

# PSYCHIATRY TREATMENT KARDEX

DIET / DATE  INDEPENDENT:  ASSIST:  FEED:	VITAL SIGNS	INTAKE / OUTPUT <input type="checkbox"/> YES <input type="checkbox"/> NO	PROGRAM	OFF-UNIT PRIVILEGES	MENTAL STATUS
	DAILY:	INCONT:	UNIT:		
	QS:		DUAL DX:		
	OTHER:	WEIGHT:	SIGNED CONTRACT: <input type="checkbox"/> YES <input type="checkbox"/> NO		

SAFETY  ORD   EXP  SIDE RAILS:  POSEY:  FALL PRECAUTIONS:  SECLUSION:  RESTRAINTS:	Q15 MINUTE CHECKS    AWOL RISK:	ACTIVITY / MOBILITY	ADLS	DISCHARGE PLANNING  INITIAL DISPOSITION:  ANTICIPATED DISPOSITION:  <input type="checkbox"/> HOME _____ <input type="checkbox"/> HOME W/ CARE _____ <input type="checkbox"/> NH _____ <input type="checkbox"/> NH PLACEMENT _____ <input type="checkbox"/> GROUP HOME _____ <input type="checkbox"/> SHELTER _____
		INDEPENDENT:	INDEPENDENT:	
		ASSIST:	ASSIST:	
		ASSISTIVE DEVICES:		
		BEDREST:	COMPLETE:	

**SPECIAL NOTICE ( H & P; CONSULTS; CLINIC APPTS; SURGICAL PROCEDURES )**

DATE ORDERED		DATE SCHED	DATE DONE	RESIDENTIAL TX:
				CONTINUING CARE:
				OTHER:
				CASE MANAGER / SOCIAL WORKER:
				PHONE #: _____
				AGENCY: _____
				SUPPORT PERSON: _____
				PHONE #: _____
				RELATIONSHIP: _____

**INTERVIEWS**


ALLERGIES	RELIGION	CONDITION	SURGICAL PROCEDURE
-----------	----------	-----------	--------------------



**PERTINENT INFORMATION**

ADDICTION:	DATE ORD	VISITATION
MEDICAL:		
OTHER:		

**PICTURE**

**PASSES**

DATE ORD	DATE OF PASS	DURATION	PURPOSE	DATE DONE

AGE	NAME	ROOM	DIAGNOSIS	PHYSICIAN	SERVICE	ADM DATE

**PART OF THE MEDICAL RECORD**