maximus

MISSISSIPPI PASRR
SERVICE MONITORING FORM

Providers are asked to complete and fax this form to Maximus (1.877.431.9568) when a quality study is requested.

Resident Name _____ Date of Birth _____ SSN _____

NF Name _____ NF City _____ Admit Date _____

A. Diagnosis (Complete all of A)

Current psychiatric and/or MR/DD diagnosis:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Medical Diagnoses:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Medical rehabilitative prognosis: ☐ good ☐ poor ☐ unknown

B. Psychotropic and Antidepressant Medications (including psychiatric medications, meds for dementia, seizures, and sleep disorders) Also Attach MDS

Medication	Dose MG/Day	Date Started	Response Y/N + any description

For the following Sections C-G, check symptoms present now or in the past 6 months. If present now or within the past 6 months, identify whether the behavior or symptom is typically present for that resident (whether the symptom represents the person's baseline)

C. Are Interpersonal and/or Personality Disorder Symptoms Present? ☐ N ☐ Y (if yes, complete below; if no, proceed to Section D)

Behavior present currently?	Present within the past 6 Months?	If present now or in the past 6 months, is this typical for the resident?		Behavior present currently?	Present within the past 6 Months?	If present now or in the past 6 months, is this typical for the resident?	
☐	☐	☐ Y ☐ N	Hostile	☐	☐	☐ Y ☐N	Inappropriate
☐	☐	☐ Y ☐ N	Refuses Care	☐	☐	☐ Y ☐ N	Anxiety/Fear of Others
☐	☐	☐ Y ☐ N	Resists Care	☐	☐	☐ Y ☐ N	Extreme hypersensitivity
☐	☐	☐ Y ☐ N	Withdrawn	☐	☐	☐ Y ☐ N	Expresses feelings of extreme jealousy
☐	☐	☐ Y ☐ N	Frequent Conflicts	☐	☐	☐ Y ☐ N	Anxiety/Fear of Others
☐	☐	☐ Y ☐ N	Avoids social situations	☐	☐	☐ Y ☐ N	Unstable relationships with others
☐	☐	☐ Y ☐ N	Agitation	☐	☐	☐ Y ☐ N	Frequent conflicts with others
☐	☐	☐ Y ☐ N	Suspicious without reason	☐	☐	☐ Y ☐ N	Believes others are exploiting, harming, deceiving, or betraying;
☐	☐	☐ Y ☐ N	Disruptive (yelling, throwing, hitting)	☐	☐	☐ Y ☐ N	Other:

D. Are Concentration or Cognition Issues Present? ☐ N ☐ Y (if yes, complete below; if no, proceed to Section E)

☐	☐	☐ Y ☐ N	Requires more assistance than s/he should with tasks	☐	☐	☐ Y ☐ N	Unable to complete tasks s/he should medically be able to complete

☐	☐	☐ Y ☐ N	Wanders	☐	☐	☐ Y ☐ N	Problems finding/using right words
☐	☐	☐ Y ☐ N	Difficulty concentrating	☐	☐	☐ Y ☐ N	Disoriented to person
☐	☐	☐ Y ☐ N	Confused	☐	☐	☐ Y ☐ N	Disoriented to place
☐	☐	☐ Y ☐ N	Fluctuating orientation	☐	☐	☐ Y ☐ N	Disoriented to time
☐	☐	☐ Y ☐ N	Short term memory loss	☐	☐	☐ Y ☐ N	Long term memory loss
☐	☐	☐ Y ☐ N	Short term memory loss	☐	☐	☐ Y ☐ N	Long term memory loss
☐	☐	☐ Y ☐ N	Other: _____	☐	☐	☐ Y ☐ N	Other:_____

If yes to any questions within this section, does the individual have a **diagnosis of dementia?** ☐ No ☐ Yes, If yes:
A) Was dementia diagnosis by: ☐ Attending MD ☐ Psychiatrist
B) Are symptoms worse in the late afternoon or evening? ☐ No ☐ Yes
C) Dementia diagnosis date: _____ D) Diagnostic Tests: _____

