# Pre-Admission Screening (PAS) Referral: Internal Routing Form

An initial Pre-Admission Screening is required for anyone seeking admission to a Minnesota Medicaid certified nursing facility, regardless of length of stay or payer source.

This form can be used internally to allow providers without direct Internet access the ability to collect necessary Pre-Admission Screening (PAS) information. This information can be submitted online once Internet access is available. This form cannot be faxed to the Senior LinkAge Line®, nor will it be accepted if faxed. To officially submit the Pre-Admission Screening, please visit https://mnhelpreferral.revation.com/.

**Fields in **bold** are required.**

| **Health Care Provider Completing Information** | | |
|---|---|---|
| **Provider Type:** | | **Type of Service: (swing bed, nursing facility, hospital, etc.)** |
| **Provider Name:** | | |
| **Address:** | | **City:** |
| **State:** | **Zip Code:** | **County:** |
| County - Out of State: | | **Name of Person Completing Form or Main Contact:** |
| **Relationship to Consumer:** | | **Direct Phone Number:** |
| Email Address: | | |
| **Consumer Information** | | |
| **First Name (Legal and Nickname):** | **Last Name:** | Middle Initial: |
| **Date of Birth:** | Age: | **Gender:** |
| Marital Status: | **Is this consumer a caregiver for someone else?** | |
| **Home Address:** | | **City:** |
| **State:** | **Zip Code**: | **Phone Number:** |
| **County:** | County – Out of State: | |

**Ethnicity** (circle one):

| | | | | |
|---|---|---|---|---|
| American Indian, Alaskan Native | Asian Indian | Black, African American | Chinese | Filipino |
| Guamanian, Chamorro | Hispanic, Latino, Spanish | Hmong | Japanese | Korean |
| Native Hawaiian | Other Asian | Other Pacific Islander | Samoan | Vietnamese |

**Housing prior to hospitalization/ER/NH Placement** (circle one):

| | | | | |
|---|---|---|---|---|
| Board and Lodge | Correctional Facility | Foster Care | Homeless | Housing with Services, Assisted Living |
| ICF/DD | Non-certified Boarding Care | Nursing Facility, Certified Boarding Care | Other home, apartment | Own home, apartment |

| **Caregiver Information** | | | |
|---|---|---|---|
| **Should contact be made with someone other than the consumer?** Yes No<br>Note: This may include family, friends, a professional or other person that the consumer requests be included in his/her care or is required to be involved due to legal authority. | | | |
| Is the caregiver a health care agent? Yes No | | | |
| Caregiver Name: | | Caregiver Relationship: | |
| Phone Number: | | Alternative Phone: | |
| Caregiver Address: | | City: | |
| State: | | Zip Code: | |

| **Financial Information** | | | |
|---|---|---|---|
| **Veterans Benefits:** Yes No | **Does the consumer currently have a care coordinator/case manager?**<br>Yes No | | |
| If no, reason for no care coordinator/case manager? | No Care Coordinator Available | | Not Eligible |
| Care Coordinator – No Response | Not Willing to Help | | Program Doesn't Pay |
| If yes, which lead agency? | | | |
| Care Coordinator/Case Manager Name: | | Phone Number: | |
| **Nursing Facility Pay Source** (circle one): | Long-term Care Insurance | Medicare | |
| Medical Assistance | Other Insurance (auto, workers comp) | Private Pay | |
| Veterans Administration | To Be Determined | | |
| **Application Needed** (circle one): | Currently on Medical Assistance | Private Pay | |
| Application for Medical Assistance Submitted | Needs to Apply for Medical Assistance | | |

| **Anticipated Nursing Facility Information** | | | |
|---|---|---|---|
| **Anticipated Nursing Facility Name:** | | **Type of Service: (swing bed, nursing facility, hospital, etc.)** | |
| **Address:** | | **City:** | **State:** |
| **County:** | County – Out of State: | **Zip Code:** | |
| **Phone Number:** | | | |
| Hospital State Date: | | ER Start Date: | |
| Number of Days in Inpatient Status: | | Number of Days in Observation Status: | |
| **Actual or Anticipated Nursing Home Admit Date:** | | | |
| **Anticipated Length of Nursing Home Stay:** | | | |
| **Name of Physician Signing Nursing Home Admit Orders:** | | | |
| **Has the consumer had a previous nursing home stay in the past year?** Yes No Unknown | | | |

