

471-000-225 Instructions for Completing Form DPI-OBRA2MR/RC. "Evaluation and Service Recommendation-MR/RC"

Use: Form DPI-OBRA2a is used for all annual resident reviews, following completion of a PASP or ARRP on Form DPI-OBRA2. Based on the previous evaluation on Form DPI-OBRA2, the information on Form DPI-OBRA2a provides updates and/or changes in information since the last PASARRP evaluation.

Number Prepared: One copy of Form DPI-OBRA2a is completed.

Completion: Form DPI-OBRA2a is completed by the mental health reviewer or QMRP as indicated on the form.

Signature: The mental health reviewer or QMRP signs and dates the form. The form must be countersigned by the validating professional for cases of serious mental illness.

Distribution: The CMHR or CBDDSP sends Form DPI-OBRA2a to the HHS/Contractor.

Retention: Form DPI-OBRA2a is retained for four years.

NEBRASKA PASARR MENTAL RETARDATION EVALUATION			FIRST MENTAL HEALTH, INC. 501 Great Circle Drive Nashville, TN 37228 FAX #: (615) 256-0788 PH #: (800) 598-6462		
Section I: IDENTIFYING DATA					
1. Name: Last First MI			2. Assessment Date		3. Date of Birth
4. Social Security #			5. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		6. Age
7. Assessment location/current living arrangement: <input type="checkbox"/> Home/alone <input type="checkbox"/> ICF/MR Setting			<input type="checkbox"/> Home/caregiver <input type="checkbox"/> Medical Hospital <input type="checkbox"/> NF <input type="checkbox"/> Other (Specify): _____		
8. Nursing facility/residence name and address			9. Permission for family interview from Patient or Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No Are Family Available? <input type="checkbox"/> Yes <input type="checkbox"/> No		10. Original NF admit date
11. Type of Assessment <input type="checkbox"/> PAS <input type="checkbox"/> ARR <input type="checkbox"/> Status Change		12. Source(s) of Information <input type="checkbox"/> Patient Interview <input type="checkbox"/> Other (Specify): _____ <input type="checkbox"/> Record/Document Review <input type="checkbox"/> Family Interview			13. Legal Representative or POA <input type="checkbox"/> Yes <input type="checkbox"/> No
14. Name, address and phone # of legal representative or Power of Attorney (specify relationship)				15. Primary physician name and address	
Section II: SOCIAL HISTORY/SOCIAL DEVELOPMENT					
1. Prim. Living Situation-Past Year <input type="checkbox"/> Independent <input type="checkbox"/> With Spouse/Family <input type="checkbox"/> Board and Care <input type="checkbox"/> NF <input type="checkbox"/> Other (Specify): _____ Length of Residence: _____		2. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married/Cohabiting <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown		3. Reason for Admission <input type="checkbox"/> Medical <input type="checkbox"/> Cognitive <input type="checkbox"/> ADL/ADL <input type="checkbox"/> Emotional <input type="checkbox"/> Other (Specify): _____	
4. Race/Ethnicity <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other (specify): _____					
5. Education <input type="checkbox"/> None <input type="checkbox"/> Elementary <input type="checkbox"/> Middle/Jr High <input type="checkbox"/> High School <input type="checkbox"/> Other _____					Special Education <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Social history					
A. Employment History (Positions Held/Length of Employment)					
B. Describe the individual's Vocational Skills/Ability to Sustain Work					
C. Current Social/Professional Support System (Relationships/Nature of Support)					
D. Briefly Describe the individual's Recreational/Leisure Time Activities					

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Name: _____

<p>7. Attitude</p> <p><input type="checkbox"/> Cooperative</p> <p><input type="checkbox"/> Oppositional</p> <p><input type="checkbox"/> Agitated</p> <p><input type="checkbox"/> Guarded</p>	<p>8. Response to interviewer</p> <p><input type="checkbox"/> Appropriately Responds</p> <p><input type="checkbox"/> Appropriately Initiates Dialogue</p> <p><input type="checkbox"/> Inappropriate Responses (describe) _____</p> <p><input type="checkbox"/> Other _____</p>
<p>9. Summary of social history:</p> <p>_____</p> <p>_____</p> <p>_____</p>	

