|  |  |  |
| --- | --- | --- |
| Person’s Name (First MI Last): | Record #: | Date of Admission: |
| Organization/Program Name: | DOB: | **Gender:**  Male  Female  Transgender |

|  |  |
| --- | --- |
| List Name(s) ofPerson(s) Present: | Person Present  No Show  Person Cancelled  Provider Cancelled Explanation:  Others Present (please identify name(s) and relationship(s) to person): |
| Place of Evaluation: | ER  Court  Police Dept.  Outpatient Office  Residential Treatment Setting  ESP  Home  School  Other: |

|  |
| --- |
| Presenting Concerns in person’s own words; what occurred to cause the person to seek services now: |
| History of Present Illness:  None Reported |
| Comprehensive Assessment has been completed? Yes  No  If yes: Date of most recent assessment: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Primary Care Provider**  **Name and Credentials** | **Tel Number** | **Fax** | **Address** | **Date of Last Exam** |
|  |  |  |  |  |

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| Physical Health History NOTE: I have reviewed the Physical Health Summary in the Comprehensive Assessment of  (date) with the person and:  No additional history to be added, **OR**  Additional History/Comments: |

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| --- |
| Family Mental Health / Substance Use History (check all that apply):  None Reported Schizophrenia  Bipolar  Depression  Anxiety Disorder  ADD  Substance Use  Suicide and / or attempts Other:       Comments-Specify family member, diagnosis, medication effectiveness: |

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| **Substance Use / Addictive Behavior History**:  **NOTE:** I have reviewed the Substance Use / Addictive Behavior History in the Comprehensive Assessment of  (date) with the person and:  No additional history to be added, **OR**  Additional history indicated below: |

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| Substance/Alcohol/Tobacco/Gambling/Other | Age of First Use | Date of Last Use | Frequency | Amount | Method |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |
| Toxicology Screen Completed: **No**  **Yes** **– If Yes,** **Results:** | | | | | |

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| Person’s Name (First MI Last): | Record #: |

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| Treatment History **NOTE:**I have reviewed the Treatment History in the Comprehensive Assessment of  (date) with the person and:  No additional history to be added OR  Additional history indicated below: | | | | |
| Type of Service: | **MH / SU** | Name of Provider/Agency: | Dates of Service: | Completed? |
|  | MH  SU |  |  | Yes No |
|  | MH  SU |  |  | Yes No |
|  | MH  SU |  |  | Yes No |
|  | MH  SU |  |  | Yes No |
|  | MH  SU |  |  | Yes No |

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| **Other Assessment Domains:**  **I have reviewed the Comprehensive Assessment of** **(date) with the person and have added other pertinent information or changes where applicable.**  **I have not reviewed the comprehensive assessment, but have indicated pertinent information for each of the areas below.** | |
| **Living Situation** No Changes | Comments: |
| **Family and Social Supports** No Changes | Comments: |
| **Legal Status** No Changes | Comments: |
| **Legal Involvement** No Changes  None Reported | Comments: |
| **Education** No Changes | Comments: |
| **Employment** No Changes | Comments: |
| **Military Service** No Changes  None Reported | Comments: |
| **Trauma** No Changes  None Reported | Comments: |
| **Developmental Issues**  N/A None Reported | Comments: |

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| Person’s Name (First MI Last): | Record #: |

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| **Mental Status Exam –** (WNL = Within Normal Limits) (**\*\***) ***– If Checked, Risk Assessment is Required*** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Appearance/ Clothing:** | WNL | Neat and appropriate | Physically unkempt | Disheveled | Out of the Ordinary |  | |
| **Eye Contact:** | WNL | Avoidant | Intense | Intermittent |  |  | |
| **Build:** | WNL | Thin | Overweight | Short | Tall |  | |
| **Posture:** | WNL | Slumped | Rigid, Tense | Atypical |  |  | |
| **Body Movement:** | WNL | Accelerated | Slowed | Peculiar | Restless | Agitated | |
| **Behavior:** | WNL | Cooperative | Uncooperative | Overly Compliant | Withdrawn | Sleepy | |
|  | Silly | Avoidant/Guarded/ Suspicious | Nervous/ Anxious | Preoccupied | Restless | Demanding | |
|  | Controlling | Unable to perceive pleasure | Provocative | Hyperactive | Impulsive | Agitated | |
|  | Angry | Assaultive | Aggressive | Compulsive  Relaxed | | | |
| **Speech:** | WNL | Mute | Over-talkative | Slowed | Slurred | Stammering | |
|  | Rapid | Pressured | Loud | Soft | Clear | Repetitive | |
| **Emotional State-Mood (in person’s words):** | WNL | Not feeling anything | Irritated | Happy | Angry | Hostile | |
|  | Depressed, sad | Anxious | Afraid, Apprehensive |  |  |  | |
| **Emotional State- Affect** | WNL | Constricted | Changeable | Inappropriate | Flat |  | |
|  | Full | Blunted, unvarying |  |  |  |  | |
| **Facial Expression** | WNL | Anxiety, fear, apprehension | Sadness, depression | Anger, hostility, irritability |  |  | |
|  | Elated | Expressionless | Inappropriate | Unvarying |  |  | |
| **Perception:** | WNL |  |  |  |  | |  |
| *Hallucinations-* | Tactile | Auditory | Visual | Olfactory | Command **\*\*** | | |
| **Thought Content:** | WNL |  |  |  |  |  | |
| *Delusions-* | None Reported | Grandiose | Persecutory | Somatic | Illogical | Chaotic | |
|  | Religious |  |  |  |  |  | |
| *Other Content-* | Preoccupied | Obsessional | Guarded | Phobic | Suspicious | Guilty | |
|  | Thought broadcasting | Thought insertion | Ideas of reference |  |  |  | |
| **Thought Process:** | WNL | Incoherent | Decreased thought flow | Blocked | Flight of ideas |  | |
|  | Loose | Racing | Chaotic | Concrete | Tangential |  | |
| **Intellectual Functioning:** | WNL | Lessened fund of common knowledge | Impaired concentration | Impaired calculation ability |  |  | |
| *Intelligence Estimate -* | Develop. Disabled | Borderline | Average | Above average | No formal testing |  | |
| **Orientation**: | WNL | **Disoriented to**: | Time | Place | Person |  | |
| **Memory**: | WNL | **Impaired:** | Immediate recall | Recent memory | Remote memory | Short Attention Span | |
| **Insight**: | WNL | Difficulty acknowledging presence of psychological problems | | Mostly blames other for problems | Thinks he/she has no problems | | |
| **Judgment**: | WNL | **Impaired Ability to Make**  **Reasonable Decisions**: | | Mild | Moderate | Severe\*\* | |
| **Past Attempts to Harm Self or Others:** | None Reported | Self\*\* | Others\*\* |  |  |  | |
| **Self Abuse Thoughts:** | None reported | Cutting\*\* | Burning\*\* | Other: | | | |
| **Suicidal Thoughts:** | None reported | Passive SI\*\* | Intent\*\* | Plan\*\* | Means\*\* |  | |
| **Aggressive Thoughts:** | None reported | Intent\*\* | Plan\*\* | Means\*\* |  |  | |

