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| **Send to:** DMH PASRR Unit | **From:**  |
| **Company/Organization:** Disability and Community ServicesCommonwealth MedicineUMass Medical School | **Company/Organization:**  |
| **Fax number:** 508-856-7696 **Phone number:**866-385-0933   | **Sender Phone number:****Sender Fax Number:** |
| **Re: PASRR**  | **Date:** **Total pages, including cover:**  |

### **To Be Completed by Sender:**

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| Please identify the appropriate referral type and check-off the additional, required documentation you are attaching to this referral. Please submit this form, along with the completed PAS I form and all required documentation. * Full Level II PASRR Evaluation/ Resident Review/ Expiration of CD or EHD

 [ ]  Psych evaluation, when available* Advanced Dementia Exclusion

[ ]  H&P[ ]  Medical Record documentation supporting dementia is advanced & primary over SMI, with signature from MD/NP/PA [ ]  Psych evaluation, when available* Convalescent Care:

[ ]  Admission note to hospital including primary diagnosis[ ]  H&P[ ]  Reason seeking convalescent care (i.e. requires rehab, or further nutritional support & education)[ ]  Psych evaluation* Terminal Illness:

[ ]  Hospice Election Benefit; or[ ]  Medical Record documentation supporting terminal illness, with signature from MD/NP/PA[ ]  Psych evaluation* Severe Physical Illness:

[ ]  H&P[ ]  Medical Record Documentation supporting severe physical illness[ ]  Psych evaluation, when available* Provisional Emergency:

[ ]  H&P[ ]  Statement from referral source identifying the need for emergency/protective services[ ]  Psych evaluation, when available* Respite:

[ ]  H&P[ ]  Statement from referral source identifying the need for respite & confirmation of plan for the individual to return to the caregiver[ ]  Psych evaluation, when available |