SECTION III: FUNCTIONAL ASSESSMENT/PLACEMENT POTENTIAL

<p>1. Vision</p> <p>___ Adequate without aids</p> <p>___ Adequate with aids _____</p> <p>___ Little or no residual capacity</p> <p>___ Other _____</p> <p>3. Communication abilities</p> <p>___ Speech ___ Adaptive Equipment _____</p> <p>___ Gestures ___ Speech with Deficits _____</p> <p>___ No Deficits ___ No Residual Capacity _____</p> <p>5. Transfer</p> <p>___ Independent without assistance</p> <p>___ Independent with assistive devices _____</p> <p>___ Assistance of 1 or 2</p> <p>___ Immobile</p> <p>___ Other _____</p> <p>7. Bowel continence</p> <p>___ Continent ___ Usual Incontinence</p> <p>___ Occasional incontinence ___ Frequent incontinence</p> <p>___ Inappropriate continence ___ Incontinent</p> <p>___ On toileting schedule</p>	<p>2. Hearing</p> <p>___ Adequate without aids</p> <p>___ Adequate with aids _____</p> <p>___ Little or no residual capacity</p> <p>___ Other _____</p> <p>4. Comprehends others</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>6. Eating</p> <p>___ Independent ___ Supervisor/prompts</p> <p>___ Adaptive equipment ___ Refuses or appetite loss</p> <p>___ Tube or parenteral ___ On feeding program</p> <p>___ Independent after tray set up ___ Other _____</p> <p>8. Bladder continence</p> <p>___ Continent ___ Usual incontinent</p> <p>___ Occasional incontinence ___ Frequent incontinence</p> <p>___ Inappropriate continence ___ Incontinent</p> <p>___ On toileting schedule ___ Catheter</p>
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9. Identify level of assistance with the following

0 = Independent 1 = Prompts/supervision 2 = On training program 3 = Assistance of 1 or 2 4 = Total assistance

<p>___ A. Bathing</p> <p>___ B. Grooming</p> <p>___ C. Toileting</p> <p>___ D. Dressing</p> <p>___ E. Medication administration</p> <p>___ F. Use telephone</p> <p>___ G. Schedule own medical or mental health treatment</p>	<p>___ H. Treat own minor physical problems</p> <p>___ I. Use transportation</p> <p>___ J. Prepare meals</p> <p>___ K. Maintain an adequate diet</p> <p>___ L. Respond to emergency/ask for assistance</p> <p>___ M. Manage financial affairs</p> <p>___ N. Mobility (ID Method/Ability to use) _____</p>
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<p>10. Oral/nutritional</p> <p>___ No problems ___ Special diet _____</p> <p>___ Weight loss _____</p> <p>___ Fluid monitoring ___ Other _____</p>	<p>11. Therapies</p> <p>___ None ___ Speech/language ___ Audiological</p> <p>___ Physical ___ Occupational ___ Other</p> <p>Frequency _____</p>
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Name: _____

