



Office for People With Developmental Disabilities

OPWDD PASRR LEVEL II REFERRAL FORM

To ensure timely processing of the PASRR Level II evaluation, please complete and return this form along with copies of the specified documents to the DDRO PASRR Coordinator.

Patient's Name: _____ Phone: _____

Home Address: _____ Zip Code: _____

Date of Birth: _____ County of Residence: _____

Advocate/Contact Person Name: _____ Relationship: _____

Home Address: _____ Phone: _____

Referral Organization: _____

Address: _____ Zip: _____

Referral Contact Name: _____ Referral Contact Phone: _____

Referral Contact Email: _____ Fax: _____

Reason for Referral to Nursing Home: _____

Nursing Home Referral Type (Check one): Categorical Determination (YES selected for any of items 27-30 on Level I SCREEN) Long-Term Care Significant Change

Anticipated Hospital Discharge Date: _____ Anticipated Nursing Facility Admission Date: _____

Name of Nursing Facility: _____

NF Address: _____

NF Contact Person: _____ NF Contact Phone: _____

Please send a copy of the following documents to the DDRO PASRR Coordinator:

- H/C PRI or PRI + SCREEN
- Complete Medical History including results of most recent physical examination
- Psychosocial evaluation including current living arrangements, medical, support systems, and day program information (if available)
- Supportive documentation for diagnosis of intellectual and/or developmental disability
- List of current medications
- Medical documentation supporting the need for nursing home level of care