Rim Country Health
& Rehabilitation

Please send a hard copy for all narcotic scripts.

The pharmacy will not fill orders without a hard copy.

Note: Please do not write “range orders” for any medication.

We request that you write i.e. :

Percocet 5/325mg 1 tab po Q6hrs prn for pain level 4-7

Percocet 5/325mg 2 tabs po Q6hrs prn for pain level 8-10

Thank you!

Rim Country Health Skilled Nursing and Rehabilitation
807 West Longhorn Road, Payson, Arizona 85541
Phone: (928)474-1120 **Fax: (928)474-0505**

Admissions Fax 1-800-948-9419

Facility: RIM COUNTRY HEALTH
807 W. Longhorn Rd.
Payson, AZ 85541-4263
(928) 474-1120

Institutional/DEA number _____ Prescriber _____

Patient:
Address:

Order Date:
DOB:
Age: Sex:

Rx: .

On Hospice services with _____

for DX of _____

Dispense: ☐ Refills: ☐ Maximum Daily Dose: ☐

Prescriber signature X _____

This prescription will be filled generically unless prescriber writes "DAW" in the box below.

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PHYSICIAN ADMISSION ORDERS

TRANSFER MEDICATION ORDERS

May use generic equivalent to Rx if available – Yes ❑ No ❑

Medication / Dose / Route / Frequency

1	
Diagnosis:	
2	
Diagnosis:	
3	
Diagnosis:	
4	
Diagnosis:	
5	
Diagnosis:	
6	
Diagnosis:	
7	
Diagnosis:	
8	
Diagnosis:	
9	
Diagnosis:	
11	
Diagnosis:	
12	
Diagnosis:	
13	
Diagnosis:	
14	
Diagnosis:	
15	
Diagnosis:	

CONTINUING CARE ORDERS

1) Admission Diagnosis: _____

_____

_____

2) Resident was informed of condition ❑ Yes ❑ No

3) Allergies: Rx: _____

Food: _____

4) ❑ Patient shows no clinical evidence of active pulmonary TB
Shown by CXR dated:_____ OR PPD dated _____

5) Code Status: ❑ Full Code ❑ Do Not Resuscitate

6)

Diet Type		Texture
❑ Regular	❑ ↓Fat ↓Chol	❑ Regular
❑ CCHO	❑ Cardiac (NAS, ↓Fat)	❑ Mech Soft
❑ NAS	❑ Kcal ADA_____	❑ Puree
❑ Liberal/House Renal	❑ 2gm NA	❑ Liquid
❑ Tube Feeding:_____		

7) Therapy Evaluation & Treatment ❑ PT ❑ OT ❑ ST

8) Discharge Potential _____

9) Annual TB testing to be done by ❑ PPD ❑ CXR

10) Resident may go out on pass w/Medications ❑ Yes ❑ No

11) Resident may have annual influenza vaccine ❑ Yes ❑ No

12) Resident may have routine pneumovac ❑ Yes ❑ No

13) Schedule activities as tolerated ❑ Yes ❑ No

14) **Skin/Wound Care** _____

_____

_____

15) **Lab Orders** _____

_____

16) **Foley Catheter Orders**
Foley Cath Supporting Diagnosis:_____
❑ Indwelling catheter to straight drainage: Size: _____
Balloon: _____
❑ May change PRN for blockage or obstruction, but no more often than once per month unless MD is notified.
❑ May attach catheter to leg bag when out of bed. Change leg bag twice per month.
❑ Routine Catheter Care Per facility protocol.

17) **IV / PICC CARE ORDERS**
❑ Change and Care per facility protocol

18) **OXYGEN:**____liters/hour Type

19) **OTHER ORDERS / FOLLOW UP APPOINTMENTS:**

_____

_____

_____

_____

PATIENT INFORMATION

NAME: _____

DOB: _____ PCP: _____

_____ _____
Physician Signature Date

_____ _____
Nurse Signature (Noted By) Date

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HISTORY AND PHYSICAL

Chief Complaint
Past History
Family History
Allergies
Operations (Minor)
Operations (Major)
Physical Findings BP Temp Pulse Resp. Weight
Head
Neck
Chest
Cardio-Vascular
Abdominal
Genito-Urinary
Skin
Bones and Joints
Glandular
Neuromuscular
Pain: Present Yes No Date of Onset
Origin Location
Current Diagnosis
Rehabilitation Potential
Patient Informed of Medical Condition Yes No
If No, give reason
Advance Directives Yes No
Date Attending Physician's Signature

