

PROVIDERS ARE ASKED TO COMPLETE AND RETURN THIS FORM WHEN A DOCUMENT-BASED REVIEW, TRANSFER FROM A PASRR-RESTRICTED NF ADMISSION, OR QUALITY STUDY IS REQUESTED.

A. DEMOGRAPHICS				B. MDS SIGNIFICANT STATUS CHANGE			
Admit Date: NF Name: NF City:				<input type="checkbox"/> No significant status change on the MDS since the PASRR <input type="checkbox"/> Significant status change on the MDS since the PASRR <input type="radio"/> Medical <input type="radio"/> Psychiatric Comments:			
C. DEMENTIA				D. DIAGNOSIS			
Does the individual have a diagnosis of dementia ? <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes: A) Was diagnosis by: <input type="checkbox"/> Attending MD <input type="checkbox"/> Psychiatrist B) Are symptoms worse in the late afternoon or evening? <input type="checkbox"/> No <input type="checkbox"/> Yes C) Diagnosis date _____ D) Diagnostic tests conducted:				Current psychiatric and/or MR/DD diagnosis: Medical Diagnoses: Medical rehabilitative prognosis: <input type="checkbox"/> good <input type="checkbox"/> poor <input type="checkbox"/> unknown			
E. MEDICAL/FUNCTIONAL							
Treatments <input type="checkbox"/> Suctioning <input type="checkbox"/> Trach care <input type="checkbox"/> Feeding Tube <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> Respiratory therapy <input type="checkbox"/> IV therapy <input type="checkbox"/> Oxygen <input type="checkbox"/> Dialysis <input type="checkbox"/> Peritoneal <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Pressure/stasis ulcers <input type="checkbox"/> Skin lesions/surgical wounds Admission weight _____ Current Weight _____ Overall ADL Assist Needs <input type="checkbox"/> None <input type="checkbox"/> Supervision <input type="checkbox"/> Limited <input type="checkbox"/> Extensive <input type="checkbox"/> Dependent Medication Assistance <input type="checkbox"/> None <input type="checkbox"/> supervision/prompts <input type="checkbox"/> Insulin admin by nursing <input type="checkbox"/> insulin sliding scale <input type="checkbox"/> subcutaneous <input type="checkbox"/> Central or peripheral venous line or port				Dressing & Personal Hygiene <input type="checkbox"/> None <input type="checkbox"/> Supervision <input type="checkbox"/> Limited Assist <input type="checkbox"/> Extensive Assist <input type="checkbox"/> Dependent Transfer, Walking, Locomotion <input type="checkbox"/> None <input type="checkbox"/> Supervision <input type="checkbox"/> Limited Assist <input type="checkbox"/> Extensive Assist <input type="checkbox"/> Dependent Recent falls? <input type="checkbox"/> No <input type="checkbox"/> Yes Eating <input type="checkbox"/> None <input type="checkbox"/> Supervision <input type="checkbox"/> Limited Assist <input type="checkbox"/> Extensive Assist <input type="checkbox"/> Dependent Continence <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Requires Assist <input type="checkbox"/> Ostomy/ileal conduit <input type="checkbox"/> indwelling/suprapubic catheter <input type="checkbox"/> Intermittent <input type="checkbox"/> CAPD			
F. PSYCHOTROPIC AND ANTIDEPRESSANT MEDICATIONS (INCLUDING PSYCHIATRIC MEDICATIONS, MEDS FOR DEMENTIA, SEIZURES, AND SLEEP DISORDERS)							
Medication		Dose MG/Day		Date Started		Response Y/N + any description	
G. INTERPERSONAL: CHECK SYMPTOMS PRESENT NOW OR IN THE PAST 6 MONTHS. IF APPLICABLE, IDENTIFY WHETHER THAT SYMPTOM IS A BASELINE BEHAVIOR.							
Current symptom?	Symptom Within the past 6 Mos	Is this a baseline symptom? (answer if either current or 6 months is marked)		Current symptom?	Symptom Within the past 6 Mos	Is this a baseline symptom? (answer if either current or 6 months is marked)	
		<input type="checkbox"/> Y <input type="checkbox"/> N	Sociable			<input type="checkbox"/> Y <input type="checkbox"/> N	Hostile
		<input type="checkbox"/> Y <input type="checkbox"/> N	Cooperative			<input type="checkbox"/> Y <input type="checkbox"/> N	Refuses Care

		<input type="checkbox"/> Y <input type="checkbox"/> N	Appropriate			<input type="checkbox"/> Y <input type="checkbox"/> N	Resists Care
Current symptom?	Symptom Within the past 6 Mos	Is this a baseline symptom? (answer if either current or 6 months is marked)		Current symptom?	Symptom Within the past 6 Mos	Is this a baseline symptom? (answer if either current or 6 months is marked)	
		<input type="checkbox"/> Y <input type="checkbox"/> N	Attends Activities			<input type="checkbox"/> Y <input type="checkbox"/> N	Conflicts
		<input type="checkbox"/> Y <input type="checkbox"/> N	Withdrawn			<input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety/Fear of Others
		<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent Conflicts			<input type="checkbox"/> Y <input type="checkbox"/> N	Suicidal Ideation
		<input type="checkbox"/> Y <input type="checkbox"/> N	Inappropriate			<input type="checkbox"/> Y <input type="checkbox"/> N	Homicidal Ideation

