



**Colorado Pre-Admission Screening and Resident Review Program (PASRR)  
 Post Admission Level I Update (PAL I)**

Client Information		
First Name:	MI:	Last Name:
DOB:	SSN#:	Primary Language:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Prefers not to identify		
Nursing Facility Admission Date:		
Payer Source: <i>(if multiple, check all that apply)</i>		
<input type="checkbox"/> Medicaid <i>(if checked, enter Medicaid ID# _____)</i> <input type="checkbox"/> Medicare <input type="checkbox"/> Private Pay <input type="checkbox"/> Private Insurance <input type="checkbox"/> VA <input type="checkbox"/> PACE <input type="checkbox"/> Hospice <input type="checkbox"/> Other: _____ Primary Payer Source: _____		

Medical Information/Diagnosis
Section I – Trigger for Status Change
<input type="checkbox"/> Admitted without PAS Level I <input type="checkbox"/> PAS Level I missing a mental health diagnosis <input type="checkbox"/> PAS Level I missing psychiatric meds for a mental health diagnosis <input type="checkbox"/> Increase in Psychiatric Symptoms <input type="checkbox"/> New mental health diagnosis <i>(list date of diagnosis and name of person making diagnosis in comments section)</i> <input type="checkbox"/> Contradictory mental health diagnoses requiring clarification <input type="checkbox"/> New discovery of Intellectual/Developmental Disability <input type="checkbox"/> New or worsened serious symptoms – not due to Dementia or other organic condition <i>(see Section V)</i> <input type="checkbox"/> New category of psychiatric medication started for psychiatric diagnosis <i>(Beer's limit is not relevant)</i> <input type="checkbox"/> New or increased Psychiatric medications <b>for Dementia</b> over the Beer's limit or not on the Beer's list <input type="checkbox"/> Significant improvement in condition <input type="checkbox"/> Expiration of Time-Limited Approval at admission <i>(no Level II done)</i> Expiration date: _____  <input type="checkbox"/> Terminal Illness <input type="checkbox"/> 60-day Convalescent <input type="checkbox"/> Severity of Illness <input type="checkbox"/> 30-day PACE Respite <input type="checkbox"/> Provisional <input type="checkbox"/> Exempted Hospital Discharge <input type="checkbox"/> Rehab <i>(include a copy of the reviewer's approval)</i> <input type="checkbox"/> Expiration of Time-Limited Approval on Letter of Determination <i>(Level II was done)</i> Approval date of NOD: _____    Length of Approval: _____ <i>(include a copy of the Letter of Determination)</i> <input type="checkbox"/> Level II no longer representative of client's current condition <i>(include possible change in primary diagnosis status, facility suspects Level II is inaccurate, etc. in comments section)</i>

**Medical Information/Diagnosis**

**Section II: New Serious Symptoms**

- Self-Injurious Behavior
- Delusions/Hallucinations
- Suicidal Talk/Attempt (*within last 6 months*)
- Altercations (*evictions/unstable employment*)
- Physical Violence/Threat
- Aggressive/Belligerent Behavior
- Excessive Irritability
- Excessive Tearfulness
- Any safety issues for client or others
- Other (*explain in comments section*)

Provide Additional Information if Serious Symptoms Checked (*use comments section if needed*):

Reason for SNF admission/continued stay:

**Section III: Diagnosis of Major Mental Illness**

**IIIA. MMI diagnoses**

- \*Bipolar Disorder
- \*Major Depression or Dysthymic Disorder/Persistent Depressive Disorder (*if F32.9, provide more information in comment section*)
- \*Schizoaffective Disorder
- \*Unspecified Mood Disorder (*excludes Mood Disorder due to a medical condition*)
- Psychotic/Delusional Disorder Unspecified
- Schizophrenia or any Schizophrenia Spectrum Disorders (*including Unspecified*)

**IIIB. Other psychiatric diagnoses**

- \*Depression Mild or Situational (*includes adjustment disorder*)
- Anxiety Disorder
  - Panic Disorder
  - Obsessive-Compulsive Disorder
  - Generalized Anxiety Disorder
  - Unspecified Anxiety Disorder
- Posttraumatic Stress Disorder
- Personality Disorder
- Somatoform Disorder

**Last three GDS or PHQ-9 Scores and Date Completed (required for mood component diagnoses)**

Report score for diagnoses with an \* in 1A or 1B

- Unable to administer due to cognitive impairment

1. <input type="checkbox"/> GDS or <input type="checkbox"/> PHQ	Score:	Date completed:
2. <input type="checkbox"/> GDS or <input type="checkbox"/> PHQ	Score:	Date completed:
3. <input type="checkbox"/> GDS or <input type="checkbox"/> PHQ	Score:	Date completed:

**Section IV: Diagnosis of Dementia/Organic Condition**

- Alzheimer's Disease/Dementia
- Traumatic Brain Injury (TBI)
- Cerebrovascular Accident (CVA)
- Delirium
- Medication or substance-induced psychotic symptoms
- Other: \_\_\_\_\_
- None

**Medical Information/Diagnosis****If any of the above boxes are checked, report at least one of the scores below:** Brief Interview for Mental Status (BIMS)

