COMMUNITY HOSPITAL INITIAL PSYCHIATRIC SCREENING INFORMATION FORM

Instructions: This form is to be completed, signed, and dated on all patients who are being referred for psychiatric commitment and disposition.

Time of Call: _______:_________ **Date of Call:** _____/_____/______

Patient Name:____ **Sex:** ☐Male ☐Female

Birth Date:______/______/_______ **Social Security #:** _________/__________/___________

Ethnicity/Culture: ☐African American ☐Caucasian ☐ Asian American ☐Hispanic ☐ Other: __________________

Language Preference: ☐English ☐ Spanish ☐ Creole ☐Chinese ☐ Other:______________
Hearing-Impaired: ☐Yes ☐No **Interpreter Needed:** ☐Yes ☐No

Out of State: ☐Yes ☐No **State:** ________________
County of Residence: ☐Kent ☐ New Castle ☐Sussex

Medicaid #: _____________
Insurance: ☐Aetna ☐BC/BS ☐Carve-out ☐Cigna ☐ Coventry ☐Diamond State Partners ☐DPCI ☐Medicare ☐None ☐Tri-care ☐ Other:______________

DSAMH Provider: ☐ Connections ☐Horizon House ☐ FHR ☐ PSI ☐ NCCMH / 809 ☐Hudson Center ☐ GMHC ☐KMHC ☐None ☐ Other: _______________

Was Provider notified: ☐Yes ☐ No **Contact Person:** ________________________
Veteran: ☐ Yes ☐No

Presentation to ER: ☐Self ☐ Family ☐Police ☐CCCP ☐ VA☐ Ambulance ☐ Other: _____________

Time of Arrival @ ER:_____:_____☐A.M. ☐P.M. **Source of Information/ Facility:** ______________
Contact # ____________________________________

Presenting Complaint (History of presenting problem, participating factors, and current systems):

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____

Recent Stressors: ☐Relationship ☐Family ☐Job ☐Housing ☐Financial ☐Legal ☐Other: ______________________

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Health Issues: ☐IDDM ☐NIDDM ☐Hypertension ☐Cardiac ☐HIV Status ☐Hepatitis C
☐Other: ___________________________

Special Needs: ☐Wheelchair ☐ Oxygen ☐Crutches ☐Cane ☐Walker ☐Other:_______________________

Describe:____

Danger to Self	**Danger to Others**	**Current Level of Functioning**
Suicidal Thoughts ☐Yes ☐No	**Homicidal Thought/ Violence** ☐Yes ☐No	**Any difficulty in the following areas:**
Suicidal Attempt ☐Yes ☐No	**Past History of Violence/Aggression** ☐Yes ☐No	**Sleeping** ☐Yes ☐No
Past History of Gestures/Attempts ☐Yes ☐No	**Access to Weapons** ☐Yes ☐No	**Eating** ☐Yes ☐No
Current Plan ☐Yes ☐No	**Current Plan** ☐Yes ☐No	**Going to Work/School** ☐Yes ☐No
Did they act on Plan ☐Yes ☐No	**Verbal Threats** ☐Yes ☐No	**Personal Hygiene** ☐Yes ☐No
What stopped them? ______________________________	**Physical Aggression** ☐Yes ☐No **Command Hallucinations to Harm Others** ☐Yes ☐No	**Weight Gain** ☐Yes ☐No **Weight Loss** ☐Yes ☐No **Relationships** ☐Yes ☐No **Marital Status** ☐Yes ☐No
Hopelessness ☐Yes ☐No **Command Hallucinations of Self-Harm** ☐ Yes ☐ No **Self-Mutilation** ☐Yes ☐No **Describe**:__________________________	**Describe:** ______________________________	**Describe:** ______________________________

Previous Psychiatric Treatment: ☐Yes ☐No
Treating Psychiatrist: ________________________
Where/ Date: _________________________________

List all medication that the client is currently taking:

____

____

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Mental Status Assessment:
Mood: ☐Calm ☐Anxious ☐Depressed ☐Manic ☐Hostile ☐Sad ☐Irritable ☐Anger

Judgment: ☐Intact ☐Impaired
☐Decreased Energy
☐Labile
☐Impulsiveness
☐Psychotic Symptoms (Delusions, Paranoia) **Describe:** ____

History of Substance Abuse: ☐ Yes or ☐No
☐Opiates ☐Cocaine ☐Cannabis ☐ Benzos ☐Amphetamines ☐Alcohol _________ BAL/Breathalyzer
☐UDS Other: ____
Amount/Frequency: ____________________ **Last Use:** ___________________________

Withdrawal Symptoms: Describe (History of Seizures, Vital Signs)
____
____
____

List all Medications Administered in the ER.
____
____
____

Restraints ☐Yes ☐No

Initial information taken by:_______________________ **Date:** _______/_________/________

Form Completed by: _______________________________ **Date:** _______/_________/________