

STATE OF HAWAII

Department of Human Services

Med-QUEST Division

PREADMISSION SCREENING RESIDENT REVIEW (PAS/RR) LEVEL I SCREEN	PATIENT'S NAME: (Last Name, First, M.I.)	DATE OF BIRTH: (MM/DD/YY)
	PRIMARY DIAGNOSIS:	MEDICAID I.D. NUMBER:
	REFERRAL SOURCE: (Physician's Name; Nursing Facility; Hospital; Etc.)	

PART A: SERIOUS MENTAL ILLNESS (SMI):

YES NO

1. The individual has a current diagnosis of a Major Mental disorder and/or a Substance Related disorder, which seriously affects interpersonal functioning (difficulty interacting with others; altercations, evictions, unstable employment, frequently isolated, avoids others), and/or completing tasks (difficulty completing tasks, required assistance with tasks, errors with tasks; concentration; persistence; pace), and/or adapting to change (self-injurious, self-mutilation, suicidal, physical violence or threats, appetite disturbance, hallucinations, delusions, serious loss of interest, tearfulness, irritability, withdrawal):

	<input type="checkbox"/> <input type="checkbox"/>
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 - a. A **SCHIZOPHRENIC** disorder, **MOOD** disorder, **DELUSIONAL (PARANOID)** disorder, **PANIC OR OTHER SEVERE ANXIETY** disorder, **SOMATOFORM** disorder, **PERSONALITY** disorder, **SUBSTANCE RELATED** 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. Does the SMI individual have Dementia? If yes, include evidence/presence of workup, comprehensive mental status exam.

	<input type="checkbox"/> <input type="checkbox"/>
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3. Has psychoactive drug(s) been prescribed on a regular basis for the individual within the last two (2) years with or without current diagnosis of SMI ?

	<input type="checkbox"/> <input type="checkbox"/>
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PART B: INTELLECTUAL DISABILITY/DEVELOPMENTAL DISABILITIES (ID/DD):

YES NO

1. The individual has a diagnosis of **ID** or has a history indicating the presence of **ID prior** to age 18.

	<input type="checkbox"/> <input type="checkbox"/>
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2. The individual has a diagnosis of **DD/related condition** (evidence/affects intellectual functioning, adaptive functioning; autism, epilepsy, blindness, cerebral palsy, closed head injury, deaf) or has a history indicating the presence of **DD prior** to age 22. Age of diagnosis/presence: _____

	<input type="checkbox"/> <input type="checkbox"/>
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3. Does the ID/DD individual have a primary diagnosis or presence of **Dementia**? If yes, include evidence/presence of Dementia work-up, comprehensive mental status exam, if available.

	<input type="checkbox"/> <input type="checkbox"/>
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4. The individual has functional limitations relating to **ID/DD** (mobility, self-care/direction, learning, understanding/use of language, capacity for living independently).

	<input type="checkbox"/> <input type="checkbox"/>
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5. The individual received/receives **ID/DD** services from an agency serving individuals with ID/DD; (past and/or present; referred/referrals). Describe past AND present receipt of services and referrals made from agencies that serve individuals with ID/DD. _____

	<input type="checkbox"/> <input type="checkbox"/>
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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 ID/DD THE PATIENT MAY BE ADMITTED TO THE NF:	DATE AND TIME COMPLETED:
_____ SIGNATURE OF PHYSICIAN, APRN, RN	_____ MM/DD/YY
_____ PRINT NAME	_____ Time

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 require **provisional admission which is not to exceed 7 days**, for further assessment in emergency situations that require 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. () ()

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:
SIGNATURE OF PHYSICIAN, APRN, RN	MM/DD/YY
PRINT NAME	TIME