

**PASRR EVALUATION COMPUTER SUMMARY**

UPDATE

*This form must be submitted for every Level II Evaluation billed to the DBHDID and must be completed by evaluator.*

**NOTE: ANSWER EACH QUESTION COMPLETELY.**

**DATE SUBMITTED TO DBHDID:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**NAME OF EVALUATOR:** \_\_\_\_\_

**REGION OF EVALUATOR:(Check One):** 1  2  3  4  5  6  7  8  9  10  11  12  13  14  15

**CLIENT IDENTIFYING NUMBER:** \_\_\_\_-- \_\_\_\_-- \_\_\_\_

**CLIENT NAME:** (Please Print) \_\_\_\_\_

**CLIENT BIRTHDATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **SEX:**  M  F

**TYPE OF EVALUATION:** (Check One in Each Section)

**Section 1**

- 1.  BH
- 2.  ID/DD (circle)
- 3.  Dual

**Section 2**

- 1.  Pre-Admission/Initial
  - New to Facility/PASRR Pre-Admission
  - Provisional/Initial
  - Exempted Hospital Discharge/Initial
- 2.  Subsequent Review

**TIMEFRAME:**

Pre-Admission/Initial/Subsequent Reviews

- a. Date of Referral: \_\_\_\_/\_\_\_\_/\_\_\_\_
- b. Date Verbal Given: \_\_\_\_/\_\_\_\_/\_\_\_\_
- c. Date Written Report Sent to NF \_\_\_\_/\_\_\_\_/\_\_\_\_
- d. Date of Admission to NF \_\_\_\_/\_\_\_\_/\_\_\_\_

**PASRR REFERRAL APPROPRIATE:** (Check One)  Y  N

If yes, continue on. If no, stop and check Disposition #9.

**RECOMMEND NURSING FACILITY PLACEMENT:** (Check One)  Y  N **Region:** \_\_\_\_\_

If yes, continue on. If no, stop and circle Disposition #9

**NAME OF NURSING FACILITY PLACEMENT (if applicable)** \_\_\_\_\_

**REQUIRES SPECIALIZED SERVICES:** (Check One)  Y  N If yes, check all boxes below that apply:

**Treatment Type**

- 1.  BH
- 2.  ID/DD (circle)

**Treatment Site**

- 1.  Nursing Facility
- 2.  Community/Other

**Length of Stay in NF**

- 1.  More Than 30 Months
- 2.  Less Than 30 Months

**REQUIRES SERVICES OF LESSER INTENSITY THAN SPECIALIZED SERVICES:**  Y  N

**IF ID/DD/DID COMMITTEE AGREE WITH CMHC DETERMINATION:**  Y  N

**DISPOSITION:** (Check One)

<input type="checkbox"/> 1.	Admission To or Continued Stay in NF; No Specialized Services Recommended
<input type="checkbox"/> 2.	Admission To or Continued Stay in NF; With Specialized Services Recommended
<input type="checkbox"/> 3.	Admission To or Continued Stay in NF; With Specialized Services/Client Declined
<input type="checkbox"/> 4.	Not Admitted to NF or Does Not Need NF Care; Recommended to State Treatment Facility/CMHC Program
<input type="checkbox"/> 5.	Not Admitted to NF or Does Not Need NF Care; Recommended to Private Treatment Facility/Community Program
<input type="checkbox"/> 6.	Not Admitted to NF; No Action Taken
<input type="checkbox"/> 7.	Admission To or Continued Stay in State IMD
<input type="checkbox"/> 8.	Admit to Out-of-State Nursing Facility <b>Where:</b>
<input type="checkbox"/> 9.	Inappropriate Referral/Meets Exemption/Process Stops, Dementia
<input type="checkbox"/> 10.	Deceased Date:
<input type="checkbox"/> 11.	Discharged <b>From:</b> <b>To:</b> <b>Date:</b>