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| --- | --- |
| **Comments:** |  |

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| --- | --- |
| Person’s Name (First MI Last): | Record #: |
| **Other symptoms of note or information from other sources (family, referring agency, etc.)**  **None Reported** | |

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| --- | --- | --- |
| **Diagnosis:**  DSM-IV Codes  DSM 5 Codes  ICD-9 Codes  ICD-10 Codes | | |
| **Check Primary/Billing Diagnosis** | **Code** | **Narrative Description** |
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| Medication Information NOTE: I have reviewed the Medication Information in the Comprehensive Assessment of  (date) with the person and:  There have been no medication changes, **OR**  Additional medication changes below (include OTC/Herbal Supplements) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Current or Past** | **Rationale/ Condition** | **Dosage / Route / Frequency** | **Person Taking/Took Meds as Prescribed?**  WA**=***With Assistance* |
|  | C P |  |  | No  Yes  WA |
|  | C P |  |  | No  Yes  WA |
|  | C P |  |  | No  Yes  WA |
|  | C P |  |  | No  Yes  WA |
|  | C P |  |  | No  Yes  WA |
|  | C P |  |  | No  Yes  WA |
|  | C P |  |  | No  Yes  WA |
|  | C P |  |  | No  Yes  WA |

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| --- |
| Reported side effects / adverse drug reactions / other comments on current or past medications: |

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| --- | --- |
| Person’s Name (First MI Last): | Record #: |
| Does person served have any medical conditions that require consideration in prescribing (i.e. pregnancy, diabetes, etc.)?  Yes  None reported or known If yes, specify: | |

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| --- |
| Medication Status / Orders None  As indicated below: |

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| --- | --- | --- | --- | --- |
| **Medication** | **Status** | **Rationale/ Condition** | **Dosage / Route / Frequency** | **Amount/ Refills** |
|  | New/Adjusted  Refill  Discontinued |  |  |  |
|  | New/Adjusted  Refill  Discontinue |  |  |  |
|  | New/Adjusted  Refill  Discontinue |  |  |  |
|  | New/Adjusted  Refill  Discontinue |  |  |  |
|  | New/Adjusted  Refill  Discontinue |  |  |  |
|  | New/Adjusted  Refill  Discontinue |  |  |  |

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| --- | --- | --- | --- | --- |
| Explained rationale for medication choices, reviewed mixture of medications, discussed possible risks, benefits, effectiveness (if applicable) and alternative treatment with the person (parent/guardian):   No  Yes | | | | |
| Person | Understands information | Does not understand | Agrees with Medication | Refuses Medication |
| Guardian | Understands information | Does not understand | Agrees with Medication | Refuses Medication |

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| **Laboratory Tests Ordered:**  None Ordered |

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| Follow Up Plan/Referrals (Include all referrals, including commitment orders, those to higher levels of care, labs to be ordered, medical strategies/recommendations, other types of treatment, frequency/interval of next visit and duration): **1.**  **2.**  **3.**  **4.** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Person’s Name (First MI Last): | | | | | | | | | | | Record #: | | | | |
| **Other Psychopharmalogical Considerations to be added to Individualized Action Plan:**  None indicated at this time | | | | | | | | | | | | | | | | |
| Person’s /Guardian Response to Plan:  N/A | | | | | | | | | | | | | | | | |
| **Physician/APRN/RNCS - Print Name/Credential:** | | | | | **Date:** | | **Supervisor - Print Name/Credential** (if needed): | | | | | | | | **Date:** | |
| **Physician/APRN/RNCS Signature:** | | | | | **Date:** | | **Supervisor Signature** (if needed): | | | | | | | | **Date:** | |
| **Person’s Signature** (optional, if appropriate)**:** | | | | | **Date:** | |  | | | | | | | |  | |
| Date of Service | Provider Number | Loc. Code | Prcdr. Code | Mod 1 | | Mod2 | | Mod3 | Mod4 | Start Time | | Stop Time | Total Time | Diagnostic Code | | |
|  |  |  |  |  | |  | |  |  |  | |  |  |  | | |