State of Florida Agency for Health Care Administration
Pre-Admission Screening and Resident Review (PASRR)

RESIDENT REVIEW (RR) – EVALUATION REQUEST

For a Significant Change for Serious Mental Illness (SMI)
and/or Intellectual Disability or Related Conditions (ID)
Use for Medicaid Certified Nursing Facility (NF) Only

_____-___-_______ Social Security Number*   ___/___/_____ Date of Birth

____
Name   ☐ Male ☐ Female Age ____

____   ____-_____-______
Legal Guardian Name, Address, City, State Zip (if applicable)   Phone Number

Pay Source: ☐ Private Pay ☐ Medicaid ☐Medicare ☐Private Insurance

____
Medicaid Number

*WHY ARE WE ASKING FOR YOUR SOCIAL SECURITY NUMBER? Federal law permits the State to use your social security number for screening and referral to programs or services that may be appropriate for you (42 CFR § 435.910). We use the number to create a unique record for every individual that we serve, and the SSN ensures that every person we serve is identified correctly so that services are provided appropriately. Any information the State collects will remain confidential and protected under penalty of law. We will not use it or give it out for any other reason unless you have signed a separate consent form that releases us to do so.

Section I: Current Location

☐ NF _______________________________________   ___-____-_____   _________________
Name, Address, City, State, Zip   Phone Number   NF License Number

____/____/_______ NF Admission Date   _____/_____/________ Date of Level I PASRR   ____/____/______ Date of most current Level II PASRR or RR (if applicable)

_________________________ _________
Primary Diagnosis (May use ICD-10 Code)

Level II PASRR Determination: ☐ SMI ☐ ID ☐ SMI and ID ☐ N/A

Section II: Significant Change

Date of Onset _______/_______/________

Describe significant changes in the resident's condition.

☐ **Decline in Resident's Status (check all that apply):**

☐ Increase in behavioral, psychiatric, or mood-related symptoms.
☐ Behavioral, psychiatric, or mood-related symptoms that have not responded adequately to ongoing treatment.
☐ Sudden increase or decrease in weight.
Current weight ______ Date ___/___/_____
Prior weight ________ Date ___/___/_____
Reason for change: _____________________
____
☐ Change in behavior, psychiatric or mood suggestive of a suspicion of SMI (where dementia is not the primary diagnosis).
☐ Will not resolve itself without intervention by staff or the implementation of standard disease-related clinical interventions and/or modification of care plan.
☐ In more than one area of resident's health status (check all that apply):
☐ Behavior change not due to a medical condition.
☐ Adaption to change.
☐ Medical condition exacerbating current SMI/ID symptomatology.

☐ **Improvement in Resident's Status (check all that apply):**

☐ Decrease in behavioral, psychiatric or mood-related symptoms.
☐ Behavioral, psychiatric or mood-related symptoms that have responded adequately to ongoing treatment.
☐ Improvement in medical condition requiring interdisciplinary review and/or modifications in the plan of care.
☐ Improvement in more than one area of resident's health status. Areas affected:
____
____
________ ____________________________
☐ Has required implementation and/or modification in care plan. Specifically:
____
____
____
☐ No longer requires specialized services.

Additional information: ____
____

Section III: Completion of Request for Evaluation

By signing this form below, I attest that I have completed the above request for the individual to the best of my knowledge.

______________________________ ______________________________
Screener's Name Signature

____
Credentials

__________________________ ______________________ ________________________
Date Phone Fax

____
Place of Employment

**************************Incomplete forms will not be accepted**************************

Resident Review Request for Level II Evaluation Distributed to:

☐ Local DOH** office, under the age of 21 years Date: ___/___/_____
☐ Local CARES*** office, age 21 years or older Date: ___/___/_____

Documentation included (check all that apply):

☐ Request for Resident Review
☐ Level I PASRR screen
☐ Level II PASRR evaluation and determination or most recent Resident Review
☐ MDS
☐ Case Notes
☐ Record of treatment
☐ Medication Administration Record
☐ Psychiatric or psychological evaluation
☐ Most recent physical assessment
☐ Other: ____
____

Notice of referral of Resident Review evaluation distributed to (including how to obtain the evaluation):

☐ Individual
☐ Representative
Name: ____

**Department of Health
***Department of elder Affairs' Comprehensive Assessment and Review for Long-Term Care Services