ASCEND MANAGEMENT INNOVATIONS

DOCUMENT-BASED REVIEW AND NF SPECIFIC TRANSFER FORM

Resident Name_____ Date of Birth___/___/_____SSN/State ID_____

COMPLETE AND RETURN THIS FORM WHEN A DOCUMENT-BASED REVIEW, TRANSFER FROM A PASRR-RESTRICTED NF ADMISSION, OR QUALITY REVIEW OF SPECIALIZED SERVICE DELIVERY IS REQUESTED.

A. DEMOGRAPHICS

Admit Date:

NF Name:

NF City:

B. MDS SIGNIFICANT STATUS CHANGE

☐ No significant status change on the MDS since the PASRR

☐ Significant status change on the MDS since the PASRR

☐ Medical ☐ Psychiatric

Comments:

C. DEMENTIA

Does the individual have a **diagnosis of dementia?**

☐ No ☐ Yes, If yes:

A) Was diagnosis by: ☐ Attending MD ☐ Psychiatrist

B) Are symptoms worse in the late afternoon or evening?

☐ No ☐ Yes

C) Diagnosis date_____

D) Diagnostic tests conducted:

D. DIAGNOSIS

Current psychiatric and/or ID/DD diagnosis:

Medical Diagnoses:

Medical rehabilitative prognosis: ☐ good ☐ poor ☐ unknown

E. MEDICAL/FUNCTIONAL

Treatments

☐ Suctioning ☐ Trach care ☐ Feeding tube

☐ PT ☐ OT ☐ SLP

☐ Oxygen ☐ IV therapy ☐ Respiratory therapy

☐ Dialysis ☐ Peritoneal ☐ Hemodialysis

☐ Skin lesions/surgical wounds ☐ Pressure/stasis ulcers

Admission weight _____ Current Weight _____

Overall ADL Assist Needs

☐ None ☐ Supervision ☐ Limited ☐ Extensive ☐ Dependent

Medication Assistance

☐ None ☐ Supervision/prompts

☐ Insulin—admin by nursing ☐ Insulin—sliding scale

☐ Subcutaneous

☐ Central or peripheral venous line or port

Dressing & Personal Hygiene

☐ None ☐ Supervision ☐ Limited assist

☐ Extensive assist ☐ Dependent

Transfer, Walking, Locomotion

☐ None ☐ Supervision ☐ Limited assist

☐ Extensive assist ☐ Dependent

Recent falls? ☐ No ☐ Yes

Eating

☐ None ☐ Supervision ☐ Limited assist

☐ Extensive assist ☐ Dependent

Continence

☐ Continent ☐ CAPD ☐ Incontinent

☐ Requires assist ☐ Ostomy/ileal conduit

☐ Indwelling/suprapubic catheter ☐ Intermittent

F. PSYCHOTROPIC AND ANTIDEPRESSANT MEDICATIONS (INCLUDING PSYCHIATRIC MEDICATIONS, MEDS FOR DEMENTIA, SEIZURES, AND SLEEP DISORDERS)

Medication	Dose MG/Day	Date Started	Response Y/N + any description

G. INTERPERSONAL: CHECK SYMPTOMS PRESENT NOW OR IN THE PAST 6 MONTHS. IF APPLICABLE, IDENTIFY WHETHER THAT SYMPTOM IS A BASELINE BEHAVIOR.

Current symptom?	Symptom Within the past 6 Mos	Is this a baseline symptom? (answer if either current or 6 months is marked)			Current symptom?	Symptom Within the past 6 Mos	Is this a baseline symptom? (answer if either current or 6 months is marked)	
		☐ Y ☐ N	Sociable				☐ Y ☐ N	Hostile
		☐ Y ☐ N	Cooperative				☐ Y ☐ N	Refuses care
		☐ Y ☐ N	Appropriate				☐ Y ☐ N	Resists care

