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| --- | --- |
| Person’s Name: | Date of Psychiatric Evaluation: |
| Date of Birth: | Treating Psychiatrist: |
| Address: |  |

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| --- |
| **CURRENT SYMPTOMS/PRESENTING PROBLEM**  **0=None**  **1=** **Mild**/ Occasional impairment but no interference with daily activities  **2=** **Moderate**/ Currently experiencing difficulties and frequent disruption to daily activities  **3=** **Severe**/Currently experiencing severe distress or chronic disruption to daily activities; potential risk for harm to self/others  **NA**= **Not Assessed** |

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| --- | --- | --- | --- | --- | --- |
| **Anxiety** | 0 | 1 | 2 | 3 | NA |
| **Aggressive Behavior** | 0 | 1 | 2 | 3 | NA |
| **Attention Deficit Hyperactivity Disorder** | 0 | 1 | 2 | 3 | NA |
| **Inappropriate Sexual Behavior** | 0 | 1 | 2 | 3 | NA |
| **Legal Problems** | 0 | 1 | 2 | 3 | NA |
| **Mood Disturbance (Depression)** | 0 | 1 | 2 | 3 | NA |
| **Mood Disturbance (Mania)** | 0 | 1 | 2 | 3 | NA |
| **Mood Disturbance (Bipolar-Depression and Mania)** | 0 | 1 | 2 | 3 | NA |
| **Post-Traumatic Stress Disorder** | 0 | 1 | 2 | 3 | NA |
| **Property Destruction** | 0 | 1 | 2 | 3 | NA |
| **Psychosis/Hallucinations/Delusions** | 0 | 1 | 2 | 3 | NA |
| **Repetitive, stereotyped behavior** | 0 | 1 | 2 | 3 | NA |
| **Self-injurious behavior** | 0 | 1 | 2 | 3 | NA |
| **Somatic Complaints** | 0 | 1 | 2 | 3 | NA |
| **Substance Abuse/Dependence** | 0 | 1 | 2 | 3 | NA |
| **Medical/Physical Condition that affects behavior (e.g. Dementia, Diabetes)** | 0 | 1 | 2 | 3 | NA |
| **Weight Change associated with a Behavioral Diagnosis** | 0 | 1 | 2 | 3 | NA |
| **Other** | 0 | 1 | 2 | 3 | NA |

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| --- | --- |
| **CURRENT DIAGNOSES** |  |
| Mental Health Diagnosis |  |
| Intellectual/Developmental Diagnosis  (Refer to Health Passport) |  |
| Medical Diagnosis  (Refer to Health Passport) |  |

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| --- | --- |
| **Diagnoses that are resolved or in remission** |  |
| Mental Health Diagnosis  Resolved or in Remission |  |

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| --- |
| **CURRENT RISK ASSESSMENT**  **0=None**  **1= Mild**/ Ideation only  **2= Moderate**/ Attempts, but no injury within the last year  **3= Severe**/ Caused injury within the last year  **NA**= Not Assessed |

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| --- | --- | --- | --- | --- | --- |
| Patient’s risk for dangerousness to self | 0 | 1 | 2 | 3 | NA |
| Patient’s risk for dangerousness to others | 0 | 1 | 2 | 3 | NA |

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| --- | --- | --- |
| **CURRENT PSYCHOTROPIC MEDICATIONS** |  |  |
| **Medication** | **Dosage, Frequency, and Route** | **Symptom targeted by medication** |
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| All medication dosages are within accepted recommended prescribing guidelines:  Yes  No |
| If No, please explain. |
| For prescribed medications that require serum level monitoring and/or laboratory tests to screen for medication side effects, provide the date test results were last reviewed:  Date |

|  |
| --- |
| **TREATMENT PLAN**  **Treatment outcomes over past year**  Unknown  Improved  No Change  Worse  **Medication adherence**  Unknown  Poor  Fair  Good  **Medication side effects reported**  Unknown  None  Mild  Moderate  Severe  **Current treatment plan reflects stabilization or improvement in symptoms within past 90 days or, if not, patient’s condition has been re-evaluated and adjustments in treatment plan made accordingly.**  Yes  No  **Medication side effects discussed with patient and patient’s caregiver:** Date |

|  |  |
| --- | --- |
| **Risks and benefits of current treatment** |  |
| Risks |  |
| Benefits |  |

|  |
| --- |
| **Specific behavioral criteria at which medication titration or discontinuation will be considered:** |

|  |
| --- |
| **If titration is not indicated at this time, what is the clinical justification for continuing current medication regimen:** |

|  |  |
| --- | --- |
| **ADDITIONAL TREATMENT RECOMMENDATIONS, IF ANY:** | |
|  | |
| **Signature of Treating Physician:** | **Date:** |