Name: _____

TENNESSEE PREADMISSION SCREENING and RESIDENT REVIEW

Select Type: ☐ Pre-admission ☐ Resident Review ☐ Status Change
Select Type(s): ☐ MI ☐ MR ☐ RC

1. Demographics

Individual's Name _____ **Assessment Date** _____
(First) (Middle) (Last)

SS# _____ **Date of Birth** _____ **Age** _____

Marital status: ☐ Never married ☐ Married/cohabitating ☐ Divorced ☐ Separated ☐ Widowed

Individual's Address _____ **City** _____

State _____ **Zip** _____ **County** _____

Race: ☐ Caucasian ☐ American Indian ☐ Hispanic ☐ African American ☐ Asian or Pacific Islander
☐ Other _____

Gender: ☐ Male ☐ Female

Current Facility Name: _____

Address _____ **City** _____

State _____ **Zip** _____ **Phone/Fax** _____

Facility Type: ☐ Medical Hospital ☐ Psychiatric Hospital ☐ Nursing facility ☐ Home ☐ Community setting

Discharge Planner Name: _____ **Phone/Fax**: _____

Date of admission: _____ Reason for admission: _____

Residence for the past year including length of stay:
☐ Independent _____ ☐ With family _____ ☐ Board and care _____ ☐ Assisted living _____ ☐ NF _____
☐ Other (describe) _____

Legal status of individual: ☐ Legally competent adult ☐ Incompetent/family conservator ☐ Incompetent /Other conservator
Legal guardian _____ **Phone** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Primary physician _____ **Phone** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Documentation of interviews and information gathering including the individual.
Include successful contacts and unsuccessful attempts.

Contact's Name	Relationship to Individual	Date	Time	Duration	Nature of contact

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Name: _____

3. Psychiatric History

In total, including current psychiatric hospitalization, approximately how many psychiatric hospitalizations have occurred?

_____

Does the individual have a prior history of serious mental illness? ☐ Yes ☐ No ☐ Unknown

If **yes**, answer the following questions:

A. When did psychiatric symptoms first emerge? _____

B. What is the estimated frequency of decompensation episodes? _____

D. What is the typical intensity of episodes of decompensation? ☐ Mild ☐ Moderate ☐ Severe ☐ Unknown

E. What are the typical decompensation symptoms? Typical symptoms include: _____

_____

F. What is the date the most recent decompensation occurred? _____ ☐ Unknown

G. Does the individual have a history of suicide attempts, homicide attempts, or physical violence? ☐ Yes ☐ No

If ***yes***, explain the circumstances, including precipitating and resulting events, if known: _____

_____

Current and past mental health services received, and their frequency, include: (*check all that apply*):

Current	Past 1-6 Months	> Past 6 Months	Service	Typical Frequency
☐	☐	☐	None	
☐	☐	☐	Case Management	
☐	☐	☐	Psychiatrist	
☐	☐	☐	Individual therapy	
☐	☐	☐	Group therapy	
☐	☐	☐	Vocational therapy	
☐	☐	☐	Partial hospitalization/day treatment	
☐	☐	☐	Other, specify:	
☐	☐	☐	Inpatient psychiatric treatment	Date(s) of admission:

4. Behavioral Assessment (Check all that apply and describe seriousness below)

Check the behaviors exhibited within the past 30 – 180 days. If behaviors occurred *within the past 30 days*, note in the boxes below how frequently this behavior occurred.

	Within the past 30 days	Within 31-180 days?	Frequency if symptom was present the past 30 days		Within the past 30 days?	Within 31-180 days?	Frequency if symptom was present the past 30 days
Sadness/Depression ☐ **No mood related symptoms are present currently or have been present within the past 6 months**				**General and Interpersonal** ☐ **No behavioral or interpersonal concerns are present currently or have been present within the past 6 months**			
Tearfulness	☐	☐		Verbal aggression	☐	☐	
Feelings of hopelessness	☐	☐		Physical aggression/ Combative behaviors	☐	☐	
Feelings of worthlessness	☐	☐					
Suicidal thoughts	☐	☐		Destructive behaviors	☐	☐	
Suicidal threats	☐	☐		Threats toward others	☐	☐	
Suicide attempts/gestures	☐	☐		Resistance receiving care	☐	☐	
Medication refusal	☐	☐		Disruptive behaviors	☐	☐	
Refusal of food	☐	☐		Conflicts with others	☐	☐	
Euphoria	☐	☐		Inappropriate communication of anger	☐	☐	
Sleep disruption ☐Hypersomnia ☐Insomnia	☐	☐					
Lability/mood swings	☐	☐		Self-injurious/Self-abuse behaviors	☐	☐	
Mania	☐	☐					