Name: Last, First, Middle	Physician	Record No.	Room/Bed

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CERTIFICATION AND RECERTIFICATION

(Skilled Nursing Facility)

PATIENT	ADMISSION DATE	HEALTH INSURANCE CLAIM NUMBER

CERTIFICATION of patient admission. Required at time of admission.

I certify that SNF services are required to be given on an inpatient basis because of the above named patient's need for skilled nursing care on a continuing basis for the condition(s) for which he/she was receiving impatient hospital services prior to his/her transfer to the SNF.

PHYSICIAN _____ DATE _____

RECERTIFICATION of continued SNF in-patient care. **On or before the 14th day.**

I certify that continued SNF inpatient care is necessary for the following reasons.

_____

_____

_____

I estimate that the additional period of SNF inpatient care will be _____ days (or_____weeks.)

Plans for post SNF-care are: ☐ Home Health Agency ☐ Office Care ☐ Other (specify)

_____

Continued SNF care for same condition(s) for which patient received inpatient hospital services:

☐ YES ☐ NO

Date Due_____

PHYSICIAN _____ DATE _____

RECERTIFICATION of continued SNF in-patient care. **On or before the 44th day.**

I certify that continued SNF inpatient care is necessary for the following reasons.

_____

_____

_____

I estimate that the additional period of SNF inpatient care will be _____ days (or_____weeks.)

Plans for post SNF-care are: ☐ Home Health Agency ☐ Office Care ☐ Other (specify)

_____

Continued SNF care for same condition(s) for which patient received inpatient hospital services:

☐ YES ☐ NO

Date Due_____

PHYSICIAN _____ DATE _____

RECERTIFICATION of continued SNF in-patient care. **On or before the 74th day.**

I certify that continued SNF inpatient care is necessary for the following reasons.

_____

_____

_____

I estimate that the additional period of SNF inpatient care will be _____ days (or_____weeks.)

Plans for post SNF-care are: ☐ Home Health Agency ☐ Office Care ☐ Other (specify)

_____

Continued SNF care for same condition(s) for which patient received inpatient hospital services:

☐ YES ☐ NO

Date Due_____

PHYSICIAN _____ DATE _____

AMBULANCE SERVICE: I hereby certify that ambulance service was medically necessary for the above named patient.

PHYSICIAN _____ DATE _____

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Tuberculosis Clearance Overview

I have examined this resident and found him/her to be free of Pulmonary Tuberculosis

Resident Name_____MR#_____

Physician Name (PRINT)_____

Physician Signature_____Date_____

Diagnosis must be based on current PPD

Skin Test or Chest X-Ray

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Date Transportation Requested: _____ Pickup Time: _____

Pickup Address: _____

Resident Room #: _____ Bed #: _____ Wing: _____ Floor: _____

Discharge Contact Person: _____

* * * IMPORTANT INFORMATION * * *

Please indicate if resident requires any special equipment during transport.

- ☐ Oxygen
- ☐ Stretcher
- ☐ Bariatric Wheelchair
- ☐ Escort
- ☐ IV
- ☐ _____
- ☐ _____
- ☐ _____

Initial PASRR identification and evaluation must take place prior to admission to a Medicaid certified nursing facility (NF). If a referral for a Level II is indicated, the member must not be admitted to a Medicaid certified nursing facility until the Level II evaluation has been completed.

