STATE OF HAWAII

DEPARTMENT OF HUMAN SERVICES — Med-QUEST Division

PREADMISSION SCREENING RESIDENT REVIEW (PASRR) **LEVEL I SCREEN**	**PATIENT'S NAME:** ***(Last Name, First, M.I.)***	**DATE OF BIRTH:** ***(mm/dd/yy)***
	SOCIAL SECURITY NUMBER:	**MEDICAID I.D. NUMBER:**
	REFERRAL SOURCE: ***(Physician's Name; Nursing Facility; Hospital; Etc.)***	

PART A: SERIOUS MENTAL ILLNESS (SMI):	**YES**	**NO**
1. Does the individual, currently meet the criteria for **SMI**? Must have a current diagnosis of a Major Mental Disorder, which is:	( )	( )
a. A **SCHIZOPHRENIC** disorder, **MOOD** disorder, **DELUSIONAL (PARANOID)** disorder, **PANIC OR OTHER SEVERE ANXIETY** disorder, **SOMATOFORM** disorder, **PERSONALITY** disorder, or **PSYCHOTIC** disorder not elsewhere classified that may lead to a chronic disability; **BUT**		
b. **NOT** a primary or secondary diagnosis of **DEMENTIA**, including **ALZHEIMER'S DISEASE OR A RELATED DISORDER.**		
2. Has psychoactive drug(s) been prescribed on a regular basis for the individual within the last two (2) years for **SMI**?	( )	( )

PART B: DEVELOPMENTAL DISABILITY/INTELLECTUAL DISABILITY/ (DD/ID):	**YES**	**NO**
1. The individual has a diagnosis of **ID** or has a history indicating the presence of **ID prior** to age 18.	( )	( )
2. The individual has a diagnosis of **DD** or has a history indicating the presence of **DD prior** to age 22.	( )	( )

DETERMINATION:

1. If any of the answers in Parts A or B are **YES, COMPLETE PART C (page 2)** of this form.

2. If all of the answers in Parts A or B are **NO, SIGN** and **DATE** BELOW:

LEVEL I SCREEN IS NEGATIVE FOR SMI OR DD/ID THE PATIENT MAY BE ADMITTED TO THE NF:	**DATE AND TIME COMPLETED:**
_____ **MD**	_____
SIGNATURE OF PHYSICIAN	**mm/dd/yy**
_____	_____
PRINT NAME OF PHYSICIAN	**time**

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PART C:		**YES**	**NO**
1.	Is this individual being discharged from an acute care hospital and admitted to the NF for recovery from an illness or surgery **not to exceed 120 days** and is not considered a danger to self and/or others?	( )	( )
2.	Is this individual **certified** by his physician to be terminally ill **(prognosis of a life expectancy of 6 months or less)** and is not considered a danger to self and/or others?	( )	( )
3.	Is this individual comatose, ventilator dependent, functioning at the brain stem level or diagnosed as having a **severe physical illness,** such as, COPD, Parkinson's Disease, Huntington's Chorea, or amyotrophic lateral sclerosis; which result in a level of impairment so severe that the person cannot be expected to benefit from specialized services?	( )	( )
4.	Does this individual require **provisional admission** pending further Assessment in cases of delirium where an accurate diagnosis cannot be made until the delirium clears?	( )	( )
5.	Does this individual **provisional admission** **not to exceed 7 days** for further assessment for emergency situations requiring protective services?	( )	( )
6.	Does this individual require admission for **a brief stay of 30 days for respite care**? The individual is expected to return to the same caregivers following this brief NF stay.	( )	( )

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CHECK ONLY ONE:

[ ] If **any** answer to Part C is **Yes,** **NO REFERRAL for LEVEL II** evaluation and determination is necessary at this time. **NOTE TIME CONSTRAINTS!**

[ ] If **all** answers to Part C are **No,** **REFERRAL for LEVEL II** evaluation and determination **MUST BE MADE.**

SIGN and DATE this form.

DATE & TIME COMPLETED:

_____ **MD** _____

SIGNATURE OF PHYSICIAN *mm/dd/yy*

_____ _____

PRINT NAME OF PHYSICIAN *time*