

McLaren Print System Order

Order No: 9979
 Order Date: 2015-03-21
 User: anna parsian
 Phone: 810-342-2375

Ship Location: Shannon Smith & Anna Parsian
 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: 24.90

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: None
 Drill: 5 Hole Top
 Misc Info: Previous Editions Obsolete

Michigan Department of Community Health PREADMISSION 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 Name (Last, First, Middle) _____		Sex of the patient <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street and Number) _____		City/Township/County _____
City State ZIP Code _____		Telephone (Area Code) _____
Do you have a legal representative or guardian? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		F.O.B. (Last name of legal representative) _____
Date of birth (Month/Day/Year) _____		Address (Street, Room, Apt. Number or Suite Number) _____
High School (Name and Address) _____		City State ZIP Code _____
Working Family Name (Last Name) _____		Telephone Number _____
Working Family Name (First Name) _____		City/Township/County _____
Working Family Name (Middle Name) _____		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.		
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 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.		
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/Township/County _____
City State ZIP Code _____		Telephone Number _____
HOSPITAL/CLINIC: _____ (Name, Address, City, State, ZIP Code) (If not applicable, delete this section)		The recipient of community health care is 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.		

