Initial Psychiatric Evaluation

This form is to be completed by a psychiatrist, NPP, or other professional who is qualified to conduct and document an initial psychiatric evaluation.

Data Field	Individual Demographic Information
Organization and Program Name	Record the names of the Organization and the Program if applicable
Individual's Name	Record the first name, last name, and middle initial of the Individual being served. Order of name is at agency discretion.
Record #	Record your agency's established Record number for the Individual.
Date of Birth	Record the date of birth of the Individual. **(e.g. MM/DD/YYYY)**
Data Field	**Present at Session**
List Name(s) of Individual(s) Present	Check box, *Individual Present as appropriate;* If *Others Present*, identify name(s) and relationship(s) to Individual.
Data Field	**Presenting Concern/History of Present Illness/Comprehensive Assessment Completed?**
Presenting Concerns in Individual's own words	Use the Individual's own words to document the reason the Individual is asking for help. This should be a concise but complete description of why the Individual is seeking help now, including troublesome symptoms, behaviors, and problems in functioning in life roles.
If child or adolescent, family/guardian's description of problem	If psychiatric evaluation is being conducted for a child/adolescent, provide family/guardian's perception of problem/difficulties.
History of Present illness	Provide relevant information as it pertains to the history of the present illness. This should include onset of symptoms and what was done to manage illness prior to seeking help. Check *None Reported* if applicable.
Comprehensive Assessment has been completed?	Check appropriate box. If "Yes", provide date of most recent assessment.
Data Field	**Substance Use/Addictive Behavior History**
Substance Use /Addictive Behavior History	Review the Substance Use/Addictive Behavior section of the Comprehensive Assessment, if applicable. Document any additional information that is obtained.
Data Field	**Developmental History**
Developmental History	Refer to Comprehensive Assessment, if completed, for related information. Document any additional information that is obtained.
Has Individual been previously diagnosed with a developmental disability?	Check appropriate box. If "Yes", provide specific information with regard to how the disability may impact treatment and services to be provided, particular disability, needs as a result of the disability, impact on family, and causes of disability if known.
Data Field	**Family Mental Health / Substance Use History**
Family Mental Health / Substance Use History	Check all that apply or *none reported* and comment as necessary.
Data Field	**Physical Health History**
Physical Health History	Provide relevant information as it pertains to Individual's physical health. Refer to Comprehensive Assessment, if applicable. Document any additional information that is obtained.

Data Field	Mental Status Exam
Mental Status Examination	If completing Mental Status Evaluation Addendum, check the box on top, Refer to Attached Mental Status Evaluation. If not completing the addendum, provide a thorough written narrative below and answer the current risk related questions. Consider the following: • Avoid judgmental perceptions. • Take into account cultural differences. • Think of creating a picture of the individual served so that anyone reading the results of the exam would be able to clearly perceive the individual just as you do. Assessment items are "in the moment"; in other words, as the individual presents to you at the present time. There are other sections of the assessment form that address historical information. If individual did not report any Danger To Self/Others, check the box. If any of the current risk related questions are checked, complete and attach the Risk Assessment Addendum.
Data Field	**For Children/Adolescents**
For Children/Adolescents	Complete for individuals under the age of eighteen. Record responses and note any significant changes since last evaluation.
Data Field	**Summary of Current Mental Health Functioning**
Summary of Current Mental Health Functioning/Symptoms/ Strengths and Limitations related to Medication Management/Self Administration	Record summary of Individual's current mental health functioning, symptoms, strengths, and limitations related to medication management and self administration.
Information from other sources	Record any other pertinent information from other sources (family, referring agency, other professionals). Include reports of diagnostic tests/exams and consultations. If the individual is a child or adolescent, include information related to past cognitive/achievement testing. If no other information reported, check box for None Reported.
Data Field	**Diagnosis**
Diagnoses/ Rationale	Check appropriate box to indicate whether you are recording a DSM or ICD Diagnosis. Record Axis I – V where indicated. Each agency should have adequate internal processes to ensure the diagnostic impression recorded in the Comprehensive Assessment is reconciled with the diagnoses in the Psychiatric Evaluation.
Reported side effects/adverse drug reactions/other comments on current or past medications) **What medications have worked well for you in the past?**	Record and comment on any side effects/adverse reactions reported by Individual /guardian to past or present medications. Provide any other comments regarding medications as deemed relevant. This section should be completed for all Individuals, regardless of whether the information has already been completed in the Comprehensive Assessment. **Comments on Past Medications:** Include what medications have worked well previously, and/or which one(s) the Individual would like to avoid taking in the future.