<p>12. Special Treatments</p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"> <input type="checkbox"/> None <input type="checkbox"/> Heparin lock <input type="checkbox"/> IV fluids <input type="checkbox"/> IV meds <input type="checkbox"/> Transfusions <input type="checkbox"/> Dialysis <input type="checkbox"/> Suctioning <input type="checkbox"/> Tracheostomy care <input type="checkbox"/> Gastrostomy care <input type="checkbox"/> NG tube </td> <td style="width:50%; border: none;"> <input type="checkbox"/> Decubiti <input type="checkbox"/> Aseptic dressing <input type="checkbox"/> Respiratory treatment/ oxygen therapy <input type="checkbox"/> Diabetic monitoring <input type="checkbox"/> Wound care <input type="checkbox"/> Ileostomy <input type="checkbox"/> Catheter care <input type="checkbox"/> Lung aspirations <input type="checkbox"/> Other _____ </td> </tr> </table>	<input type="checkbox"/> None <input type="checkbox"/> Heparin lock <input type="checkbox"/> IV fluids <input type="checkbox"/> IV meds <input type="checkbox"/> Transfusions <input type="checkbox"/> Dialysis <input type="checkbox"/> Suctioning <input type="checkbox"/> Tracheostomy care <input type="checkbox"/> Gastrostomy care <input type="checkbox"/> NG tube	<input type="checkbox"/> Decubiti <input type="checkbox"/> Aseptic dressing <input type="checkbox"/> Respiratory treatment/ oxygen therapy <input type="checkbox"/> Diabetic monitoring <input type="checkbox"/> Wound care <input type="checkbox"/> Ileostomy <input type="checkbox"/> Catheter care <input type="checkbox"/> Lung aspirations <input type="checkbox"/> Other _____	<p>13. Medical Conditions</p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"> <input type="checkbox"/> None <input type="checkbox"/> Comatose <input type="checkbox"/> Dizziness/vertigo <input type="checkbox"/> Edema <input type="checkbox"/> Fever <input type="checkbox"/> Fractures <input type="checkbox"/> Frequent falls <input type="checkbox"/> Hypertension (controlled) <input type="checkbox"/> Hypertension (uncontrolled) </td> <td style="width:50%; border: none;"> <input type="checkbox"/> Hypotension <input type="checkbox"/> Seizures (controlled) <input type="checkbox"/> Seizures (uncontrolled) (specify frequency _____) <input type="checkbox"/> Skin disorder <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ </td> </tr> </table>	<input type="checkbox"/> None <input type="checkbox"/> Comatose <input type="checkbox"/> Dizziness/vertigo <input type="checkbox"/> Edema <input type="checkbox"/> Fever <input type="checkbox"/> Fractures <input type="checkbox"/> Frequent falls <input type="checkbox"/> Hypertension (controlled) <input type="checkbox"/> Hypertension (uncontrolled)	<input type="checkbox"/> Hypotension <input type="checkbox"/> Seizures (controlled) <input type="checkbox"/> Seizures (uncontrolled) (specify frequency _____) <input type="checkbox"/> Skin disorder <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____																																								
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<p>14. Body control problems</p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"> <input checked="" type="checkbox"/> None <input type="checkbox"/> Balance loss <input type="checkbox"/> Unsteady gait <input type="checkbox"/> Gait disturbance <input type="checkbox"/> Loss of head or extremity control (specify) _____ <input type="checkbox"/> Other _____ </td> <td style="width:50%; border: none;"> <input type="checkbox"/> Contractures <input type="checkbox"/> Paralysis <input type="checkbox"/> Tremors <input type="checkbox"/> Amputation </td> </tr> </table>	<input checked="" type="checkbox"/> None <input type="checkbox"/> Balance loss <input type="checkbox"/> Unsteady gait <input type="checkbox"/> Gait disturbance <input type="checkbox"/> Loss of head or extremity control (specify) _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Contractures <input type="checkbox"/> Paralysis <input type="checkbox"/> Tremors <input type="checkbox"/> Amputation	<p>15. Restraint use</p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"> <input type="checkbox"/> None <input type="checkbox"/> Bed rails <input type="checkbox"/> Trunk restraint </td> <td style="width:50%; border: none;"> <input type="checkbox"/> Limb restraint <input type="checkbox"/> Gait chair <input type="checkbox"/> Wander guard </td> </tr> </table> <p>Frequency of above _____</p> <p>Purpose _____</p>	<input type="checkbox"/> None <input type="checkbox"/> Bed rails <input type="checkbox"/> Trunk restraint	<input type="checkbox"/> Limb restraint <input type="checkbox"/> Gait chair <input type="checkbox"/> Wander guard																																								
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<p>16. Medical status</p> <input type="checkbox"/> Condition/disease makes cognitive, ADL, or behavior status unstable <input type="checkbox"/> Current acute episode of a recurrent/chronic condition <input type="checkbox"/> Condition is stable	<p>17. Lab values: Any abnormal lab values within the past 90 days?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes (specify) _____ _____ _____																																												
<p>18. History of significant medical problems/treatment (attach additional page as needed):</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:35%;">Diagnosis/Condition</th> <th style="width:15%;">Onset Date</th> <th style="width:35%;">Medication(s)/Treatment</th> <th style="width:15%;">Status</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>		Diagnosis/Condition	Onset Date	Medication(s)/Treatment	Status																																								
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Name: _____