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☐	**Absent or minimal symptoms** *(e.g., mild anxiety before an event)*, good functioning in all areas, interested/involved in a range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns *(e.g., an occasional argument with family members)*
☐	**Transient and expectable reactions to psychosocial stressors** *(e.g., difficulty concentrating after family argument)*, no more than slight impairment in social and/or occupational functioning.
☐	**Some mild symptoms** *(e.g., depressed mood and mild insomnia)* **OR** some difficulty in social or occupational functioning but generally functioning pretty well, has some meaningful interpersonal relationships.
☐	**Moderate symptoms** *(e.g., flat affect and circumstantial speech, occasional panic attacks)* **OR** moderate difficulty in social or occupational functioning *(e.g., few friends, conflicts with peers or co-workers)*.
☐	**Serious symptoms** *(e.g., suicidal ideation/plan, severe obsessional rituals, frequent shoplifting)* **OR** any serious impairment in social or occupational functioning *(e.g., no friends, unable to keep a job)* **OR** behavior is influenced by delusions or hallucinations **OR** serious impairment in communication or judgment *(e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation)* **OR** inability to function in almost all areas *(e.g., stays in bed all day, no job, home, or friends)* **OR** some danger of hurting self or others *(e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement)* **OR** fails to maintain minimal personal hygiene **OR** serious suicidal act with clear expectation of death.
☐	**Inadequate information/Unknown**

Who reported the intensity of the overall symptoms and/or behaviors?

☐ Direct Observation ☐ Individual Interview ☐ Family Interview ☐ Medical Record ☐ Interview with Staff ☐ Legal Guardian/ Conservator/Health Designee ☐ Other (specify)

Do you believe there is a *current* risk to the individual or others, based on psychiatric symptoms and behaviors?

☐ Yes ☐ No ☐ Unable to Assess

If ***yes*** or ***unable to assess,*** explain choice: _____

_____

Note the extent of psychiatric hospitalization required at the present time:

☐ ***Does not require (or no longer requires)*** inpatient psychiatric placement.

☐ ***Requires admission or continuation of inpatient psychiatric treatment.*** *(Mark this if the individual is psychiatrically unstable such that placement in the community or a NF could not occur. If the person is currently hospitalized, do not assume s/he needs to remain in that setting unless symptoms have not stabilized)*

Has an effective strategy been identified to manage these symptoms? ☐ Yes ☐ No If ***yes,*** describe the reported most effective strategy used to manage these symptoms: _____

_____

Are there other strategies not currently in place that may be useful in managing these symptoms? ☐ Yes ☐ No

If ***yes,*** based on your professional experience, what other strategies may be useful to manage the symptoms? _____

_____

Triggers and Decompensation

Are there important early signs of psychiatric or behavioral decompensation for caregivers to recognize? ☐ Yes ☐ No

If ***yes,*** describe these early signs: _____

Is a pattern of triggers identifiable? ☐ Yes ☐ No If ***yes,*** triggers that generally precede psychiatric or behavioral decompensation include: _____

_____

Are decompensation avoidance or recovery methods identifiable? ☐ Yes ☐ No If ***yes,*** explain how to ***avoids/ recovers from*** decompensation: _____

_____

Has a formal plan for mental health decompensation been developed in terms of who should be contacted, which hospital should admit, where to be treated, etc.? ☐ Yes ☐ No ☐ Unknown

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Mental Status Observations: *Observe during exam, interview, and while interacting in the current setting.*

Movements				
☐ Unremarkable	☐ Tremors	☐ Tics		☐ Akathisia
☐ Dystonia	☐ Abnormal movements	☐ Tardive Dyskinesia		
Speech				
☐ Clear	☐ Rapid	☐ Soft	☐ Slurred	☐ Monosyllabic
☐ Slow	☐ Pressured	☐ Monotone	☐ Loud	
Thought Process				
☐ Logical & linear	☐ Circumstantial	☐ Derailed	☐ Rapid	
☐ Incoherent	☐ Perseverations	☐ Concrete	☐ Blocked	
☐ Flight of ideas	☐ Tangential	☐ Loose		
Thought Content				
☐ Unremarkable	☐ Preoccupations associated with (specify):		☐ Ideas of reference associated with (specify):	
Oriented to				
☐ Person	☐ Place	☐ Time	☐ Situation	☐ Disoriented X 4

