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

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 ☐ Medicaid Pending ☐ Medicaid #_____________________
☐ Hospice ☐ PACE ☐ 30 Day PACE Respite

** 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
☐ Schizoaffective Disorder
☐ Major Depression
☐ Psychotic/Delusional Disorder
☐ Bipolar Disorder (manic depression)
☐ Paranoid Disorder

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____

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
(ASCEND 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 - **Screening information must be submitted to Ascend online at www.PASRR.com for a determination of whether further screening is required.**

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: ASCEND OUTCOME: ASCEND USE ONLY**

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

www.PASRR.com Revised 3.15.2010