

MENTAL HEALTH SERVICES

2014

**MEDICAL**

# PSYCHIATRIC ASSESSMENT - EHR

2014

**WHEN:** At the time a client is initially evaluated for medication.

**ON WHOM:** Every client who is initially evaluated for medication.

**COMPLETED BY:** MD, DO, MD Trainee.

**MODE OF COMPLETION:** Data must be entered into the Electronic Health Record.

**REQUIRED ELEMENTS:** All clinically appropriate elements should be completed.

**NOTE:** Every assessment within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved (status is “open green locked”) is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Assessments are not viewed as complete and active until the assessment is final approved (red locked).

**San Diego County Mental Health Services  
PSYCHIATRIC ASSESSMENT**

\*Client Name: \_\_\_\_\_ \*Case Number: \_\_\_\_\_

\*Assessment Date: \_\_\_\_\_ \*Program Name: \_\_\_\_\_

**\*CHIEF COMPLAINT/REASON FOR EVALUATION:** *Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors. Include information on 5150 and Police transport.-*

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**CLINICAL UPDATE** *Interval note, describe current presentation and risk assessment to include danger to self and others, reason for visit.*

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**\*PAST PSYCHIATRIC HISTORY:** *Previous history of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods.-*

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Client Name:

Case Number:

Assessment Date:

Program Name:

**SUBSTANCE USE INFORMATION:**

\*Substance Use?  No  Yes  Client declined to report

If Yes, specify substances used:

Name of Drug	Priority	Method of Administration	Age 1 <sup>st</sup> used	Freq- uency of Use	Days of use in last 30 days	Date of last use	Amount of last use	Amount used on a typical Day	Largest Amount Used in One Day

The client has been advised that smoking is a serious health risk that may lead to lung cancer, cardiovascular disease and the possibility of premature death:  Yes  N/A

When applicable, outline how substance use impacts current level of functioning:

\_\_\_\_\_

History of substance use treatment: *Types of treatment, level of care, length of treatment, etc.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Recommendation for further substance use treatment:  No  Yes  Not applicable

If Yes: \_\_\_\_\_

**FAMILY HISTORY:**

\*Living Arrangement: *Select from Living Arrangement table listed in the Instructions Sheet*

\_\_\_\_\_

Those living in the home with client: \_\_\_\_\_

Have any relatives ever had any of the following conditions *Select from Relatives table listed in the Instructions Sheet*.

Substance abuse or addiction: \_\_\_\_\_

Other addictions: \_\_\_\_\_

Suicidal thoughts, attempts: \_\_\_\_\_

Emotional/mental health issues: \_\_\_\_\_

Mental retardation: \_\_\_\_\_

Developmental delays: \_\_\_\_\_

Arrests: \_\_\_\_\_

Include relevant family information impacting the client:

\_\_\_\_\_

Client Name:  
Assessment Date:

Case Number:  
Program Name:

**MEDICAL HISTORY:**

\*Does client have a Primary Care Physician? No Yes Unknown  
If No, has client been advised to seek primary care? No Yes

Primary Care Physician: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Seen within the last:  6 months  12 months  Other: \_\_\_\_\_

Hospital of choice (physical health): \_\_\_\_\_

Been seen for the following (provide dates of last exam):

Dental exam: \_\_\_\_\_

Hearing exam: \_\_\_\_\_

Vision exam: \_\_\_\_\_

Physical Health issues:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Elevated BMI     | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension          | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Liver Disease    | <input type="checkbox"/> Neurological  |
| <input type="checkbox"/> None at This Time     | <input type="checkbox"/> Sedentary Lifestyle | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Smoking       |
| <input type="checkbox"/> Other, specify: _____ |  |   |  |

Referred to primary health physician:  Yes  N/A

Physical health problems affecting mental health functioning:

Head injuries: No Yes, specify:

Medical and/or adaptive devices:

Significant Developmental Information (when applicable):

\*Allergies and adverse medication reactions: No Unknown/Not Reported  
 Yes, specify:

Other prescription medications:  None  Yes:

Herbals/Dietary Supplements/Over the counter medications:  None  Yes:

Healing and Health: *(Alternative healing practices and beliefs. Apart from mental health professionals, who or what helps client deal with disability/illness and/or to address substance use issues? Describe):*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any known medical condition or past history of abuse that requires special consideration if physical restraint is needed, specifically: breathing problems, significantly overweight, pregnancy, etc? No Yes

If yes, explain:

MMSE: \_\_\_\_\_

Client Name:  
Assessment Date:

Case Number:  
Program Name:

**MENTAL STATUS EXAM**

Unable to assess at this time.