Appearance	☐ Well Groomed	☐ Unkempt	☐ Disheveled	☐ Malodorous
Memory:	☐ Intact (ST/LT)	☐ Adequate	☐ Poor	
Judgment:	☐ Appropriate	☐ Inappropriate		
Behavior:	☐ Appropriate	☐ Inappropriate	☐ Compulsive	
Attention:	☐ Adequate	☐ Short	☐ Distractible	
Affect:	☐ Appropriate	☐ Flat/Blunt	☐ Incongruent	☐ Shallow
Attitude:	☐ Cooperative	☐ Oppositional	☐ Agitated	☐ Guarded

Estimated IQ level: ☐ MR ☐ Low Average ☐ Average ☐ High Average

5. Testing Summary

TESTING: *Saint Louis University Mental Status Examination (SLUMS)* Score _____
☐ Refused test ☐ Physically unable to complete

WHO raw score: _____ WHO percentage Scores: _____

Are the tests an accurate reflection of this individuals current functioning? ☐ Yes ☐ No

If unable to test, provide a very clear rationale: _____

6. Axis I and II diagnoses

Axis I Diagnoses: Current Psychiatric diagnoses and most dementias

A. Diagnosis one: _____
☐ by respondent report
☐ by record

B. Diagnosis two: _____
☐ by respondent report
☐ by record

C. Diagnosis three: _____
☐ by respondent report
☐ by record

Axis II Diagnoses: Developmental and Intellectual Disability and Personality Disorders

A. Diagnosis one: _____
☐ by respondent report
☐ by record

B. Diagnosis two: _____
☐ by respondent report
☐ by record

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Name: _____

☐ Loss of head or extremity control ☐ Amputation (location):
☐ Other(specify): ☐ Joint repair/replacement—location: date:

Gait

☐ No issues ☐ Deformities affecting gait (specify):
☐ Shuffling ☐ History of falls; date of last fall:
☐ Unsteady ☐ Mobility/assistive device (specify):
☐ Physical therapy evaluation recommended
☐ Occupational therapy evaluation recommended

Endocrine System

☐ No issues ☐ Thyroid disease ☐ Chronic fatigue
☐ Excessive thirst ☐ Heat intolerance ☐ Night sweats
☐ Insulin Dependent Diabetes ☐ Cold intolerance ☐ Other (specify):
☐ Non-insulin Dependent Diabetes, controlled by: ☐ Medication ☐ Diet

Other conditions

☐ None Identified ☐ Hepatitis
☐ Fevers ☐ Terminal diagnosis (specify):
☐ Chills ☐ Other (specify):
☐ Cancer (specify type): _____ ☐ Chemotherapy ☐ Radiation ☐ Other treatment (specify):

Neurological

☐ No issues ☐ L-side weakness ☐ Cerebral Palsy
☐ Stroke ☐ L-side paralysis ☐ Multiple Sclerosis
☐ TIA ☐ R-side weakness ☐ Paraplegia
☐ ALS (Lou Gehrig's disease) ☐ R-side paralysis ☐ Quadriplegia
☐ Alzheimer's ☐ Other (specify):
☐ Head injury; if brain damage, note age of occurrence: ☐ Neurological exam recommended
☐ History of seizures (describe frequency) Date of last seizure: Medication controlled ☐ Yes ☐ No
If neurological issues are present, note whether the individual is: ☐ Left handed ☐ Right handed
☐ Chronic pain, specify location:

Please check and describe any of the following that may apply:

☐ Changes in eyelid symmetry such as drooping ☐ Weakness in jaw
☐ Weakness/Facial drooping ☐ Numbness in jaw
☐ Abnormal movements of tongue ☐ Pain in jaw
☐ Changes in sense of taste ☐ Changes in hearing
☐ Abnormal motion when turning head ☐ Weakness in arms
☐ Grossly uncontrolled movements ☐ Weakness in legs
☐ Abnormal muscle tone ☐ Weakness in hands
☐ Excessively slow movements ☐ Weakness in feet
☐ Alterations in response to pain/touch/temperature

List history of surgeries/serious illness/accidents: _____

List any other relevant medical history: _____

List current physician-ordered nursing services and medical treatments not listed previously: _____

Medical information was obtained from which of the following sources? *(check all that apply.)*

☐ Individual Interview ☐ Family Interview ☐ Medical Record ☐ Interview with Staff ☐ Legal Guardian/ Conservator/ Health Designee ☐ Other (specify)

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Transfer Ability to transfer		☐	☐	☐	☐

