

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		B. MDS SIGNIFICANT STATUS CHANGE						
Admit Date: NF Name: NF City:	<input type="checkbox"/> No significant status change on the MDS since the PASRR <input type="checkbox"/> Significant status change on the MDS since the PASRR <input type="checkbox"/> Medical <input type="checkbox"/> Psychiatric Comments:							
C. DEMENTIA		D. DIAGNOSIS						
Does the individual have a diagnosis of dementia ? <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes: A) Was diagnosis by: <input type="checkbox"/> Attending MD <input type="checkbox"/> Psychiatrist B) Are symptoms worse in the late afternoon or evening? <input type="checkbox"/> No <input type="checkbox"/> Yes C) Diagnosis date _____ D) Diagnostic tests conducted:		Current psychiatric and/or ID/DD diagnosis: Medical Diagnoses: Medical rehabilitative prognosis: <input type="checkbox"/> good <input type="checkbox"/> poor <input type="checkbox"/> unknown						
E. MEDICAL/FUNCTIONAL								
Treatments <input type="checkbox"/> Suctioning <input type="checkbox"/> Trach care <input type="checkbox"/> Feeding tube <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> Oxygen <input type="checkbox"/> IV therapy <input type="checkbox"/> Respiratory therapy <input type="checkbox"/> Dialysis <input type="checkbox"/> Peritoneal <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Skin lesions/surgical wounds <input type="checkbox"/> Pressure/stasis ulcers Admission weight _____ Current Weight _____		Dressing & Personal Hygiene <input type="checkbox"/> None <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assist <input type="checkbox"/> Extensive assist <input type="checkbox"/> Dependent Transfer, Walking, Locomotion <input type="checkbox"/> None <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assist <input type="checkbox"/> Extensive assist <input type="checkbox"/> Dependent Recent falls? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Overall ADL Assist Needs <input type="checkbox"/> None <input type="checkbox"/> Supervision <input type="checkbox"/> Limited <input type="checkbox"/> Extensive <input type="checkbox"/> Dependent Medication Assistance <input type="checkbox"/> None <input type="checkbox"/> Supervision/prompts <input type="checkbox"/> Insulin—admin by nursing <input type="checkbox"/> Insulin—sliding scale <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Central or peripheral venous line or port		Eating <input type="checkbox"/> None <input type="checkbox"/> Supervision <input type="checkbox"/> Limited assist <input type="checkbox"/> Extensive assist <input type="checkbox"/> Dependent Continence <input type="checkbox"/> Continent <input type="checkbox"/> CAPD <input type="checkbox"/> Incontinent <input type="checkbox"/> Requires assist <input type="checkbox"/> Ostomy/ileal conduit <input type="checkbox"/> Indwelling/suprapubic catheter <input type="checkbox"/> 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)	Current symptom?	Symptom Within the past 6 Mos	Is this a baseline symptom? (answer if either current or 6 months is marked)
		<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N

