STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF MENTAL HEALTH

PREADMISSION SCREENING AND RESIDENT REVIEW/ MENTAL ILLNESS (PASARR/MI) LEVEL II EVALUATION DOCUMENT

MH 1733 (7/98)

PLEASE INDICATE IN PEN ONLY YOUR RESPONSE TO EACH QUESTION BY CHECKING THE APPROPRIATE BOX OR BY PROVIDING INFORMATION IN THE INDICATED SPACE

Reason Assessment Was Not Completed: 1 ☐ Attempt 2 ☐ Suspend Reason: _____

IDENTIFICATION

01. DMH ID NUMBER ☐☐☐ ☐☐☐ 02. MEDI-CAL ID NUMBER ☐☐☐ ☐☐ ☐☐☐☐ ☐☐☐ ☐☐

03. SOCIAL SECURITY NUMBER ☐☐☐ ☐☐ ☐☐☐☐

04. RESIDENT NAME LAST _____ FIRST _____ MI ☐

05. DATE OF BIRTH MM ☐☐ DD ☐☐ YYYY ☐☐☐☐ 06. SEX MALE ☐ FEMALE ☐

07. LANGUAGE UTILIZED FOR THE EVALUATION a. RESIDENT'S LANGUAGE _____

b. INTERPRETER'S NAME _____ c. INTERPRETER'S RELATIONSHIP _____

08. FACILITY NAME _____ 09. FACILITY NUMBER ☐☐ ☐☐☐☐ ☐☐☐

10. DATE OF CURRENT NF ADMISSION MM ☐☐ DD ☐☐ YYYY ☐☐☐☐ 11. MONTHS IN CURRENT NF ☐☐☐ 12. LEGAL CLASS CODE ☐☐

13. DATE OF LEVEL I SCREENING MM ☐☐ DD ☐☐ YYYY ☐☐☐☐ 14. DATE OF LEVEL II SCREENING MM ☐☐ DD ☐☐ YYYY ☐☐☐☐

DSM-IV MULTIAXIAL CLASSIFICATION

15. Axis I. Clinical Disorders ☐☐☐.☐ ☐☐☐.☐ _____

Axis II. Personality Disorder/MR ☐☐☐.☐

Axis III. General Medical Conditions ☐☐☐.☐ _____

Axis IV. Psychosocial/Environmental ☐, ☐, ☐, ☐

Axis V. Global Assessment Functioning (GAF): Highest Past Year ☐☐ Current ☐☐

CURRENT MENTAL STATUS EXAMINATION

Appearance, Attitude, Behavior	None	Mild	Moderate	Severe
16. Untidy/Unkempt	1 ☐	2 ☐	3 ☐	4 ☐
17. Uncooperative	1 ☐	2 ☐	3 ☐	4 ☐
18. Belligerent	1 ☐	2 ☐	3 ☐	4 ☐
19. Agitation/Excitement	1 ☐	2 ☐	3 ☐	4 ☐
20. Anxiety/Restlessness	1 ☐	2 ☐	3 ☐	4 ☐
21. Inappropriate	1 ☐	2 ☐	3 ☐	4 ☐
22. Withdrawn/Psychomotor Retardation	1 ☐	2 ☐	3 ☐	4 ☐
Thought Process:				
23. Incoherent/Irrelevant	1 ☐	2 ☐	3 ☐	4 ☐
24. Blocking	1 ☐	2 ☐	3 ☐	4 ☐
25. Mutism	1 ☐	2 ☐	3 ☐	4 ☐
26. Flight of Ideas	1 ☐	2 ☐	3 ☐	4 ☐
27. Disorientation	1 ☐	2 ☐	3 ☐	4 ☐
Emotional Status:				
28. Inappropriate	1 ☐	2 ☐	3 ☐	4 ☐
29. Flat/Blunted	1 ☐	2 ☐	3 ☐	4 ☐
30. Depressed	1 ☐	2 ☐	3 ☐	4 ☐

