



CPRS Sample Templates Based on PCMHI Co-Located Collaborative Care Training Tools

Note: The templates provided here are intended to display local CPRS templates implemented in the field. These are not nationally mandated templates, but rather demonstrations of local practices which can be adapted for local site utilization. Adaptation may be needed for local coding requirements for various disciplines.

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CCC Initial Appointment: Functional Assessment

Example from Dr. Joe Barron, Bay Pines

PRIMARY CARE-MENTAL HEALTH INTEGRATION (PC-MHI) FUNCTIONAL ASSESSMENT

DEMOGRAPHICS:

Name: |PATIENT NAME|

Age: |PATIENT AGE|

Sex: |PATIENT SEX|

|SC DISABILITIES + RATED|

Primary Care Provider: |PRIMARY CARE PRACTITIONER|, |PRIMARY CARE TEAM|

Length of Visit: {FLD:TEXT 10} minutes

{FLD:BUTTON []} Warm Hand-Off {FLD:BUTTON []} Scheduled Visit {FLD:BUTTON []} Walk-in

The veteran was appropriately identified and informed about the nature of PC-MHI services and this screening visit as well as limits of confidentiality.

Clinical Reminders are Due: {FLD:00 YES/NO}

Urgency of need for care: {FLD:BUTTON []} Routine {FLD:BUTTON []} Stat

Appropriate setting for care: {FLD:BUTTON []} Outpatient {FLD:BUTTON []} ER

MAIN CONCERN: Veteran was referred by physician/medical team due to {FLD:TEXTBOX}

Problem History (Duration/Frequency/Intensity): {FLD:TEXTBOX}

Treatment History for Problem: {FLD:TEXTBOX}

Factors that Improve/Exacerbate Problem, if applicable: {FLD:TEXTBOX}

Any Other Concerns of Veteran or Relevant Mental Health History: {FLD:TEXTBOX}

How Presenting Problem Impacts the Following:

-Sleep: {FLD:TEXTBOX}{FLD:BUTTON []} No changes

-Work/School: {FLD:TEXTBOX}{FLD:BUTTON []} No changes

-Relationships/Interpersonal: {FLD:TEXTBOX}{FLD:BUTTON []} No changes

- Leisure/Recreation: {FLD:TEXTBOX} {FLD:BUTTON []} No changes
- Physical/Medical/Pain: {FLD:TEXTBOX} {FLD:BUTTON []} No changes
- ETOH/Illicit Substance Use/Tobacco/Caffeine: {FLD:TEXTBOX}

Symptom Measurements:

PHQ9 (Depression):

(RANGES: 0-4 Minimal; 5-9 Mild; 10-14 Moderate; 15-19 Moderately severe; 20-27 Severe)

GAD7 (Anxiety):

(RANGES: 0-4 Minimal; 5-9 Mild; 10-14 Moderate; 15-21 Severe)

PCL-5 (Trauma-Related Symptoms):

(RANGES: 0-10: Minimal; 11-20: Mild; 21-40: Moderate; 41-60: Severe;
61-80: Very Severe symptoms)

AUDIT (Alcohol Use):

(RANGES: A score of 8 or more indicates a strong likelihood of hazardous or harmful alcohol consumption.)

WENDER UTAH RATING SCALE (Self-Report Measure of Childhood ADHD symptoms):

(RANGES: Data suggest a cutoff score of 46 or higher correctly identified 86% of the patients with attention deficit hyperactivity disorder and 99% of the normal subjects.)

MONTREAL COGNITIVE ASSESSMENT (MoCA):

(RANGES: 0-30; Score of 25 or less is indicative of possible cognitive dysfunction.)

BOMC (Orientation/Cognition):

(RANGES: This screener has a range of 0 to 28. A score greater than 10 is consistent with the presence of a possible cognitive disorder. Values less than 7 are considered normal for the elderly.)

