**PASRR Office for New Hampshire**
**400 Technology Way, Scarborough, ME 04074**
**Number: 1-844-526-4480**
**TDY: 1-855-843-4776**
**Fax: 1-844-490-9555**
**NHReviews@kepro.com**

KEPRO INTELLIGENT VALUE

SEAL OF THE STATE OF NEW HAMPSHIRE 1776

**NEW HAMPSHIRE PRE ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)**

# PASRR REFERRAL FORM

## ALL SECTIONS MUST BE COMPLETED

**REFERRAL AGENCY IDENTIFICATION**

Agent or Agency Name:

Contact Person: | Phone Number:

**PATIENT IDENTIFICATION**

Patient Name: | Date of Birth:

Medicaid Number: ☐ Private Pay

**DIAGNOSIS:**

**PRIMARY:**

**SECONDARY:**

**NURSING FACILITY SERVICES NEEDED:**

☐ Long-Term

☐ Short Term _____ (list length of stay requesting)

Date of Admission:

**FUNCTIONAL STATUS:**

| | Independent | With Assistance | Unable to Do |
|---|---|---|---|
| Bathing | | | |
| Toileting | | | |
| Eating | | | |
| Dressing | | | |
| Walking | | | |
| Stair climbing | | | |
| Wheelchair | | | |
| Transfers | | | |

| **MENTAL STATUS:** | Never | Sometimes | Always |
|---|---|---|---|
| Oriented | | | |
| Depressed | | | |
| Wanders | | | |
| Aggressive | | | |

| **IMPAIRMENTS:** | None | Partial | Total |
|---|---|---|---|
| Vision | | | |
| Speech | | | |
| Hearing | | | |
| Loss of Sensation | | | |
| Dentition | | | |

| **Special Care:** | Type | Frequency |
|---|---|---|
| Decubitus ulcer care | | |
| Dressing | | |
| Irrigation | | |
| Tube feeding | | |
| Psychotherapy | | |
| Restraints | | |
| Therapies OT/PT/ST | | |
| Patient/Family Education | | |
| Diet | | |
| Parenteral Fluids & Medications | | |
| Other | | |

**PATIENT USES:**

☐ Glasses ☐ Dentures ☐ Hearing Aids ☐ Prosthesis

☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair

| **DISABILITIES:** | None | Partial | Total | Location |
|---|---|---|---|---|
| Paralysis | | | | |
| Contracture | | | | |
| Amputation | | | | |
| Joint Motion | | | | |
| Fracture | | | | |

| | **Bowel Function** | **Bladder Function** |
|---|---|---|
| No Problem | | |
| Incontinent | | |
| Colostomy | | |
| Catheter | | |

**BRIEF SUMMARY OF PHYSICIAN / NURSING PLAN OF CARE / REHABILITATION GOALS:**

**MD/APRN/Physician Assistant Signature:** **Date:**