E. Are Mood Issues Present? ☐ N ☐ Y (if yes, complete below; if no, proceed to Section F)

Behavior present currently	Present within the past 6 Months?	If present now or in the past 6 months, is this typical for the resident?		Behavior present currently	Present within the past 6	If present now or in the past 6 months, is this typical for the resident?	
☐	☐	☐ Y ☐ N	Depressed Mood	☐	☐	☐ Y ☐ N	Changes in sleep patterns
☐	☐	☐ Y ☐ N	Loss of interest in previously enjoyed activities	☐	☐	☐ Y ☐ N	Feelings of worthlessness, helplessness, or guilt
☐	☐	☐ Y ☐ N	Weight gain or loss	☐	☐	☐ Y ☐ N	Difficulty concentrating
☐	☐	☐ Y ☐ N	Changeable, unpredictable, and rapidly switching emotions	☐	☐	☐ Y ☐ N	Mania (persistently elevated or irritable moods, reduced sleep, increased talkativeness, or inflated self-esteem)
☐	☐	☐ Y ☐ N	Fatigue and loss of energy	☐	☐	☐ Y ☐ N	Suicidal thoughts or feelings
☐	☐	☐ Y ☐ N	Expresses hopelessness or helplessness	☐	☐	☐ Y ☐ N	Frequent refusal to eat (or significant weight loss) and/or refuses medications
☐	☐	☐ Y ☐ N	Personality Changes	☐	☐	☐ Y ☐ N	Homicidal behaviors or history
☐	☐	☐ Y ☐ N	Other:_____	☐	☐	☐ Y ☐ N	Other: _____

F. Are Anxiety/Stress Symptoms Present? ☐ N ☐ Y (if yes, complete below; if no, proceed to Section G)

☐	☐	☐ Y ☐ N	Excessive anxiety, worry, or apprehension (not due to a medical condition)	☐	☐	☐ Y ☐ N	Persistent thoughts or memories prompting re-experiencing of a traumatic event.
☐	☐	☐ Y ☐ N	Excessive nervousness	☐	☐	☐ Y ☐ N	Extreme and irrational fear of things
☐	☐	☐ Y ☐ N	Persistent and unpleasant thoughts or ideas (obsessions)	☐	☐	☐ Y ☐ N	Repetitive actions (compulsions) believed to prevent a threatening event
☐	☐	☐ Y ☐ N	Intense terror/fear that strikes without warning	☐	☐	☐ Y ☐ N	Other:_____

G. Are Psychotic Symptoms Present? ☐ N ☐ Y (if yes, complete below; if no, proceed to Section H)

☐	☐	☐ Y ☐ N	Behaviors or speech which may appear eccentric, silly, or unusual.	☐	☐	☐ Y ☐ N	Incoherent, nonsensical, or loosely associated speech
☐	☐	☐ Y ☐ N	Delusions - Erroneous beliefs or misinterpretations (e.g., that s/he has certain powers or someone is attempting to cause harm	☐	☐	☐ Y ☐ N	Hallucinations - seeing, hearing, or sensing presence of others not there; may mumble or speak to no one in particular or become upset without reason
☐	☐	☐ Y ☐ N	Paranoia, such as feeling that others are trying to cause harm	☐	☐	☐ Y ☐ N	Other:_____

H. provider Treatments and Services (please respond to all questions in this section)

If no, explain:_____

1. How do symptoms affect the individual's ability to complete Activities of Daily Living?

- ☐ Psychiatric symptoms do not impact patient's ability to participate in ADLs
- ☐ Psychiatric symptoms marginally impact patient's ability to participate in ADLs
- ☐ Psychiatric symptoms significantly impair patient's ability to participate in ADLs

2. <u>What services are being provided to (or planned for) the individual by an outside provider not on staff or a consultant of the facility (such as a community mental health center provider)?</u>

