

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status:  M  S  W  D  Other:

Gender:  Male  Female Race:  Caucasian  African American  Asian  Hispanic  Other: \_\_\_\_\_

Payment Method:  Medicare  Private Pay  Medicaid Pending  Medicaid # \_\_\_\_\_  Status Change

Current Living Situation:  Nursing Facility: \_\_\_\_\_  Basic Care  Hospital  Other: \_\_\_\_\_

Current Location: \_\_\_\_\_ Admission Date: \_\_\_\_\_  N/A

Medical Facility  Psychiatric Facility  Nursing Facility  Community  Other: \_\_\_\_\_

Receiving Nursing Facility: \_\_\_\_\_ Date Admitting: \_\_\_\_/\_\_\_\_/\_\_\_\_

Receiving Nursing Facility Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Section I: MENTAL ILLNESS**

<p><b>1. Does the individual have any of the following Major Mental Illnesses (MMI)?</b></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Suspected: One or more of the following diagnoses is suspected (check all that apply)</p> <p><input type="checkbox"/> Yes: (check all that apply)</p> <p><input type="checkbox"/> Schizophrenia <input type="checkbox"/> Paranoid Disorder</p> <p><input type="checkbox"/> Schizoaffective Disorder</p> <p><input type="checkbox"/> Major Depression</p> <p><input type="checkbox"/> Psychotic/Delusional Disorder</p> <p><input type="checkbox"/> Bipolar Disorder (manic depression)</p>	<p><b>2. Does the individual have any of the following mental disorders?</b></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Suspected: One or more of the following diagnoses is suspected (check all that apply)</p> <p><input type="checkbox"/> Yes: (check all that apply)</p> <p><input type="checkbox"/> Personality Disorder</p> <p><input type="checkbox"/> Anxiety Disorder</p> <p><input type="checkbox"/> Panic Disorder</p> <p><input type="checkbox"/> Depression (mild or situational)</p>	<p><b>3. Does the individual have a diagnosis of a mental disorder that is not listed in #1 or #2? (do not list dementia here)</b></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes (if yes, enter the diagnosis(es) below):</p> <p><input type="checkbox"/> Diagnosis 1: _____</p> <p><input type="checkbox"/> Diagnosis 2: _____</p>
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**Section II: SYMPTOMS**

<p><b>4. Interpersonal– Currently or within the <u>past 6 months</u>, has the individual exhibited interpersonal symptoms or behaviors [not due to a medical condition]?:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Serious difficulty interacting with others</p> <p><input type="checkbox"/> Altercations, evictions, or unstable employment</p> <p><input type="checkbox"/> Frequently isolated or avoided others or exhibited signs suggesting severe anxiety or fear of strangers</p>	<p><b>4. Concentration/Task related symptoms – Currently or within the <u>past 6 months</u>, has the individual exhibited any of the following symptoms or behaviors [not due to a medical condition]?:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Serious difficulty completing tasks that she/he should be capable of completing</p> <p><input type="checkbox"/> Required assistance with tasks for which s/he should be capable</p> <p><input type="checkbox"/> Substantial errors with tasks in which she/he completes</p>	
<p><b>Adaptation to change–Currently or within the <u>past 6 months</u>, has the individual exhibited any symptoms in #6, 7, or 8 related to adapting to change?</b> <input type="checkbox"/> No (proceed to Section III) <input type="checkbox"/> Yes (complete 6-8)</p>		
<p><b>6.</b> <input type="checkbox"/> Self injurious or self mutilation</p> <p><input type="checkbox"/> Suicidal talk</p> <p><input type="checkbox"/> History of suicide attempt or gestures</p> <p><input type="checkbox"/> Physical violence</p> <p><input type="checkbox"/> Physical threats (with potential for harm)</p>	<p><b>7.</b> <input type="checkbox"/> Severe appetite disturbance</p> <p><input type="checkbox"/> Hallucinations or delusions</p> <p><input type="checkbox"/> Serious loss of interest in things</p> <p><input type="checkbox"/> Excessive tearfulness</p> <p><input type="checkbox"/> Excessive irritability</p> <p><input type="checkbox"/> Physical threats (no potential for harm)</p>	<p><b>8.</b> <input type="checkbox"/> Other major mental health symptoms (this may include recent symptoms that have emerged or worsened as a result of recent life changes as well as ongoing symptoms. Describe Symptoms: _____)</p>

