

**PREAMMISSION SCREEN RESIDENT REVIEW (PASRR) LEVEL II
ADULT MENTAL HEALTH EVALUATION INTAKE FORM
Telephone: (516) 326-2110 or 1 (800) 633-9441 Fax: (516) 326-6179**

Name: _____
(Last) (First)

Address: _____

City State: Zip

Private Home/Apt. Rm: _____
County: _____

Is the patient in:
 Acute Care OMH Psychiatric Center
 ACF/Community Private Home Other/Jail
 RHCF: Preadmission - or - Significant Change
 VAMC Out of State

Building: _____ Ward: _____

Gender: Male Female DOB: / /

Social Security #: _____
Medicaid #: _____

Payer Source: Medicare Medicaid
 Medicaid Pending Other/Self Pay

Referral Organization: _____
Address: _____

City: State: Zip:

Contact Name: _____
Department: _____
Phone# (s): _____
Alternate #: _____
Fax #: _____

Attending Physician: _____
Address: _____

City: State: Zip

MR# _____
What is the RUG's II score: _____
What is the ADL score: _____

ADDITIONAL REQUIRED INFORMATION

<p>FOR COMMUNITY REFERRALS:</p> <p>Patient Contact Person/Relationship: _____</p> <p>Phone #: _____</p>
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<p>Legal Representative:</p> <p>Address: _____</p> <p>Phone: _____</p>

<p>Does the Patient Speak English: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is an Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, what language: _____</p>

<p>Is The Patient Receiving ECT: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, date of next treatment: / /</p> <p><i>IPRO ASSESSOR CAN SEE THE PATIENT ONLY 24 HOURS AFTER THE LAST ECT TREATMENT</i></p>
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PLEASE COMPLETE REVERSE FOR DOCUMENTATION REQUIREMENTS

The following information is required to complete the assessment. If the information is not provided to the IPRO consultant at the Level II Evaluation, the evaluator must obtain the information before proceeding.

PROVIDED

(Check all that are included)

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 1. A comprehensive history and physical examination, including a complete medical history, review of all body systems, specific evaluation of the individual's neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves and abnormal reflexes. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 2. A functional assessment of the individual's ability to engage in ADLs and IADLs. The assessment must address self-monitoring of health status, self-administering and scheduling of medical treatment, including medication compliance, self-monitoring of nutritional status, handling of money, dressing appropriately, and grooming. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 3. A psychosocial evaluation including current living arrangements, medical and support systems. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 4. A comprehensive psychiatric evaluation, including a complete psychiatric history, evaluation of intellectual functioning, memory functioning and orientation, description of current attitudes and overt behaviors, affect, suicidal or homicidal ideation, paranoia, and degree of reality testing (presence and content of delusions) and hallucinations. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 5. PRI or H/C/PRI |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 6. SCREEN |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 7. Physician request for RHCF placement or current RHCF monthly order sheet. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 8. Social Service and Discharge Planning documentation relevant to PASRR request. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 9. RHCF progress notes and psychiatric/applicable consults related to significant change |

- *This form WILL NOT be processed if INCOMPLETE and will be returned to facility.*
- *Failure to provide all listed documents to the IPRO consultant will result in a delay in processing case review while all documents are acquired.*



Improving Healthcare for the Common Good

IPRO/PASRR Department
1979 Marcus Avenue
Lake Success, New York 11042
Phone: 516-326-2110 or 800-633-9441
Fax: 516-326-6179

TO: Facility Representative Requesting PASRR Evaluation

FROM: Doreen Walz RN
Assistant Director PASRR

DATE: September 1, 2011

SUBJECT: Instructions For Completion Of The PASRR Adult Mental Health Intake Form

The PASRR Adult Mental Health Evaluation Intake Form has been revised to coincide with the change in the PASRR Adult Mental Health Evaluation and Report that will take effect on September 1, 2011. Please follow the directions below for completion of the Intake Form.

- Information is required to schedule an individual's assessment and to provide each entity with a report when the evaluation is completed. The PASRR report must be provided to the individual, the facility, the individual's attending physician, the RHCF and the individual's legal representative. Each section on the form must be completed. Any form that is incomplete will not be processed and will be returned to the facility.

Form Instructions:	
Name & Address	Individual/Patient's name and address
Is the patient in	Check the facility type where the individual/patient is currently located
Building & Ward	Indicate the exact location where the individual/patient can be found in the facility
Gender	Check the correct individual/patient gender
DOB	Indicate the individual/patient date of birth
Social Security #	Indicate the individual/patient 9 digit social security number. If none, write in none.
Medicaid #	Indicate the individual/patient Medicaid number. The Medicaid number is 2 letters, 5 digits and 1 letter (AA55555A) If none, write in none
Payer Source	Check the appropriate payer source
Referral Organization Name & Address	The name and address of the organization making the PASRR request
Referral Organization Contact Name	The name of the person who will be the contact for the PASRR evaluation process
Department / Phone number / Alternate # / FAX #	The contacts department name, phone number, another phone number (cell or beeper) and department FAX number
Attending Physician Name & Address	Indicate the individual/patient attending physicians name and address
MR#	Indicate the individual/patient medical record number



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Rug's II score & ADL score	Indicate the most recent RUG's score & ADL score as found on the first page of the PRI.
For Community Referrals	When the individual/patient resides in the community indicate a contact person's name, relationship to the individual and their phone number
Legal Representative	Indicate the individual/patient legal representatives name, address and phone number
Does the Patient speak English	Check either yes or no for each question and if yes to interpreter, indicate language spoken
Is the Patient Receiving ECT	Check either yes or no and if yes indicate the date of the last ECT treatment. (Patient can only be seen 24 hours after the last ECT treatment.

- On the second page of the Intake form there is a document request list. Please review the list, obtain the documents and have them ready for the assessor on arrival to conduct the PASRR evaluation. Check that each document has been obtained and provide a copy of the list to the assessor with the documents. If a document is not provided please explain why not to the assessor. The assessor will not conduct the PASSR evaluation without provisions of all necessary documents.

If you have any questions concerning these instructions please contact me at (516) 209-4444.