Initial Psychiatric Evaluation

This form is to be completed by a psychiatrist, CNS or other APN with credential in psychiatry and prescribing privileges, to document an initial psychiatric evaluation.

Data Field	Person Demographic Information
Person's Name	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
DOB	Record the person's date of birth
Date of Admission	Record the date of admission per agency policy (usually first service date for this service episode).
Organization Name	Record the organization for whom you are delivering the service.
Data Field	**Present at Session**
List Name(s) of Person(s) Present	Check appropriate box: *Person Present; Person No Show; Person Cancelled.* If *Provider Cancelled* is checked, document explanation as relevant. If *Others Present* is checked, identify name(s) and relationship(s) to person.
Data Field	**Place of Evaluation**
Place of Evaluation	Check the appropriate box to indicate where the evaluation took place. If other, specify.
Data Field	**Presenting Concern**
Presenting Concerns in person's own words; what occurred to cause the person to seek services now	Use the person's own words to document the reason the person is asking for help. This should be a concise but complete description of why the person is seeking help now; including troublesome symptoms, behaviors and problems in functioning in life roles.
Data Field	**Comprehensive Assessment**
History of Present Illness	Document/summarize any history with the present illness. This can include onset of symptoms and what was done to manage illness prior to seeking help. Check *None Reported* if applicable.
Comprehensive Assessment has been completed?	Check Yes or No and indicate date of most recent assessment.
Data Field	**Medication Information/Side Effects/Adverse Drug Reactions**
Medication Information **(Medication, Current or Past, Rationale/Condition, Dosage/Route/Frequency, Person Taking/Took Meds as Prescribed)**	If Comprehensive Assessment has not been completed and been reviewed, complete this section. If the CA has been completed and reviewed, provide any relevant updates. **Comments on Past Medications:** Include what medications have worked well previously, any adverse side effects, and/or which one(s) the person would like to avoid taking in the future. If there have been no medication changes (including dosage changes, added or discontinued medications, etc.), check *There Have Been No Medication Changes*. If there are changes, **OR** if the Comprehensive Assessment has not been reviewed, check *Additional Medication Changes Below* and provide the information on this form in the grid below. Include medication name, current (C) or past (P), rationale/condition for which the medication is/was taken, dosage/route/frequency and if meds were taken as prescribed. Be sure to include all types of medications: prescribed, herbal, and over-the-counter. **Example:** If the person has discontinued a medication since the assessment, this should be so indicated by listing medication and checking (P) in the Current/Past column. This would also apply if the person began and discontinued a medication since the assessment reviewed.

Reported side effects/adverse drug reactions/other comments on current or past medications	Record and comment on any side effects reported by person /guardian to past or present medications or check "none reported." This section should be completed for all persons, regardless of whether the information has already been completed in the Comprehensive Assessment.
Data Field	**Primary Care Provider Information**
Primary Care Provider (PCP) Name and Credentials/ Address/ Telephone Number/Fax/Date of Last Exam	Record the person's PCP contact information. This may be a RNP, Pediatrician or PCP but must be the medical professional primarily in charge of the person's overall physical health care.
Data Field	**Physical Health History**
Physical Heath History	Review the Physical Health section of the Comprehensive Assessment with the person and record the date of the Comprehensive Assessment reviewed. If there is no additional pertinent physical health history, check *No Additional History to be Added*. If there is additional pertinent physical health history, **OR** if the Comprehensive Assessment was not reviewed, check *Additional History/ Comments* and provide the information.
Data Field	**Family Mental Health / Substance Use History**
Family Mental Health / Substance Use History	Check all that apply or *none reported* and comment as necessary.
Data Field	**Substance Use/Addictive Behavior History**
Substance Use /Addictive Behavior History	Review the Substance Use/Addictive Behavior section of the Comprehensive Assessment with the person and record the date of the Comprehensive Assessment reviewed. If there is no additional pertinent substance use/addictive behavior history, check *No Additional History to be Added*. If there is additional pertinent substance use history, **OR** if Comprehensive Assessment was not reviewed: check *Additional History Indicated Below* and provide the information on this form in the grid below. For reporting substance use, include age of first use, date of last use, frequency, amount and method of use.
Toxicology Screen Completed	Record *Yes* or *No*. If yes, indicate results.
Data Field	**Treatment History**
Type of Service/ Mental Health or Substance Use Name of Provider/Agency/ Dates of Service/Completed (Y/N)	Review the Treatment History section in the Comprehensive Assessment (mental health (MH) and substance use (SU) with the person and record the date of Comprehensive Assessment reviewed. If there is no additional pertinent treatment history, check *No Additional History to be Added*. If there is additional treatment information, **OR** if the Comprehensive Assessment has not been reviewed, check Additional *History Indicated Below* and provide the information on this form in the grid below. record the treatment episodes on this form in the grid below
Data Field	**Assessment Domains**
Additional Pertinent Information	Review each area if the Assessment Domains listed in the Comprehensive Assessment and record the date of Comprehensive Assessment reviewed. For each area, if there is no additional pertinent treatment history, check *No*. If there is additional treatment information, **OR** if the Comprehensive Assessment has not been reviewed, check Yes and provide the information in *Comments.*
Data Field	**Mental Status Exam**
Mental Status Examination	Check appropriate boxes for each area of the Mental Status Exam or provide a thorough written narrative below. Elaborate on findings from Mental Status Exam. **Please note**: Any noted risk factors require a Risk Assessment. **Examples:** Comment on content of delusions or describe specific hallucinations; give examples of thought disorganization; record hours of sleep or weight changes in mood disorders; describe specific suicidal or homicidal thoughts or threats, etc.
Data Field	**Summary of Current Mental Health Functioning**
Summary	Record summary of person's current mental health functioning, symptoms, strengths and limitations related to medication management and self administration.
Other notable symptoms	Record any other pertinent information/ symptoms of note, including that from other sources (family, referring agency, etc).