Check the column that best describes the individual's physical capacity to perform each IADL. Only one box per row may be selected. <u>Consider what type of assistance the individual would need to complete IADLs safely in the community. Rate current needs and not what is currently provided.</u>	***Specify Medical Condition(s) Impacting IADL Scoring***	***Always***	***Usually***	***Usually Not***	***Never***
Housework: The ability to make beds, clean the bathrooms, sweep and mop floors, dust, clean and store dishes, pick up clutter, and take out trash.		☐	☐	☐	☐
Telephoning: The ability to make and answer telephone calls.		☐	☐	☐	☐
Accessing Transportation: The ability to acquire and use transportation.		☐	☐	☐	☐
Managing legal and/or financial affairs: The ability to pay bills, write checks, balance a checkbook, access insurance and public benefits, and interact with the legal system.		☐	☐	☐	☐
Managing medical treatments and/or appointments: The ability to self-administer medical treatment and to schedule and attend appointments.		☐	☐	☐	☐
Shopping: Shopping reflects the individual's ability to prepare a shopping list and purchase groceries, clothing, and household items.		☐	☐	☐	☐
Meal preparation: Reflects the individual's ability to plan nutritional meals and cook any kind of food.		☐	☐	☐	☐
Personal laundry: Reflects the individual's ability to wash and dry clothing and personal items by machine or by hand.		☐	☐	☐	☐

8. Summary: *Summarize functioning and needs in the following areas.*

Summarize physical appearance & behavior: _____

Summarize social history:

Summarize psychiatric diagnostic and treatment history:

Does the individual have the potential for community placement within the next 6 months (if provided supportive services in the community)? ☐ Yes, **indicate services below** ☐ No

To be safe and healthy in a community placement at discharge from NF, she/he would need:

☐ **Environmental Management (Housecleaning, Heavy Chores, Yard work, Laundry)**
☐ Cleaning Service ☐ Lawn Service ☐ Assistive Technology ☐ Home Aide ☐ Other (specify)

☐ **Access to community resources (Transportation)**
☐ Public Transportation/Bus Pass ☐ Supported Public Transportation ☐ Arranged public transportation (taxi, car service)
☐ Family, Friends or Others ☐ Assistive Technology ☐ Other (specify) _____

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Name: _____

☐ **Shopping**
☐ Home Aide ☐ Family, Friends or Others ☐ Assistive Technology ☐ Other (specify) _____

☐ **Meal Preparation**
☐ Meals on Wheels ☐ Assistive Technology ☐ Family, Friends or Others ☐ Other (specify)_____

☐ **Behavioral Health Supports**
☐ Case Management ☐ Individual Therapy ☐ Psychiatrist ☐ Partial Hospitalization/ Day Treatment ☐ Group Therapy ☐ Other(specify) _____

Describe the types of supports the individual or family have used to maintain living in the community (i.e. specialists, nurse visits, personal assistance or home health): Include agency support:_____

_____

_____

If the individual is dangerous to self or others, explain safety needs:

_____

_____

Summarize the individual's positive traits/strengths:

_____

_____

Summarize the individual's needs or problem areas:

_____

_____

9. Individual Placement and Service Recommendations

Recommended Specialized Services

☐ **Mental Illness** Acute Inpatient Psychiatric Treatment	☐ **Mental Retardation** referral to DIDD Case Manager for Waiver placement

Recommended Rehabilitative Services to be provided in the Nursing Facility

☐ Training in ADLs	☐ Case management services to explore supported community living
☐ Training in Community living skills	☐ Family involvement in the individual's care
☐ Training in self-health care management	☐ Family therapy with a therapist trained in family group work.
☐ Education regarding medication compliance and/or side effects.	☐ Mental Health Counseling
☐ Occupational Therapy Evaluation	☐ Supportive counseling from NF staff
☐ Physical Therapy Evaluation	☐ Obtain archive psychiatric records to clarify history
☐ Audiological Evaluation	☐ Evaluation for a diagnosis of dementia, Alzheimer's, or other organic mental disorder
☐ Speech/Language Therapy	☐ A minimum of a yearly comprehensive psychiatric evaluation to clarify the current psychiatric diagnosis and appropriate treatments
☐ Vision Evaluation	☐ Ongoing evaluation of the effectiveness of current psychotropic medications on target symptoms
☐ Neurological examination	☐ A behaviorally-based treatment plan.
☐ Dental Evaluation	☐ A guardian/conservator for decisions regarding health and safety
☐ Vocational services	☐ Crisis Intervention Plan/Safety Plan
☐ Foreign language services	☐ A support group for substance abuse recovery (AA, NA, etc.)
☐ Services for the visually/hearing impaired	☐ Socialization/leisure/recreation activities
☐ Other:	☐ Other:

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Name: _____

MR and/or RC Assessment Supplement ☐ Not Applicable

Use this section for MR and/or RC evaluations only.