Resident Name_____ Date of Birth___/___/_____SSN/State ID_____

Current symptom?	Symptom Within the past 6 Mos	Is this a baseline symptom? (answer if either current or 6 months is marked)			Current symptom?	Symptom Within the past 6 Mos	Is this a baseline symptom? (answer if either current or 6 months is marked)	
		☐ Y ☐ N	Attends activities				☐ Y ☐ N	Conflicts
		☐ Y ☐ N	Withdrawn				☐ Y ☐ N	Anxiety/fear of others
		☐ Y ☐ N	Frequent conflicts				☐ Y ☐ N	Suicidal ideation
		☐ Y ☐ N	Inappropriate				☐ Y ☐ N	Homicidal ideation
H. CONCENTRATION: CHECK SYMPTOMS PRESENT NOW OR IN THE PAST 6 MONTHS. IF APPLICABLE, IDENTIFY WHETHER THAT SYMPTOM IS A BASELINE BEHAVIOR								
		☐ Y ☐ N	Cannot complete tasks s/he should medically be able to complete				☐ Y ☐ N	Psychosis with paranoia hallucinations, delusions
		☐ Y ☐ N	Requires more assistance than s/he should with tasks				☐ Y ☐ N	Changeable, unpredictable, and rapidly switching emotions
		☐ Y ☐ N	Concentration difficulties				☐ Y ☐ N	Disruptive behaviors (yelling, throwing, hitting, wandering)
		☐ Y ☐ N	Personality Changes				☐ Y ☐ N	Problems finding/using right words
I. COGNITION: CHECK SYMPTOMS PRESENT NOW OR IN THE PAST 6 MONTHS. IF APPLICABLE, IDENTIFY WHETHER THAT SYMPTOM IS A BASELINE BEHAVIOR.								
		☐ Y ☐ N	Alert				☐ Y ☐ N	Confused
		☐ Y ☐ N	Intact memory				☐ Y ☐ N	Fluctuating orientation
		☐ Y ☐ N	Oriented to person				☐ Y ☐ N	Short term memory loss
		☐ Y ☐ N	Oriented to place				☐ Y ☐ N	Long term memory loss
		☐ Y ☐ N	Oriented to time				☐ Y ☐ N	Other:
J. MOOD DISORDERS: CHECK SYMPTOMS PRESENT NOW OR IN THE PAST 6 MONTHS. IF APPLICABLE, IDENTIFY WHETHER THAT SYMPTOM IS A BASELINE BEHAVIOR.								
		☐ Y ☐ N	Depressed mood				☐ Y ☐ N	Changes in sleep patterns
		☐ Y ☐ N	Loss of interest in previously enjoyed activities				☐ Y ☐ N	Feelings of worthlessness, helplessness, or guilt
		☐ Y ☐ N	Weight gain or loss				☐ Y ☐ N	Difficulty concentrating
		☐ Y ☐ N	Fatigue and loss of energy				☐ Y ☐ N	Suicidal thoughts or feelings
		☐ Y ☐ N	Psychosis, such as feeling that others are trying to cause harm (also called paranoia), overvalued ideas, delusions or seeing, hearing, or sensing the presence of others not actually there (also called hallucinations)				☐ Y ☐ N	Mania (overactive, having persistently elevated or irritable moods, decreased need for sleep, increased talkativeness, racing thoughts or ideas, inappropriate social behavior, impaired judgment, inflated self esteem)
K. ANXIETY/STRESS DISORDERS: CHECK SYMPTOMS PRESENT NOW OR IN THE PAST 6 MONTHS. IF APPLICABLE, IDENTIFY WHETHER THAT SYMPTOM IS A BASELINE BEHAVIOR.								
		☐ Y ☐ N	Excessive anxiety, worry, or apprehension for an extended period of time				☐ Y ☐ N	Overwhelming nervousness and self-consciousness in a social situation
		☐ Y ☐ N	Anxiety not related to a medical condition (breathing trouble, dizziness, sweating, stomach pains or chest pains)				☐ Y ☐ N	Extreme and irrational fear of things like heights, elevators, driving on a highway or across a bridge, dogs, injuries involving blood, and others
		☐ Y ☐ N	Persistent and unpleasant thoughts or ideas (obsessions) that cause him or her to perform repetitive actions (compulsions) to prevent a threatening event				☐ Y ☐ N	Persistent thoughts or memories (for at least 30 days) & re-experiencing the traumatic event. Going out of the way to avoid things that may trigger memories of the event

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Current symptom?	Symptom Within the past 6 Mos	Is this a baseline symptom? (answer if either current or 6 months is marked)		Current symptom?	Symptom Within the past 6 Mos	Is this a baseline symptom? (answer if either current or 6 months is marked)	
		☐ Y ☐ N	Intense terror/fear that strikes without warning			☐ Y ☐ N	Other:
L. PERSONALITY DISORDERS: CHECK SYMPTOMS PRESENT NOW OR IN THE PAST 6 MONTHS. IF APPLICABLE, IDENTIFY WHETHER THAT SYMPTOM IS A BASELINE BEHAVIOR.							
		☐ Y ☐ N	Unstable relationships with others			☐ Y ☐ N	Emotionally withdrawn from or avoiding social situations
		☐ Y ☐ N	Agitation			☐ Y ☐ N	Frequent conflicts with others
		☐ Y ☐ N	Severe discomfort in social situations; tending to be withdrawn and isolated; and exhibiting odd thoughts, speech, and eccentric behavior.			☐ Y ☐ N	Suspicion and distrust of others, without reason, and believes that others are exploiting, harming, deceiving, or betraying them; experiencing feelings of extreme jealousy
		☐ Y ☐ N	Extreme hypersensitivity			☐ Y ☐ N	Other:
M. THOUGHT DISORDERS: CHECK SYMPTOMS PRESENT NOW OR IN THE PAST 6 MONTHS. IF APPLICABLE, IDENTIFY WHETHER THAT SYMPTOM IS A BASELINE BEHAVIOR.							
		☐ Y ☐ N	Disorganized behavior: Behaviors which may appear bizarre, silly, or unusual.			☐ Y ☐ N	Incoherent, nonsensical, or loosely associated speech
		☐ Y ☐ N	Delusions: A firmly erroneous belief and/or misinterpretation of experiences (e.g., belief that she/he has certain powers or that someone is attempting to harm him/her)			☐ Y ☐ N	Hallucination: Distorted or exaggerated sensory perception. May hear internal voices or experience sensations not connected to an obvious source (may mumble or speak to no one in particular or become upset without clear reason)