**Section III: HISTORY OF PSYCHIATRIC TREATMENT**

<p><b>9. Currently or within the <u>past 2 years</u>, has the individual received any of the following mental health services?</b> <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes (the individual has received the following service[s]):</p> <p><input type="checkbox"/> Inpatient psychiatric hospitalization (if yes, provide date: _____)</p> <p><input type="checkbox"/> Partial hospitalization/day treatment (if yes, provide date: _____)</p> <p><input type="checkbox"/> Residential treatment (if yes, provide date: _____)</p> <p><input type="checkbox"/> Other: _____ (if yes, provide date: _____)</p>	<p><b>10. Currently or within the <u>past 2 years</u>, has the individual experienced significant life disruption because of mental health symptoms?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (check all that apply):</p> <p><input type="checkbox"/> Legal intervention due to mental health symptoms (date: _____)</p> <p><input type="checkbox"/> Housing change because of mental illness (date: _____)</p> <p><input type="checkbox"/> Suicide attempt or ideation (date[s]: _____)</p> <p><input type="checkbox"/> Other: _____ (date: _____)</p>
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**11. Has the individual had a recent psychiatric/behavioral evaluation?**  No  Yes (date: \_\_\_\_\_)

**Section IV: DEMENTIA**

<p><b>12. Does the individual have a diagnosis of dementia or Alzheimer's disease?</b></p> <p><input type="checkbox"/> No (proceed to 14) <input type="checkbox"/> Yes</p>	<p><b>13. If yes to #12, is corroborative testing or other information available to verify the presence or progression of the dementia?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (check all that apply):</p> <p><input type="checkbox"/> Dementia work up <input type="checkbox"/> Comprehensive Mental Status Exam <input type="checkbox"/> Other (specify): _____</p>
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Patient Last Name \_\_\_\_\_

Patient First Name \_\_\_\_\_

**Section V: PSYCHOTROPIC MEDICATIONS**

**14. Has the individual been prescribed psychoactive (mental health) medications now or within the past 6 months?**  No  Yes (list below) [use separate sheet if necessary] \* **Do not list medications if used for a medical diagnosis**

Medication	Dosage MG/Day	Diagnosis	Started	Ended

**VI: INTELLECTUAL DISABILITY & DEVELOPMENTAL DISABILITIES**

<b>15. Does the individual have a diagnosis of intellectual disability (ID)?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>16. Does the individual have presenting evidence of intellectual disability (ID) but it has not been diagnosed?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes
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<b>17. Is there presenting evidence of a cognitive or behavioral impairment prior or suspicion of ID condition that occurred prior to age 18?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>18. Has the individual ever received services from an agency that serves people affected by ID?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes – agency: _____
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<b>19. Does the individual have a diagnosis which affects intellectual or adaptive functioning?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes – (specify) <input type="radio"/> Autism <input type="radio"/> Epilepsy <input type="radio"/> Blindness <input type="radio"/> Cerebral Palsy <input type="radio"/> Closed Head Injury <input type="radio"/> Deaf <input type="radio"/> Other: _____	<b>20. Are there substantial functional limitations in any of the following?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (Specify) <input type="radio"/> Mobility <input type="radio"/> Self-Care <input type="radio"/> Self-Direction <input type="radio"/> Learning <input type="radio"/> Understanding/Use of Language <input type="radio"/> Capacity for living independently
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<b>21. Did this condition develop prior to age 22?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes
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**VII: EXEMPTION AND CATEGORICAL DECISIONS**

**(ASCEND MUST APPROVE USE OF CATEGORIES AND EXEMPTION PRIOR TO ADMISSION)**

**22. Does the admission meet criteria for 30 day Convalescence?**  No  Yes (meets all the following criteria:  
 Admission to NF directly from hospital after receiving acute medical care; and  
 Need for NF is required for the condition treated in the hospital, and  
 The attending physician has certified prior to NF admission the individual will require less than 30 calendar days of NF services.

\*Individuals meeting all criteria are exempt from a Level II screens for 30 calendar days. The NF must update the Level I and NF Level of Care screens at such time that is appears the individual’s stay will exceed 30 days. Screens must be update on or before the 30<sup>th</sup> calendar day.

**23. If the individual meets one of the 2 following criteria, s/he may be admitted for up to 7 calendar days:**  
 Provisional Emergency: emergency protective services situation necessitating NF care for no greater than 7 calendar  
 Provisional Delirium: presence of delirium precluded the ability to make accurate diagnosis and the patient’s Level I Screen will be updated no greater than 7 calendar days following admission.

**24. Additional Comments:** \_\_\_\_\_  
\_\_\_\_\_

**Section VIII: Guardianship & Physician Information**

**25. Does the individual have a legal guardian?**  No legal guardian.  Yes, legal guardian information is below:

Guardian Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Phone: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**26. Primary Physician’s Name:** \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Section IX: REFERRAL SOURCE SIGNATURE**

Print Name:	Signature:	Date: / /
Agency/Facility:	Phone:	Fax:

Enter online at [www.PASRR.com](http://www.PASRR.com)