DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2050 Worth Road
Fort Sam Houston, Texas 78234-6000

MEDCOM Circular
No. 40-13

27 June 2006

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Medical Services

DEPRESSION OUTPATIENT FORMS

1. HISTORY. This issue publishes an update of this publication due to administrative revisions; however, the content of this publication remains the same.

2. PURPOSE.

a. This circular provides policy and implementing instructions for use of the depression outpatient forms prescribed by this circular: U.S. Army Medical Command (MEDCOM) Form 717-R, Depression Outpatient Documentation and MEDCOM Form 723-R, Behavioral Health Referral/Response Documentation.

b. These forms will facilitate outpatient treatment record (OTR) documentation by cueing military treatment facility (MTF) practitioners to document key aspects in their assessment and treatment of depressed patients. A panel of expert consultants from the Army, Navy, Air Force, and Department of Veterans Affairs (VA) identified key aspects by thoroughly examining scientific evidence on depression. This panel synthesized the evidence on treatment of depression in the Department of Defense/VA Practice Guideline on the Management of Major Depressive Disorder. Key aspects were then transformed onto the forms named in paragraph “a” above and prescribed by this circular.

3. APPLICABILITY. This circular applies to all MEDCOM facilities and grants use of the test forms (prescribed herein) in the documentation of care and referral of all depressed adolescent and adult patients assessed and treated in an outpatient clinic.

4. REFERENCE. AR 40-66, Medical Record Administration and Health Care Documentation, provides guidance on medical record documentation and is applicable (other than those exceptions addressed in this circular).

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*This circular supersedes MEDCOM Circular 40-13, 27 June 2004.

5. EXPLANATION OF ABBREVIATIONS AND TERMS.

a. Abbreviations.

AR.....Army Regulation
DD.....Department of Defense
MEDCOM.....U.S. Army Medical Command
MTF.....military treatment facility
OTR.....outpatient treatment record
SF.....standard form
VA.....Department of Veterans Affairs

b. Terms. See AR 40-66.

6. RESPONSIBILITIES. See AR 40-66.

7. POLICY.

a. Personnel in MTFs may use MEDCOM Forms 717-R and 723-R for the period of the test (through 27 June 2008) or as directed by the MEDCOM.

b. The MEDCOM test forms prescribed by this circular will be filed in the OTR with the standard form (SF) 600 (Health Record-Chronological Record of Medical Care) in reverse chronological order (most recent on top).

c. MEDCOM Form 717-R may be used in lieu of the SF 600 only for patients being evaluated or treated for depression on an outpatient basis in the MTF.

d. MEDCOM Form 723-R may be used in lieu of the SF 513 (Medical Record-Consultation Sheet) or DD Form 2161 (Referral for Civilian Medical Care) only for patients being evaluated or treated for depression on an outpatient basis.

e. All current requirements of AR 40-66, other than those addressed in this circular, remain in effect.

8. INSTRUCTIONS FOR USE OF THE DEPRESSION OUTPATIENT FORMS.
Note: Both forms are authorized for local reproduction (that is, "-R" forms) and are contained in appendix A of this circular. Forms are to be printed head to foot.

a. MEDCOM Form 717-R, Depression Outpatient Documentation.

(1) Purpose. This form is used to document the assessment and treatment of patients with depression.

(2) Preparation. This form has three sections. Section I, vital signs/visit information, is completed by ancillary support staff. Section II, depression

self-assessment, is completed by the patient. Section III, medical assessment/ diagnosis/treatment plan/education, is completed by the provider.

(3) Content. Section I includes documentation of reason for clinic visit, age, height, weight, vital signs, tobacco use assessment, pain assessment, deployment related assessment, allergies, and staff signature block. Section II includes questions concerning prescribed and over-the-counter medication use, alcohol and/or illicit drug use, and a self-administered depression assessment (PRIME-MD PATIENT HEALTH QUESTIONNAIRE). There is a signature block for the patient to complete. Section III includes check box and free-hand areas for documentation of the patient's medical history/physical assessment, mental status assessment, diagnosis, treatment plan, and patient/family education and instruction. There is a signature block for the primary care manager to complete.

