UNIVERSITY MEDICAL CENTER

DEPARTMENT OF PSYCHIATRY ADMISSION PROFILE

AFFIX PATIENT INFO LABEL HERE

Date: _____ Time: _____ am/pm **Patient Name** _____ **MR#** _____

Referral Source: _____

Arrival Mode: _____ Source of Information: _____

ALLERGIES: ☐ Denies ☐ Latex ☐ Contrast Dye ☐ Pets ☐ Food: _____

☐ Medications: _____

☐ Other: _____

Explain Reaction: _____

History of NMS date(s): _____

Presenting Problem: _____

Precipitating Event(s): _____

PSYCHIATRIC HISTORY

Inpatient Hospitalizations (Include hospital names, dates, and reasons for admission, exclude substance abuse history): _____

Outpatient Treatment (Include name of psychiatrist, therapist, facility and date of most recent follow up): _____

Current Medications Able to swallow pills? ☐ Yes ☐ No

Name or Purpose	Dose / Route / Frequency	Change	Source

Signature/Title: _____ Date/Time: _____

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

Family History of Psychiatric Illness and Substance Abuse (include extended family): _____

History of Physical and Sexual Abuse / Neglect (detail as victim and / or as abuser): _____

☐ **Patient is at greater psychological risk during restraint and/or seclusion.**

MENTAL STATUS EXAM

Appearance

☐ Neatly Groomed ☐ Disheveled ☐ Age Appropriate
☐ Casual ☐ Malodorous ☐ Hospital Gown

Detail _____

Attitude

☐ Cooperative ☐ Demanding ☐ Hopeless ☐ Helpless ☐ Optimistic
☐ Evasive ☐ Provocative ☐ Resistant ☐ Pessimistic

Detail _____

Motor Activity

☐ Catatonic ☐ Psychomotor Retardation ☐ Gait Unsteady
☐ Restless ☐ Eye Contact Appropriate
☐ Pacing ☐ No Eye Contact
☐ Tremors ☐ Psychomotor Agitation

Detail _____

Speech

☐ Over Productive ☐ Mute ☐ Rambling ☐ Guarded
☐ Pressured ☐ Quiet ☐ Hesitant
☐ Rapid ☐ Slurred ☐ Clear
☐ Loud ☐ Stuttering ☐ Normal Rate and Tone
☐ Under Productive

Detail _____

Mood

☐ Depressed ☐ Grandiose ☐ Anxious ☐ Angry ☐ Irritable

Detail (ask patient to describe mood and detail _____

Signature/Title: _____ Date/Time: _____

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

Affect

- ☐ Appropriate to Content
- ☐ Constricted
- ☐ Blunted
- ☐ Flat
- ☐ Anxious
- ☐ Tense
- ☐ Congruent
- ☐ Incongruent

Detail _____

Sleep / Appetite Disturbance

Detail _____

Thought Process

- ☐ Logical
- ☐ Lucid
- ☐ Coherent
- ☐ Irrelevant
- ☐ Thought Blocking
- ☐ Perseveration
- ☐ Goal Directive
- ☐ Flight of Ideas
- ☐ Thought Broadcasting
- ☐ Tangential

Detail _____

Thought Content

- ☐ No evidence psychotic thought process
- ☐ Obsessions
- ☐ Delusions (Type)
- ☐ Compulsions
- ☐ Phobias
- ☐ Suicidal / Homicidal Ideations
- ☐ Ideas of Reference
- ☐ Hallucinations, Auditory / Visual / Other

Detail _____

Sensorium and Intelligence ☐ **Stuporous** ☐ **Lethargic**

Alert and oriented to:	☐ Person	☐ Place	☐ Time
Able to complete serial additions and subtractions:	☐ Yes	☐ No	
Short Term Memory:	☐ Intact	☐ Impaired	
Long Term Memory:	☐ Intact	☐ Impaired	
Judgement:	☐ Intact	☐ Impaired	☐ Fair
Insight:	☐ Intact	☐ Impaired	☐ Fair

Detail _____

Risk of Harm to Self (current threats, intent, plan)

Detail _____

History of Suicide Attempts (in community and/or while hospitalized)

Detail _____

Risk of Harm to Others

☐ Threatening ☐ Homicidal Thoughts ☐ Assaultive ☐ Plan / Intent

Detail _____

Access to Weapon

☐ Yes ☐ No

Detail _____

Legal History and Current Legal Involvement

Detail _____

Signature/Title: _____ Date/Time: _____

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

ASSESSMENT FOR RISK FOR VIOLENCE TO SELF/OTHERS

(Complete on admission)

DIRECTION: Indicate the response of the patient to the following questions by checking YES or NO. Check the corresponding score if the answer is yes.

