Level I Pre-Admission Screening and Resident Review (PASRR)
COLORADO LEVEL I

First Name:________________________**Middle Initial:**________**Last Name:**_____________________________________

Mailing Address:__________________________________**City:**_________**State:**___**Zip:**_________**Phone:** ______________

Social Security #:___________-______-____________________**Date of Birth:**_________/______/____________________

Gender: ☐ **Male** ☐ **Female** **Race:** ☐ **Caucasian** ☐ **African American** ☐ **Asian** ☐ **Hispanic** ☐ **Other:**_______________

Current Location: ☐ ***Medical Facility** ☐ ***Psychiatric Facility** ☐ ***Nursing Facility** ☐**Community** ☐ **Other:**_________

Provide Admission Date*:______________________________Receiving Nursing Facility:**____________________________

Receiving Nursing Facility Address:________________________**City:**________________**State:**_________**Zip:**__________

Payment Method: ☐ **Medicare** ☐ **Private Pay** ☐ **Medicaid HMO** ☐ ****Medicaid Pending** ☐****Medicaid #**___________

** **Provide ULTC Scores if Medicaid or Medicaid Pending:**
Bathing_________**Dressing** _______**Toileting** ___________ **Mobility**______
Transfer_______ **Eating** _________ **Supervision Behaviors** _________ **Supervision Memory/Cognition** ____

Section I: MENTAL ILLNESS

1. Does the individual have any of the following Major Mental Illnesses (MMI)?
☐No
☐Suspected: One or more of the following diagnoses is suspected (check all that apply)
☐Yes: (check all that apply)
☐Schizophrenia ☐Paranoid Disorder
☐Schizoaffective Disorder
☐Major Depression
☐Psychotic/Delusional Disorder
☐Bipolar Disorder (manic depression)

2. Does the individual have any of the following mental disorders?
☐No
☐Suspected: One or more of the following diagnoses is suspected (check all that apply)
☐Yes: (check all that apply)
☐ Personality Disorder
☐ Anxiety Disorder
☐ Panic Disorder
☐ Depression (mild or situational) (provide GDS Score): _________

3. Does the individual have a diagnosis of a mental disorder that is not listed in #1 or #2? (do not list dementia here)
☐No
☐Yes (if yes, enter the diagnosis(es) below):
☐Diagnosis 1:______________
☐Diagnosis 2:_______________

Section II: SYMPTOMS

4. Interpersonal– Currently or within the past 6 months, has the individual exhibited interpersonal symptoms or behaviors [not due to a medical condition]?: ☐No ☐Yes
☐ Serious difficulty interacting with others
☐ Altercations, evictions, or unstable employment
☐ Frequently isolated or avoided others or exhibited signs suggesting severe anxiety or fear of strangers

5. Concentration/Task related symptoms – Currently or within the past 6 months, has the individual exhibited any of the following symptoms or behaviors [not due to a medical condition]? ☐No ☐Yes
☐Serious difficulty completing tasks that she/he should be capable of completing
☐Required assistance with tasks for which s/he should be capable
☐Substantial errors with tasks in which she/he completes

Adaptation to change–Currently or within the past 6 months, has the individual exhibited any symptoms in #6, 7, or 8 related to adapting to change? ☐No (proceed to Section III) ☐ Yes (complete 6-8)

6. ☐ Self injurious or self mutilation
☐ Suicidal talk
☐ History of suicide attempt or gestures
☐ Physical violence
☐ Physical threats (with potential for harm)

7. ☐ Severe appetite disturbance
☐ Hallucinations or delusions
☐ Serious loss of interest in things
☐ Excessive tearfulness
☐ Excessive irritability
☐ Physical threats (no potential for harm)
GDS Score: __(if any areas in #7 are marked)

8. ☐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:
____
____

Section III: HISTORY OF PSYCHIATRIC TREATMENT

9. Currently or within the past 2 years, has the individual received any of the following mental health services? ☐No
☐Yes (the individual has received the following service[s]):
☐Inpatient psychiatric hospitalization(if yes, provide date:__________)
☐Partial hospitalization/day treatment(if yes, provide date:__________)
☐Residential treatment (if yes, provide date:____________________)
☐ Other:____________________(if yes, provide date:__________)

10. Currently or within the past 2 years, has the individual experienced significant life disruption because of mental health symptoms? ☐No ☐Yes (check all that apply):
☐Legal intervention due to mental health symptoms (date:________)
☐Housing change because of mental illness(date:________________)
☐Suicide attempt or ideation (date[s]________________________)
☐ Other:______________ (date:____________________)

