

STATE OF VERMONT
PRE-ASSESSMENT SCREENING AND RESIDENT REVIEW (PASRR): LEVEL 1
FOR MENTAL ILLNESS, DEVELOPMENTAL DISABILITY, OR RELATED CONDITION

Patient Name:

DOB:

SSN:

Diagnoses: Primary

Secondary:

Level of Care:

Where is Patient Now?

To Which NF is patient going?

Part A – Hospital Discharge for Short-Stays (30 days or less) – PASRR Exempt

1. Is this person being admitted to a nursing facility directly following an acute hospitalization for treatment of a condition that he/she was hospitalized for? (The attending physician must certify before admission that the individual is likely to require less than 30 days in the nursing facility in order to qualify for this exemption).

Yes No

(Physician's Signature Required)

Note: If response to Part A is YES, the patient may be admitted to a nursing facility without further screening. However, if it is later decided the patient will exceed 30 days, complete parts B and C. If there are 3 YES answers under Part B, or ANY YES answers under Part C, call the appropriate State Agency PASRR Coordinator immediately to arrange a PASRR Step II evaluation.

Part B – Mental Illness

1. Yes, a major psychiatric disorder from the list below is present:
Schizophrenia, Mood Disorder (Depression, Bipolar Disorder), Delusional Disorder (Paranoid Disorder), Personality Disorder, Somatoform Disorder, Psychotic Disorder (Schizoaffective Disorder; Atypical Psychosis; Schizophreniform Disorder; Brief Reactive Psychosis), Anxiety Disorder (Panic Disorder; Phobia; Obsessive-Compulsive Disorder; Post-Traumatic Stress Disorders; Severe Anxiety)

No, None of the above

2. Has this individual had a disability or impairment in major life functions in the last 6 months as a result of the above psychiatric disorder? Yes No
3. Has this individual had a psychiatric hospitalization within the past 2 years or required intensive psychiatric treatment to maintain his/her functioning in the community? Yes No

Note: If ALL responses to questions 1-3 in Part B are YES, a Step II MENTAL HEALTH PASRR is needed. Notify the MH PASRR Field Coordinator or Department of Mental Health and forward this copy to Department of Mental Health, Attn: MH PASRR Coordinator, 280 State Drive, NOB 2 North, Waterbury, VT 05671-2010 or Fax (802) 241-0100 or call (802) 241-0090.

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**PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR): LEVEL 1
FOR MENTAL ILLNESS, DEVELOPMENTAL DISABILITY, OR RELATED CONDITION**

Part C – Intellectual or Developmental Disability or Related Condition

1. Does the individual have a diagnosis of developmental disability or related condition?
Yes No
2. Does the individual have a history of developmental disability or related condition?
Yes No
3. Is there presenting evidence (cognitive or behavioral) that indicates the individual may have a developmental disability or a related condition? If yes, explain: Yes No
4. Was the individual referred by or receiving services from an agency that serves individuals with developmental disabilities?
Yes No

NOTE: If response to ANY question in Part C is YES, a STEP II DEVELOPMENTAL DISABILITIES PASRR is required. Notify the DDS PASRR Coordinator, 280 State Drive, HC 2 South, Waterbury, VT 05671-2030 or FAX (802) 241-0410, or call (802) 241-0306.

IF A STEP II IS REQUIRED: Please give the patient or legal guardian a copy of this form as notification that a PASRR Step II evaluation will be initiated.

Name & Title of Person Completing Form: _____
(Please Print)

Signature of Person Completing Form: _____

Facility Address: _____

Phone #: _____ Date: _____

As noted above under Part B, please mail the original signed form to: Department of Mental Health, Attn: MH PASRR Coordinator, 280 State Drive, NOB 2 North, Waterbury, VT 05671-2010 or Fax (802) 241-0100.

➔ Copies should also be distributed to: Hospital of record, nursing facility and patient/legal guardian(s).