PASRR PSYCHOSOCIAL EVALUATION

DATE:	
CLIENT NAME:	
SOCIAL SECURITY:	
DATE OF BIRTH:	
MEDICAID #:	(IF NO MEDICAID #, LEAVE BLANK)
REFERRING NURSING FACILITY OR AGENCY:	
PHONE:	

PSYCHOSOCIAL HISTORY AND MEDICAL NEEDS
PAST AND CURRENT LIVING ARRANGEMENTS (Lived alone, required community supports, assisted living facility, etc.):
EDUCATIONAL AND WORK HISTORY (Grades completed, special educational needs, work history):

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Estimated level of cognitive functioning:

☐Extremely Low ☐Borderline ☐Low Average ☐Average ☐Above Average ☐Superior

FAMILY AND SOCIAL HISTORY (Marital status, significant life events, legal history, hobbies, history of mental illness in family):

MEDICAL SUPPORT NEEDS (Durable medical equipment needed, in-home nursing services, hearing aids, glasses):

DAILY LIVING SUPPORTS AVAILABLE AND NEEDED (Family assistance, live-in aid, in-home nursing needed but not available):

CULTURAL, LANGUAGE, AND ETHNIC ORIGIN (and applicable adaptations required):

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ACTIVITIES OF DAILY LIVING/ IADL (RESIDENT'S ABILITY TO ACCESS COMMUNITY RESOURCES, COMMUNICATE, AND TO MANAGE PERSONAL FINANCES) (Ability to schedule a medical appointment, manage finances, communicate with others, available of transportation to community resources, shopping, laundry, housekeeping, etc):

PSYCHIATRIC/SUBSTANCE USE HISTORY

COMPLETE PSYCHIATRIC HISTORY (Include all psychiatric hospitalizations and outpatient treatments): COPIES OF DISCHARGE SUMMARIES FOR THE PAST TWO (2) YEARS ARE REQUIRED **IF AVAILABLE**:

PSYCHIATRIC DIAGNOSES WITH DATE OF ONSET (List all current psychiatric disorders and date of diagnosis **IF Available**:

SUBSTANCE USE/ABUSE HISTORY

(Inpatient and outpatient treatment with diagnoses and date of onset **IF Available**. Include substance name, method and frequency of use, duration of use and/or abstinence, and patient's insight regarding use):

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MENTAL STATUS EVALUATION				
ORIENTATION: Ask for the date (day, month, year, and day of the week) and current location. Record response as well as whether or not client is correct or incorrect:				
REGISTRATION: Name three objects (enter below) and have person repeat them back. Give one point for each correct answer on the first trial:				
1.	2.	3.		
Then repeat them (up to 6x) until all three are learned. [Number of trials:]				
ATTENTION AND CALCULATION: Ask the client to begin with 100 and count backwards by 7. Stop after five subtractions. Check correct answers:				
☐93	☐86	☐79	☐72	☐65
Alternatively spell “world” backwards if client unable or unwilling to do math:				
☐D	☐L	☐R	☐O	☐W
RECALL: Ask for the names of the three objects learned above. Check each correct answer:				
☐1.	☐2.	☐3.		
DESCRIPTION OF CURRENT ATTITUDES AND OVERT BEHAVIORS (Describe behaviors that may be suggestive of a serious psychiatric illness. See optional Behavioral Observation Checklist for possible descriptions):				

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MOOD AND AFFECT (If patient has s/s of depression you may use optional Geriatric Depression Scale):
SUICIDAL/HOMICIDAL IDEATION (Past and current, passive versus active ideations, last attempt, plan and means available to hurt self):
DEGREE OF REALITY TESTING (Presence and content of hallucinations and/or delusions, fixed or loose, command, etc.):
SUMMARY OF CLIENT'S STRENGTHS, WEAKNESSES AND NEEDS:

EVALUATOR'S DIAGNOSTIC IMPRESSIONS
Must include DSM-V Code:

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PLEASE COMPLETE THE FOLLOWING:

If the client **DOES NOT** have a primary diagnosis of dementia, but **DOES** have a primary or secondary diagnosis or a serious mental disorder[1], the client:

☐is ☐is not experiencing an acute episode of this serious mental disorder.

☐does ☐ does not require specialized services (the level of services provided in an institution for mental diseases or an inpatient psychiatric hospital).

☐is ☐is not dangerous to self or others.