Level of Consciousness

Alert       Lethargic       Stuporous

Orientation

Person    Place    Day    Month    Year    Current Situation  
 All Normal    None

Appearance

Good Hygiene       Poor Hygiene       Malodorous       Disheveled  
 Reddened Eyes       Normal Weight       Overweight       Underweight

Speech

Normal       Slurred       Loud       Soft       Pressured  
 Slow       Mute

Thought Process

Coherent    Tangential    Circumstantial    Incoherent    Loose Association

Behavior

Cooperative    Evasive    Uncooperative    Threatening    Agitated    Combative

Affect

Appropriate    Restricted    Blunted    Flat    Labile    Other

Intellect

Average    Below Average    Above Average    Poor Vocabulary  
 Poor Abstraction    Paucity of Knowledge    Unable to Rate

Mood

Euthymic    Elevated    Euphoric    Irritable    Depressed    Anxious

Memory

Normal       Poor Recent       Poor Remote       Inability to Concentrate  
 Confabulation       Amnesia

Motor

Age Appropriate/Normal    Slowed/Decreased    Psychomotor Retardation  
 Hyperactive    Agitated    Tremors    Tics    Repetitive Motions

Judgment

Age Appropriate/Normal       Poor       Unrealistic  
 Fair       Limited       Unable to Rate

Insight

Age Appropriate/Normal    Poor    Fair    Limited    Adequate    Marginal

Command Hallucinations

No       Yes, specify: \_\_\_\_\_

Auditory Hallucinations

No       Yes, specify: \_\_\_\_\_

Visual Hallucinations

No       Yes, specify: \_\_\_\_\_

Client Name:

Case Number:

Assessment Date:

Program Name:

Tactile Hallucinations

No  Yes, specify: \_\_\_\_\_

Olfactory Hallucinations

No  Yes, specify: \_\_\_\_\_

Delusions

No  Yes, specify: \_\_\_\_\_

Other observations/comments when applicable:

**DIAGNOSIS**

**If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Psychiatric Assessment.**

**VITAL SIGNS:**

Height	Weight	Temp	Resp	Pulse	BP

Pain: No Yes Unable to determine

Pain Intensity Level: \_\_\_\_\_

Location of pain: \_\_\_\_\_ How long: \_\_\_\_\_

**DIAGNOSTIC SUMMARY:**

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**PLAN:**

Psychosocial/Rehab Needs: *Other available treatment and/or recovery services recommended, within program or in community.*

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**San Diego County Mental Health Services  
PSYCHIATRIC ASSESSMENT  
Instructions**

**Anasazi Tab 1**

Program Name: Required Field.

Unit Number: Required Field.

**PRESENTING PROBLEMS/NEEDS:** This is a required field. Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and summary of client’s request for services including client’s most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors. Include information on 5150 and Police transport.

**CLINICAL UPDATE:** Document in the space provided. Interval note, describe current presentation and risk assessment to include danger to self and others, reason for visit.

**PAST PSYCHIATRIC HISTORY:** This is a required field. Previous history of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods.

**SUBSTANCE USE INFORMATION:** Required field. Select “No” or “Yes” as it applies to the client. If client indicates “yes,” provide information on which substances the client reports in the space provided.

If client declines to report substance use, indicate by checking the appropriate box.

Educate the client regarding the effects of smoking by reading the following statement: “Smoking is a serious health risk that may lead to lung cancer, cardiovascular disease and the possibility of premature death.” Indicate that you have provided this advisement by selecting the “Yes” check box.

Use the space provided to document how substance use impacts the client’s current level of functioning.

History of Substance Use Treatment: Provide types of treatment, level of care, length of treatment, etc.

Recommendation for Further Substance Use Treatment: Check box “No”, “Yes”, or “Not Applicable. If “yes,” explain in the box provided.

**FAMILY HISTORY:**

The “Living Arrangement” prompt is Required.

Enter your response on the form based on the Living Arrangement Table below. Include the ID and Description in your documentation.