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		<input type="checkbox"/> Y <input type="checkbox"/> N	Attends activities			<input type="checkbox"/> Y <input type="checkbox"/> N	Conflicts
		<input type="checkbox"/> Y <input type="checkbox"/> N	Withdrawn			<input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety/fear of others
		<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent conflicts			<input type="checkbox"/> Y <input type="checkbox"/> N	Suicidal ideation
		<input type="checkbox"/> Y <input type="checkbox"/> N	Inappropriate			<input type="checkbox"/> Y <input type="checkbox"/> 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							
		<input type="checkbox"/> Y <input type="checkbox"/> N	Cannot complete tasks s/he should medically be able to complete			<input type="checkbox"/> Y <input type="checkbox"/> N	Psychosis with paranoia hallucinations, delusions
		<input type="checkbox"/> Y <input type="checkbox"/> N	Requires more assistance than s/he should with tasks			<input type="checkbox"/> Y <input type="checkbox"/> N	Changeable, unpredictable, and rapidly switching emotions
		<input type="checkbox"/> Y <input type="checkbox"/> N	Concentration difficulties			<input type="checkbox"/> Y <input type="checkbox"/> N	Disruptive behaviors (yelling, throwing, hitting, wandering)
		<input type="checkbox"/> Y <input type="checkbox"/> N	Personality Changes			<input type="checkbox"/> Y <input type="checkbox"/> 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.							
		<input type="checkbox"/> Y <input type="checkbox"/> N	Alert			<input type="checkbox"/> Y <input type="checkbox"/> N	Confused
		<input type="checkbox"/> Y <input type="checkbox"/> N	Intact memory			<input type="checkbox"/> Y <input type="checkbox"/> N	Fluctuating orientation
		<input type="checkbox"/> Y <input type="checkbox"/> N	Oriented to person			<input type="checkbox"/> Y <input type="checkbox"/> N	Short term memory loss
		<input type="checkbox"/> Y <input type="checkbox"/> N	Oriented to place			<input type="checkbox"/> Y <input type="checkbox"/> N	Long term memory loss
		<input type="checkbox"/> Y <input type="checkbox"/> N	Oriented to time			<input type="checkbox"/> Y <input type="checkbox"/> 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.							
		<input type="checkbox"/> Y <input type="checkbox"/> N	Depressed mood			<input type="checkbox"/> Y <input type="checkbox"/> N	Changes in sleep patterns
		<input type="checkbox"/> Y <input type="checkbox"/> N	Loss of interest in previously enjoyed activities			<input type="checkbox"/> Y <input type="checkbox"/> N	Feelings of worthlessness, helplessness, or guilt
		<input type="checkbox"/> Y <input type="checkbox"/> N	Weight gain or loss			<input type="checkbox"/> Y <input type="checkbox"/> N	Difficulty concentrating
		<input type="checkbox"/> Y <input type="checkbox"/> N	Fatigue and loss of energy			<input type="checkbox"/> Y <input type="checkbox"/> N	Suicidal thoughts or feelings
		<input type="checkbox"/> Y <input type="checkbox"/> 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)			<input type="checkbox"/> Y <input type="checkbox"/> 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.							
		<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive anxiety, worry, or apprehension for an extended period of time			<input type="checkbox"/> Y <input type="checkbox"/> N	Overwhelming nervousness and self-consciousness in a social situation
		<input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety not related to a medical condition (breathing trouble, dizziness, sweating, stomach pains or chest pains)			<input type="checkbox"/> Y <input type="checkbox"/> N	Extreme and irrational fear of things like heights, elevators, driving on a highway or across a bridge, dogs, injuries involving blood, and others
		<input type="checkbox"/> Y <input type="checkbox"/> N	Persistent and unpleasant thoughts or ideas (obsessions) that cause him or her to perform repetitive actions (compulsions) to prevent a threatening event			<input type="checkbox"/> Y <input type="checkbox"/> 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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		<input type="checkbox"/> Y <input type="checkbox"/> N	Intense terror/fear that strikes without warning			<input type="checkbox"/> Y <input type="checkbox"/> 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.

		<input type="checkbox"/> Y <input type="checkbox"/> N	Unstable relationships with others			<input type="checkbox"/> Y <input type="checkbox"/> N	Emotionally withdrawn from or avoiding social situations
		<input type="checkbox"/> Y <input type="checkbox"/> N	Agitation			<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent conflicts with others
		<input type="checkbox"/> Y <input type="checkbox"/> N	Severe discomfort in social situations; tending to be withdrawn and isolated; and exhibiting odd thoughts, speech, and eccentric behavior.			<input type="checkbox"/> Y <input type="checkbox"/> N	Suspicion and distrust of others, without reason, and believes that others are exploiting, harming, deceiving, or betraying them; experiencing feelings of extreme jealousy
		<input type="checkbox"/> Y <input type="checkbox"/> N	Extreme hypersensitivity			<input type="checkbox"/> Y <input type="checkbox"/> 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.

		<input type="checkbox"/> Y <input type="checkbox"/> N	Disorganized behavior: Behaviors which may appear bizarre, silly, or unusual.			<input type="checkbox"/> Y <input type="checkbox"/> N	Incoherent, nonsensical, or loosely associated speech
		<input type="checkbox"/> Y <input type="checkbox"/> 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)			<input type="checkbox"/> Y <input type="checkbox"/> 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)

<p>Are behaviors/behavioral health symptoms manageable? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the PASRR evaluation in the floor record? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Current psychiatric status: <input type="checkbox"/> Stable <input type="checkbox"/> Moderately Stable <input type="checkbox"/> Unstable</p> <p>Are PASRR recommendations incorporated in Care Plan? (please attach copy of care plan) <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Yes, If yes, how?</p> <p>Please explain selections:</p>	<p>Are current behavioral health services received? <input type="checkbox"/> No behavioral health services <input type="checkbox"/> Psychiatric consultation (date below) <input type="checkbox"/> Ongoing psychiatrist services (most recent below) <input type="checkbox"/> Counseling services <input type="checkbox"/> Day treatment/PHP <input type="checkbox"/> Inpatient psychiatric <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____</p> <p>Is a transfer to another NF being contemplated? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, did the previous PASRR limit the individual's admission to the current NF? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which NF is being considered? Name: _____ City: _____ Contact Person: _____ Phone: _____</p>
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O. BEHAVIORAL HEALTH SERVICES RECEIVING

Current	Past 6 mos	Services	Clinician	Frequency	Most Recent Date
		Psychiatrist			

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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

Notes:

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

 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