KEY: Score of 5 & Above - **HIGH RISK**
Score Below 5 - LOW RISK

			SCORE
1. Have you ever lost your temper	☐ No	☐ Yes	1 ☐
2. When you lose your temper, do you . . .			
a. hurt yourself?	☐ No	☐ Yes	3 ☐
• thoughts of hurting self?	☐ No	☐ Yes	2 ☐
• Plan of hurting self?	☐ No	☐ Yes	5 ☐
b. harm others by . . .	☐ No	☐ Yes	3 ☐
• grabbing	☐ No	☐ Yes	2 ☐
• hitting	☐ No	☐ Yes	2 ☐
• biting	☐ No	☐ Yes	2 ☐
• kicking	☐ No	☐ Yes	2 ☐
• pushing	☐ No	☐ Yes	2 ☐
• threatening	☐ No	☐ Yes	2 ☐
• throwing objects	☐ No	☐ Yes	2 ☐
• thoughts of harming others	☐ No	☐ Yes	2 ☐
c. break objects>	☐ No	☐ Yes	2 ☐
d. hit objects>	☐ No	☐ Yes	2 ☐

3. ALERTS: Check any history that may contribute to the patient's potential for violence to self/others:

☐ suicide attempt/gesture: Method _____	5 ☐
☐ assault on others	5 ☐
☐ incarceration	1 ☐
☐ substance abuse	1 ☐
☐ alcohol ☐ drug	
☐ physical abuse	1 ☐
☐ sexual abuse	1 ☐
☐ personality disorder	1 ☐
☐ medical problem	1 ☐
☐ others: describe: _____	1 ☐

TOTAL SCORE _____

4. Where was the last time you lost control ☐ Home ☐ Hospital
☐ Other _____ When _____

5. What reason/situation makes you angry to the point of losing control?

_____

6. What helps you regain control of your behavior?

☐ PRN medication ☐ Talking to staff/others ☐ Exercise
☐ Quiet room/environment ☐ Personal space ☐ Writing in Journal
☐ Others: _____ ☐ Music

NOTE: Score of 5 and above, patient is high risk. Initiate the BEHAVIORAL CONTRACT

• BEHAVIORAL CONTRACT initiated by RN ☐ Yes

RN Signature: _____ Date/Time: _____

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Patient Name _____ MR# _____

SUBSTANCE ABUSE ASSESSMENT

☐ Patient denies substance abuse history

Patterns of Abuse	ETOH	COKE	HEROIN	POT	BZD'S	NARC	NICOTINE	OTHER
Age of 1st use								
Amount of last use								
Longest period of non-use								
Pattern of use								

Code: E = Experimental O = Occasional R = Recreational H = Heavy B = Binge

SUBSTANCE ABUSE TREATMENT HISTORY

Inpatient Treatment (type of program(s), hospital or facility, length of stay, and response to treatment)

Detail _____

Outpatient Treatment (type of program(s), hospital or facility, length of stay, and response to treatment)

Detail _____

Legal History and Current Legal Involvement

Detail _____

Emancipated Minor ❑ Yes ❑ No

Withdrawal History

☐ Shakes / Tremors ☐ Sweats / Fever ☐ Insomnia ☐ Delirium ☐ Convulsions ☐ Blackouts
☐ Aches / Cramps ☐ Hallucinations ☐ Nausea/Vomiting ☐ Cold / Clammy Skin ☐ Cravings ☐ Piloerection

Detail _____

Current Withdrawal Symptoms

Detail (include any biomedical complications): _____

Present Observations of Staff

❑ Minimizing ❑ Rationalizing ❑ Drug Seeking ❑ Appears Under Influence

Detail _____

Marital Status (present and past relationships)

Detail _____

Employment Status

Detail _____

Is child attending school? ❑ Yes ❑ No

Developmental Level: _____

Developmental Needs: _____

Signature/Title: _____ Date/Time: _____

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

Subsidy or Entitlement

Detail _____

Current Living Situation (barrier preventing return) ☐ **Homeless**

Detail _____

Family Involvement

Describe _____

Would they be able to contribute information to the assessment? ☐ Yes ☐ No

Name of Contact Person: _____

Telephone# _____ Best Time to Call: _____

Spirituality

1. Can you tell me about your spiritual Beliefs? What sorts of things give you comfort? (For example, sitting quietly, reflecting, meditating, keeping a journal, listening to certain types of music, relaxation techniques and the like). _____

2. Who or what provides strength or hope? _____

3. Do you use prayer? ☐ Yes ☐ No

4. How do you keep going day after day? _____

5. What type of spiritual/religious support do you desire? _____

6. Would you like to see a clergy person, Chaplain or a Pastoral Care representative? ☐ Yes ☐ No

7. Cultural needs/considerations affecting hospitalization and plan of care: _____ ☐ None Requested

TEACHING

Is there anything you would like to learn about your health? _____

How do you learn best? ☐ Demonstration ☐ Reading ☐ Video ☐ Discussion ☐ Other: _____

