STATE OF HAWAII **Med-QUEST Division**

Department of Human Services

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 symptom(s) and/or 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): ( ) ( )
   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. ( ) ( )
3. Has psychoactive drug(s) been prescribed on a regular basis to treat behavioral/mental health symptom(s) for the individual within the last two (2) years with or without current diagnosis of SMI? ( ) ( )

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. ( ) ( )
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: ____ ( ) ( )
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. ( ) ( )
4. The individual has functional limitations relating to **ID/DD** (mobility, self-care/direction, learning, understanding/use of language, capacity for living independently). ( ) ( )
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. _____ ( ) ( )

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, HOSPITAL DC PLANNER 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 <u>not to exceed 7 days</u>,** 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**? <u>The individual is expected to return to the same caregivers following this brief NF stay.</u>	( )	( )

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<u>CHECK ONLY ONE:</u>

[ ] If **any** answer to Part C is **Yes, <u>NO REFERRAL for LEVEL II</u>** <u>evaluation and determination is necessary at this time.</u> **<u>NOTE TIME CONSTRAINTS!</u>**

[ ] If **all** answers to Part C are **No, <u>REFERRAL for LEVEL II</u>** <u>evaluation and determination</u> **<u>MUST BE MADE.</u>**

SIGN and DATE this form.

	DATE & TIME COMPLETED:
SIGNATURE OF PHYSICIAN, APRN, HOSPITAL DC PLANNER RN	**MM/DD/YY**
PRINT NAME	**Time**