Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

Request for Skilled Nursing in a Community Setting

Instruction to Nurse: This request is for a nurse to accompany a PASRR client on community outing(s) to provide nursing assistance as needed. Nurses accompany the client and DDA-contracted community services provider (community engagement or community inclusion). The nurse is not expected to provide transportation for the client. Prior to the first outing, a meeting will be scheduled with the nurse, nursing facility staff, and community services provider to allow for sharing of any needed information. Following each outing, please submit progress notes to the PASRR Assessor. If you have questions, please contact the Nursing Services Unit Manager or your regional Nursing Care Coordinator.

Instruction to PASRR Assessor: Prior to first community outing, schedule a meeting for the client, nurse, community services provider, and nursing facility staff who can provide information about equipment (if any) and nursing oversight needed. Attach the following documents to this form: History and Physical (H and P), most recent PASRR Level 2 and most recent Follow-up (if any), and consent for exchange of information listing the nurse or nursing agency and community services provider.

RESIDENT'S NAME	ADSA ID NUMBER
GUARDIAN'S NAME (IF APPLICABLE)	GUARDIAN'S PHONE NUMBER
FACILITY'S NAME	
NURSING FACILITY CONTACT'S NAME	NURSING FACILITY CONTACT'S PHONE NUMBER
COMMUNITY SERVICES PROVIDER'S NAME	COMMUNITY SERVICES PROVIDER'S PHONE NUMBER
NURSE'S OR NURSING AGENCY'S NAME	NURSE'S OR NURSING AGENCY'S PHONE NUMBER
PASRR ASSESSOR'S NAME	PASRR ASSESSOR'S PHONE NUMBER
REASON FOR REQUEST: WHAT TASKS NEED NURSING SUPPORT OR JUDGMENT?	
SPECIALIZED EQUIPMENT: DOES THE CLIENT NEED EQUIPMENT AND IS EQUIPMENT AVAILABLE FOR TRANSPORTING WITH CLIENT?	
ANTICIPATED FREQAUENCY, DURATION, AND SCHEDULE OF OUTINGS	

TRANSPORTATION PLAN FOR OUTINGS
DATE AND TIME OF INITIAL MEETING

Nursing Progress Notes

RESIDENT'S NAME	ADSA ID NUMBER
DATE OF OUTING	NURSE'S OR NURSING AGENCY'S NAME
PROGRESS NOTES	
NURSE'S SIGNATURE	