Service provided by an <u>outside provider</u> that is not on staff or a consultant of the facility (<u>such as a mental health center</u>)	**Currently receiving**	**Frequency (approximate); Legend:** **A=** Every 4-6 months as needed **B=** Every 2-3 months as needed **C=** Every month as needed **D=** 2-3 times monthly **E=** Once weekly **F=** 2-3 times weekly **G=** 4-5 times weekly	**Most recent date of service; Legend:** **A=** Within the last week **B=** >1 week but < 1 mo **C=** > 1 mo but <2 mos **D=** > 2 mos but <3 mos **E=** >3 mos but <4 mos **F=** > 4 mos but <5 mos **G=** >5 mos but <6 mos **H=** >6 months	**Received over the past 6 months but not currently**	**Name of mental health provider agency (or community mental health center)**	**Services are planned but have not begun**
Psychiatric medication monitoring	☐	☐A ☐B ☐C ☐D ☐E ☐F ☐G	☐A ☐B ☐C ☐D ☐E ☐F ☐G ☐H	☐	_____	☐
Individual therapy	☐	☐A ☐B ☐C ☐D ☐E ☐F ☐G	☐A ☐B ☐C ☐D ☐E ☐F ☐G ☐H	☐	_____	☐
Family Therapy	☐	☐A ☐B ☐C ☐D ☐E ☐F ☐G	☐A ☐B ☐C ☐D ☐E ☐F ☐G ☐H	☐	_____	☐
Group Therapy by non-NF entity	☐	☐A ☐B ☐C ☐D ☐E ☐F ☐G	☐A ☐B ☐C ☐D ☐E ☐F ☐G ☐H	☐	_____	☐
Psychosocial Rehabilitation Services	☐	☐A ☐B ☐C ☐D ☐E ☐F ☐G	☐A ☐B ☐C ☐D ☐E ☐F ☐G ☐H	☐	_____	☐
Other (identify):	☐	☐A ☐B ☐C ☐D ☐E ☐F ☐G	☐A ☐B ☐C ☐D ☐E ☐F ☐G ☐H	☐	_____	☐

3. What behavioral health services <u>is the NF providing</u> currently or within the past 6 months:

Service provided by an NF provider or consultant	**Currently receiving**	**Received over the past 6 months but not currently**	**Services are planned but have not begun**	**Are these services provided by an employee of the agency?**	**If services are being provided by an outside provider that provides consulting to the NF, name the outside provider agency**
Psychiatric medication monitoring	☐	☐	☐	Y☐ N☐	_____
Supportive counseling	☐	☐	☐	Y☐ N☐	_____
Behavior plan	☐	☐	☐	Y☐ N☐	_____
Other (identify):	☐	☐	☐	Y☐ N☐	_____

4. Is the prior PASRR evaluation in the patient's record (floor record)? ☐ Yes ☐ No, but I was able to locate a copy ☐ No, it could not be located.

5. Are PASRR recommendations incorporated in Care Plan? ☐ Yes, they are currently incorporated ☐Yes, they were initially incorporated, but service needs have since changed ☐No ☐ Unknown because the document could not be located

Comments:_____

I. Psychiatric Services (please respond to all questions in this section)

1. List any inpatient psychiatric admissions. If the individual has been a long-term resident, limit the responses to the past 2 years:

Date	Circumstances, if known:
Date	Circumstances, if known:
Date	Circumstances, if known:
Date	Circumstances, if known:

J. Guardianship and Physician Information

Does the individual have a legal guardian? ☐ ***No*** ☐ ***Yes, legal guardian information is below:***

Legal Representative Last Name:_____ First Name:_____ Phone: _____

Street:_____ City:_____ State:_____ Zip:_____

Primary Physician's Name:_____ Phone: _____ Fax:_____

Street: _____ City:_____ State:_____ Zip:_____

Section K: Check all applicable information and attach records to this submission

Provide copies of any consultations or evaluations that support and/or substantiate the mental health, physical and/or behavioral change(s) noted on this form. Select attachments included

Required Documents if NF resident:

☐MAR ☐Plan of Care ☐MDS

Preferred Documents if available and/or applicable:

☐Physician's Notes ☐Nursing Notes/Summary ☐Medical Consultation(s) ☐Psychiatric Evaluation(s)

☐Intellectual Assessment(s) ☐Other (List): _____

Signature: _____ **Printed Name:**_____

Position: _____ **Facility:**_____

Phone:_____ **Date form was submitted to Maximus:**_____

Maximus use Only

Purpose:

☐ Quality Study
Service Monitoring

☐ Approved NF
Requires onsite Level II evaluation

Quality Reviewer Name: _____ Quality Reviewer Comments: _____	Date: _____

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