LETHALITY ASSESSMENT

- Are you having thoughts of harming yourself or others? {FLD:00 YES/NO} {FLD:TEXTBOX}
- Any history of suicide attempts: {FLD:00 YES/NO} {FLD:TEXTBOX}
- Any history of violence: {FLD:00 YES/NO} {FLD:TEXTBOX}
- Risk level: {FLD:BUTTON []} LOW {FLD:BUTTON []} MODERATE {FLD:BUTTON []} HIGH

{FLD:TEXTBOX}

MENTAL STATUS:

- {FLD:BUTTON []} Within normal limits
- {FLD:BUTTON []} Other: {FLD:TEXTBOX}

DIAGNOSTIC IMPRESSIONS:

{FLD:TEXTBOX}

ASSIST PHASE:

Veteran was provided with tools for self-management including:

{FLD:BUTTON []} Handouts on: {FLD:TEXTBOX}

{FLD:BUTTON []} Online resources for: {FLD:TEXTBOX}

{FLD:BUTTON []} Skills training in: {FLD:TEXTBOX}

{FLD:BUTTON []} Education regarding: {FLD:TEXTBOX}

ACTION PLANNING: {FLD:TEXTBOX}

FOLLOW-UP PLAN:

{FLD:BUTTON []} Continue Care within PC-MHI. {FLD:TEXTBOX}. RTC in {FLD:TEXT 10} weeks

{FLD:BUTTON []} Referral to General/Specialty Mental Health

{FLD:TEXTBOX}

Outcome and recommendations will be discussed with the referring provider and other relevant PACT team members as needed.

EDUCATION:

Veteran was provided with opportunity to address any questions or concerns.

The veteran was provided with written contact information. The veteran is aware of the Suicide Prevention Hotline number (1-800-273-8255) in case of crisis.

If experiencing a mental health emergency, the veteran should present to nearest emergency room or call 911 immediately.

Example from Dr. Kristen Perry, Seattle

Primary Care Mental Health Integration Functional Assessment

 Age: |PATIENT AGE| GENDER: |SEX| RACE: |RACE|
 |PRIMARY CARE TEAM|
 Current |PRIMARY CARE PROVIDER|
 Date: {FLD:DATE (TODAY)}
 Visit Duration: 20 min therapy (25 min face-to-face)

Brief evaluation with Veteran completed during which Veteran's questions and concerns were addressed and engagement in care was facilitated. Discussed nature/purpose of psychological treatment, the undersigned's role on treatment team, the use of information (including notations of care in CPRS), limits of confidentiality, and the voluntary nature of treatment. Veteran orally expressed informed consent to engage in this evaluation.

REFERRAL PROBLEM: {FLD:W-P2LINES}

HISTORY OF PROBLEM:

Problem History (Duration/Frequency/Intensity): {FLD:W-P2LINES}

Treatment History: {FLD:W-P2LINES}

Exacerbating/Alleviating Factors: {FLD:W-P2LINES}

Other Problems of Concern to Veteran: {FLD:W-P2LINES}

FUNCTIONAL ASSESSMENT:

Sleep: {FLD:YES/NO/UNKNOWN}
 Work: {FLD:YES/NO/UNKNOWN}
 Relationships: {FLD:YES/NO/UNKNOWN}
 Recreation: {FLD:YES/NO/UNKNOWN}
 Physical Activity: {FLD:YES/NO/UNKNOWN}
 ETOH: {FLD:YES/NO/UNKNOWN}
 Tobacco: {FLD:YES/NO/UNKNOWN}
 Drugs: {FLD:YES/NO/UNKNOWN}
 Caffeine: {FLD:YES/NO/UNKNOWN}

SAFETY/RISK ASSESSMENT:

Are you feeling hopeless about the present or future? {FLD:YES NO}
 Have you had thoughts about taking your life? {FLD:YES NO}
 Have you ever had a suicide attempt? {FLD:YES NO}
 Danger to others: {FLD:YES NO}

MEASUREMENT BASED CARE:

PHQ-9 =

PHQ-9 Q10 =

GAD-7 =

MENTAL STATUS:

Orientation and Consciousness: {FLD:MSE ORIENT}

Appearance and Behavior: {FLD:MSE APPEAR}

Mood and Affect: {FLD:MSE MOOD}

Speech: {FLD:MSE SPEECH}

Perceptual Disturbance: {FLD:MSE HALLUCINATE}{FLD:MSE PERCEPTUAL}

Thought Process: {FLD:MSE THOUGHT PRO}

Insight: {FLD:MSE INSIGHT TEXT}{FLD:MSE INSIGHT}

Judgment: {FLD:MSE JUDGE TEXT}{FLD:MSE INSIGHT}

DIAGNOSIS:

{FLD:W-P2LINES}

TREATMENT PLAN:

Immediate Mental Health care needed. Crisis response initiated.

Mental Health (non-urgent, within 14 days) needed.

Next appointment: [INCLUDE CLINIC, DATE/TIME]

Veteran declines Mental Health care.

Addressed any concerns, and provided emergency contact numbers to Veteran:

VA contact during working hours: **ENTER PROVIDER NAME AND PHONE LINE**

24 hour VA Veteran's Crisis Line: 1-800-273-8255, option 1

911

Example from Dr. Beret Skroch, Minneapolis

PRIMARY CARE/MENTAL HEALTH INTEGRATION EVALUATION AND TREATMENT PLAN

PROCEDURES: 30-minute behavioral health provider evaluation and treatment for XX

VETERAN SELF-REPORT/REASON FOR REFERRAL:

TREATMENT PLAN:

Treatment goals negotiated with patient include:

- 1.
- 2.

INTEGRATED SUMMARY:

DIAGNOSTIC IMPRESSIONS:

Presenting Problem History (Duration/Frequency/Intensity):

Treatment History of Presenting Problem:

What Makes the Presenting Problem Better/Worse:

Other Problems of Concern to Veteran:

IMPACT OF PRESENTING PROBLEM ON FUNCTIONING/DAILY LIFE

Sleep:

Physical/Nutrition/Exercise:

Work:

Relationships/Social Functioning:

Recreation:

Alcohol:

Tobacco:

Drugs:

Caffeine:

RISK ASSESSMENT:

Risk Factors:

Protective factors:

Based on risk and protective factors, the patient is considered to be a XX risk for committing suicidal/homicidal acts at this time.

ADDITIONAL ASSESSMENT:

PHQ-9: (minimal/mild/moderate/moderately severe/severe depression)

GAD-7: (minimal/mild/moderate/severe anxiety)

Insomnia severity index: (no insomnia/subthreshold insomnia/moderate insomnia/severe insomnia)

Pain Screen: (0=none; 10=bad as you can imagine)

Pain on the average past week=

Pain interference with enjoyment in life=

Pain inference with general activity=

Informed Consent: Information was reviewed with the patient regarding the role and services of the behavioral health provider, documentation procedures, and confidentiality and limits to confidentiality of patient data. Patient willingly agreed to evaluation.

In addition to the assessors' contact information, the following emergent mental health resources were discussed. Mental health crisis 612-467-1921 or 1-866-414-5058 extension 1921 during business hours and VA emergency department 612-467-2771 after business hours and weekends. National suicide prevention hotline: 1-800-273-8255. Life threatening emergency: 911.

Example from Dr. Joel Baskin, North Texas (Non-Prescribing Provider)

PRIMARY CARE - MENTAL HEALTH INTEGRATION INITIAL EVALUATION

[TODAY'S DATE]

[PATIENT NAME]

DOB: [PATIENT DATE OF BIRTH]

Military background: [MILITARY SERVICE]

SC? [SC PERCENTAGE]

Purpose of visit and limits of confidentiality were reviewed with Veteran. They agreed to proceed with assessment.

