

Substance Use:

Tobacco Use: Current Drug Use: Need Detox: Yes No

Substance	Frequency	Duration	Last Use	History of serious withdrawal	
Alcohol				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Benzodiazepines				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Barbiturates				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cocaine				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Methamphetamine				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hallucinogens				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Marijuana				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Opiate				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other:					

Past Outpatient Attempts: _____

Past Detox or Rehab admissions – List Dates: _____

Hx of DT's or Seizures: Yes No If Yes, Last Date of DT's or Seizure _____

CIWA Score: _____ Nausea Vomiting Sweats Agitation Anxiety Disoriented Headache
Tremor Tactile/Visual/Auditory Disturbances Diarrhea Muscle Cramping

Medical History:

History of Traumatic Brain Injury: Yes No

Confirmed Mental Retardation: Yes No

Mild Moderate Severe IQ Deficits **and**

Mild Moderate Severe Adaptive Deficits

Allergies:

Current Medications	Dosage	Frequency	Compliance Issues	Prescriber

Were the following labs and patient information sent in to this facility?

Vital Signs:
Yes:
No:

CBC:
Yes:
No:

CMP:
Yes:
No:

UDS:
Yes:
No:

BAL:

Height:

Weight:

ADL's

Feeds self	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Gait Stable	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bathes self	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Ambulatory	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Continent of Urine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Assistance Needed	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Continent of Bowel	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fall History	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Current/Pending Legal charges and Court Dates:

Legal History (Including Incarceration History):

Probation/Parole Officer Name:

Phone Number:

Mental Status Exam
(If accepted in the Emergency Department)

Dress/Appearance: Unremarkable Disheveled Eccentric Inappropriate for Conditions Poor Hygiene

Sleep: Rested More Than Usual Poor **Appetite:** Typical More Than Usual Less Than Usual

Attitude: Cooperative Withdrawn Guarded Suspicious Uncooperative Manipulative

Motor Activity: Unremarkable Slowed Repetitive Restless Agitated Tremor Catatonic

Affect: Appropriate Labile Constricted Blunted Flat Inappropriate

Mood: Euthymic Depressed Anxious Euphoric Irritable Angry

Speech: Unremarkable Over-talkative Spontaneous Impoverished Slow Pressured Loud
 Soft Monotone Slurred Aphasic

Thought Process: Unremarkable Vague Incoherent Circumstantial Tangential Perseverative
 Flight of Ideas Loose Associations Self-contradictory

Thought Content : Goal Oriented Obsessions Compulsions Ruminations Phobias

Delusions: None Paranoia Persecution Infidelity Grandiose Somatic Thought Insertion
 Thought Broadcasting Erotomanic

Hallucinations/Illusions: None Tactile Visual Auditory Olfactory Taste

Trauma: None Sexual Physical Emotional Military Significant Death Natural Disaster
 Health Condition Refugee Other: _____

Trauma Reaction: Depersonalization Derealization Fugue Nightmares Hallucination/Re-experiencing
 Socially Avoidant Hypervigilant Limited Dissociation Dissociative Identities

Consciousness: Alert Drowsy Dull Intoxicated **Not Oriented:** Person Place Time Situation

Cognition: Effective Distractible Concentration Problem Short-term Memory Deficit
 Long-term Memory Deficit Poor Problem Solving No Insight Into Problem

Judgment: Intact Poor Impulsive Impaired

Motivation: Unmotivated Minimizing Contemplating Preparing Action Oriented

Current Diagnostic and Level of Care Impressions (If known and required by referring or accepting facility):

Axis I: _____ - _____ - _____
Axis II: _____ - _____ - _____
Axis III: _____ - _____ - _____
Axis IV: _____
Axis V: GAF _____ or LOCUS, CALOCUS, or ECSII Level: _____ ASAM Score (SA Referral): _____

Recommendations:

Disposition:

Inpatient Program _____
 Detox Program _____
 Discharge to _____

Crisis Stabilization Unit: _____
 Partial Hospitalization / IOP _____
 Referral to Other _____

Accepting MD or Medical Provider and Facility Name: _____

Law Enforcement Observation Tool (LEOT) Circle the number(s) that apply to patient's ED presentation, add scores, and total below	After ED arrival, patient fights or attempts to flee from custody	5 <input type="checkbox"/>	Aggression leading to ED visit significantly harmed another	5 <input type="checkbox"/>	Extremely belligerent and verbally threatening others in ED	2 <input type="checkbox"/>
	Client has known history of harm to law enforcement or hospital staff	5 <input type="checkbox"/>	Racing, uncontrollable, and commanding psychotic thoughts	3 <input type="checkbox"/>	Extreme emotions driving impulsive actions	2 <input type="checkbox"/>
	Before ED arrival, patient fights or attempts to flee from custody	5 <input type="checkbox"/>	Destroying property in ED	3 <input type="checkbox"/>	Currently intoxicated or "high" to the point of loss of self-control	2 <input type="checkbox"/>
Total Points:			<input type="checkbox"/> 0 to 4 points – ED staff observation during assessment could be sufficient		<input type="checkbox"/> 5 or more points – Law enforcement observation would likely be needed	

Complete this section ONLY IF considering, 3-Way Psychiatric Hospital, Hospital Based IOP, or State Facility:

Reasons recent tx not successful: No Meds/Not Taken/Abused/Sold OP Provider Issue Traumatic Life Event
 Symptom Acuity Abuse/Neglect Substance Use Needed Higher LOC Other: _____

Other prior tx: Med-only OP therapy OP Enhanced Residential Crisis Unit Hospital x _____?

Treatment Goals: Med Stabilization Harm Reduction Tx and Crisis Plan Dev. OP Follow-up

Other: _____

Discharge Plan (ONLY if known):

OP Provider: _____ OP Medication Follow-up: _____

D/C to what residence?: _____ Transportation by whom?: _____

Authorization Number: _____
(Given By Managed Care Organization)