1. **Major Mental Illness**: The definition for MI under these regulations is a psychiatric disorder of thought and/or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life (Schizophrenia, Depression, Major Affective Disorders, Schizoaffective Disorders, Atypical Psychosis, including any other DSM-V Psychotic Disorder. **Excludes**: Dementia, Alzheimer's Disease, Alcoholism, Substance Abuse,)

If specialized services for mental health (the level of services provided in psychiatric inpatient setting) are needed, identify all of these services to meet client's needs, regardless of availability of those services:

If specialized services for mental health are **NOT** needed, but client needs (or is receiving) other **mental health** services, please list these below:

COMMENTS:

Date of Evaluation:	Name of Mental Health Center:

Evaluator's signature:_____

PRINT NAME AND DEGREE:_____

Appearance:	☐Normal grooming/hygiene	☐Disheveled	☐Obese	
	☐Underweight	☐Bizarre	☐Other (describe):	
Attitude:	☐Calm	☐Cooperative	☐Guarded	☐Suspicious
	☐Hostile	☐Withdrawn	☐ Attentive	☐Other (describe):

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Facial Expression:	☐Sad ☐Happy ☐Vacant ☐Other (describe):
Eye Contact:	☐Good ☐Fair ☐Poor ☐Intermittent ☐Other (describe):
Motor Activity:	☐Unremarkable ☐Restless ☐Uncoordinated ☐Tics ☐Purposeless movement ☐Retardation ☐Hyperactive ☐ Other (describe):
Gait:	☐Unremarkable ☐Shuffles ☐Stiff ☐Leans ☐Brisk ☐Other:
Speech:	☐Normal ☐Rapid ☐Slow ☐Impaired Fluency ☐Loud ☐Aphasic ☐Mute ☐Dysphasic ☐Neologisms ☐Pressured ☐Other (describe):
Mood:	☐Euthymic ☐Anxious ☐Irritable ☐Depressed ☐Elevated ☐Angry ☐Other (describe):
Affect:	☐Full Range ☐Labile ☐Flat ☐Inappropriate ☐Blunted ☐Constricted ☐Appropriate ☐Other (describe):
Perception:	☐Hallucinations ☐Delusions ☐Illusions ☐Depersonalization ☐Derealization ☐None of the Above ☐Other (describe):
Thought Processes:	☐Goal-directed ☐Logical ☐Disorganized ☐Incoherent ☐Loose ☐Circumstantial ☐ Tangential ☐Illogical ☐Blocked ☐Flight of Ideas ☐Impoverished ☐Other (describe):
Thought Content:	☐Suicidal ☐Homicidal ☐Delusional ☐Obsessions ☐Compulsions ☐Phobias ☐Suspiciousness ☐Paranoia ☐Ideas of Reference ☐Somatic Preoccupation ☐Other (describe):
Attention/Concentration:	☐Unimpaired ☐Mildly Impaired ☐Moderately Impaired ☐Severely Impaired
Orientation:	☐Person ☐Place ☐Time ☐Situation
Abstract Reasoning:	☐Normal ☐Concrete ☐ Poor ☐Other:
Memory:	☐Intact ☐Impaired Recent ☐Impaired Remote ☐Impaired Immediate ☐ Confabulation
Insight:	☐Adequate ☐Poor/Minimal ☐ None/Denial ☐Other (describe):
Judgment:	☐Good ☐Fair ☐Poor ☐Other (describe):
Appetite:	☐Normal ☐Decreased ☐Increased ☐ Other:
Sleep:	☐No complaints ☐Interrupted ☐Early A.M. Waking ☐Insomnia ☐Medication Dependent ☐Hypersomnia ☐Other

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GERIATRIC DEPRESSION SCALE (GDS)			
Number	**Question**	**Response:**	
1.	Are you basically satisfied with your life?	☐Yes	☐No
2.	Have you dropped many of your activities and interests?	☐Yes	☐No
3.	Do you feel that your life is empty?	☐Yes	☐No
4.	Do you often get bored?	☐Yes	☐No
5.	Are you in good spirits most of the time?	☐Yes	☐No
6.	Are you afraid that something bad is going to happen to you?	☐Yes	☐No
7.	Do you feel happy most of the time?	☐Yes	☐No
8.	Do you often feel helpless?	☐Yes	☐No
9.	Do you prefer to stay at home, rather than going out and doing new things?	☐Yes	☐No
10.	Do you feel you have more problems with memory than most?	☐Yes	☐No
11.	Do you think it is wonderful to be alive now?	☐Yes	☐No
12.	Do you feel pretty worthless the way you are now?	☐Yes	☐No
13.	Do you feel full of energy?	☐Yes	☐No
14.	Do you feel that your situation is hopeless?	☐Yes	☐No
15.	Do you think that most people are better off than you are?	☐Yes	☐No
Total	**Score 1 point for each bolded answer:**	**/15**	

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