Learning Needs: ☐ Disease Process _____ ☐ Diagnostic Tests/Procedures: _____

☐ ECT: _____

☐ Other: _____ ☐ Medications: _____ ☐ Diet: _____

☐ Pain Management Plan

☐ Barriers to Learning, Cognitive and Physical Limitations, Language: _____

☐ Understands English ☐ Reads English **Primary Language:** _____

☐ Speaks English ☐ Interpreter Required (if other than English)

Signature/Title: _____ Date/Time: _____

NUTRITION

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

❒ Special Diet at Home _____

_____

Would you like information about your diet? ❒ Yes ❒ No

If YES, enter CONSULT for Nutrition Education in IDX Order#: _____

High Nutrition Risk Criteria

ANY HIGH RISK DIAGNOSIS OR YES ANSWER TO THE QUESTIONS BELOW INDICATES HIGH NUTRITION RISK AND REQUIRES REFERRAL VIA THE IDX-LASTWORD SYSTEM

High Risk Diagnosis & Current Physical Findings:

❒ Breast Feeding/Pregnancy not on maternity units
If yes also contact Pharmacy
❒ Renal Failure
❒ Dysphagia
❒ Homeless
❒ Other _____

❒ Supplements (i.e., Ensure) / Tube Feed / TPN _____
❒ Newly diagnosed Diabetes
❒ Pressure Ulcer - Stage II or greater
❒ Dehydration
❒ Eating Disorder
❒ Liver Failure

Weight History

Actual Weight _____ Stated Weight _____ Stated Height _____

Unintentional weight change > 10 lbs. in last 3 months? ❒ Yes ❒ No _____ lbs. In _____ Months

Reason: _____

Reduce intake (less than 1/2 of usual for last 5 days) ❒ Yes ❒ No Diarrhea (> 3 days) ❒ Yes ❒ No

Vomiting (> 3 days) ❒ Yes ❒ No

Referral for High Nutritional Risk entered into IDX? ❒ **Yes** ❒ **No** **Order#** _____

Elimination

Usual pattern **of Bowel Movement:** Frequency: _____ Last BM: _____

History of: ❒ Constipation ❒ Diarrhea ❒ Hemorrhoids ❒ Ostomy ❒ Denies any problems

Describe any of the above if checked: _____

Usual Pattern **of Urination:** _____

History of: ❒ Frequency ❒ Urgency ❒ Dysuria ❒ Burning ❒ Nocturia ❒ Incontinence ❒ Retention

❒ Ostomy ❒ Urinary Catheter ❒ Denies any problems

Describe any of the above if checked: _____

PHYSICAL ASSESSMENT

Current Vital Signs (detail)

Blood Pressure _____/_____ Pulse _____

Respiration _____ Temperature _____

Primary Care Physician(s) (name, specialty and affiliation with HUMC)

Detail _____

_____

Medical / Surgical History (treatment and response)

Detail _____

_____

Current Medical / Surgical Problems (treatment and response)

Detail _____

_____

Recent Infections or Exposures: ☐ Denies ☐ Chicken Pox ☐ Herpes Zoster/Shingles ☐ TB
(within the last month) ☐ Other: _____

☐ **Patient is at greater physical risk during restraint and/or seclusion.**

Restraints/Seclusion are emergency measures only. Alternatives and least restrictive measures are attempted/considered first.

☐ The patient/family have been informed of the organization's restraint/seclusion philosophy.

Comments: _____

Signature/Title: _____ Date/Time: _____

AFFIX PATIENT INFO LABEL HERE

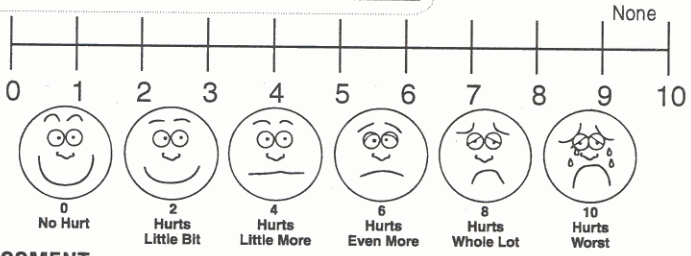
Patient Name _____ MR# _____

PAIN HISTORY ASSESSMENT

PAIN INTENSITY SCALE – 0 - 10

0	1-3	4-7	8-10
None	Mild	Moderate	Severe

☐ Faces



PAIN HISTORY ASSESSMENT:

Do you have pain now? ❒ Yes ❒ No Intensity: _____

Describe: _____

Have you had pain in the last several weeks or months? ❒ Yes ❒ No Intensity: _____

Describe: _____

Is your pain related to your admission today? ❒ Yes ❒ No

How do you express pain? (Word child/adolescent uses for pain) _____

What pain medications has or has not relieved your pain in the past? _____

_____

If current or past pain intensity ≥ 4, continue with pain assessment.