H. CONCENTRATION

CHECK SYMPTOMS PRESENT NOW OR IN THE PAST 6 MONTHS. IF APPLICABLE, IDENTIFY WHETHER THAT SYMPTOM IS A BASELINE BEHAVIOR

		<input type="checkbox"/> Y <input type="checkbox"/> N	Cannot complete tasks s/he should medically be able to complete			<input type="checkbox"/> Y <input type="checkbox"/> N	Psychosis with paranoia hallucinations, delusions
		<input type="checkbox"/> Y <input type="checkbox"/> N	Requires more assistance than s/he should with tasks			<input type="checkbox"/> Y <input type="checkbox"/> N	Changeable, unpredictable, and rapidly switching emotions
		<input type="checkbox"/> Y <input type="checkbox"/> N	Concentration difficulties			<input type="checkbox"/> Y <input type="checkbox"/> N	Disruptive behaviors (yelling, throwing, hitting, wandering)
		<input type="checkbox"/> Y <input type="checkbox"/> N	Personality Changes			<input type="checkbox"/> Y <input type="checkbox"/> N	Problems finding/using right words

I. COGNITION

		<input type="checkbox"/> Y <input type="checkbox"/> N	Alert			<input type="checkbox"/> Y <input type="checkbox"/> N	Confused
		<input type="checkbox"/> Y <input type="checkbox"/> N	Intact Memory			<input type="checkbox"/> Y <input type="checkbox"/> N	Fluctuating orientation
		<input type="checkbox"/> Y <input type="checkbox"/> N	Oriented to person			<input type="checkbox"/> Y <input type="checkbox"/> N	Short term memory loss
		<input type="checkbox"/> Y <input type="checkbox"/> N	Oriented to place			<input type="checkbox"/> Y <input type="checkbox"/> N	Long term memory loss
		<input type="checkbox"/> Y <input type="checkbox"/> N	Oriented to time			<input type="checkbox"/> Y <input type="checkbox"/> N	Other:

J. MOOD DISORDERS

Are mood related symptoms present? N Y

(if yes, complete questions in this section by marking those that are current or within the past 6 months. For those marked, then identify whether they are baseline)

		<input type="checkbox"/> Y <input type="checkbox"/> N	Depressed Mood			<input type="checkbox"/> Y <input type="checkbox"/> N	Changes in sleep patterns
		<input type="checkbox"/> Y <input type="checkbox"/> N	Loss of interest in previously enjoyed activities			<input type="checkbox"/> Y <input type="checkbox"/> N	Feelings of worthlessness, helplessness, or guilt
		<input type="checkbox"/> Y <input type="checkbox"/> N	Weight gain or loss			<input type="checkbox"/> Y <input type="checkbox"/> N	Difficulty concentrating
			Fatigue and loss of energy				Suicidal thoughts or feelings
		<input type="checkbox"/> Y <input type="checkbox"/> N	Psychosis, such as feeling that others are trying to cause harm (also called paranoia), overvalued ideas, delusions or seeing, hearing, or sensing the presence of others not actually there (also called hallucinations)			<input type="checkbox"/> Y <input type="checkbox"/> N	Mania (overactive, having persistently elevated or irritable moods, decreased need for sleep, increased talkativeness, racing thoughts or ideas, inappropriate social behavior, impaired judgment, inflated self esteem)

K. ANXIETY/STRESS DISORDERS

Are anxiety related symptoms present? N Y

(if yes, complete questions in this section by chose those present currently or in the past 6 months. If checked, identify whether they are baseline)

		<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive anxiety, worry, or apprehension for an extended period of time			<input type="checkbox"/> Y <input type="checkbox"/> N	Overwhelming nervousness and self-consciousness in a social situation
		<input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety not related to a medical condition (breathing trouble, dizziness, sweating, stomach pains or chest pains)			<input type="checkbox"/> Y <input type="checkbox"/> N	Extreme and irrational fear of things like heights, elevators, driving on a highway or across a bridge, dogs, injuries involving blood, and others

Current symptom? Symptom Within the past 6 Mos	Is this a baseline symptom? (answer if either current or 6 months is marked)		Current symptom? Symptom Within the past 6 Mos	Is this a baseline symptom? (answer if either current or 6 months is marked)	
	<input type="checkbox"/> Y <input type="checkbox"/> N	Persistent and unpleasant thoughts or ideas (obsessions) that cause him or her to perform repetitive actions (compulsions) to prevent a threatening event		<input type="checkbox"/> Y <input type="checkbox"/> N	Persistent thoughts or memories (for at least 30 days) & re-experiencing the traumatic event. Going out of the way to avoid things that may trigger memories of the event
	<input type="checkbox"/> Y <input type="checkbox"/> N	Intense terror/fear that strikes without warning		<input type="checkbox"/> Y <input type="checkbox"/> N	Other:

L. PERSONALITY DISORDERS

Are personality related symptoms/behaviors present? N Y

(if yes, complete questions in this section by chose those present currently or in the past 6 months. If checked, identify whether they are baseline)

<input type="checkbox"/> Y <input type="checkbox"/> N	Unstable relationships with others	<input type="checkbox"/> Y <input type="checkbox"/> N	Emotionally withdrawn from or avoiding social situations
<input type="checkbox"/> Y <input type="checkbox"/> N	Agitation	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent conflicts with others
<input type="checkbox"/> Y <input type="checkbox"/> N	Severe discomfort in social situations; tending to be withdrawn and isolated; and exhibiting odd thoughts, speech, and eccentric behavior.	<input type="checkbox"/> Y <input type="checkbox"/> N	Suspicion and distrust of others, without reason, and believes that others are exploiting, harming, deceiving, or betraying them; experiencing feelings of extreme jealousy
<input type="checkbox"/> Y <input type="checkbox"/> N	Extreme hypersensitivity	<input type="checkbox"/> Y <input type="checkbox"/> N	Other:

M. THOUGHT DISORDERS

Are thought related symptoms/behaviors present? N Y

(if yes, complete questions in this section by chose those present currently or in the past 6 months. If checked, identify whether they are baseline)

<input type="checkbox"/> Y <input type="checkbox"/> N	Disorganized behavior – Behaviors which may appear bizarre, silly, or unusual.	<input type="checkbox"/> Y <input type="checkbox"/> N	Incoherent, nonsensical, or loosely associated speech
<input type="checkbox"/> Y <input type="checkbox"/> N	Delusions - A firmly erroneous belief and/or misinterpretation of experiences (e.g., belief that she/he has certain powers or that someone is attempting to harm him/her	<input type="checkbox"/> Y <input type="checkbox"/> N	Hallucination – Distorted or exaggerated sensory perception. May hear internal voices or experience sensations not connected to an obvious source (may mumble or speak to no one in particular or become upset without clear reason)

N. STATUS & SERVICES (PLEASE RESPOND TO ALL QUESTIONS IN THIS SECTION)

Are behaviors/behavioral health symptoms manageable?

Yes No

Is the PASRR Evaluation in the Floor Record? No Yes

Current psychiatric status:

Stable Moderately Stable Unstable

Are PASRR recommendations incorporated in Care Plan?

(please attach copy of care plan)

No Don't Know Yes, If yes, how?

Please explain selections:

Current behavioral health services received?

No behavioral health services

Psychiatric consultation (date below)

Ongoing psychiatrist services (most recent below)

Counseling services

Day Treatment/PHP Inpatient Psychiatric

Other _____

Other _____

Is a transfer to another NF being contemplated? No Yes

If yes, did the previous PASRR limit the individual's admission to the current NF? No Yes

If yes, which NF is being considered?

Name: _____ City: _____

Contact Person: _____ Phone: _____

O. BEHAVIORAL HEALTH SERVICES RECEIVING

Current	Past 6 mos	Services	Clinician	Frequency	Most Recent Date
		Psychiatrist			
		Psychologist			
		LCSW			
		Nurse Practitioner			
		Other:			

P. GUARDIANSHIP AND PHYSICIAN INFORMATION

Does the individual have a legal Representative/guardian? No Yes, Conservator/legal guardian information is below:

Legal Representative Last Name _____ First Name _____ Phone: _____

Street _____ City _____ State _____ Zip _____

Primary Physician's Name: _____ Phone: _____ Fax: _____

Street _____ City _____ State _____ Zip _____

SECTION Q: CHECK ALL APPLICABLE INFORMATION AND ATTACH RECORDS TO THIS SUBMISSION

Provide copies of any consultations or evaluations that support and/or substantiate the mental health, physical and/or behavioral change(s) noted on this form. Select attachments included:

- Physician's Notes
- Nursing Notes/Summary
- MAR Sheet(s)
- Hospital Records
- Medical Consultation(s)
- Psychiatric Evaluation(s)
- Intellectual Assessment(s)
- Plan of Care (required when a transfer is requested and the prior PASRR determined that the individual could not relocate to another NF without prior approval)
- Other (List): _____

Signature: _____ Printed Name: _____

Position: _____ Facility: _____

Phone: _____ Date form was submitted to Ascend: _____

Ascend use Only; Purpose:

- Verification of PASRR Service Delivery : Y N The PASRR report is in the floor record
 - Y N The facility's care plan sufficiently incorporates the PASRR report
 - Y N Services appear to meet the resident's needs
- Quality Study Compliant Not Compliant
- Notes:
- Document-Based Review (requires new summary): Approved NF Requires onsite Level II evaluation Denied
- Transfer request (requires new summary): Approved transfer (SOF must be updated) Requires onsite Level II evaluation Denied transfer (appeal rights must be issued)

Rationale:

Print Name:

Signature:

Date: / /