(4) Filing. The completed MEDCOM Form 717-R is filed in the patient's OTR. Refer to section 7b of this circular for filing instructions.

b. MEDCOM Form 723-R, Behavioral Health Referral/Response Documentation.

(1) Section I, Primary Care Clinic Referral to Behavioral Health.

(a) Purpose. Section I, page 1, of this form is used by MTF primary care managers to initiate a patient referral/consultation to a military (or civilian) behavioral health clinic. If this form is used as a referral to a civilian behavioral health clinic, a completed (and approved) DD Form 2161 must also be attached.

(b) Preparation. Section I, page 1, of this form has four parts. Parts A through D are completed by the primary care manager.

(c) Content. Part A describes the reason for the referral or consultation; Part B documents medical problems and provides the depression assessment; Part C documents the mental status assessment; and Part D describes the patient’s current medical treatment. There is a signature block for the primary care manager to complete.

(d) Routing. After completion of Parts A through D, the form is sent forward per your facility’s referral procedures.

(2) Section II, Behavioral Health Response.

(a) Purpose. Section II, page 2, of this form may be used by any military (or civilian) behavioral health care specialist to document examination, findings, and recommendations. When this form is completed by a civilian provider, it must be attached to the original DD Form 2161.

(b) Preparation. This form has four parts. Parts A through D are completed by the behavioral health care specialist after evaluation of the patient.

(c) Content. Part A summarizes the diagnostic impression; Part B describes the treatment plan; Part C documents patient education; and Part D gives continuity of care recommendations. There is a signature block for the behavioral health care specialist to complete.

(d) Routing. The completed MEDCOM 723-R is sent from the behavioral health care specialist to the initiating provider in the primary care clinic.

(e) Filing. The completed MEDCOM Form 723-R, Sections I and II, when returned to the primary care clinic and after review by the patient's primary care manager, is filed in the patient's OTR. The behavioral health clinic may make a copy of Sections I and II of this form for their departmental outpatient records. Refer to section 7b of this circular for filing instructions.

(f) Therapy Termination. The behavioral health care specialist providing therapy to the referred patient will notify the initiating primary care manager at the conclusion or discontinuation of therapy.

APPENDIX A

Appendix A contains the following "-R" forms (authorized for local reproduction).

MEDCOM Form 717-R (Depression Outpatient Documentation)

MEDCOM Form 723-R (Behavioral Health Referral/Response Documentation)

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: _____ BP: _____ 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/A

Are 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 Days	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 would be better off dead or of hurting yourself in some way.	0	1	2	3

2. If you checked off any problem 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

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-MED 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 with plan, means, pt/family history of)
HOMICIDE: _____	☐	(ideation, intent with plan, means, past history of violence)
RESPONSE to INTERVIEW: _____	☐	(cooperative, frightened, distrustful, hostile, etc)

PART C - DIAGNOSIS / RISK FACTOR

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 Depressive Mood ☐ Other: _____

PART D - TREATMENT PLAN

1. MEDICATION: _____
2. MONITORING PLAN: _____
3. REFERRAL: ☐ Self Care ☐ Nutrition ☐ Tobacco Cessation ☐ Pastora ☐ 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-Management Guidelines Booklet
   ☐ Tobacco Cessation Literature ☐ Safety Plan ☐ Other: _____
3. CONTINUITY of CARE: ☐ PCM F/U Appointment Info ☐ Activity ☐ Diet ☐ Referral Appointment
4. OTHER: _____ _____

Primary Care Mgr Signature / Date

BEHAVIORAL HEALTH REFERRAL / RESPONSE DOCUMENTATION
For use of this form see MEDCOM Circular 40-13

DATE OF REQUEST

SECTION I - PRIMARY CARE CLINIC REFERRAL to BEHAVIORAL HEALTH

PART A - REASON for REFERRAL

Evaluation and Treatment: (Check all that apply)

