

## McLaren Print System Order

Order No: 7667  
 Order Date: 2014-12-15  
 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: 6/2014  
 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
<b>SECTION I - Patient, Legal Representative, and Agency Information</b>		
Patient's Print or Last Name		Sex of the patient <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street and Number)		City or Township
City		State
Zip		Telephone (Area Code and Number)
Has the patient ever been hospitalized for a mental illness? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		FACILITY (Name of Legal Representative)
Facility to which the legal representative was assigned (Name, Address, Street, Apt. Number or Suite Number)		Address (Street, Apt. Number or Suite Number) City State ZIP Code
High School (Name and Address) City State ZIP Code		Address (Street, Apt. Number or Suite Number) City State ZIP Code
Working Family Name (Employer's Name) City State ZIP Code		Address (Street, Apt. Number or Suite Number) City State ZIP Code
Working Family Name (Residential Address) City State ZIP Code		Address (Street, Apt. Number or Suite Number) City State ZIP Code
Note: If A or B of this form must be completed by a registered nurse, licensed teacher or master social worker, licensed professional counselor, psychologist, physician's assistant, or technician.		
<b>SECTION II - Screening Criteria (All 8 items must be completed)</b>		
1. <input type="checkbox"/> NO <input type="checkbox"/> YES	The person has a current diagnosis of <b>MENTAL ILLNESS</b> or <b>DEMENTIA</b> (Circle One)	
2. <input type="checkbox"/> NO <input type="checkbox"/> YES	The person has received treatment for <b>MENTAL ILLNESS</b> or <b>DEMENTIA</b> 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 prevailing evidence of mental illness or dementia including signs and disturbances 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 prevailing 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, circle the word "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 person meets at least one of the exemption criteria.		
<b>SECTION III - CLINICIAN'S STATEMENT: I certify to the best of my knowledge that the above information is accurate</b>		
Signature Address (Street and Number) City State ZIP Code		Date (Month and Day) Signature (Print Name)
Telephone (Area Code and Number) City State ZIP Code		Address (Street, Apt. Number or Suite Number) City State ZIP Code
I hereby certify that I am a registered nurse, licensed teacher or master social worker, licensed professional counselor, psychologist, physician's assistant, or technician.		The recipient of community health care is equal opportunity employer, individual, 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.