<b>Living Arrangement</b>		
A-House or Apartment	G-Substance Abuse Residential Rehab Ctr	O-Other
B-House or Apt with Support	H-Homeless/In Shelter	R-Foster Home-Child
C-House or Apt with Daily Supervision Independent Living Facility	I-MH Rehab Ctr (Adult Locked)	S-Group Home-Child (Level 1-12)
D-Other Supported Housing Program	J-SNF/ICF/IMD	T-Residential Tx Ctr-Child (Level 13-14)
E-Board & Care – Adult	K-Inpatient Psych Hospital	U-Unknown
F-Residential Tx/Crisis Ctr – Adult	L-State Hospital	V-Comm Tx Facility (Child Locked)
	M-Correctional Facility	W- Children’s Shelter

Those Living In The Home With The Client: List the names and relationship to client in the text box. Include relevant family information impacting the client in the text box provided.

Have Any Relatives Ever Had Any Of The Following Conditions: For each listed condition, enter information from the family members table, if applicable, in the spaces provided. Leave blank if there are none:

ID	DESCRIPTION	ID	DESCRIPTION	ID	DESCRIPTION
<b>Aunt Bio</b>	Aunt – Biological	<b>Fath InLaw</b>	Father – In-Law	<b>Niece NBio</b>	Niece – Non-biological
<b>Aunt NoBio</b>	Aunt – Non-biological	<b>Gdaug Bio</b>	Granddaughter – Biological	<b>Other</b>	Other
<b>Bro Adop</b>	Brother – Adopted	<b>GDaug Nbio</b>	Granddaughter – Non-biological	<b>Signif Oth</b>	Significant Other
<b>Bro Bio</b>	Brother – Biological	<b>GrFa Bio</b>	Grandfather – Biological	<b>Sig Supp</b>	Significant Support Person
<b>Bro Foster</b>	Brother – Foster	<b>GrFa NBio</b>	Grandfather – Non-biological	<b>Sis Adopt</b>	Sister – Adopted
<b>Bro InLaw</b>	Brother – In-Law	<b>GrMo Bio</b>	Grandmother – Biological	<b>Sis Bio</b>	Sister – Biological
<b>Bro Step</b>	Brother – Step	<b>GrMo Nbio</b>	Grandmother – Non-biological	<b>Sis Foster</b>	Sister – Foster
<b>Cous Bio</b>	Cousin – Biological	<b>GrSon Bio</b>	Grandson – Biological	<b>Sis In Law</b>	Sister – In-Law
<b>Cous Nbio</b>	Cousin – Non-biological	<b>GrSon Nbio</b>	Grandson – Non-biological	<b>Sis Step</b>	Sister – Step
<b>Daug Adopt</b>	Daughter – Adopted	<b>Husband</b>	Husband	<b>Son Adopt</b>	Son – Adopted
<b>Daug Bio</b>	Daughter – Biological	<b>Mother Ado</b>	Mother – Adopted	<b>Son Bio</b>	Son – Biological
<b>Daug Foster</b>	Daughter – Foster	<b>Mother Bio</b>	Mother – Biological	<b>Son Foster</b>	Son – Foster
<b>Daug InLaw</b>	Daughter – In-Law	<b>Mother Fos</b>	Mother – Foster	<b>Son In Law</b>	Son – In-Law
<b>Daug Step</b>	Daughter – Step	<b>Mo In Law</b>	Mother – In-Law	<b>Son Step</b>	Son – Step
<b>Dom Partner</b>	Domestic Partner	<b>Mo Step</b>	Mother – Step	<b>Uncle Bio</b>	Uncle - Biological
<b>Fath Adop</b>	Father – Adopted	<b>Neph Bio</b>	Nephew – Biological	<b>Uncl NBio</b>	Uncle – Non-biological
<b>Fath Bio</b>	Father – Biological	<b>Neph NBio</b>	Nephew – Non-biological	<b>Wife</b>	Wife
<b>Fath Fost</b>	Father – Foster	<b>Niece Bio</b>	Niece – Biological		

Include relevant family information impacting the client: (Further explain family member’s involvement in substance use)

**MEDICAL HISTORY:**

Does client have a Primary Care Physician: This is a required field. Check box “No”, “Yes”, “Unknown” If No, check “No” or “Yes” client been advised to seek primary care.

Primary Care Physician: Enter the name and phone number of the physician in the text boxes provided. “Seen within the Last” period of time question is a required field. Check box “6 months”, “12 months”, or “Other” and explanation in text box provided.

The “Physical Health Issues” prompt is a Required Field. Check boxes for health issues are provided. Check all that apply.