CHIEF COMPLAINT/REFERRAL PROBLEM:

HISTORY OF PRESENT ILLNESS:

Problem History (Duration/Frequency/Intensity):

Treatment History (Including Med Trials, Adherence, Adverse Reactions):

What Makes the Concern Better/Worse:

Other Problems of Concern to Veteran:

FUNCTIONAL ASSESSMENT/TYPICAL DAY:

Sleep:

Work:

Close relationships:

Family:

Friends:

Recreation:

Physical:

Alcohol:

Tobacco:

Drugs:

Caffeine:

PSYCHOMETRIC SUMMARIES (see Mental Health Assistant for details):

PHQ-9:

GAD-7:

PCL-5:

AUDC:

CLINICAL REMINDERS:

RISK ASSESSMENT:

MEDICATIONS:

|ALL ACTIVE MEDS COMBINED|

PERTINENT MEDICAL HISTORY INCLUDING PROBLEM LIST FROM CPRS:

|ACTIVE PROBLEMS|

MENTAL STATUS EXAM:

LOC:

A:

B:

S:

M:

A:

TP:

TC:

P:

I:

J:

C/A:

M:

FoK:

IMPRESSION: |PATIENT NAME| is a |PATIENT AGE| year old |PATIENT SEX| Veteran presenting with the XXXXXXXXXXXXXXXX

DSM-5 DIAGNOSES:

PLAN:

I have reviewed diagnosis and treatment options with the patient. Based on that, the Veteran's stated goal for change is, "XXX." After review of r/b/a of proposed treatment, patient agreed to the following plan.

Medication Referral

=====

-

Psychotherapy

=====

-Psychotherapy performed for XX minutes.

Techniques used:

Topics discussed:

Patient response:

Consults

=====

-

Patient Education

=====

-following handouts provided:

-written prescription for next steps provided to patient

Follow up

=====

-

-I have reviewed the signs of worsening depression and indications for initiating crisis procedures of calling crisis line, calling 911, or presenting to nearest ER.

-I have explained, and Veteran understands, how to contact PC-MHI at XXXXXXXXXX during working hours.

Example from Dr. Joel Baskin, North Texas (for Psychiatrists/APRNs/PAs/Clinical PharmDs)

PRIMARY CARE - MENTAL HEALTH INTEGRATION INITIAL EVALUATION

[TODAY'S DATE]

[PATIENT NAME]

DOB: [PATIENT DATE OF BIRTH]

Military background: [MILITARY SERVICE]
SC? [SC PERCENTAGE]

CHIEF COMPLAINT/REFERRAL PROBLEM:

HISTORY OF PRESENT ILLNESS:

Problem History (Duration/Frequency/Intensity):

Treatment History (Including Med Trials, Adherence, Adverse Reactions):

What Makes the Concern Better/Worse:

Other Problems of Concern to Veteran:

FUNCTIONAL ASSESSMENT/TYPICAL DAY:

Sleep:

Work:

Close relationships:

Family:

Friends:

Recreation:

Physical:

Alcohol:

Tobacco:

Drugs:

Caffeine:

PSYCHOMETRIC SUMMARIES (see Mental Health Assistant for details):

PHQ-9:

GAD-7:

PCL-5:

AUDC:

CLINICAL REMINDERS:

RISK ASSESSMENT:

MEDICATIONS:

|ALL ACTIVE MEDS COMBINED|

ALLERGIES:

|ALLERGIES/ADR|

PERTINENT MEDICAL HISTORY INCLUDING PROBLEM LIST FROM CPRS:

|ACTIVE PROBLEMS|

MENTAL STATUS EXAM:

LOC:

A:

B:

S:

M:

A:

TP:

TC:

P:

I:

J:

C/A:

M:

FoK:

RECENT PERTINENT LABS:

Thyroid function:

|LR TSH|

Hepatic Panel:

|LR AST|

|LR ALT|

Electrolytes:

|LR BUN|

|LR CREATININE|

UDS:

IMPRESSION: |PATIENT NAME| is a |PATIENT AGE| year old |PATIENT SEX| Veteran presenting with the XXXXXXXXXXXXXXXX

DSM-5 DIAGNOSES:

PLAN:

I have reviewed diagnosis and treatment options with the patient. Based on that, the Veteran's stated goal for change is, "XXX." After review of r/b/a of proposed treatment, patient agreed to the following plan.