## Medical Information

**Category of Primary Diagnosis** (choose from the categories below)**:**

Examples (not all inclusive):

- Heart/Circulation: Anemia, A-Fib, CHF, DVT, Hypertension
- Gastrointestinal: GERD, Cirrhosis, Colitis
- Genitourinary: Renal Failure, ESRD, Neurogenic Bladder
- Infections: Pneumonia, TB, Viral Hepatitis, Wound Infection
- Metabolic: Diabetes, Hyperlipidemia, Thyroid Disorder
- Musculoskeletal: Arthritis, Osteoporosis, Hip Fracture, Other Fracture
- Neurological: Alzheimer's, CVA/TIA, Dementia, MS, Parkinson's, Paraplegia/Quadriplegia, TBI, Seizure Disorder/Epilepsy
- Nutritional: Malnutrition
- Psychiatric/Mood Disorder: Anxiety, Depression, Bipolar, Schizophrenia, PTSD
- Pulmonary: Asthma, COPD, Respiratory Failure
- Vision: Cataracts, Glaucoma, Macular Degeneration

**Primary Diagnosis:**

**Reason for Nursing Facility/Swing Bed Admission** (circle one): Therapy Services

Respite Care Hospice Care Permanent Placement

Unknown Unsafe for Care at Home Other

**Other Reason:**

**Neuromuscular Diagnosis:** Yes No

Neuromuscular includes:

- Diseases of the nervous system, excluding sense organs and Alzheimer's
- Cerebrovascular disease, excluding atherosclerosis
- Fracture of the skull, excluding cases without intracranial injury
- Spinal cord injury, without evidence of spinal bone injury
- Injury to nerve roots and spinal plexus
- Neoplasms of the brain and spine

**Does your organization's health care record contain any information that would indicate a history of Developmental Disability diagnosis *prior to age 21*?** Yes No

If so, what is the DD Diagnosis: Age at Onset:

Evidence of Diagnosis (circle one): Currently Receiving Services Medical Record

Verbal from Family Verbal from Medical Professional Unknown

**Does your organization's health care record contain any information that would indicate a history of Mental Illness diagnosis?** Yes No

If so, what is the MI diagnosis?

Age at Onset: Current Suicidal Ideation?

Evidence of Diagnosis (circle one): Currently Receiving Services Medical Record

Verbal from Family Verbal from Medical Professional Unknown

**What services is the consumer currently receiving related to their MI diagnosis?**
ACT ARMHS Day Treatment Medication Treatment for MI Outpatient Therapy None Unknown Other

**Does your organization's health care record contain any information that would indicate a history of Brain Injury?**
Yes No
If so what is the BI diagnosis? Brain Injury – Other:

Age at Onset:

Evidence of Diagnosis (circle one): Currently Receiving Services Medical Record

Verbal from Family Verbal from Medical Professional Unknown

Current Prescriptions (Write in as needed)

## Health and Functional Needs at Discharge

**Indicate the level of assistance the consumer requires or the status of the following using these selections:**

Dressing (circle one)
- 00 Can dress without help of any kind
- 01 Needs and gets minimal supervision or reminders
- 02 Needs some help from another person to put clothes on
- 03 Cannot dress self and somebody dresses him/her
- 04 Is never dressed

Grooming (circle one)
- 00 Can comb hair, wash face, shave or brush teeth without help of any kind
- 01 Needs and gets supervision or reminding for grooming activities
- 02 Needs and gets daily help from another person
- 03 Is completely groomed by somebody else

Bathing (circle one)
- 00 Can bathe or shower without any help
- 01 Needs and gets minimal supervision
- 02 Needs and gets supervision only
- 03 Needs and gets help getting in and out of the tub
- 04 Needs and gets help washing and drying their body
- 05 Cannot bathe and shower, needs complete help