	None	Mild	Moderate	Severe
31. Elated	1 ☐	2 ☐	3 ☐	4 ☐
32. Liable	1 ☐	2 ☐	3 ☐	4 ☐
Thought Content:				
33. Hallucinations	1 ☐	2 ☐	3 ☐	4 ☐
34. Delusions	1 ☐	2 ☐	3 ☐	4 ☐
35. Ideas of Reference	1 ☐	2 ☐	3 ☐	4 ☐
36. Suicidal	1 ☐	2 ☐	3 ☐	4 ☐
37. Homicidal	1 ☐	2 ☐	3 ☐	4 ☐
Current Cognitive Status:				
38. a. Attention Deficit	1 ☐	2 ☐	3 ☐	4 ☐
b. Short Term Memory Deficit	1 ☐	2 ☐	3 ☐	4 ☐
c. Long Term Memory Deficit	1 ☐	2 ☐	3 ☐	4 ☐
d. Poor Concentration	1 ☐	2 ☐	3 ☐	4 ☐
e. Problem in Abstraction	1 ☐	2 ☐	3 ☐	4 ☐
f. Poor Insight	1 ☐	2 ☐	3 ☐	4 ☐
g. Poor Judgement	1 ☐	2 ☐	3 ☐	4 ☐
39. **Overall Severity of Psychiatric Illness**	1 ☐	2 ☐	3 ☐	4 ☐

PSYCHIATRIC HISTORY

	Unknown	None	Mild	Moderate	Severe
40. a. Drug Abuse	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
b. Alcohol Abuse	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

41. Age at onset of mental illness ____

42. Primary living situation (more than 6 months) during past year:
1 ☐ State Hospital 3 ☐ Board and Care 5 ☐ Independent Living
2 ☐ Nursing Facility 4 ☐ With Family 6 ☐ Other _____

43. No. of psychiatric hospitalizations in past two years ____

	0-30 Days	31-60 Days	61-90 Days
44. No. of suicide attempts in past	___	___	___
45. No. of assaultive incidents in past	___	___	___
46. No. of AWOL or attempts in past	___	___	___
47. No. of PRN psychiatric medications in past	___	___	___

	Good	Fair	Poor	N/A
48. Response to psychiatric medications	1 ☐	2 ☐	3 ☐	4 ☐

PSYCHIATRIC MEDICATIONS

49. Psychiatric medications taken during the past year:

	Name	Code	Total Daily Dose in Milligrams	Reg.	PRN
a.	_____	___	___.___	☐	☐
b.	_____	___	___.___	☐	☐
c.	_____	___	___.___	☐	☐
d.	_____	___	___.___	☐	☐

Long acting psychiatric medication:

		Code	Dose (MG)
e.	_____	___	___.___

Times Per:

wk	2 wks	3 wks	mo
1 ☐	2 ☐	3 ☐	4 ☐

50. Current psychiatric medications:

	Name	Code	Total Daily Dose in Milligrams	Reg.	PRN
a.	_____	___	___.___	☐	☐
b.	_____	___	___.___	☐	☐
c.	_____	___	___.___	☐	☐
d.	_____	___	___.___	☐	☐
e.	_____	___	___.___	☐	☐
f.	_____	___	___.___	☐	☐

Long acting psychiatric medication:

		Code	Dose (MG)
g.	_____	___	___.___

Times Per:

wk	2 wks	3 wks	mo
1 ☐	2 ☐	3 ☐	4 ☐

51. Is resident taking any non-psychiatric medication(s) that may mask symptoms of mental illness? . . . Yes ☐ No ☐

Specify _____

52. Is resident taking any non-psychiatric medication(s) that might mimic psychiatric symptoms? . . . Yes ☐ No ☐

Specify _____

CURRENT PLACEMENT POTENTIAL

53. If placed in the community could the resident:

	Independent	With Supervision	With Asst	Not Able
a. Obtain food	1 ☐	2 ☐	3 ☐	4 ☐
b. Prepare a meal	1 ☐	2 ☐	3 ☐	4 ☐
c. Obtain shelter	1 ☐	2 ☐	3 ☐	4 ☐
d. Clean residence	1 ☐	2 ☐	3 ☐	4 ☐
e. Obtain clothing	1 ☐	2 ☐	3 ☐	4 ☐
f. Do laundry	1 ☐	2 ☐	3 ☐	4 ☐
g. Take medication	1 ☐	2 ☐	3 ☐	4 ☐
h. Budget money	1 ☐	2 ☐	3 ☐	4 ☐
i. Keep clinic appointments	1 ☐	2 ☐	3 ☐	4 ☐
j. Seek medical assistance	1 ☐	2 ☐	3 ☐	4 ☐
k. Maintain employment	1 ☐	2 ☐	3 ☐	4 ☐
l. Use public transportation	1 ☐	2 ☐	3 ☐	4 ☐
m. Participate in community activities	1 ☐	2 ☐	3 ☐	4 ☐

54. If placed in the community would the resident refrain from:

a. Drug abuse	Yes ☐	No ☐
b. Alcohol abuse	Yes ☐	No ☐
c. Assaultive behavior	Yes ☐	No ☐
d. Verbal abuse	Yes ☐	No ☐
e. Inappropriate sexual behavior	Yes ☐	No ☐
f. Fire setting	Yes ☐	No ☐
g. Property destruction	Yes ☐	No ☐

55. Would the resident cooperate with placement in the community? . . . Yes ☐ No ☐

56. Has the resident been free of placement problems in the community? . . . Yes ☐ No ☐

a. Has the resident been treated in an NF/STP facility? . . . Yes ☐ No ☐

b. If yes, was the resident successful in the program? . . . Yes ☐ No ☐

57. Does the resident have friends or relatives to provide care in the community? . . . Yes ☐ No ☐

PHYSICAL HEALTH HISTORY

58. Current physical health problems:

- 0 ☐ None
- 1 ☐ Impaired Vision
- 2 ☐ Impaired Hearing
- 3 ☐ Impaired Speech
- 4 ☐ Hypertension
- 5 ☐ Cardiac Arrhythmia
- 6 ☐ Congestive Heart Failure (CHF)
- 7 ☐ Other Cardiovascular Disorders
- 8 ☐ Chronic Obstructive Pulmonary Disease (COPD)
- 9 ☐ Other Respiratory Disorders
- 10 ☐ Gastrointestinal Disorders
- 11 ☐ Genitourinary Disorders
- 12 ☐ Obesity
- 13 ☐ Diabetes
- 14 ☐ Thyroid Disorder
- 15 ☐ Other Endocrine Disorders
- 16 ☐ Cancer of Major Organ/System
- 17 ☐ Decubitus Ulcers
- 18 ☐ Fractures
- 19 ☐ Arthritis
- 20 ☐ Osteoporosis
- 21 ☐ Tardive Dyskinesia
- 22 ☐ Seizure Disorder
- 23 ☐ Alzheimer's Disease
- 24 ☐ Dementia other than Alzheimer's
- 25 ☐ Huntington's Disease
- 26 ☐ Parkinson's Disease
- 27 ☐ CVA-Stroke
- 28 ☐ Traumatic Brain Injury
- 29 ☐ Weakness/Paralysis
- 30 ☐ Multiple Sclerosis
- 31 ☐ Other _____

59. Skilled nursing procedures required:

- 0 ☐ None
- 1 ☐ Restraints
- 2 ☐ Oxygen Therapy
- 3 ☐ Ventilator/Respirator
- 4 ☐ Tracheostomy Care
- 5 ☐ Catheter/Ostomy Care
- 6 ☐ Dialysis
- 7 ☐ Intake/Output
- 8 ☐ Decubitus Care
- 9 ☐ Suctioning
- 10 ☐ IV Feeding/Fluids
- 11 ☐ Parenteral Medications
- 12 ☐ Tube Feeding
- 13 ☐ Special Diet
- 14 ☐ Incontinence Care
- 15 ☐ Physiotherapy
- 16 ☐ Insulin Treatment
- 17 ☐ Other _____

	Never	Occasionally	Frequently
60. Incontinence of urine	1 ☐	2 ☐	3 ☐
61. Incontinence of feces	1 ☐	2 ☐	3 ☐