LOCATION OF PAIN: Mark site with letter A or B if more than one site

PAIN SITE:

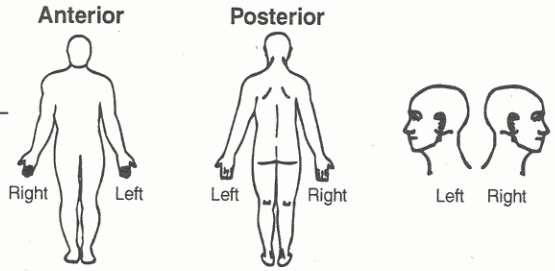
Location of Pain _____

Appearance of Pain Site _____

Worst Pain Felt (Intensity Score) _____

Least Pain Felt (Intensity Score) _____

Qualities (ache, dull, burn, sharp, etc.) _____



ONSET/DURATION:

When did your pain begin? _____

How long is the pain episode? _____

Is it constant or does it come and go? _____

Does the pain radiate? If yes, where _____

What causes or increases the pain? _____

What relieves the pain? _____

_____

_____

What accompanies the pain? (dizziness, nausea, anxiety, etc.) _____

Do you feel pain interferes with your everyday life/activities? If yes, How? _____

_____

_____

PATIENT/FAMILY GOALS

❒ **Complete Relief** ❒ **Acceptable level of pain** _____

❒ **Other** _____

Signature/Title: _____ Date/Time: _____

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

Hendrich Fall Risk Model - Assessment Tool **Score ≥3 Refer to Fall/Injury Prevention Protocol for High Risk Interventions**

Risk Factors	Points
Recent History of Falls	+7 PT eval/screen
Depression	+4
Altered Elimination	+3
Confusion/Disorientation	+3

Risk Factors (contd.)	Points
Dizziness/Vertigo	+3 PT eval/screen
Poor Judgement	+3
Poor Mobility/Generalized Weakness	+2
TOTAL INITIAL RISK SCORE	

KEY	
0 - 2	Normal/Low Risk
3 - 6	Level 1/High Risk
More than 6 PT eval/screen	Level 2/Extremely High Risk

PERFORMANCE OF ADL

Trouble feeding self/opening jars and containers ❒ Yes ❒ No

Difficulty with Dressing ❒ Yes ❒ No

Difficulty with Personal Hygiene ❒ Yes ❒ No

If yes to any of the above questions is a change from the pre-admission level then enter OT Eval/Screen into IDX Order # _____

Unsteady gait / balance ❒ Yes ❒ No

Use of Assistive Devices / Prosthetics ❒ Yes ❒ No

If yes to either of the above questions: PT Eval / Screen entered into IDX Order # _____

If 65 or older, date of last Flu Vaccine _____ ☐ Never received **Pneumonia Vaccine** _____ ☐ Never received

If states never received vaccines, initiate influenza/pneumococcal vaccine order sheets.

Do you use complementary medical therapies: ***(i.e., chiropractor, massage, acupuncture, herbs, vitamins)***

☐ Yes ☐ No If yes, explain: _____

_____

Signature of Psychiatric RN: _____ Date/Time: _____

Signature/Title: _____ Date/Time: _____

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

UNIVERSITY MEDICAL CENTER

DISPOSITION PAGE

Advanced Directive: ☐ No ☐ Deferred, not clinically indicated at this time ☐ Yes, Copy on Chart
☐ Yes, Copy Requested from: ☐ Patient/Family ☐ MD ☐ Medical Records ☐ Less than 18 years old N/A
Collateral Contacts and Additional Information Obtained

Detail: _____

Do you have a Behavioral Health Advance Directive? ☐ Yes ☐ No
If yes, copy requested from : ☐ Pt./Family ☐ MD ☐ Medical Records

If not available, content of Behavioral Health Advance Directive _____

Pertinent Patient Care information communicated to Patient's Care Providers on Staff / not on Staff.
(Patient must sign consent for release for outside agencies.)

Patient aware of financial implications of care choices? ☐ Yes ☐ No

Signature/Title: _____ Date/Time: _____

Identification of Patient Needs In Order of Priority / Initial Plan

Presenting Problem(s) Immediate Goal(s)

1. _____

2. _____

3. _____

Signature/Title: _____ Date/Time: _____

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

NOTES