DEMOGRAPHICS

First Name: _____ Middle Initial: ____ Last Name: _____ Date: _____

Date of Birth: _____ Marital Status: ☐ M ☐ S ☐ W ☐ D Gender: ☐ M ☐ F

Payment Method: AHCCCS ID #:_____ Medicare ID #:_____ Self-Pay: ☐

Current Living Situation:
(*Individual's Place of Residence*)

☐ Nursing Facility ☐ Hospital ☐ Homeless ☐ Home with Family
☐ Home Alone ☐ Group Home ☐ Other

Address: _____ City: _____ State: ____ Zip: _____ Phone: _____

Current Location:
(*Individual's location at the time form is completed*)

☐ Medical Facility ☐ Psychiatric Facility ☐ Hospital ED
☐ Community ☐ Nursing Facility ☐ Other

Name of Current Location/Facility: _____ Admission Date: _____

Address: _____ City: _____ State: ____ Zip: _____ Phone: _____

PASRR Level I Review Type: ☐ Pre-Admission ☐ Status Change ☐ Conclusion of a Time Limit Approval
If individual is in the facility < 30 days

EXEMPTIONS AND CATEGORICAL DETERMINATIONS (SECTION A)

If any questions below result in a "yes" answer, ***NO REFERRAL IS NECESSARY,*** *and the remaining questions need not be answered.* ***Proceed to sections D and F.***

Does the admission meet criteria for 30-day Convalescent Care? ☐ No ☐ Yes, meets criteria below:

- Admission to the NF directly from hospital after receiving acute medical care, and
- The attending physician has certified, prior to NF admission, individual will require < 30 calendar days of NF services, and
- There is no current risk to self or others and behaviors/symptoms are stable.

**The NF must update the Level I at such time that it appears the individual's stay will exceed 30 days*

Does the individual meet the following criteria for Respite admission for up to 30 calendar days?

☐ No ☐ Yes, meets criteria below:

- The individual requires respite care for up to 30 calendar days to provide relief to the family or caregiver, and
- There is no current risk to self or others and behaviors/symptoms are stable.

Effective Dates: 11/27/18, 10/01/19, 05/15/23
Approval Dates: 09/09/18, 09/05/19, 03/16/23

**The NF must update the Level I at such time that it appears the individual's stay will exceed 30 days*

Does the individual meet one or more of the following criteria for NF approval as a result of terminal state or severe illness?

☐ No ☐ Yes, meets criteria below:

☐ Terminal Illness:

- Prognosis of life expectancy of < 6 months (records supporting the terminal state must be present), and
- There is no current risk to self or others and behaviors/symptoms are stable.

☐ Severe Illness:

- Coma state, ventilator dependent, brain-stem dysfunction, progressed ALS, progressed Huntington's disease, etc., of such severity that the individual would be unable to participate in a program of specialized care associated with their MI and/or ID or related condition.
- There is no current risk to self or others and behaviors/symptoms are stable.

**The NF must update the Level I if the individual's medical state improves to the extent they could potentially benefit from a program of services to address their MI and/or ID/RC.*

Does the individual have a **primary** diagnosis of dementia or Alzheimer's disease?

☐ No

☐ No, individual has dementia, but it is not primary

☐ Yes *If yes, is corroborative testing or other information available to verify the presence of or progression of the Dementia? Check all that apply:* ☐ None ☐ Dementia workup ☐ Comprehensive Mental Status Exam ☐ Other (specify):_____

MENTAL ILLNESS (SECTION B)
(ANSWER ALL QUESTIONS IF APPLICABLE)

Does the individual have any of the following Serious Mental Illnesses (SMI)?

☐ No

☐ Suspected – *one or more of the following diagnoses is suspected*

☐ Yes (check all that apply)

☐ Schizophrenia

☐ Schizoaffective Disorder

☐ Major Depression

☐ Psychotic/Delusional Disorder

☐ Bipolar Disorder (Manic Depression)

☐ Paranoid Disorder

Does the individual have any of the following mental disorders?

☐ No

☐ Suspected – *one or more of the following diagnoses is suspected*

☐ Yes (check all that apply)

☐ Personality Disorder

☐ Anxiety Disorder

☐ Panic Disorder

☐ Depression (mild or situational)

☐ Other (list):_____
**Do not list Dementia here*

Does the individual have a substance related disorder?

☐ No ☐ Yes

List all substance related diagnoses:

_____

Is NF need associated with this diagnosis?

☐ No ☐ Yes

When did the most recent substance use occur?

