

North Dakota Level I Form
Pre-Admission Screening and Resident Review (PASRR)



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

Section II: SYMPTOMS

<p>4. Interpersonal- Currently or within the past 6 months, has the individual exhibited interpersonal symptoms or behaviors [not due to a medical condition]?: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Serious difficulty interacting with others <input type="checkbox"/> Altercations, evictions, or unstable employment <input type="checkbox"/> Frequently isolated or avoided others or exhibited signs suggesting severe anxiety or fear of strangers</p>	<p>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]?: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Serious difficulty completing tasks that she/he should be capable of completing <input type="checkbox"/> Required assistance with tasks for which s/he should be capable <input type="checkbox"/> Substantial errors with tasks in which she/he completes</p>			
<p>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? <input type="checkbox"/> No (proceed to Section III) <input type="checkbox"/> Yes (complete 6-8)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; vertical-align: top; padding: 5px;"> <p>6. <input type="checkbox"/> Self injurious or self mutilation <input type="checkbox"/> Suicidal talk <input type="checkbox"/> History of suicide attempt or gestures <input type="checkbox"/> Physical violence <input type="checkbox"/> Physical threats (with potential for harm)</p> </td> <td style="width: 33%; vertical-align: top; padding: 5px;"> <p>7. <input type="checkbox"/> Severe appetite disturbance <input type="checkbox"/> Hallucinations or delusions <input type="checkbox"/> Serious loss of interest in things <input type="checkbox"/> Excessive tearfulness <input type="checkbox"/> Excessive irritability <input type="checkbox"/> Physical threats (no potential for harm)</p> </td> <td style="width: 33%; vertical-align: top; padding: 5px;"> <p>8. <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> </td> </tr> </table>		<p>6. <input type="checkbox"/> Self injurious or self mutilation <input type="checkbox"/> Suicidal talk <input type="checkbox"/> History of suicide attempt or gestures <input type="checkbox"/> Physical violence <input type="checkbox"/> Physical threats (with potential for harm)</p>	<p>7. <input type="checkbox"/> Severe appetite disturbance <input type="checkbox"/> Hallucinations or delusions <input type="checkbox"/> Serious loss of interest in things <input type="checkbox"/> Excessive tearfulness <input type="checkbox"/> Excessive irritability <input type="checkbox"/> Physical threats (no potential for harm)</p>	<p>8. <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>
<p>6. <input type="checkbox"/> Self injurious or self mutilation <input type="checkbox"/> Suicidal talk <input type="checkbox"/> History of suicide attempt or gestures <input type="checkbox"/> Physical violence <input type="checkbox"/> Physical threats (with potential for harm)</p>	<p>7. <input type="checkbox"/> Severe appetite disturbance <input type="checkbox"/> Hallucinations or delusions <input type="checkbox"/> Serious loss of interest in things <input type="checkbox"/> Excessive tearfulness <input type="checkbox"/> Excessive irritability <input type="checkbox"/> Physical threats (no potential for harm)</p>	<p>8. <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>9. Currently or within the past 2 years, has the individual received any of the following mental health services? <input type="checkbox"/> No <input type="checkbox"/> Yes (the individual has received the following service[s]): <input type="checkbox"/> Inpatient psychiatric hospitalization(if yes, provide date: _____) <input type="checkbox"/> Partial hospitalization/day treatment(if yes, provide date: _____) <input type="checkbox"/> Residential treatment (if yes, provide date: _____) <input type="checkbox"/> Other: _____ (if yes, provide date: _____)</p>	<p>10. Currently or within the past 2 years, has the individual experienced significant life disruption because of mental health symptoms? <input type="checkbox"/> No <input type="checkbox"/> Yes (check all that apply): <input type="checkbox"/> Legal intervention due to mental health symptoms (date: _____) <input type="checkbox"/> Housing change because of mental illness(date: _____) <input type="checkbox"/> Suicide attempt or ideation (date[s] _____) <input type="checkbox"/> Other: _____ (date: _____)</p>
--	--

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

Section IV: DEMENTIA

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

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: MENTAL RETARDATION & DEVELOPMENTAL DISABILITIES

15. Does the individual have a diagnosis of mental retardation (MR)? No Yes

16. Does the individual have presenting evidence of mental retardation (MR) but it has not been diagnosed? No Yes

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

18. Has the individual ever received services from an agency that serves people affected by MR? No
 Yes – agency: _____

19. Does the individual have a diagnosis which affects intellectual or adaptive functioning? No
 Yes – (specify) Autism Epilepsy Blindness
 Cerebral Palsy Closed Head Injury
 Deaf Other: _____

20. Are there substantial functional limitations in any of the following? No
 Yes (Specify) Mobility Self-Care
 Self-Direction Learning
 Understanding/Use of Language
 Capacity for living independently

21. Did this condition develop prior to age 22? No Yes

VII: EXEMPTION AND CATEGORICAL DECISIONS

(DDM 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 30th 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