Discharge Date _____

32. Has the individual received any of the following medications on a regular basis within the last two years? Yes No

33. Was this medication used to treat a neurological disorder? Yes No

- Chlorpromazine Thorazine Perphenazine Trilafon Haloperidol Haldol
- Promazine Sparine Fluphenazine Prolixin Molindone Moban
- Trifupromazine Vesprin Fluphenazine HCl Permitil Loxapine Loxitane
- Thioidazine Mellaril Trifluphenazine Stelazine Clozapine Clozaril
- Mesoridazine Serentil Chlorprothixene Taractan Prochlorperazine
- Actiphenazine Tindal Thiothixene Navane Compazine

Medication	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

34. Clinical and Psychosocial Data - Please check any of the following behaviors which the individual has exhibited in the past two years.

- a. Substance Abuse (Identify _____)
- b. Combative
- c. Withdrawn/Depressed
- d. Hallucinations
- e. Delusional
- f. Disoriented
- g. Bizarre Behavior
- h. Bangs Head
- i. Sets Fires
- j. Displays Inappropriate Social Behavior
- k. Seriously Impaired Judgment
- l. Suicidal Thoughts, Ideations/Gestures
- m. Cannot Communicate Basic Needs
- n. Talks About His/Her Worthlessness
- o. Unable to Understand Simple Commands
- p. Physically Dangerous to Self and Others, if Unsupervised
- q. Verbally Abusive
- r. Demonstrates Severe Challenging Behaviors
- s. Specialized Training Needs
- t. Sexually Aggressive

Does the individual have Alzheimer's, multi-infarct, senile dementia, or related condition? Yes No
 Other (Specify) _____

DATE: _____

IV. PHYSICIAN RECOMMENDATION

NAME: _____

35. Prognosis - Check one only: a__ Stable b__ Improving c__ Deteriorating d__ Terminal Other _____	
36. Rehabilitative Potential (Check one only) a__ Good b__ Limited c__ Poor	
37. Diagnosis: a. Primary _____ b. Secondary _____ c. Other medical conditions requiring services _____	
38. Physician Recommendations	
<p>A. FOR NURSING FACILITY PLACEMENT ONLY On the basis of present medical findings, the individual may eventually be able to return home or be discharged.</p> <p>a__ Yes b__ No</p> <p>If yes, check one of the following:</p> <p>a. <input type="checkbox"/> Less than 3 months b. <input type="checkbox"/> 3-6 months c. <input type="checkbox"/> Over 6 months d. <input type="checkbox"/> Terminal illness</p>	<p>B. I recommend that the services and care to meet these needs can be provided at the level of care indicated.</p> <p>a. <input type="checkbox"/> Nursing Home b. <input type="checkbox"/> Nursing Home waiting A/D Waiver c. <input type="checkbox"/> A/D Waiver d. <input type="checkbox"/> Personal Care</p>
39. To the best of my knowledge, the patient's medical and related needs are essentially as indicated above (Must be signed by M.D. or D.O.)	
Physician's Signature _____ MD/DO _____ Date This Assessment Completed: _____	TYPE OR PRINT Physician's name/address below: _____ _____ _____

DISCLAIMER: Approval of this form does not guarantee eligibility for payment under the State Medicaid Plan.

NOTE: Information gathered from this form may be utilized for statistical/data collection.

V. ELIGIBILITY DETERMINATION

DATE: _____

NAME: _____

**DEPARTMENT USE ONLY
LEVEL I (Medical Screen)**

Medical and other professional personnel of the Medicaid Agency or its designees **MUST** evaluate each individual's need for admission by reviewing and assessing the evaluations required by regulation.

Exemptions from requirements for Level II Assessment

40. Does the individual have or require:

- a. Diagnosis of dementia (Alzheimer's or related disorder)? Yes No
- b. Thirty days of respite care? Yes No
- c. Serious Medical Condition? Yes No

41. Medical Eligibility Determination:

- a. Nursing Facility Services/Aged/Disabled Waiver b. Personal Care Services
- c. No Services Needed d. Optional Services

42. PASARR Determination:

- a Level II required b Level II not required

Nurse Reviewer's Signature - Title Date Control Number

Printed Name

WAIVER ONLY: Level of Care: _____ Number of Hours: _____

**DEPARTMENTAL USE ONLY
LEVEL II (MI/MR Screen)
(Completed by PASARR Provider)**

43. DETERMINATION:

- a. Nursing facility services needed - Specialized services not needed.
- b. Nursing facility services needed - Specialized services needed.
- c. Alzheimer's or related disorder identified.
- d. Thirty day Respite care needed.
- e. Terminal illness identified.
- f. Serious illness identified.
- g. Nursing facility services not needed.

44. RECOMMENDED PLACEMENT:

- a. Nursing Facility Services/Aged/Disabled Wavier
- b. Psychiatric Hospital (21 years or under)
- c. ICF/MR or MR/DD Waiver
- d. Other-Identify: _____

PASARR Reviewer's Signature Title Printed Name

Agency Name Date

A COPY OF THIS FORM MUST BE IN THE INDIVIDUAL'S MEDICAL RECORDS