PASRR LEVEL II

OKLAHOMA Health Care Authority

Provider Name: _____ Provider ID w/ Service Loc: _____

Person Ordering PASRR: _____ Phone Number: _____

Member Name: _____ Member ID: _____

Social Security # _____ Member's DOB: _____

Legal Guardian: _____ Legal Guardian Name: _____

Race		Ethnicity		Gender	

Payor Source	Marital Status

If the individual is discharging from a hospital please provide the name, address, phone number of contact person, and member room number at the hospital.
Does the individual have a legal guardian/POA (list the name, address, and phone number of the individual)? Is the legal guardian/POA related to the member? Does the individual agree to have either a POA or personal contact know about or be present for the PASRR?
Does the individual have an emergency contact? If so, please include the name, address, telephone number, and relation to the client.
Please list the individual's diagnoses (Starting with the primary diagnosis first).
Please provide a detailed list of medications and dosages.

If the diagnosis is a "Related Condition" please explain how the diagnosis has affected the individual prior to the age of 22 (i.e. did they graduate high school, work, drive, live independently, get married, have children, etc)? Please provide as much detail as possible.
Does the individual have a legal guardian/POA (list the name, address, and phone number of the individual)? Is the legal guardian/POA related to the member? Does the individual agree to have either a POA or personal contact know about or be present for the PASRR?
Does the individual have any evidence of serious mental illness, including possible disturbances in orientation or mood?
Does the individual have a diagnosis of either Dementia, Alzheimer's, or Major Neurological Cognitive Disorders? (dementia or other organic mental disorders are not considered a serious mental illness).
Does the individual have a diagnosis of serious mental illness (such as schizophrenia, paranoia, panic, mood, anxiety, depressive, somatoform, personality, or psychotic disorder)?
Does the individual have any other mental health disorders that may lead to chronic disability?
Does the individual have a current or past diagnosis of intellectual delay? Was the member on an IEP or 504 Plan?

Does the individual have any evidence of possible intellectual delay or a related condition?
Has the individual previously completed a PASRR, if so please provide the date if known?
Is it recommended that someone else be present with the individual due to a history of aggressive behavior, sexual offending behavior, or violence?
Is there any other pertinent information that may be helpful to the evaluator?