Eating (circle one)
- 00 Can eat without help of any kind
- 01 Needs and gets minimal reminding or supervision
- 02 Needs and gets help in cutting food, buttering bread or arranging food
- 03 Needs and gets some personal help with feeding or someone needs to be sure they don't choke
- 04 Needs to be fed completely or tube feeding or IV feeding

Bed Mobility (circle one)
- 00 Can move in bed without any help
- 01 Needs and gets help sometimes to sit up
- 02 Always needs and gets help to sit up
- 03 Always needs and gets help to be turned or change positions

Transferring (circle one)

00 Can get in and out of bed or chair without help of any kind
01 Needs somebody to be there to help guide him/her, but can move in and out of a bed or chair
02 Needs one other person to help
03 Needs two other people or a mechanical aid to help
04 Never gets out of a bed or chair

Walking (circle one)

00 Walks without help of any kind
01 Can walk with help of a cane, walker, crutch or push wheelchair
02 Needs and gets help from one person to help walk
03 Needs and gets help from two people to help walk
04 Cannot walk at all

Behavior (circle one)

00 Behavior requires no intervention
01 Needs occasional staff intervention in the form of cues or redirection less than 4 times per week
02 Needs regular staff intervention in the form or cues or redirection 4 or more times per week
03 Needs behavior management or instruction. Person may be resistant to redirection/intervention.
04 Needs behavior management. Person may physically resist redirection/intervention or instruction.

Toileting Supervision (circle one): Yes No

Does the person need constant supervision and/or the assistance of another person to begin and complete toileting?

Special Treatments (circle one): 00 None 01 Tube Feeding 02 Other treatments

Does the person receive tube feeding or other special treatments? Other special treatments include:

- Intravenous fluids or medications
- Blood transfusions
- Drainage tubes
- Symptom control for terminal illness
- Isolation precautions
- Hickman catheter
- Oxygen & respiratory therapy
- Ostomies & catheters
- Wound care/decubiti and skin care

Clinical Monitoring (circle one): 00 None 01 At least once every 24 hours 02 At least once every 8 hours

Clinical monitoring includes nursing procedures emanating from the client's diagnosis and medically unstable condition and high risk condition(s). The medical record must establish that:

1. The physician has identified the medically unstable condition for which the clinical monitoring is needed;
2. A registered nurse has completed an assessment identifying the high risk condition(s);
3. A written plan for clinical monitoring has been developed;
4. Systematically recorded measurements (such measurements may be collected by licensed or unlicensed nursing personnel) have been made;
5. The clinical monitoring data has been interpreted by a registered nurse and communicated to the physician; **and**
6. The physician has documented periodic reassessment of the client's medical status and documented the need for continued clinical monitoring.

Orientation (circle one)

Orientation is defined as the awareness of an individual to his/her present environment in relation to time, place and person.

00 Oriented
01 Minor forgetfulness
02 Partial or intermittent periods of disorientation
03 Totally disoriented, does not know time, place, identity
04 Comatose
05 Not determined

Self-Preservation (circle one)

Does the consumer have the judgment and physical ability to cope, make appropriate decisions and take action in a changing environment or a potentially harmful situation?

00 Independent
01 Minimal supervision
02 Mentally unable
03 Physically unable
04 Both mentally and physically unable

Hearing (circle one)

00 No hearing impairment
01 Hearing difficulty at level of conversation
02 Hears only very loud sounds
03 No useful hearing
04 Not determined

Visual (circle one)

00 Has no impairment of vision
01 Has difficulty seeing at level of print
02 Has difficulty seeing obstacles in environment
03 Has no useful vision
04 Not determined

Falls (circle one): 00 No 01 Yes 03 Yes–Resulted in a fracture in the last 12 months

Mechanical Vent (circle one): 00 N/A 01 Less than 6 hours/day 02 At least 6 hours/day 03 Continuous

Indicate the level the person is dependent on mechanical ventilation for life support. DO NOT include intermittent or PRN need for oxygen, use of oxygen monitor or apnea monitor only, nebulizer treatments or CPAP for snoring or sleep apnea.

Living Arrangement (circle one): 01 Living Alone 02 Living with spouse/parent

03 Living with family/friend 04 Living in congregate setting 05 Homeless

Who was the consumer living with prior to hospitalization/emergency room visit/nursing home admission?