☐ ≤ 7 days ☐ 7-14 days

☐ 14-28 days ☐ 28 days – 2 months

☐ 2-3 months ☐ Unknown

SYMPTOMS
(ANSWER ALL QUESTIONS IF APPLICABLE)

Interpersonal – Has the individual exhibited interpersonal symptoms or behaviors (not due to a medical condition)?

☐ No ☐ Yes:

- ☐ Serious difficulty interacting with others
- ☐ Altercations, evictions, or unstable employment
- ☐ Frequently isolated or avoided others or exhibited signs suggesting severe anxiety or fear of strangers

Concentration/Task related symptoms – Has the individual exhibited any of the following symptoms or behaviors (not due to a medical condition)?

☐ No ☐ Yes:

- ☐ Serious difficulty completing tasks that they should be capable of completing
- ☐ Required assistance with tasks for which they should be capable
- ☐ Substantial errors with tasks which they complete

Adaptation to Change – Has the individual exhibited any of the following symptoms related to adapting to change? (Check all that apply)

- ☐ Self-injurious or self-mutilation
- ☐ Suicidal talk
- ☐ History of suicide attempt or gestures
- ☐ Physical violence
- ☐ Physical threats (with potential for harm)
- ☐ Severe appetite disturbance
- ☐ Hallucinations or delusions
- ☐ Serious lack of interest in things
- ☐ Excessive tearfulness
- ☐ Excessive irritability
- ☐ Physical threats (no potential for harm)
- ☐ Other major mental health symptoms (this may include recent symptoms that have emerged or worsened as a result of recent life changes as well as ongoing symptoms). Describe symptoms: _____

HISTORY OF PSYCHIATRIC TREATMENT
(ANSWER ALL QUESTIONS IF APPLICABLE)

Currently, or within the <u>past 2 years</u>, has the individual received any of the following mental health services?

☐ No ☐ Yes:

- ☐ Inpatient psychiatric hospitalization
- ☐ Partial hospitalization/day treatment
- ☐ Residential treatment
- ☐ Other: _____

Date of Service: _____

Currently, or within the <u>past 2 years</u>, has the individual experienced significant life disruption because of mental health symptoms?

☐ No ☐ Yes:

- ☐ Legal intervention due to mental health symptoms
- ☐ Housing change because of mental illness
- ☐ Suicide attempt or ideation
- ☐ Current homelessness
- ☐ Homelessness within the past 6 months (but not current)
- ☐ Other: _____

Has the individual had a recent psychiatric/behavioral evaluation?

☐ No ☐ Yes If yes, what date: _____

Effective Dates: 11/27/18, 10/01/19, 05/15/23
Approval Dates: 09/09/18, 09/05/19, 03/16/23

PSYCHOTROPIC MEDICATIONS
(COMPLETE THIS SECTION IF APPLICABLE)

Has the individual been prescribed psychotropic (mental health) medications now or within the last 6 months?

☐ No ☐ Yes (list below):

Medication	Dosage MG/Day	Condition used to treat	Discontinued?
			☐
			☐
			☐
			☐
			☐

INTELLECTUAL DISABILITY (ID) AND DEVELOPMENTAL DISABILITIES (DD) (SECTION C)
(ANSWER ALL QUESTIONS IF APPLICABLE)

Does the individual have a diagnosis of intellectual disability (ID)? ☐ No ☐ Yes

Does the individual have presenting evidence of intellectual disability (ID) that has not been diagnosed?

☐ No ☐ Yes

Is there evidence of a cognitive or developmental impairment that occurred prior to age 18? ☐ No ☐ Yes

Has the individual ever received services from an agency that serves people with ID? ☐ No ☐ Yes

Does the individual have a diagnosis which affects intellectual or adaptive functioning?

☐ No ☐ Yes:

☐ Autism ☐ Epilepsy
☐ Blindness ☐ Cerebral Palsy
☐ Closed head injury ☐ Other
☐ Down Syndrome

Are there substantial functional limitations in any of the following?

☐ No ☐ Yes:

☐ Mobility ☐ Self-Care
☐ Self-Direction ☐ Learning
☐ Understanding/Use of Language
☐ Capacity for living independently

If yes, did this condition develop prior to age 22?