Date/age of onset of related condition_____ **Date/age of onset of mental retardation**_____

MR/RC services *currently* receiving: ☐ None

☐ Prevocational sheltered workshop ☐ Behavior management ☐ Case management ☐ OT
☐ Psychotropic medication monitoring ☐ Communication/speech ☐ Reading/writing skills ☐ PT
☐ Self-Help skills ☐ Community living skills ☐ Day treatment program in NF ☐ Speech Therapy
☐ Competitive employment ☐ Personal care ☐ Day treatment program outside NF ☐ ADL Assistance
☐ Individual habilitation planning ☐ Adaptive equipment _____

☐ Other _____

Describe services and frequency: _____

_____

MR/RC services *received in the past*: ☐ None

☐ Prevocational sheltered workshop ☐ Behavior management ☐ Case management
☐ Psychotropic medication monitoring ☐ Communication/speech ☐ Reading/writing skills
☐ Self-Help skills ☐ Community living skills ☐ Day treatment program in NF
☐ Competitive employment ☐ Personal care ☐ Day treatment program outside NF
☐ Individual habilitation planning ☐ Adaptive equipment _____

☐ Other _____

Describe services and frequency: _____

_____

_____

MR condition present according to AAMR definition? ☐ No MR ☐ Mild ☐ Moderate ☐ Severe ☐ Profound
☐ Evidence of MR before age 18 ☐ Suggestion of MR before age 18 ☐ No evidence of MR before age 18

Related condition/RC present? *(RC is a lifelong disability resulting in substantial impairments in intellectual or adaptive behavior)*
☐ Evidence of RC before age 22 ☐ Suggestion of RC before age 22 ☐ No evidence of RC before age 22

Name of related condition: _____

Substantial limitations present (in at least 3 of the following)
☐ Self Care ☐ Understanding of language ☐ Mobility ☐ Learning ☐ Self-direction ☐ Independent living

Current MR/RC treatment received: ☐ Medical Monitoring ☐ ADL assistance ☐ OT ☐ PT ☐ Other_____

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Name: _____

Saint Louis University Mental Status (SLUMS) Examination

Points	Questions
❑ 0 ❑1	1. What day of the week is it? (1 point for the right answer)
❑ 0 ❑1	2. What is the year? (1 point)
❑ 0 ❑1	3. What state are we in? (1 point)
4. Please remember these five objects. I will ask you what they are later: apple, pen, tie, house, car. (No points yet)	
5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.	
❑ 0 ❑1	o How much did you spend? (1 point)
❑ 0 ❑2	o How much do you have left? (2 points)
❑ 0 ❑1❑2❑3	6. Please name as many animals as you can in one minute. (No point for naming 0-4; 1 point for naming 5-9; 2 points for naming 10-14; and 3 points for naming 15 or more.)
❑ 0 ❑1❑2❑3 ❑ 4 ❑5	7. What were the five objects I asked you to remember? (1 point for each object remembered.)
8. I am going to say a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.	
❑ 0	o 87 (0 points)
❑ 0 ❑1	o 649 (1 point)
❑ 0 ❑1	o 8537 (1 point)
9. (Draw circle.) This circle represents a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.	
❑ 0 ❑2	o (2 points for hour markers labeled correctly)
❑ 0 ❑2	o (2 points for correct time)
❑ 0 ❑1	10. (Show a triangle, a square and a rectangle.) Please place an X in the triangle. (1 point)
❑ 0 ❑1	11. Which of those objects is the largest? (1 point)
12. I am going to tell you a story. Please listen carefully because afterward, I'm going to ask you some questions about it. Jill was a very successful stockbroker. She made a lot of money in the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped working and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.	
❑ 0 ❑2	o What was the female's name? (2 points)
❑ 0 ❑2	o When did she go back to work? (2 points)
❑ 0 ❑2	o What work did she do? (2 points)
❑ 0 ❑2	o What state did she live in? (2 points)
	Total

Scoring

High School Education		Less than High School Education
27-30	Normal	25-30
21-26	Mild Neurocognitive Disorder	20-24
1-20	Dementia	1-19

CLINICIAN'S SIGNATURE _____ DATE _____ TIME _____

SH Tariq, N Tumosa, JT Chibnall, HM Perry III, and JE Morley. The Saint Louis University Mental Status (SLUMS) Examination for detecting mild cognitive impairment and dementia is more sensitive than the Mini-Mental Status Exam (MMSE) – A pilot study. Am J Geriatr Psych 14:900-10, 2006

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