The Allergies and adverse medication reactions” prompt is a Required Field.

Referred to primary health physician: Check box “Yes” or “N/A”.

Physical health problems affecting mental health functioning: Explain in text box provided.

Head Injuries: Check box “No” or “Yes”. If Yes, specify.

Describe any medical and/or adaptive devices used by client.

Describe any significant developmental information (when applicable).

Allergies and adverse medication reactions is a required field. Check box “No”, or “Yes”. If yes, specify in text box provided

Other prescription medications: Check box “None” or “Yes”. If Yes, describe in text box provided.

Herbals/Dietary Supplements/Over the counter medications: Check box “None” or “Yes”. If Yes, describe in text box provided.

Healing and Health: Alternative healing practices and beliefs. Apart from mental health professionals, who or what helps client deal with disability/illness and/or to address substance use issues?

Any known medical condition or past history of abuse that requires special consideration if physical restraint is needed, specifically: breathing problems, significantly overweight, pregnancy, etc? Check box “No”, “Yes”. If yes, explain.

**MMSE: (Mini Mental Status Exam):** Enter 2 digit code

**Anasazi Tab 2**

**MENTAL STATUS EXAM :** This is a Required Field. Check each area as applicable to client. Document other observations in the space provided.

**Anasazi Tab 3**

**DIAGNOSIS**

**If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Psychiatric Assessment.**

**Anasazi Tab 4**

**VITAL SIGNS:** Enter appropriate values for each prompt.

Pain: Check box “No”, “Yes”, “Unable to determine”.

Pain intensity level: Enter information in text box provided.

Location of pain: Enter information in text box provided, and how long client has had pain.

Doctor notified: Enter information in text box provided.

**DIAGNOSTIC SUMMARY:** Document the summary of your assessment in the space provided.

**PLAN:** Enter documentation of the Psychosocial/Rehab needs in the space provided. Include available treatment and/or recovery services recommended, within your program or in the community.

**PRESCRIPTIONS ORDERED NOW:** If client is taking psychiatric or psychotropic medications enter in medication table provided in the form.

For “Side Effects Discussed”, “Medication Consent Forms”, “Ex-Parte” and “Conservator”, check boxes “No”, “Yes”, or “N/A”.

Diagnostic Examinations Ordered Now: Enter information in space provided.

Laboratory Tests Ordered Now: Enter information in space provided

Placement Needs: Enter information in space provided

**SIGNATURES:** Enter the name, credential, date and Anasazi ID number for the Physician requiring a co-signature (if applicable); and/or the Physician completing/accepting the evaluation.

**WHEN:** Is not required if information is documented in the progress note.

**ON WHOM:** All clients receiving anti-psychotic medication. For clients under sixty (60) years of age due once a year and for clients over sixty (60) years of age every six (6) months.

**COMPLETED BY:** M.D., D.O., or Registered Nurse.

**MODE OF COMPLETION:** Data must be entered into the Electronic Health Record

**REQUIRED ELEMENTS:** Facial and oral movements, extremity movements, trunk movements, global judgments, dental status, response to medication.

**San Diego County Mental Health Services**  
**ABNORMAL INVOLUNTARY MOVEMENT SCALE**  
**(AIMS)**

**\*Client Name:** \_\_\_\_\_

**\*Case #:** \_\_\_\_\_

**\*Date:** \_\_\_\_\_

**\*Program Name:** \_\_\_\_\_

**FACIAL AND ORAL MOVEMENTS**

- |                                 |                               |                                  |                               |                                   |                                 |
|---------------------------------|-------------------------------|----------------------------------|-------------------------------|-----------------------------------|---------------------------------|
| 1. Muscles of Facial Expression | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| 2. Lips and Perioral Area       | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| 3. Jaw                          | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| 4. Tongue                       | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |

**EXTREMITY MOVEMENTS**

- |  |                               |                                  |                               |                                   |                                 |
|--|-------------------------------|----------------------------------|-------------------------------|-----------------------------------|---------------------------------|
| 5. Upper (Arms, Wrist, Hands, Fingers) | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| 6. Lower (Legs, Knees, Ankles, Toes)   | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |

**TRUNK MOVEMENTS**

- |                          |                               |                                  |                               |                                   |                                 |
|--------------------------|-------------------------------|----------------------------------|-------------------------------|-----------------------------------|---------------------------------|
| 7. Neck, Shoulders, Hips | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
|--------------------------|-------------------------------|----------------------------------|-------------------------------|-----------------------------------|---------------------------------|