☐ No ☐ Yes

REFERRAL DETERMINATION (SECTION D)

☐ No referral necessary for any Level II
☐ Yes, referral for Level II determination for MI only
☐ Yes, referral for Level II determination for ID only (ADES)
☐ Yes, referral for Level II determination for Dual ID/MI

Reviewer Individualized Service Recommendations (if applicable):

☐ Evaluate psychotropic medications ☐ Training in ADLs ☐ Training in self-health care management
☐ Supportive counseling ☐ Medication education ☐ Foreign Language services
☐ Explore/prepare for lower level of care ☐ Obtain prior behavioral health records to clarify need
☐ Other:

Effective Dates: 11/27/18, 10/01/19, 05/15/23
Approval Dates: 09/09/18, 09/05/19, 03/16/23

SIGNATURE OF INDIVIDUAL OR HEALTH CARE DECISION MAKER FOR CONSENT TO A LEVEL II PASRR (SECTION E)

THE INDIVIDUAL MUST SIGN HERE, OR IF THE INDIVIDUAL HAS A HEALTH CARE DECISION MAKER (AS SPECIFIED IN AMPM 320-I), THE HEALTH CARE DECISION MAKER MUST SIGN HERE. IF THERE IS NO HEALTH CARE DECISION MAKER AND THE INDIVIDUAL CANNOT SIGN DUE TO HIS/HER MI/ID ISSUES, A DOCTOR MAY SIGN ALONG WITH SUBMITTING A STATEMENT INDICATING THE REASON FOR HIS/HER SIGNATURE.

I understand that I am required to undergo a Level II evaluation as a condition of admission to, or my continued residence in, a Title XIX Medicaid Nursing Facility. I also give permission to disclose all pertinent medical and personal information to any governmental agency involved in this evaluation. **(Primary Care Physician information must be completed)**

Individual or Health Care Decision Maker Signature: _____ Date: _____

Primary Physician's Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: ____ Zip: _____

Additional Comments: _____

SIGNATURE OF MEDICAL PROFESSIONAL COMPLETING LEVEL I PASRR (SECTION F)

I understand that this report may be relied upon for payment of claims from Federal and State funds, and any willful falsification or concealment of material fact may be prosecuted under Federal and State laws. I certify that to the best of my knowledge this information is true, accurate and complete. I acknowledge that information in this report may be shared with other State agencies.

Print Name: _____ Signature: _____ Date: _____

Title: _____ Phone: _____ Email: _____

*The PASRR Level I Screening Tool must be completed in its entirety and the following documents must be submitted in order for the request to be processed:

- ☐ Hospital or Facility Face Sheet/Demographics
- ☐ Current History and Physical
- ☐ Current medication list
- ☐ Health Care Decision Maker documentation and information (if applicable)
- ☐ Current Nurses/Physicians progress notes (last 2 days prior to transfer)
- ☐ Any recent psychiatric consults and/or evaluations

Email the entire packet together.

For individuals with mental illness, please send via encrypted email to: PASRRProgram@azahcccs.gov
For individuals with an intellectual disability, please send via encrypted email to: DDDPASRR@azdes.gov

Effective Dates: 11/27/18, 10/01/19, 05/15/23
Approval Dates: 09/09/18, 09/05/19, 03/16/23

Rim Country Health
& Rehabilitation

Patient name _____

Receiving facility name _____

Name and Title information received from _____

Behavior Questionnaire for Intake Nurse:

1. **Describe agitated**
   _____
   _____
   _____
2. **Describe Behaviors**
   _____
   _____
   _____
3. **What triggers the behavior?**
   _____
   _____
   _____
4. **What interventions are required to decrease behavior?**
   _____
   _____
5. **Are medications required to intervene with behavior?**
   _____
   _____
6. **How long does medication take to change behavior?**
   _____
7. **How many times a day does the medication need to be given?**
   _____
   _____
8. **Last Psych eval?** _____
9. **Last Psych med changes?** _____
10. **How does the resident interact with other residents?** _____
    _____
    _____
11. **Do they urinate inappropriately?** _____
12. **Do they exit seek?** _____
13. **Nurse- Nurse Comments** _____
    _____
    _____
    _____
    _____
    _____

Signature of intake nurse _____