



INDIANA PASARR PROGRAM  
 DEMENTIA ASSESSMENT CHECKLIST

State Form 47182 (R / 2-99) / BAIS 0029

This form shall become a CONFIDENTIAL RECORD upon completion in accordance with 42 CFR 483.100 et. al.

\* This State agency is requesting disclosure of your Social Security number, under 42 CFR 483.100 et. al. Disclosure is voluntary, and you will not be penalized for refusal.

Name of applicant / resident	Social Security number *	Date of birth
Name of nursing facility	Telephone number	
Address (number and street, city, state, ZIP code)		

DEMENTIA ASSESSMENT CHECKLIST

Federal PASARR regulations require documentation of a diagnosis of dementia (including Alzheimers Disease and related disorders) if an individual is excluded from PASARR / MI Level II assessment based on the dementia exclusion. An individual with a primary / principal diagnosis of a major mental illness (MI) or who is developmentally disabled (MR/DD) may not be excluded from Level II. To document the dementia diagnosis, the sections of this form may be completed or other documents which address the criteria in Sections 1-5 may be obtained. This documentation must be retained on the individual's active record in the NF. The purpose is to minimize the risk of overlooking potentially reversible conditions that may be causing or mimicking dementia.

If this form is used, ALL sections must be completed. At a minimum, the physician must sign and date the form. If sections are completed by different persons, the person completing it must also sign and date that part. Information must be current in that the condition has not changed since testing results were obtained. Information may be obtained from the physician's or hospital summaries, etc.

NOTE: The nursing facility is responsible to maintain on file acceptable documentation of dementia for any person for whom the exclusion is claimed.

1. DSM Criteria: For dementia, all areas must be checked "Yes".

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | A. Evidence of short-term and long-term memory loss.<br>(see part 2 below)              | <input type="checkbox"/> Yes <input type="checkbox"/> No | C. A & B significantly interferes with work or usual activity.  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | B. One or more of the following:  | <input type="checkbox"/> Yes <input type="checkbox"/> No | D. Not occurring exclusively during the course of delirium.   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 1. Impaired abstract thinking;  | <input type="checkbox"/> Yes <input type="checkbox"/> No | E. Insidious onset with generally progressive deteriorating course.   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. Impaired judgement;  | <input type="checkbox"/> Yes <input type="checkbox"/> No | F. Exclusion of other specific causes of dementia by history, physical and laboratory tests. (See parts 3-4 below). |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Other higher cortical dysfunction (e.g. aphasia, apraxia, constructional dyspraxia). |  |   |

2. Mental Status Examination: At least one must be checked. Enter results and interpretation. Attach an additional page if needed.

- |   |   |
|---|---|
| <input type="checkbox"/> Short Portable Mental Status Questionnaire (SPMSQ)                             | Score: _____ / _____ errors                 |
| <input type="checkbox"/> Folstein Mini Mental Status Exam   | Score: _____ / _____ errors                 |
| <input type="checkbox"/> Halstead-Reitan, Luria Nebraska or other neuropsychological assessment battery | _____                                       |
| <input type="checkbox"/> CAMCOG-Cambridge Cognitive Examination portion of CAMDEX                       | Score: _____ errors                         |
| <input type="checkbox"/> Kahn-Goldfarb MSQ; Face-Hand Test  | Score: MSQ _____ errors<br>FHT _____ errors |
| <input type="checkbox"/> CBRS-Cognitive Behavior Rating Scale   | Score: _____                                |
| <input type="checkbox"/> Mattis Dementia Rating Scale   | Score: _____                                |
| <input type="checkbox"/> Blessed Dementia Scale   | Score: _____                                |
| <input type="checkbox"/> Wechsler Tests (WAIS-R or WMS-R)   | Scores: _____<br>_____                      |
| <input type="checkbox"/> Other: _____   | Score: _____                                |

Interpretation(s):

Testing by: (If Mental Status Exam done by someone other than the physician)	Date (month, day, year)
Affiliation:	Credentials

(Continued on the reverse side)

DEMENTIA ASSESSMENT CHECKLIST (Continued)

3. MEDICAL PROCEDURES: Screening and laboratory procedures performed to either substantiate dementia or to rule out other possible causes of dementia. (Check all that have been completed and reviewed.)

- |  |  |                                    |
|--|--|------------------------------------|
| <input type="checkbox"/> Medication Review to rule out medication effects          | <input type="checkbox"/> Urinalysis                | <input type="checkbox"/> CBC       |
| <input type="checkbox"/> Vision / hearing problems                                 | <input type="checkbox"/> Electrolyte Panel         | <input type="checkbox"/> CT Scan * |
| <input type="checkbox"/> Environmental change                                      | <input type="checkbox"/> Screening Metabolic Panel | <input type="checkbox"/> MRI *     |
| <input type="checkbox"/> Assessment for depression and other psychiatric disorders | <input type="checkbox"/> B12 and Folate Levels     | <input type="checkbox"/> EEG *     |
| <input type="checkbox"/> Brain trauma / concussion                                 | <input type="checkbox"/> Chest Xray                | <input type="checkbox"/> PET *     |
| <input type="checkbox"/> ASHD / CHF / Alcoholism / Anemia / etc.                   | <input type="checkbox"/> Electrocardiogram         | <input type="checkbox"/> Biopsy *  |
| <input type="checkbox"/> Thyroid Function  | <input type="checkbox"/> Other: _____              |                                    |

Results / interpretation:


\* Not required. Record results if completed for purposes other than completion of this form.

4. PATIENT / FAMILY HISTORY: As complete a history as possible should be obtained to supplement the detection of occult medical illness in number 3 above: (NOTE: May be provided by family or other responsible party.)


5. OTHER PROCEDURES used to substantiate diagnosis or to rule out possible causes of dementia: (Indicate "None" if applicable.)  
Procedure(s):

Interpretation:


6. In your best judgment, is the dementia condition expected to be reversible, e.g., dementia following surgery, due to hypothyroidism, etc.? Or is it irreversible and anticipated to worsen?

- REVERSIBLE     IRREVERSIBLE    Comments: \_\_\_\_\_

If reversible, the NF should monitor and assure necessary services are provided for the individual's recovery.

7. Does the person have behavior problems?

- Yes     No

Is the person a danger to self or others?

- Yes     No

If Yes to number 7: Explain, including recommended strategies to deal with problems.


Information completed by (If other than the physician):

Name	Date (month, day, year)
Affiliation	Credentials

This documentation must be certified by the physician:

Signature of physician	Printed name of physician	Date (month, day, year)
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