**GLOBAL JUDGMENTS**

- |   |   |                                  |                               |                                   |                                 |
|---|---|----------------------------------|-------------------------------|-----------------------------------|---------------------------------|
| 8. Severity of Abnormal Movements             | <input type="checkbox"/> None   | <input type="checkbox"/> Minimal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| 9. Incapacity Due to Abnormal Movements       | <input type="checkbox"/> None   | <input type="checkbox"/> Minimal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| 10. Patient's Awareness of Abnormal Movements | <input type="checkbox"/> No Awareness<br><input type="checkbox"/> Aware, No Distress<br><input type="checkbox"/> Aware, Mild Distress<br><input type="checkbox"/> Aware, Moderate Distress<br><input type="checkbox"/> Aware, Severe Distress |                                  |                               |                                   |                                 |

**DENTAL STATUS**

- |                                       |                              |                             |
|---------------------------------------|------------------------------|-----------------------------|
| Current Problems with Teeth, Dentures | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does Client Usually Wear Dentures     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

TOTAL Tardive Dyskinesia-Like Score \_\_\_\_\_

Any Other Important Information, Comments or Concerns:

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**\*Signature of Physician or Nurse Completing Examination:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Anasazi ID #

## VITAL SIGNS /WEIGHT/HEIGHT RECORD - EHR

2014

- WHEN:** Assessment and tracking of physiological parameters is encouraged at every physician visit, when clinic resources allow.
- ON WHOM:** Any appropriate client.
- COMPLETED BY:** MD, RN, or LVN
- MODE OF COMPLETION:** Data must be entered into the Electronic Health Record.
- REQUIRED ELEMENTS:** All clinically appropriate elements should be completed.
- NOTE:** Every assessment within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved (status is “open green locked”) is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Assessments are not viewed as complete and active until the assessment is final approved (red locked).

San Diego County Mental Health Services

VITAL SIGNS/WEIGHT/HEIGHT/RECORD

Client Name: \_\_\_\_\_ Case #: \_\_\_\_\_

\*Program Name: \_\_\_\_\_

History:

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Temperature:	
Pulse:	
Respiration:	
Weight	
Height	
Blood Pressure	

Reason taken:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of MD, RN or LVN:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Anasazi ID #

Signature of Staff:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Anasazi ID #

## Instructions for System Outage

**WHEN:**

Once you have been trained to use the Doctor's Homepage in Anasazi, the expectation is that all medications be entered into Anasazi via the Doctor's Homepage. In the event of a system outage write prescriptions as you would on paper and follow what has been procedure prior to access to DHP. Enter the information into the DHP for the client as the system becomes available. You will not transmit electronically – make sure to mark the prescription method appropriately (handwritten, called in or faxed).

# Medical Condition Review Form-EHR

2014

- WHEN:** Once you have been trained to use the Doctor's Homepage in Anasazi, the expectation is that all new medical condition information be entered into Anasazi via the Doctor's Homepage. In the event of a system outage, this form is used for documenting a client's vitals, allergies and medical condition. Enter the Medical Condition Review into the DHP as soon as the system becomes available again.
- ON WHOM:** All clients seen by medical staff.
- COMPLETED BY:** MD or RN supporting the medical staff.
- REQUIRED ELEMENTS:** All clinically appropriate elements should be completed.

## Medical Condition Review

Client Name: \_\_\_\_\_

Client Number: \_\_\_\_\_

### General

Height: \_\_\_\_\_ ft \_\_\_\_\_ in

Weight: \_\_\_\_\_ lbs \_\_\_\_\_ oz weight circumference \_\_\_\_\_

Pregnant     Lactating/Nursing     Fathering a child

### Vital Signs

Blood pressure: \_\_\_\_\_ mmHg systolic    \_\_\_\_\_ mmHg diastolic

Temperature \_\_\_\_\_ F    Heart Rate \_\_\_\_\_/min    Respiratory Rate \_\_\_\_\_/min

### Liver/Renal Conditions

Liver Disease

Renal Function \_\_\_\_\_ mL/min    Dialysis Type \_\_\_\_\_

Medical Conditions     No Known Medical Conditions

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Allergies     No Known Allergies

***Include medication and substance allergies***

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Staff Signature: \_\_\_\_\_ Staff ID: \_\_\_\_\_

DATE: \_\_\_\_\_

# COORDINATION WITH PRIMARY CARE PHYSICIAN AND BEHAVIORAL HEALTH SERVICES

2014

- WHEN:** Within 30 days of Assignment, and whenever there are significant changes like an addition, change, or discontinuation of a medication.
- ON WHOM:** All clients, whether or not they have a Primary Care Physician.
- COMPLETED BY:** Clinical Staff
- MODE OF COMPLETION:** Complete with client present and signed by client
- NOTE:** Further Instructions are included with the form.

