

McLaren Print System Order

Order No: 6436
Order Date: 2014-10-14
User: anna parsian
Phone: 810-342-2375

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

Forms

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

Order Total Price: 111.20

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: 3 Part (White, Yellow, Pink)
Size: 8.5 x 11
Fold:
Finish:
Drill: 5 Hole Top
Misc Info:

Michigan Department of Community Health
PREADMISSION SCREENING (PAS) / ANNUAL RESIDENT REVIEW (ARR)
(Mental Illness / Mental Retardation / Related Conditions Identification)
Level I Screening

PAS
 ARR
 Change in Condition

SECTION I - Patient, Legal Representative, and Agency Information

Patient's Name and Address		City of Residence	State	<input type="checkbox"/> Michigan <input type="checkbox"/> Outside
City	State	ZIP Code	Medical Record or Number	Medical Center
<input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		Patient's Date of Birth (MM/DD/YYYY)		
Patient's Home Telephone Number		City	State	ZIP Code
Home Telephone Number	City	State	ZIP Code	
Working Family Name (Employer or Relative)		City	State	ZIP Code
Working Family Telephone Number and Street		City	State	ZIP Code

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 had any recent use or have prescribed or prescribed or antidepressant medications within the last 12 days
4	<input type="checkbox"/> NO <input type="checkbox"/> YES	There is continuing evidence of mental illness or dementia including significant disturbances in thought, conduct, emotions, or judgment
5	<input type="checkbox"/> NO <input type="checkbox"/> YES	The person has a diagnosis of mental retardation 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 continuing evidence of deficits in intellectual functioning or adaptive behavior which suggests that the person may have mental retardation or a related condition

SECTION III - CLINICIAN'S STATEMENT: I certify to the best of my knowledge that the above information is accurate.

Signature	Date	Signature	Date
Patient's Name (Write leg number or full name)		Medical Record Number	
City	State	ZIP Code	Medical Record Number

COMPLETION: This form is to be completed by the patient, legal representative, or agency provider. The Department of Community Health is an equal opportunity employer, services, and programs provider.

DISCLAIMER: If any answer to questions 1 - 6 in SECTION II is "YES", then ONE copy to the local Community Health Services Program (CHSP), with a copy of form DCH-3876 (if completion is required). The working family must retain the original of the patient record and send that a copy goes to the patient or legal representative.

DCH-3877 (2012) Revised without any discounts