

McLaren Print System Order

Order No: 6753
 Order Date: 2014-10-27
 User: anna parsian
 Phone: 810-342-2375

Ship Location: Debra Hoffman/Anna
 401 South Ballenger Hwy - 4 South
 Flint , MI 48532

Forms

Quantity: 500
 Paragon Dept No: 91570
 Dept Name: Case Management 4-South
 Company Number: 60

Order Total Price: 0.00

Item Number: DCH-3877
 Item Description: Preadmission Screening (PAS) / Annual Resident Review (ARR) Mental Illness / Mental Retardation / Related Conditions
 Revision Date:
 Print: 2 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish:
 Drill: None
 Misc Info: Previous Editions Obsolete

Michigan Department of Community Health PREAMISSION SCREENING (PAS) / ANNUAL RESIDENT REVIEW (ARR) (Mental Illness / Intellectual Disability/ Related Conditions Identification) Level I Screening		<input type="checkbox"/> PAS <input type="checkbox"/> ARR <input type="checkbox"/> Change in Condition	
SECTION I - Patient, Legal Representative, and Agency Information			
Patient's Print or Last Name		Sex of the patient <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address (Street and Number)		County of Residence	
City		Municipality (City or Village)	
State		Zip Code	
Do you have legal representation? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		If YES, the name of legal representative	
Name of legal representative (last, first, middle)		Address (Street, Box, Apt. Number or Suite Number)	
City		State	
Zip Code		Is the patient a resident of Michigan? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Name of the facility (if applicable)		County Name	
Name of the facility (if applicable)		City	
Name of the facility (if applicable)		State	
Name of the facility (if applicable)		Zip Code	
Sections I & II of this form shall be completed by a registered nurse, licensed teacher or master social worker, licensed professional counselor, psychologist, physician's assistant, or technician.			
SECTION II - Screening Criteria (All 8 items must be completed)			
1. <input type="checkbox"/> NO <input type="checkbox"/> YES	The person has a current diagnosis of MENTAL ILLNESS or DEMENTIA (Circle One)		
2. <input type="checkbox"/> NO <input type="checkbox"/> YES	The person has received treatment for MENTAL ILLNESS or DEMENTIA within the past 24 months (Circle One)		
3. <input type="checkbox"/> NO <input type="checkbox"/> YES	The person has history of suicide or has prescribed antipsychotic or antidepressant medications within the last 18 days		
4. <input type="checkbox"/> NO <input type="checkbox"/> YES	There is presenting evidence of mental illness or dementia including signs and symptoms in thought, conduct, emotions, or judgment		
5. <input type="checkbox"/> NO <input type="checkbox"/> YES	The person has a diagnosis of an intellectual disability or a related condition including, but not limited to, epilepsy, autism, or cerebral palsy		
6. <input type="checkbox"/> NO <input type="checkbox"/> YES	There is presenting evidence of deficits in intellectual functioning or adaptive behavior which suggests that the person may have an intellectual disability or a related condition		
Note: If you check "YES" to items 1, 2, 3, 4, 5, or 6, you must complete "Mental Illness" or "Dementia".			
Note: The patient consent shall be determined to require a comprehensive Level I (ARR) evaluation if any of the above items are "YES" unless a physician certifies on form DCH-3877 that the patient meets at least one of the exemption criteria.			
SECTION III - CLINICIAN'S STATEMENT: I certify to the best of my knowledge that the above information is accurate			
Signature		Date (Month/Day/Year)	
Address (Street and Number) City State Zip Code		Agency Name Address (Street and Number) City State Zip Code	
HOSPITAL: <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, the hospital name is: _____		The requirement of community health is an equal opportunity employer, minority, and program provider.	

DISTRIBUTION: If any answer to questions 1 - 6 in SECTION II is "YES", send ONE copy to the local Community Mental Health Services Program (CMHSP), with a copy of form DCH-3877 if an exemption is requested. The receiving facility must retain the original in the patient record and provide copy to the patient or legal representative.