11. Has the individual had a recent psychiatric/behavioral evaluation? ☐No ☐Yes (date:_________________________)

Section IV: DEMENTIA

12. Does the individual have a diagnosis of dementia or Alzheimer's disease?
☐No (proceed to 15) ☐ Yes

13. If yes to #12, is corroborative testing or other information available to verify the presence or progression of the dementia? ☐No ☐Yes (check all that apply):
☐Dementia work up ☐Comprehensive Mental Status Exam ☐Other (specify):____________

Patient Last Name______________________________ Patient First Name_______________________________

DDM

14. If yes to 12, list currently prescribed antidepressant or antipsychotic medications listed on the Beer's List.

Medication	Dosage MG/Day	Refer to Beer's List
		Does dosage exceed Beer's List? ☐No ☐Yes
		Does dosage exceed Beer's List? ☐No ☐Yes
		Does dosage exceed Beer's List? ☐No ☐Yes

Section V: PSYCHOTROPIC MEDICATIONS

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

***Note: If screen is entered on PASRR.com, medication will automatically be scored to determine whether further screening and referral to DDM is required.**

Medication	Dosage MG/Day	Diagnosis	Started	Ended

VI: MENTAL RETARDATION & DEVELOPMENTAL DISABILITIES

16. Does the individual have a diagnosis of mental retardation (MR) or developmental disability (DD)? ☐No ☐Yes

17. Does the individual have any history of MR or DD? ☐No ☐Yes

18. Is there presenting evidence of a cognitive or behavioral impairment prior to age 22 or suspicion of MR condition that occurred prior to age 18? ☐No ☐ Yes

19. Has the individual ever received services from an agency that serves people affected by MR/DD? ☐No ☐ Yes – agency:_____________________________

VII: EXEMPTION AND CATEGORICAL DECISIONS
(DDM MUST APPROVE USE OF CATEGORIES AND EXEMPTION PRIOR TO ADMISSION)

20. Does the admission meet criteria for Hospital Exemption?
☐No
☐Yes (meets all the following **and** has a known or suspected MMI or MR/DD):

- Admission to NF directly from hospital after receiving acute medical care, and
- Need for NF is required for the condition treated in the hospital (specify condition: ________________, and
- The attending physician has certified prior to NF admission the individual will require less than 30 calendar days of NF services –and- the individual's symptoms or behaviors are stable. Physician Name: ___________________
  Physician Phone:___________________
  Physician Licenses #:________________

22. Does the admission meet the criteria for Terminal Illness?
☐No
☐Yes (Has a known or suspected MMI or MR/DD and MD has certified in writing that the patient has 6 months or less to live. The physician signed certification must be submitted to DDM via facsimile within 6 business hours of submission of this form)

23. Does the admission meet the criteria for Severity of Illness?
☐No ☐Yes (Has a known or suspected MMI or MR/DD and is ventilator dependent or comatose unresponsive)

24. Does the admission meet criteria for 60 day Convalescence?
☐No ☐Yes (meets all the following and has a known or suspected MMI or MR/DD): ☐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 60 calendar days of NF services

21. Additional Comments:____
____

Section VIII: OUTCOME

25. Are any of the following numbers marked yes or, if applicable, suspected: 1, 6, 7, 9, 10, 14, 15, 16, 17, 18, or 19?	☐No ☐Yes
26. Check yes if #2 is marked yes or suspected and any areas in #4-7 are marked	☐No ☐Yes
27. Check yes if #4 or 5 or (any areas in) #7 are marked affirmatively and # 12 is no	☐No ☐Yes

28. Are any of #25-27 marked yes? ☐ No **(if No, NO further screening is required. Proceed to Section IX)**
☐ Yes (if yes, complete guardianship information and proceed to Section IX). **Screening information must be faxed to DDM for a determination of whether further screening is required or you can go to www.PASRR.com for screening results.**
Provide a copy of this form to the individual and, if applicable, guardian.

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

Guardian Last Name_______________________________ First Name____

Street____ City____________ State___________ Zip_________________

Section IX: REFERRAL SOURCE SIGNATURE

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

PASRR Authorization #: ____________ **Section X: DDM OUTCOME: DDM USE ONLY**

Level I Approved:☐ Level I Approved with Follow-up☐ **Level II Required:**_☐MI__☐MR/DD_☐Dual Exemption Approved ☐ Categorical ☐

Dual Diagnosis Management ◆ 227 French Landing Drive, Suite 250 ◆ Nashville, TN 37228 ◆ ph: 877.431.1388 ◆ Fax: 877.431.9568