1. Score:	2. Score:	3. Score:
Date Completed:	Date Completed:	Date Completed:

 Saint Louis University Mental Status (SLUMS)

1. Score:	2. Score:	3. Score:
Date Completed:	Date Completed:	Date Completed:

 Montreal Cognitive Assessment (MoCA)

1. Score:	2. Score:	3. Score:
Date Completed:	Date Completed:	Date Completed:

**IVA: Dementia Diagnosis, Collaborative Testing Mechanism used to Determine Presence/Progression**

- Dementia Workup/Neuropsychological Testing
- Comprehensive Mental Status Exam
- Health and physical
- Other (*explain in the comments section on page 4*)
- None

**Section V: Diagnosis of Intellectual/Developmental Disability (*known or suspected*)****If an IDD is present or suspected, a review will be required** Yes  No

If Yes, explain:

**Section VI: Psychiatric Medications Prescribed on a Regular Basis (*excluding meds for Anxiety and PRN's*)**Is this person currently prescribed psychiatric medications?  Yes  No (*if yes, list below*)

Has the person been prescribed psychiatric medications over the Beer's limit or not on the Beer's list, for Dementia?

 Yes  No (*if yes, list below*)New Category of Psychotropic Medication?  Yes  No (*if yes, list below*)

Current Medication:	Total Daily Dosage:	Date Started:	Diagnosis:	Reported to PASRR: <input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

*Ensure diagnoses listed for medications are actual diagnoses and not symptoms of the condition the medication is prescribed for.*



<b>Resident Symptom Checklist</b>			
<b>Symptoms</b>	<b>Appears to be Psychiatric</b>	<b>Appears to be Organic: CVA, Dementia</b>	<b>Unclear</b>
<b>PSYCHIATRIC SYMPTOMS</b> <i>(if symptom not present, do not check)</i>			
<b>SERIOUS SYMPTOMS</b>			
Aggressive/Belligerent Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Altercations <i>(evictions/incidents with other residents/ staff)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Tearfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Violence/Threat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Hospitalization <i>(in the past 6 months)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Injurious Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Talk/Attempt <i>(in the past 6 months)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>OTHER SYMPTOMS</b>			
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite/Weight Increased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite/Weight Decreased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased concentration/indecisiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased interest/pleasure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disorganized thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disrupted Sleep pattern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive sense of guilt or worthless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/loss of energy or motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandiose behavior or talk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mania/Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paranoia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent thoughts of death; ideation without realistic plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>BEHAVIOR CHANGES</b> <i>(not accounted for by a medical condition)</i>			
Bizarre behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Combative/Resistive to Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impaired decision-making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impaired judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intrusiveness, inappropriate sexual behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically abusive towards others/self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor impulse control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychomotor agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychomotor retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Verbally abusive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Special Concerns**

Note any special concerns that are **NOT caused by Dementia or other medical conditions.**  
*(Do not note concerns that have been present for a long time and/or do not cause significant distress or concerns for the resident, staff, or other residents.)*

**Concerning Depressive Symptoms**

- Changes in social behaviors (*isolating, decreased participation in social activities/outings, refusing visitors etc.*)
- Changes in completion of ADLs (*not wanting to bathe/shower, get dressed, eat meals etc.*)
- New expressed hopelessness, wishes for death without expressing suicidal thoughts, giving up on treatment, etc.

**Concerning Behavioral Issues**

- Unreasonably entitled/demanding or overly –dependent behavior that interferes with staff's ability to effectively complete duties and/or is disruptive to the general milieu or other residents
- Attempts to pit staff and/or family members against each other
- Blatant disregard for other residents' rights, property, feelings etc. and/or facility rules and norms
- Significant conflict in interpersonal interactions with staff, other residents, or visitors
- Unreasonably suspicious of others, believes he/she is being persecuted or violated, makes excessive accusations against others, etc.
- Self-destructive, impulsive behaviors (*self-injury, med-seeking/abusing behaviors, substance abuse on passes, etc.*)
- Harmful lack of boundaries with others (*intrusiveness, sexually provocative behaviors, instigating frequent arguments, intimidating or taking advantage of other residents, etc.*)
- Episodes of rage and/or aggression
- Suicidal threats or gestures which appear to be manipulative or attention-seeking in nature

**Concerning Thought Processes**

- Hallucinations/delusions that are causing significant fear or disruption to the resident's life/functioning
- Severely flat or inappropriate affect, lack of volition, catatonia etc.
- Significant disorganization in resident's speech/thought processes, which make it difficult to understand or meet his/her needs

**Concerning Anxious Symptoms**

Symptoms of anxiety (*panic attacks, Obsessive-Compulsive behaviors, posttraumatic stress reactions, worrisome thoughts*) are so significant, they:

- interfere with the resident's sleep, appetite, energy, or concentration,
- interfere with the resident's ability to adequately perform ADLs
- prevent or hinder the resident from leaving his/her room and/or interact with others
- cause somatic concerns (*headaches, stomach aches, muscle pain*) or cause/exacerbate medical conditions
- cause significant distress to resident or other residents around him/her

**Do you think a Level 2 is needed or would be helpful to staff at your facility?**

 Yes

 No

 Not Sure