20. Identify individual's receptive and expressive communication capabilities:

Coding: Y = Yes N = No O = Occasionally

Y N O RECEPTIVE

- Turns head toward speaker
- Understands one-step instructions
- Understands multi-step instructions
- Initiates actions when instructed
- Shakes head/nods appropriately in response to questions
- Points to an item on request

Y N O EXPRESSIVE

- Summarizes topic/story logically
- Says at least ten words which can be understood
- Speaks in at least 3-4 word sentences

Expressive Deficits/Problems: _____

21. Identify individual's functional achievement in education:

Coding: Y = Yes N = No

Y N READING

- Can recognize/read simple words
- Can recognize/read 3-4 word sentences
- Can read at level of newspaper (approximately 8th grade)

Y N MATHEMATICS

- Can perform simple addition/subtraction
- Can perform simple multiplication/division

22. Explain whether the level of support needed for activities of daily living and medical needs can be provided in an alternative community setting (other than Nursing Facility)

23. Summarize the impact of medical problems on independent functioning

24. Comments

Section IV: SENSORIMOTOR DEVELOPMENT

1. Describe individual's capabilities with the following:

Coding: Y = Yes N = No O = Occasionally

Y N O Mobility Assistance Required

- None
- Needs assistive devices (specify) _____
- Needs help of one
- Needs help of two or more

Y N O Positioning

- Sits upright for 30 seconds with head/neck straight and steady
- Rolls over independently
- Moves to and from lying position

Y N O Gross Motor Dexterity

- Can reach for & lift a book
- Can brush own hair
- Can straighten up/correct position

Y N O Visual Motor Perception

- Can touch the evaluator's extended index finger
- Can copy a circle/square

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Name: _____

1. Describe individual's capabilities with the following (cont'd.):
Coding: Y = Yes N = No O = Occasionally

Y	N	O	Fine Motor Dexterity	Y	N	O	Eye/Hand Coordination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can pick up pencil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can touch nose with finger
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can button shirt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can extend both arms and touch index fingers together
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can feed self with fork				

2. Describe the extent to which prosthetic, orthotic, corrective, or mechanical supportive devices could improve individual's sensorimotor capability:

3. Identify the extent that corrective or adaptive devices could improve the individual's functional capabilities:

4. Comments

Section V: AFFECTIVE DEVELOPMENT (check all that apply)

<p>1. Emotional</p> <p><input type="checkbox"/> Easily Frustrated</p> <p><input type="checkbox"/> Easily Angered</p> <p><input type="checkbox"/> Mood Congruent</p> <p><input type="checkbox"/> Preoccupied</p> <p><input type="checkbox"/> Withdrawn</p> <p><input type="checkbox"/> Obsessive/Ritualistic</p> <p><input type="checkbox"/> Other _____</p>	<p>2. Judgment/Independent Decisions</p> <p><input type="checkbox"/> Can Select Own Clothing</p> <p><input type="checkbox"/> Can Respond Appropriately to Printed Signs</p> <p><input type="checkbox"/> Can Identify a Plan in an Emergency Situation</p> <p><input type="checkbox"/> Can Ask for Help When Needed</p> <p><input type="checkbox"/> Can Develop a Plan/Schedule For The Day</p> <p><input type="checkbox"/> Other _____</p>
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Section VI: SPECIALIZED SERVICES COMPARISON