62. Physical health aids used or required:

- 0 ☐ None
- 1 ☐ Eyeglasses
- 2 ☐ Hearing Aid
- 3 ☐ Dentures
- 4 ☐ Other _____

63. Ambulation:

Fully Independent	Unsteady	Uses Cane or Walker	Walks Only W/ Assistance	Uses Wheel Chair: Independently	Uses Wheel Chair: Must be Pushed	Chairfast or Needs Posey Support	Bedfast
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐

64. Personal care activities:

	Fully Independent	Needs Reminders	Needs Supervision	Needs Physical Assist	Needs Total Care
a. Bathing	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
b. Dressing	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
c. Grooming	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
d. Eating	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
e. Using Toilet	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

PHYSICAL EXAMINATION

	Yes	No
65. Physical examination within last 90 days	☐	☐

66. Date of last physical examination MM ____ DD ____ YYYY ____

67. Vital Signs:

a. Blood Pressure _____ c. Respiratory Rate _____

b. Pulse Rate _____

	Good	Fair	Poor
68. Physical Appearance	1 ☐	2 ☐	3 ☐

69. Systemic Examination:

	FINDING: Normal	FINDING: Abnormal	SOURCE: Exam	SOURCE: Record	SOURCE: Not Done
a. HEENT	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
b. Skin	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
c. Chest/Heart	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
d. Respiratory	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
e. Gastrointestinal	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
f. Rectal	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
g. Genitourinary	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
h. Musculoskeletal	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
i. Lymphatic	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
j. Neurological:					
1. Cranial nerves	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
2. Sensory	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
3. Motor	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
4. Reflexes	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
5. Gait	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

70. Physical Examination Comments:

_____

_____

_____

_____

_____

_____

71. **ADDITIONAL INFORMATION/CLARIFICATION OF CLINICAL INCONSISTENCIES/DIFFERENTIAL DIAGNOSIS:**

RECOMMENDATIONS

72. Indicate the rehabilitation potential of the resident . . . . . 1 ☐ Good 2 ☐ Fair 3 ☐ Poor

73. Indicate which of the following rehabilitative services will assist the resident to attain or maintain the highest practicable physical, mental, and psychosocial functioning.

	Currently Receiving	Recommended		Currently Receiving	Recommended
1. None	1 ☐	2 ☐	6. Family therapy	1 ☐	2 ☐
2. Psychotropic medication education/monitoring	1 ☐	2 ☐	7. Cognitive behavioral therapy	1 ☐	2 ☐
3. Independent medication management/training	1 ☐	2 ☐	8. ADL training/reinforcement	1 ☐	2 ☐
4. Individual psychotherapy	1 ☐	2 ☐	9. Rehabilitation activities	1 ☐	2 ☐
5. Supportive group psychotherapy	1 ☐	2 ☐	10. Substance rehabilitative services	1 ☐	2 ☐

11. Behavioral modification program for: _____
12. Other: Recommended _____

74. Indicate the recommended level of care for the resident's current physical and psychiatric status:

1 ☐ Acute psychiatric hospital
2 ☐ Psychiatric Health Facility (PHF)
3 ☐ Nursing facility with Specialized Treatment Program (STP)
4 ☐ Nursing facility
5 ☐ Board and care facility
6 ☐ Other _____

If 1 or 2 is selected, IMMEDIATELY (within 4 hours) fax the assessment (DMH 1733) to the Contractor's office for immediate attention.

EVALUATION INFORMATION AND CERTIFICATION

75. a. Evaluation time: _____ b. Round trip mileage: _____

76. LEVEL II EVALUATOR:

PRINT NAME (FIRST) _____ (LAST) _____ DATE MM ___ DD ___ YYYY ____

X _____ SIGNATURE TITLE _____

77. PHYSICAL HISTORY AND EXAMINATION CERTIFICATION:

PRINT NAME (FIRST) _____ (LAST) _____ DATE MM ___ DD ___ YYYY ____

X _____ SIGNATURE TITLE _____

78. PASARR/MI OVERALL CERTIFICATION BY BOARD ELIGIBLE/CERTIFIED PSYCHIATRIST:

PRINT NAME (FIRST) _____ (LAST) _____ DATE MM ___ DD ___ YYYY ____

X _____ SIGNATURE