

DEPRESSION OUTPATIENT DOCUMENTATION

For use of this form see MEDCOM Circular 40-13

DATE of VISIT:

 INITIAL FOLLOW-UP**SECTION I - VITAL SIGNS / VISIT INFORMATION (To be Completed by Ancillary Support Staff)**

Reason for Visit to Primary Care Provider: _____

AGE: _____ TEMP: _____ PULSE: _____ RESP: _____ B/P: _____ HT: _____ WT: _____

Do you use tobacco products? No If yes, what type and how often? _____Are you interested in quitting? No Yes Tobacco cessation literature provided? Yes N/AAre you in pain? No If yes, severity of pain on a scale of 1-10? _____ Location: _____Is your visit today deployment related? Yes No Maybe

Allergies _____

Staff Signature**SECTION II - DEPRESSION SELF-ASSESSMENT (To Be Completed by Patient)**Do you use alcohol? Yes No Do you use drugs other than prescribed or over the counter? Yes No

List all current medications (amount, dose, how often)? _____

List all herbal remedies or supplements: _____

PRIME-MD PATIENT HEALTH QUESTIONNAIRE:

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

Circle the number that best describes your situation:

	Not At All	Several Days	More Than Half the Day	Nearly Every Day
a. Little interest or pleasure in doing things.	0	1	2	3
b. Feeling down, depressed or hopeless.	0	1	2	3
c. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
d. Feeling tired or little energy.	0	1	2	3
e. Poor appetite or overeating.	0	1	2	3
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
i. Thoughts that you may be better off dead or of hurting yourself in some way.	0	1	2	3

2. If you checked off any problems on the questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

 Not Difficult at All Somewhat Difficult Very Difficult Extremely Difficult

Adapted from PRIME-MD Patient Health Questionnaire (PHQ) * Trademark of Pfizer Inc

PATIENT'S IDENTIFICATION (For typed or written entries give: Name – last first, middle; grade; date; hospital or medical facility)

(Patient's Signature)**PRIME-MD TOTAL SCORE:** _____**Staff Instructions:** Add all numeric responses and place total in the space provided.

SECTION III – MEDICAL ASSESSMENT / DIAGNOSIS / TREATMENT PLAN / EDUCATION (To be completed by Provider)

PART A – MEDICAL HISTORY / PHYSICAL ASSESSMENT

(Include a brief medical history, personal and family history, treatment of mental illness, possible organic causes of depression, physical findings, etc)

PRIME-MD SCORE: _____ CAGE SCORE: _____

PART B – MENTAL STATUS ASSESSMENT

Document as indicated, or if N/A

Examples

- APPEARANCE: _____ (appearance to age, dress, hygiene, grooming)
SPEECH: _____ (volume, rate, clarity)
MOOD / AFFECT: _____ (euthymic, anxious, flat, tearful, blunted, etc)
SENSORIUM: _____ (time, person, place, situation)
THOUGHT COHERENCE: _____ (logical, goal directed, tangential, loose associations)
DELUSIONS / HALLUCINATIONS: _____ (paranoid, grandiose) / (auditory, visual, tactile)
HYPERACTIVITY: _____ (excitable, little or no sleep, spending sprees, talkative)
RECENT STRESSORS: _____ (death, birth, divorce, finances, unemployment, illness)
SUICIDE: _____ (ideation, intent w plan, means, pt/family history of)
HOMICIDE: _____ (ideation, intent w plan, means, past history of violence)
RESPONSE to INTERVIEW: _____ (cooperative, frightened, distrustful, hostile, etc)

PART C – DIAGNOSIS / RISK FACTORS

- RED FLAG RISK FACTORS: Check All That Apply:** Danger to Self Danger to Others
 Psychosis Delirium Personality D/O Substance Abuse Manic Symptoms
 Other mental disorder causing significant impairment of social, familial, vocational or educational functioning
DSM-IV DIAGNOSIS: Deferred Major Depressive D/O Depressive D/O NOS
 Mood D/O due to: _____ Mood D/O NOS Dysthymic D/O
Indicate the General Medical Condition
 Adjustment D/O with Depressed Mood Other: _____

PART D – TREATMENT PLAN

1. MEDICATION: _____
2. MONITORING PLAN: _____
3. REFERRAL: Self Care Nutrition Tobacco Cessation Pastoral Substance Abuse Program
 Behavioral Health Clinic Case Mgt Services Other: _____
4. CLINIC FOLLOW-UP: None 48/72 Hours One Week Two Weeks Other: _____
5. INSTRUCTIONS: _____
REVIEWED with PT: Yes No RESPONSE to PLAN: _____

PART E – PATIENT / FAMILY EDUCATION / INSTRUCTIONS

1. MEDICATION: Instruction/Precautions Literature Other: _____
2. DISEASE MANAGEMENT: Depression Brochure Depression Video Self-Mgt Guidelines Folder
 Tobacco Cessation Literature Safety Plan Other: _____
3. CONTINUITY of CARE: PCM F/U Appointment Info Activity Diet Referral Appointment
4. Other: _____

Primary Care Manager Signature / Date