Alternative Living Arrang. (circle one): 01 Living Alone 02 Living with spouse/parent

03 Living with family/friend 04 Living in congregate setting 05 Homeless

If the consumer did not admit to the nursing facility, what would be their living arrangement?

| Developmental Disability or Related Condition | | |
|---|---|---|
| **In order to consider a person for referral for further evaluation and determination of need for specialized services, an individual may meet ANY of the following criteria; diagnosis, history or evidence of developmental disability. If you answer *Yes* to ANY of the following questions, please ensure a developmental disability diagnosis is listed in the Medical Information section. Answer *Yes* or *No* to each question.** | | |
| Yes | No | Does this person have a diagnosis of developmental disability or a related condition? |
| Yes | No | Has this person ever been considered to have developmental disability or a related condition in the past? |
| Yes | No | Is there any presenting evidence (cognitive or behavioral) that may indicate the presence of developmental disability or related condition? |
| Yes | No | Has the person been referred for nursing or boarding care facility placement by an agency that serves persons with developmental disability or related condition? |

| Mental Illness | | |
|---|---|---|
| **In order to refer a person for further evaluation and determination of need for specialized mental health services, the person must meet ALL of the following criteria on diagnosis, level of impairment and duration of illness. If you answer YES to ANY of the following questions, please ensure a mental illness diagnosis is listed in the Medical Information section. Answer *Yes* or *No* to each question.** | | |
| Yes | No | Has this person had a major mental disorder diagnosable as listed in the *Diagnosis and Statistical Manual of Mental Disorders* (DSM), current edition **excluding a primary diagnosis of dementia, Alzheimer's disease or other related cognitive conditions?** |
| Yes | No | Has the major mental disorder resulted in significantly impaired functioning in major life activities that would be appropriate for the person's developmental stage within the past 3 – 6 months? |
| Yes | No | Does the person's treatment history indicate at least one of the following?<br>a. Psychiatric treatment, more intensive than outpatient care (partial hospitalization or inpatient hospitalization) has occurred more than once in the last two years.<br>b. Or, due to mental disorder within the past two years, the person has had an episode of significant disruption to the normal living situation for which support services were required to maintain functioning at home or in a residential treatment center, or which resulted in intervention by housing or law enforcement officials. |

## Other Information

**Does the consumer speak a language other than English and need translation services?** Yes No

If yes, which language?

**Does the consumer need any special accommodations to receive a phone call?** Yes No

If yes, what are the special accommodations?

Other Comments:

## Consent to Follow Up with Consumer Upon Nursing Home Discharge

**The consumer has given verbal consent to receive follow-up from the Senior LinkAge Line® or Disability Hub for options counseling upon discharge from the nursing home.*** Yes No

As you know, Pre Admission Screening is required under federal and state law. The Senior LinkAge Line® provides help to seniors recently discharged from the hospital age 60 and older. The Disability Hub provides help to individuals under the age of 60. Consent is needed so staff can contact the consumer to follow up, providing support and information about resources available for aging well in the community.

Thank you for your efforts to help the Senior LinkAge Line® and Disability Hub help Minnesotans age well in place. Please feel free to provide your patients information about the Senior LinkAge Line® by directing them to the following webpage http://www.mnaging.org/en/Advisor/SLL.aspx. Information about Disability Hub can be found at https://disabilityhubmn.org/.

***In order to submit this form, the health care provider needs to get permission from the client to provide his/her personal data to the Senior LinkAge Line®. Please inform the client that the Senior LinkAge Line® is concerned about the security and privacy of personal information in its possession; therefore it takes reasonable and legally mandated state and federal precautions to safeguard and secure the information from loss, misuse, unauthorized access, disclosure, alteration and destruction.

**Submitter Agreement:** By submitting this information, I, as a health care provider, confirm that I have received permission from the patient to collect person information for the Senior LinkAge Line® and submit via the online form. In addition, this patient has received information about and understands his/her rights regarding a choice between an institution and community services and the right to a choice of available providers. I certify that the information included in this submission is true and complete to the best of my knowledge, without any omission of any consequence.