Data Field	Special Considerations in Prescribing
Does Individual have any special medical conditions that require consideration in prescribing?	Check appropriate box. If "Yes", describe specific medical conditions that require special consideration in prescribing (i.e. diabetes, heart disease, morbid obesity, or other cardio-metabolic conditions).
Data Field	**Medication Orders**
Medication Orders	Refer to Medication Log Addendum
Explained rationale for medication choices, reviewed mixture of medications, discussed possible risks, benefits, effectiveness (if applicable) and alternative treatment with the Individual, parent/guardian	Check *Yes* or *No* to indicate whether the rationale, risks and benefits of the particular mixture of medications prescribed, any alternative treatments or medications, and effectiveness (if applicable) have been explained to the Individual during this evaluation.

Data Field	Follow Up Plan and Other Considerations
Individual/Guardian Understands Information/Agrees To Take Medication	Under *Individual /Guardian Response* check appropriate box to indicate if the Individual /guardian understood the information or not, and whether the Individual agrees to take the medication or not. If Individual served indicates he/she does not understand or refuse medications, address in the Follow Up Plan section.
Individual's/Guardian's Response	If Individual/Guardian has no specific response to medication information check "Not Applicable" Box. Otherwise, indicate response to medication plan.
Follow Up Plan/Referrals	This section should describe the immediate follow-up plan to this visit. Include as appropriate referrals, labs, or other additional testing ordered, medical strategies, other types of treatment and frequency/interval of next visit. Record issues that need to be addressed in future appointments.
Data Field	**Issues for Children/Adolescents**
Issues for Children/ Adolescents	Use the prompts provided to elicit information about the individual's wants, goals, worries, sources of pleasure and sadness, etc.

Data Field	Prioritized Assessed Needs as Evidenced by
Prioritized Assessed Needs	Based on information obtained in the evaluation, identify and record Assessed Needs of the individual. Assessed needs are not services or interventions but distressing symptoms, maladaptive behaviors, functional deficits, support deficits, etc. that prevent the individual from assuming desired life roles. To the right of each identified need check the appropriate box indicating whether the need is "Active" (i.e. will be addressed in the IAP), "Person Declined" (i.e. the individual chooses not to address this need at this time), "Deferred" (i.e. the Individual and clinician have determined not to address the need until a later time), or "referred" (i.e. the need requires referral to another program, service, or practitioner). In some cases there may be high need areas that cannot be declined or deferred without risk to the individual and must stay on the list as a treatment need. These should be the exceptions to the person-centeredness of this negotiation. These identified needs will be considered the basis for subsequent treatment goals and/or objectives and all recommendations and needs will be geared toward improving the functioning of the individual in life roles or reducing the distressing symptoms of his/her illness. **Examples: Debilitating depressive symptoms that result in isolation. Problems controlling anger. Repeated relapses with alcohol and drugs. Psychotic symptoms (i.e. delusions, hallucinations) that interfere with individual's ability to manage wellness and resume desired life roles. Social skills challenges that result isolation. Challenges with ADL skills that interfere with individual's ability to integrate into the community. Lack of social supports to help individual in recovery. Self destructive thoughts/behaviors that threaten the individual's survival and ability to pursue desired roles.**
Individual Declined/Deferred/Referred Out Rationale(s) (Explain why Individual Declined to work on Need Area; List rationale(s) for why Need Area(s) is/are Deferred or Referred Out)	Describe reasoning behind worker's decisions to defer or refer out work on any assessed needs. Also provide reasoning behind decisions by individual served to decline a recommendation at this time.
Other Psychopharmacological Considerations to be Added to the Individualized Action Plan	If clinically indicated, record suggestions for consideration of other services to be added and included in the IAP and/or IAP Revision. Check *None indicated at this time* if no other services are to be added.
Data Field	**Signatures**
Print Provider Name, Credentials, Signature, and Date	Legibly print name, credentials, and record signature of the prescriber. Record date of signature.
Supervisor – Print Name, Credentials and provide signature (if applicable)	Legibly print name, credentials, and record signature of supervisor reviewing the assessment. Record date of signature.