Date of Referral_____ Date Referral Received_____
Fax to 860-262-5832

Referral for 60 West Level of Care Assessment

60 West is a privately owned skilled nursing facility that cares for individuals who meet nursing home level of care criteria, but are difficult to place because of psychiatric and/or criminal history. It should be clear that a nursing facility is the most appropriate, least restrictive setting for the person. In addition to the 60 West Assessment Process, Federal law requires that all individuals undergo Preadmission Screening Resident Review (PASRR). Admission is ultimately determined by the facility's Utilization Management Committee.

Client's Name_____ **DOB**_____
Last Name *First Name*

Current Location (check one)	Name of Location	Date of Admission
__DMHAS in-patient facility		
__Private Hospital		
__Community Setting		
__DOC Correctional Institution		
__Other (specify)		

Is there a conservator of person? __NO __YES **Of estate?** __NO __YES
Name: _____ ___ Number: _____

Person Making Referral & Contact Information:

Please answer the following questions:

1. Does this person have an uncontrolled and/or unstable and/or chronic condition that requires continuous nursing services as evidenced by diagnosis(es), therapies, services, observation requirements, and/or frequency? ___NO ___YES (specify the condition(s) & needs)

2. Does this person have a chronic condition requiring substantial assistance with personal care (ADLs) on a daily basis? ___NO ___YES (specify the condition(s) and ADL needs)

ADL	Independent	Requires Supervision	Requires Hands-on Assistance	Requires Total Care
Bathing				
Dressing				
Toileting				
Transferring				
Ambulation				
Eating				
Meal Preparation				

Date of Referral_____ Date Referral Received_____
Fax to 860-262-5832

3. Does the person have any of the following need factors on a daily basis? ___NO ___YES (specify)

   ___Has potential for rehabilitation & can participate in services 5 times per week (e.g., PT, OT)

   ___Has cognitive deficits that require supervision for safety.

   ___Has behaviors that require supervision for safety.

   ___Has medication needs that require supervision beyond set-up.

4. Does the person have a diagnosis of dementia that is supported by corroborative evidence and has resulted in cognitive deterioration to the extent that a structured, professionally staffed environment is needed for daily monitoring, evaluating, and/or accommodating to the individual's changing needs? ___NO ___YES

5. Does the person have a psychiatric diagnosis? ___NO ___YES (specify)

6. Does the person have a history of or currently present risk in any of the following areas? ___NO ___YES (specify)

Potential Risk Factor	Overall History	Within past 6 months	Within past 3 months
Assaultiveness			
Harm to self/suicide			
Harm to others/homicide			
Arson			
Sexual Inappropriateness			
Unplanned leave/elopement			
Other (specify)			

7. Describe current potential risk factor(s) with respect to….. ___Not Applicable

   Intensity:

   Frequency:

   Duration:

   Care plan that mitigates risk(s):

Date of Referral_____ Date Referral Received_____
Fax to 860-262-5832

8. Please identify below any factors that may mitigate potential risk: ___Not Applicable

Current Function	No Impairment	Mild Impairment	Moderate Impairment	Severe Impairment
Physical Balance/ambulation Coordination Strength Paralysis/Limb Amputation Respiratory Endurance Range of Motion Sensory deficits				
Cognitive Memory Orientation Level of Attention or consciousness				

Additional Comments/Attachments to Support Nursing Home Admission *(attachments may include copies of diagnostic tests/exams; PT/OT evaluations; behavioral care plan; medications; etc.)*

Date of Referral_____ Date Referral Received_____
Fax to 860-262-5832

Outcome of Referral

Person appears to meet nursing home level of care criteria. ___NO ___YES ___Need more info

IF NO, specify reason:

IF YES, obtain a discharge packet and consider assessment.