1. Summarize the individual's ability/inability to:

A. Describe capabilities and limitations with ADLs/self-help skills (to include level of dependency on others/adaptive devices):

B. Describe ability to understand simple commands:

C. Describe expressive communication skills (verbal/gestural/alternative communication devices):

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Name: _____

D. Describe employment potential/limitations either independent and/or supportive:

E. Describe ability to learn new skills and the level of training which would be required:

Describe ability to generalize trained skills to other environments:

G. Describe orientation to time, situation and place:

H. Describe ability to make informed decisions (placement, medical, financial):

2. Describe overall developmental potential (include prior habilitative opportunities):

3. Comments:

Section VII: PARTICIPATION IN HOSPITAL OR COMMUNITY TREATMENT PROGRAMS

1. History of participation in MR/DD services:

Facility/Program	Date(s)	Purpose

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Name: _____

Section VIII: BEHAVIORAL ASSESSMENT

1. Behavioral Assessment: Check any conditions present within the past 6 months. Circle appropriate codes adjacent to identified conditions.

Frequency: H = hourly W = weekly D = daily M = monthly
Severity: MI = mild MO = moderate S = severe
Status: I = improved/resolved D = deteriorated C = chronic N = no change

Behavior	Frequency				Severity			Status			
___ Sadness	H	D	W	M	MI	MO	S	I	C	D	N
___ Tearfulness	H	D	W	M	MI	MO	S	I	C	D	N
___ Hopelessness	H	D	W	M	MI	MO	S	I	C	D	N
___ Worthlessness	H	D	W	M	MI	MO	S	I	C	D	N
___ Insomnia	H	D	W	M	MI	MO	S	I	C	D	N
___ Hypersomnia	H	D	W	M	MI	MO	S	I	C	D	N
___ Grief	H	D	W	M	MI	MO	S	I	C	D	N
___ Anxiety	H	D	W	M	MI	MO	S	I	C	D	N
___ Reclusiveness	H	D	W	M	MI	MO	S	I	C	D	N
___ Resistance	H	D	W	M	MI	MO	S	I	C	D	N
___ Hoarding	H	D	W	M	MI	MO	S	I	C	D	N
___ Stealing	H	D	W	M	MI	MO	S	I	C	D	N
___ Suicidal thoughts	H	D	W	M	MI	MO	S	I	C	D	N
___ Homicidal thoughts	H	D	W	M	MI	MO	S	I	C	D	N
___ None of the above											

Behavior	Frequency				Severity			Status			
___ Self-injurious	H	D	W	M	MI	MO	S	I	C	D	N
___ Physically aggressive	H	D	W	M	MI	MO	S	I	C	D	N
___ Verbally aggressive	H	D	W	M	MI	MO	S	I	C	D	N
___ Sexually aggressive	H	D	W	M	MI	MO	S	I	C	D	N
___ Uncooperative	H	D	W	M	MI	MO	S	I	C	D	N
___ Angry	H	D	W	M	MI	MO	S	I	C	D	N
___ Abrasive	H	D	W	M	MI	MO	S	I	C	D	N
___ PICA behavior	H	D	W	M	MI	MO	S	I	C	D	N
___ Destructive	H	D	W	M	MI	MO	S	I	C	D	N
___ Disruptive	H	D	W	M	MI	MO	S	I	C	D	N
___ Wandering	H	D	W	M	MI	MO	S	I	C	D	N
___ Confused	H	D	W	M	MI	MO	S	I	C	D	N
___ Suspicious	H	D	W	M	MI	MO	S	I	C	D	N
___ Medication refusal	H	D	W	M	MI	MO	S	I	C	D	N
___ None of the above											

