NEW JERSEY DIVISION OF MENTAL HEALTH SERVICES
PASRR RESIDENT REVIEW REFERRAL

PLEASE PRINT

DATE:_____

NURSING FACILITY: _____

ADDRESS:_____

CONTACT PERSON NAME:_____

TELEPHONE NUMBER: _____ FAX NUMBER:_____

RESIDENTS NAME:_____
LAST FIRST M.I.

SOCIAL SERCURITY NUMBER: _____

DATE OF BIRTH: _____ / _____ /_____ ADMISSION DATE: _____ / _____ / _____

PSYCHIATRIC DIAGNOSIS:_____

DEVELOPMENTAL DISORDERS / PERSONALITY DISORDERS:_____

MEDICAL DIAGNOSIS:_____

Describe the residents Significant Change in Status:

_____

_____

Have the following interventions been implemented to address the residents significant change in status?

1. Has the primary care physician and treating psychiatrist been consulted? _____ Yes _____ No

2. Ensure that the resident is not in imminent danger to self or others. If the patient is a danger to self, others or property, the patient should be evaluated immediately by Screening / Crisis.
Has the resident been evaluated by screening? _____Yes _____ No

3. Did the resident undergo a careful medical evaluation to assess for delirium, comorbid medical illness, pain or other factors that may be causing any behavioral disturbance? _____Yes _____No

4. Has a behavioral plan been formulated and implemented to address any behavioral disturbance?
_____ Yes _____ No

Fax the Resident Review Referral Form, completed PASRR Psychiatric Evaluation (completed by an independent Psychiatrist or Psychiatric APN dated within one week) and current MDS to:

PASRR COORDINATOR (609) 777-0662 (fax) (609) 777-0725 (phone)