Data Field	Diagnoses/Justification and Differential Diagnosis
Diagnoses/ Rationale	Check appropriate box to indicate whether you are recording a DSM or ICD Diagnosis. Record Axis I – V where indicated. Provide justification for all diagnoses indicating symptoms and behaviors meeting diagnostic criteria. Each agency should have adequate internal processes to ensure the diagnostic impression recorded in the Comprehensive Assessment is reconciled with the diagnoses in the Psychiatric Evaluation.
Data Field	**Medications Prescribed/Informed Consent/Lab Tests**
Medication/Status/Rational/Dosage/Refills	If there are to be no medication changes (including dosage changes, added or discontinued medications or refills), check *None.* If there are changes of any type, check either *new/adjusted* (for new medications ordered or medications being prescribed at a different frequency or dose); *refill* (for those medications simply being ordered again without change); or *discontinued* (for medications being discontinued). Include rationale/condition, dosage/route/frequency and the amount/refills being ordered. Also be sure to include all types of medications: prescribed, herbal, over-the-counter.
Explained rationale for medication choices, reviewed mixture of medications, discussed possible risks, benefits, effectiveness (if applicable) and alternative treatment with the person (parent/guardian)	Check *Yes* or *No* to indicate whether the rationale, risks and benefits of the particular mixture of medications prescribed and any alternative treatments or medications and effectiveness (if applicable) have been explained to the person during this evaluation.
Person's /Guardian Response (Informed Consent)	Under *Person /Guardian Response* check appropriate box to indicate if the person /guardian understood the information or not, and whether the person agrees to take the medication or not. If person served indicates he/she do not understand or refuse medications, address in the Follow Up Plan section.
Laboratory Tests Ordered	List all laboratory tests ordered in this session or check *None Ordered* if no laboratory tests were ordered.
Data Field	**Follow Up Plan and Other Considerations**
Follow Up Plan/Referrals	This section should describe the immediate follow-up plan to this visit. Include as appropriate referrals, labs or other additional testing ordered, medical strategies, other types of treatment and frequency/interval of next visit. Record issues that need to be addressed in future appointments.
Other Psychopharmalogical Considerations to be Added to the Individualized Action Plan	If clinically indicated, record suggestions for consideration of other services to be added and included in the IAP and/or IAP Revision. Check *None indicated at this time* if no other services are to be added.
Data Field	**Staff Signatures**
Print Provider Name and Signature/ Credentials	Legibly print name and record signature of the prescriber including his/her credentials. Example: Luisa Cabot, MD
Date	Indicate the date of the name and signature.
Supervisor – Print Name/Signature/ Credentials (if needed)	If required, legibly record supervisor's signature credentials and date.
Date	Next to printed name and signature record the date.
Person's Signature (Optional, if appropriate)	The person is given the option to sign. If completing the note after the session and/or if using electronic notes, person can sign at next session.
Next Appointment / Date / Time	Record the next appointment for the person including date and time.