N. STATUS & SERVICES (RESPOND TO ALL QUESTIONS IN THIS SECTION)

Are behaviors/behavioral health symptoms manageable?
☐ Yes ☐ No
Is the PASRR evaluation in the floor record? ☐ Yes ☐ No

Current psychiatric status:
☐ Stable ☐ Moderately Stable ☐ Unstable

Are PASRR recommendations incorporated in Care Plan?
(please attach copy of care plan)
☐ No ☐ Don't Know ☐ Yes, If yes, how?

Please explain selections:

Are current behavioral health services received?
☐ No behavioral health services
☐ Psychiatric consultation (date below)
☐ Ongoing psychiatrist services (most recent below)
☐ Counseling services
☐ Day treatment/PHP
☐ Inpatient psychiatric
☐ Other _____
☐ Other _____

Is a transfer to another NF being contemplated? ☐ Yes ☐ No
If yes, did the previous PASRR limit the individual's admission to the current NF? ☐ Yes ☐ No
If yes, which NF is being considered?
Name: City:
Contact Person: Phone:

O. BEHAVIORAL HEALTH SERVICES RECEIVING

Current	Past 6 mos	Services	Clinician	Frequency	Most Recent Date
		Psychiatrist			

ASCEND MANAGEMENT INNOVATIONS

DOCUMENT-BASED REVIEW AND NF SPECIFIC TRANSFER FORM

Resident Name_____ Date of Birth___/___/_____SSN/State ID_____

Current	Past 6 mos	Services	Clinician	Frequency	Most Recent Date
		Psychologist			
		LCSW			
		Nurse Practitioner			
		Other:			

P. GUARDIANSHIP AND PHYSICIAN INFORMATION

Does the individual have a legal Representative/guardian? ☐ ***No*** ☐ ***Yes, Conservator/legal guardian information is below:***

Legal Representative Last Name_____ ___First Name_____ Phone:_____

Address_____City_____ State_____ Zip_____

Primary Physician's Name:_____ Phone:_____ Fax:_____

Address _____City_____State_____Zip_____

SECTION Q: CHECK ALL APPLICABLE INFORMATION AND ATTACH RECORDS TO THIS SUBMISSION

Provide copies of any consultations or evaluations that support and/or substantiate the mental health, physical and/or behavioral change(s) noted on this form. Select attachments included:

☐ Physician's Notes ☐ Nursing Notes/Summary ☐ MAR Sheet(s) ☐ Hospital Records
☐ Medical Consultation(s) ☐ Psychiatric Evaluation(s) ☐ Intellectual Assessment(s)
☐ Plan of Care (required for quality review of specialized service delivery in NF **and** when a transfer is requested and the prior PASRR determined the individual could not relocate to another NF without prior approval)
☐ Other (List): _____

Signature: _____ Printed Name:_____

Position: _____ Facility:_____

Phone:_____ Date form submitted to Ascend: _____

Ascend use Only

Purpose:

☐ Verification of PASRR Service Delivery :

☐ Quality Study

Outcome:

☐Y ☐N The PASRR report is in the floor record
☐Y ☐N The facility's care plan sufficiently incorporates the PASRR report
☐Y ☐N Services appear to meet the resident's needs
☐ Compliant ☐ Not Compliant

Notes:

☐ Document-Based Review (requires new summary): ☐ Approved NF ☐ Requires onsite Level II evaluation ☐ Denied
☐ Transfer request (requires new summary): ☐ Approved (SOF must be updated) ☐ Requires onsite Level II evaluation
☐ Denied transfer (reconsideration and appeal rights must be issued)

Rationale:

Print Name:	Signature:	Date: / /

Complete and fax to Ascend Iowa Team at 877.431.9568