- ☐ Medication
- ☐ Psychological Testing
- ☐ Psychotherapy
- ☐ Group Therapy
- ☐ Family Therapy
- ☐ Marital Counseling
- ☐ Other: _____

Advice for Treatment: (Check all that apply)

- ☐ Capacity for Management in the Primary Care Setting
- ☐ Initial Medication Recommendation
- ☐ Medication Failure
- ☐ Side Effects from Current Medication
- ☐ Life-style Modification Plan
- ☐ Resource Identification
- ☐ Other: _____

PART B - MEDICAL PROBLEMS and DEPRESSION ASSESSMENT

Relevant Medical Findings:

Allergies: _____ Support System: _____

Depression Assessment: (Check all that apply)

- ☐ Feeling Down, Empty, Hopeless
- ☐ Loss of Interest or Pleasure
- ☐ Worthlessness, Guilt
- ☐ Poor Concentration
- ☐ Poor Energy
- ☐ Anxiety
- ☐ Sleep Disturbance (___ hrs/night)
- ☐ Decreased Appetite
- ☐ Increased Appetite
- ☐ Danger to Self/Others
- ☐ Drug Misuse/Abuse
- ☐ Periods of Hyperactivity/Excitability
- ☐ Weight Loss (___lbs in ___ weeks)
- ☐ Weight Gain (___lbs in ___ weeks)
- ☐ Past Use of Psychotropic Medication
- ☐ Past History of Depression
- ☐ Past Psychiatric Hospitalization
- ☐ Other: _____

Diagnosis: _____ **PRIME-MD SCORE:** _____ **CAGE-AID SCORE:** _____

PART C - MENTAL STATUS ASSESSMENT

Document as indicated, or ☒ if N/A		**Examples**
Appearance: _____	☐	(appearance to age, dress, hygiene, grooming)
Speech: _____	☐	(volume, rate, clarity)
Response to Interview: _____	☐	(cooperative, frightened, distrustful, hostile, etc)
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)
Suicide / Homicide: _____	☐	(ideation, intent w plan, means, pt/family history)
Intelligence: _____	☐	(below average, average, above average)

PART D - CURRENT MEDICAL TREATMENT

All Current Medications/Herbals/Supplements (amount & dose): _____

Current Interventions: _____

Other: _____

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

_____
Signature of Primary Care Manager / Date

Clinic: _____

Telephone: _____

BEHAVIORAL HEALTH REFERRAL / RESPONSE DOCUMENTATION For use of this form see MEDCOM Circular 40-13	TO: PRIMARY CARE CLINIC PCM:	DATE OF CONSULT

SECTION II - BEHAVIORAL HEALTH RESPONSE

PART A - DIAGNOSTIC IMPRESSION

PART B - TREATMENT PLAN

MEDICATION: (Check and describe all that apply)

☐ Antidepressant Medications:

☐ Other Medications:

INTERVENTION: (Check and describe all that apply)

☐ Psychological Testing
☐ Cognitive Behavioral Therapy
☐ Interpersonal Psychotherapy
☐ Brief Dynamic Psychotherapy
☐ Group Therapy
☐ Family Therapy
☐ Marital Counseling
☐ Other: _____

Frequency:

Anticipated Length of Treatment:

PART C - PATIENT EDUCATION

Patient Response to Plan: _____

Medication Information: _____ Disease Management Information: _____

Appointment Schedule: _____ Other: _____

PART D - CONTINUATION of CARE RECOMMENDATIONS

RECOMMENDATIONS TO PCM:

PCM Clinic Follow-up Appointments: _____

Indications for Referral Back to Behavioral Health: _____

Medication Adjustment: _____

Laboratory Studies: _____ Other: _____

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

_____
Signature of Behavioral Health Specialist / Date

Clinic: _____

Telephone: _____

NOTE: At Conclusion or Discontinuation of Therapy Please Notify the Patient's PCM.

The proponent of this publication is the Office of the Assistant Chief of Staff for Health Policy and Services. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, U.S. Army Medical Command, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6026.

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