## Coordination with Primary Care Physicians and Behavioral Health Services

Coordination of care between behavioral health care providers and health care providers is necessary to optimize the overall health of a client. Behavioral Health Services (BHS) values and expects coordination of care with health care providers, linkage of clients to medical homes, acquisition of primary care provider (PCP) information and the entry of all information into the client's behavioral health record. With healthcare reform, BHS providers shall further strengthen integration efforts by improving care coordination with primary care providers. Requesting client/guardian authorization to exchange information with primary care providers is mandatory, and upon authorization, communicating with primary care providers is required. **County providers shall utilize the *Coordination and/or Referral of Physical & Behavioral Health Form & Update Form*, while contracted providers may obtain legal counsel to determine the format to exchange the required information. This requirement is effective immediately and County QI staff and/or COTR will audit to this standard beginning FY 13-14.**

### For all clients:

#### Coordination and/or Referral of Physical & Behavioral Health Form:

- Obtain written consent from the client/guardian on the *Coordination and/or Referral of Physical & Behavioral Health Form*/ contractor identified form at intake, but no later than 30 days of episode opening.
- For clients that do not have a PCP, provider shall connect them to a medical home. Contractor will initiate the process by completing the *Coordination and/or Referral of Physical & Behavioral Health Form* /contractor form and sending it to the PCP within 30 days of episode opening. It is critical to have the specific name of the treating physician.
- Users of the form shall check the appropriate box at the top of the *Coordination and/or Referral of Physical & Behavioral Health Form* /contractor form noting if this is a referral for physical healthcare, a referral for physical healthcare and medication management, a referral for total healthcare, or coordination of care notification only. If it is a referral for physical healthcare, or physical healthcare and medication management, type in your program name in the blank, and select appropriate program type.

#### Coordination of Physical and Behavioral Health Update Form:

- Update and send the *Coordination of Physical and Behavioral Health Update Form* /contractor form if there are significant changes like an addition, change or discontinuation of a medication.
- Notify the PCP when the client is discharged from services by sending the *Coordination of Physical and Behavioral Health Update Form* /contractor form. The form shall be completed prior to completion of a discharge summary.

#### Tracking Reminders:

- Users of the form shall have a system in place to track the expiration date of the authorization to release/exchange information.
- Users of the form shall have a system in place to track and adhere to any written revocation for authorization to release/exchange information.
- Users of the form shall have a system in place to track and discontinue release/exchange of information upon termination of treatment relationship. Upon termination of treatment the provider may only communicate the conclusion of treatment, but not the reason for termination.



**Coordination and/or Referral of Physical & Behavioral Health Form**

- Referral for *physical* healthcare – [ \_\_\_\_\_ ] will continue to provide specialty behavioral health services  
 Mental Health       Alcohol and Drug
- Referral for *physical* healthcare & Medication Management – [ \_\_\_\_\_ ] will continue to provide limited specialty behavioral health services  
 Mental Health       Alcohol and Drug
- Referral for *total* healthcare – [ \_\_\_\_\_ ] is no longer providing specialty behavioral health services.  
 Available for psychiatric consult.
- Coordination of care notification only.

**Section A: CLIENT INFORMATION**

Client Name: Last	First	Middle Initial	AKA	<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address			Date of Birth	
City			Telephone #	
Zip			Alternate Telephone #	

**Section B: BEHAVIORAL HEALTH PROVIDER INFORMATION**

Name of Treatment Provider:	Name of Treating Psychiatrist (If applicable)
Agency/Program	
Street Address	City, State, Zip
Telephone #	Specific provider secure fax # or secure email address:
Date of Initial Assessment:	
Focus of Treatment ( <i>Use Additional Progress Note if Needed</i> )	
Case Manager/ Mental Health Clinician/ Alcohol and Drug Counselor/ Program Manager:	Behavioral Health Nurse: Phone #:



Date Last Seen	Mental Health Diagnoses:
	Alcohol and Drug Related Diagnoses:

Current Mental and Physical Health Symptoms *(Use Additional Progress Note if Needed)*

Current Mental Health and Non-Psychiatric Medication and Doses  
*(Use Additional Medication/Progress Note if Needed)*

Last Psychiatric Hospitalization  
 Date:  None

**Section C: PRIMARY CARE PHYSICIAN INFORMATION**

Provider's Name

Organization OR Medical Group

Street Address

City, State, Zip

Telephone #:	Specific provider secure fax # or secure email address:
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**Section D: FOR PRIMARY CARE PHYSICIAN COMPLETION  
 ACCEPTED FOR TREATMENT OR REFERED BACK TO SDCBHS  
 PROGRAM (PLEASE COMPLETE THE FOLLOWING INFORMATION AND  
 RETURN TO BEHAVIORAL HEALTH PROVIDER WITHIN TWO WEEKS  
 OF RECEIPT)**

Coordination of Care notification received.  
 If this is a primary care referral, please indicate appropriate response below:

1.  Patient accepted for physical health treatment only
2.  Patient accepted for physical healthcare and psychotropic medication treatment while additional services continue with behavioral health program
3.  Patient accepted for total healthcare including psychotropic medication treatment
4.  Patient not accepted for psychotropic medication treatment and referred back due to:



**Sensitive Information:** I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about mental health services or treatment for alcohol and drug abuse.

**Right to Revoke:** I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

**Photocopy or Fax:**

I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

**Redisclosure:** If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

**Other Rights:** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section 164.524.

**SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE**

SIGNATURE:	DATE:
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**Client Name (Please type or print clearly)**

<b>Last:</b>	<b>First:</b>	<b>Middle:</b>
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IF SIGNED BY LEGAL REPRESENTATIVE, PRINT NAME:	RELATIONSHIP OF INDIVIDUAL:
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**Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** \_\_\_\_\_

**If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed, or 60 days after termination of treatment.**

- |  |  |
|--|--|
| <input type="checkbox"/> Information Contained on this form<br><input type="checkbox"/> Current Medication & Treatment Plan<br><input type="checkbox"/> Substance Dependence Assessments<br><input type="checkbox"/> Assessment /Evaluation Report | <input type="checkbox"/> Discharge Reports/Summaries<br><input type="checkbox"/> Laboratory/Diagnostics Test Results<br><input type="checkbox"/> Medical History<br><input type="checkbox"/> Other _____ |
|--|--|

*The above signed authorizes the behavioral health practitioner and the physical health practitioner to release the medical records and Information/updates concerning the patient. The purpose of such a release is to allow for coordination of care, which enhances quality and reduces the risk of duplication of tests and medication interactions. Refusal to provide consent could impair effective coordination of care.*



**I would like a copy of this authorization**  **Yes**  **No**  
**Clients/Guardians Initials**

**→ Please place a copy of this Form in your client's chart**

**TO REACH A PLAN REPRESENTATIVE**

Care1st Health Plan  
(800) 605-2556

Community Health Group  
(800) 404-3332

Health Net  
(800) 675-6110

Kaiser Permanente  
(800) 464-4000

Molina Healthcare  
(888) 665-4621

Access & Crisis Line  
(888) 724-7240





**COORDINATION OF PHYSICAL AND BEHAVIORAL HEALTH UPDATE FORM**

**CLIENT NAME**

Last	First	Middle
Date of Birth	<input type="checkbox"/> Male	<input type="checkbox"/> Female

**BEHAVIORAL HEALTH UPDATE**

Treating Provider Name	Phone	FAX
Treating Psychiatrist Name (If applicable)	Phone	FAX

<input type="checkbox"/> Medications prescribed on _____ Date	Name/Dosage: _____
<input type="checkbox"/> Medications changed on _____ Date	Name/Dosage: _____
<input type="checkbox"/> Medications discontinued on _____ Date	Name/Dosage: _____

<input type="checkbox"/> Medications prescribed on _____ Date	Name/Dosage: _____
<input type="checkbox"/> Medications changed on _____ Date	Name/Dosage: _____
<input type="checkbox"/> Medications discontinued on _____ Date	Name/Dosage: _____

**Diagnosis Update :**

**Key Information Update:**

**Discharge from Treatment Date:**

**Follow-up Recommendations:**

**PRIMARY CARE PHYSICIAN UPDATE**

Please provide any relevant Update/Change to Patient's Physical Health Status.