



STATE OF TENNESSEE
 DEPARTMENT OF FINANCE AND ADMINISTRATION
 DIVISION OF INTELLECTUAL DISABILITIES SERVICES
 PASRR Coordinator
 ANDREW JACKSON BUILDING, 15th FLOOR
 500 DEADERICK STREET
 NASHVILLE, TENNESSEE 37243

DIDS REPORT FORM FOR CHANGE IN MENTAL/HEALTH STATUS

Background Information:

Patient Name: _____

Date of Birth: - - **Social Security Number:** : - -

TennCare/Medicaid Number: _____

Address: _____

Provider: _____

Provider Address: _____

Instructions: Please respond to the following questions by checking either "Yes" or "No."

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Has the resident had any previous evidence of mental illness?
<input type="checkbox"/>	<input type="checkbox"/>	2. Does the resident have any current signs or symptoms of mental illness? If yes, please check the items below that apply. <input type="checkbox"/> Affect changes <input type="checkbox"/> Delusions <input type="checkbox"/> Depression (Profound) <input type="checkbox"/> Hallucinations <input type="checkbox"/> Mood changes <input type="checkbox"/> Paranoia <input type="checkbox"/> Problems with orientation <input type="checkbox"/> Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	3. Are any of these symptoms more pronounced than is typical for this resident?
<input type="checkbox"/>	<input type="checkbox"/>	4. Please check and/or list any current and/or past medical /psychiatric diagnoses that the resident has received. <input type="checkbox"/> Anxiety <input type="checkbox"/> Autism <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Dementia <input type="checkbox"/> Depression <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Psychosis <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Other _____ _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	5. Has the resident experienced any significant changes in behavior? If yes, please describe the behavior including its onset and duration.
<input type="checkbox"/>	<input type="checkbox"/>	6. Is the resident a danger to self or others? <input type="checkbox"/> Self <input type="checkbox"/> Others <input type="checkbox"/> Both Please provide a brief description. _____ _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	7. Have there been any recent changes in the resident's medications? If yes, please describe the changes including dates of initiation or discontinuing therapy. If possible, please describe any relationship the medication changes have had on the resident's behavior.

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<input type="checkbox"/>	<input type="checkbox"/>	8. Has the resident recently experienced a sudden increase or decrease in weight? If yes, please describe the amount of weight change that has occurred, the time frame involved. Please include a description of the most likely reason for the change.
<input type="checkbox"/>	<input type="checkbox"/>	9. Has the resident had any significant changes in physical functioning or medical status? If yes, please describe the changes, including the onset and duration.
<input type="checkbox"/>	<input type="checkbox"/>	10. Has there been a neurological, history and/or physical evaluation performed within the past 6 to 12 months by a physician to rule out an organic or medical cause for this change in mental/health status? If yes, please submit the information with this form.

Additional information such as hospital records, physician notes or nursing notes that describe the resident's behavior may be included with this Change in Mental/Health Status request. Your facility should also include any consultations or evaluations that support and/or substantiate the mental health, physical and/or behavioral change(s) noted on this form. Thank you.

Required Signatures:

 Signature of RN or Social Worker Completing This Form

 Today's Date

Please Check Attachments Included:

- Physician's Notes Nursing Notes/Summary MAR Sheet(s) Hospital Records Medical Consultation(s)
 Psychiatric Evaluation(s) Intellectual Assessment(s) Other (Please explain): _____
