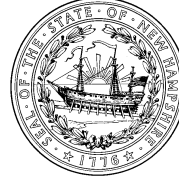


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**NEW HAMPSHIRE
 PRE ADMISSION SCREENING
 AND RESIDENT REVIEW
 (PASRR)**

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:				<input type="checkbox"/> Private Pay			
DIAGNOSIS:							
PRIMARY:							
SECONDARY:							
NURSING FACILITY SERVICES NEEDED:							
<input type="checkbox"/> Long-Term						Date of Admission:	
<input type="checkbox"/> Short Term _____ (list length of stay requesting)							
FUNCTIONAL STATUS:				Special Care:		Type	Frequency
	Independent	With Assistance	Unable to Do	Decubitus ulcer care			
Bathing							
Toileting							
Eating				Dressing			
Dressing							
Walking				Irrigation			
Stair climbing							
Wheelchair				Tube feeding			
Transfers							
MENTAL STATUS:	Never	Sometimes	Always	Psychotherapy			
Oriented							
Depressed				Restraints			
Wanders							
Aggressive				Therapies OT/PT/ST			
IMPAIRMENTS:	None	Partial	Total	Patient/Family Education			
Vision							
Speech							
Hearing				Diet			
Loss of Sensation							
Dentition				Parenteral Fluids & Medications			
PATIENT USES:				Other			
<input type="checkbox"/> Glasses	<input type="checkbox"/> Dentures	<input type="checkbox"/> Hearing Aids	<input type="checkbox"/> Prosthesis				
<input type="checkbox"/> Cane	<input type="checkbox"/> Crutches	<input type="checkbox"/> Walker	<input type="checkbox"/> Wheelchair				
DISABILITIES:	None	Partial	Total	Location	Bowel Function	Bladder Function	
Paralysis					No Problem		
Contracture					Incontinent		
Amputation					Colostomy		
Joint Motion					Catheter		
Fracture							
BRIEF SUMMARY OF PHYSICIAN / NURSING PLAN OF CARE / REHABILITATION GOALS:							
MD/APRN/Physician Assistant Signature:						Date:	