2. Describe interventions used for problem behaviors identified, as well as the degree of response to those interventions:

3. Socialization

- | | | | |
|---------------------------------|---------------------------------|---------------------------------|-------------------------------|
| ___ Active participant | ___ No interaction | ___ Resists interactions | ___ Socially inappropriate |
| ___ Passive participant | ___ Initiates interactions | ___ Habitually disruptive | ___ Socially appropriate only |
| ___ Interacts only with prompts | ___ Offers assistance to others | ___ Attends facility activities | ___ with prompts |

Section IX: SERVICE DELIVERY

1. Currently Receiving:

- | | |
|---|---|
| <input type="checkbox"/> Prevocational/Sheltered Workshop | <input type="checkbox"/> Case Management |
| <input type="checkbox"/> Behavioral Management | <input type="checkbox"/> Psychotropic Medication Monitoring |
| <input type="checkbox"/> Communication/Speech | <input type="checkbox"/> Reading/Writing Skills Training |
| <input type="checkbox"/> Self-Help Skills | <input type="checkbox"/> Community Living Skills Training |
| <input type="checkbox"/> Day Treatment Program in NF | <input type="checkbox"/> Competitive Employment |
| <input type="checkbox"/> Day Treatment Program outside NF | <input type="checkbox"/> Adaptive Equipment (specify) _____ |
| <input type="checkbox"/> Personal Care | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Individual Habilitation Planning | <input type="checkbox"/> None |
| <input type="checkbox"/> Occupational or Physical Therapy | |

Describe services and frequency: _____

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Name: _____

Section X: SUMMARY

1. Diagnoses of Record

Axis I:	Primary _____	Secondary _____
Axis II:	Primary _____	Secondary _____
Axis III:	(Medical) _____	_____

2. Halted criteria:

Meets PASARR population:

- A. Has diagnosis of mental retardation
- B. Has a related condition (RC). RC is a chronic disability (e.g. cerebral palsy, epilepsy, or similar conditions other than MI) which substantially impairs intellectual OR adaptive functions, is manifested prior to age 22, likely to be indefinite, and substantially limits functioning in 3 or more of the following: self care, understanding/use of language, learning, mobility, self direction, & indep. living capacity.

Halted evaluation - Does not have diagnosis of mental retardation or a related condition. If this block is checked, complete 4-6 and sign and date the assessment.

3.A. Summary of Testing - Results of prior testing/diagnosis may be reported if: i) Evaluation is an ARR; ii) Evaluation is a PAS & prior testing was performed within the past 3 years, or; iii) Evaluation is a PAS & recent testing is not available but the individual is receiving MR/RC services from a community-based provider or ICF/MR.

If any of the above apply, complete A.I. and A.II. below and omit 3.B.

A.I.) Prior Intellectual Test results or diagnosis (reported level of IQ/cognitive functioning): _____
Protocol: _____ Test Date: _____

A.II.) Prior Adaptive Behavior Assessment (reported level of adaptive functioning): _____
Protocol: _____ Administrative Date: _____

3.B. Current Intellectual Testing - Psychological testing (and completion of this section) is required if all of the three elements in 3.A. (i-iii) are not applicable or if the accuracy of prior testing is questioned.

I.) Intellectual Test Protocol: _____ Test Date: _____
Test Scores: _____
Clinical estimation of cognitive functioning (interpretation of test scores). If not testable, explain reason and provide clinical impression of cognitive functioning: _____

II.) Adaptive Behavior Assessment (reported level of functioning): _____
Protocol: _____ Administrative Date: _____
Axis II Diagnosis: _____

Licensed Psychologist signature _____ Date: _____
(Required only if testing administered or if new Axis II diagnosis assigned)

4. Summary of medical and social history (include discussion of current medical and behavioral status):

5. Strengths (Internal/environmental capabilities): _____

6. Weakness (Internal/environmental limitations): _____