Medication

=====
-

Labs

=====
-

Psychotherapy

=====
-Psychotherapy performed for minimum of 16 minutes.
Techniques used: behavioral activation
Topics discussed:
Patient response:

Consults

=====
-

Patient Education

=====
-following handouts provided:
-written prescription for next steps provided to patient

Follow up

=====
-

- I have warned patient not to drive or operate machinery if sleepy or otherwise impaired. Patient voiced understanding.
- I have reviewed the signs of worsening depression and indications for initiating crisis procedures of calling crisis line, calling 911, or presenting to nearest ER.
- I have explained, and Veteran understands, how to contact PC-MHI at XXXXXXXXXX during working hours.

Example from Dr. Rachel Colbert, Martinsburg

Intro Script

- Describe who you are/role in the clinic*
- How long visit will be
- What will happen during the visit
- Type of follow-up which may occur
- Note from visit will go in medical record. Ask if it is okay to type.
- PCP will get feedback
- Reporting obligations*

Primary Care Mental Health Integration Note

Procedure Code: 96150, 90832

Length of visit: 30 minutes

Referred by:

Referred for: *Identifies and/or clarifies the presenting problem*

Session: 1

Identifying Information:

ASSESS

History of Problem: *(Asks about duration, frequency, and intensity of physical sensations, behaviors/habits, thoughts, and emotions, as appropriate to presenting problem-Duration/Frequency/Intensity)*

Treatment Hx:

Psychotropic Medications:

What Makes the Concern Better/Worse:

Other Problems of Concern to Veteran:

Functional Assessment/Typical Day: *Evaluates how presenting problem impacts patient's functioning in all the below areas*

Sleep:

Physical:

Exercise:

Work:

Close relationships:

Family:

Friends:

Recreation:
 ETOH:
 Tobacco:
 Illegal Drugs:
 Caffeine:

Additional Assessment: *Uses/references assessment measures appropriate to primary care (e.g., PHQ9, GAD-7, PCL)**

Measurement-based care

PHQ-9:
 GAD-7:
 PCL:
 BAM/AUDIT-C:

Other:

Pain (Source) 0-10- use behavioral anchors for 0 and for 10 (i.e. 0=never have pain and 10=pain is so bad can't get out of bed)

Today = ___/10, High = ___/10, Low = ___/10, Avg = ___/10

Risk Assessment (e.g., lethality, suicidality/homicidality): *Appropriately assesses and manages risk of harm to self/others**

Suicide

Current Suicide Risk Factors

_____ Does not have thoughts of suicide or self-harm at this time
 _____ Does not express feelings of hopelessness or helplessness at this time

Current Suicide Assessment

_____ Low: Patient judged NOT to be at significant risk for self-harm
 _____ Moderate: Patient judged to be at increased risk for suicide but not imminently dangerous to self
 _____ High: Patient judged to be at imminent risk for self-harm

Impression/Diagnosis/Assessment Summary: *Provides patient succinct summary of assessment information and biopsychosocial impressions/formulation of problem. Integrates key biological, psychological, social or environmental factors in the formulation*

ADVISE

Share Options and Discuss Strengths/Needs: *Specific, personalized options for treatment that are based in the evidence; discussion of how symptoms can be decreased and functioning and quality of life/health improved. Review behavioral change options for addressing identified concerns and implementing next steps**

Options:

Strengths/Needs:

AGREE

Patient's goals for change: *(Based on treatment options reviewed in advise- the patient is interested in and willing/motived to engage in these options)*

PCP & PACT/or PC-MH Team Input:

ASSIST

-Starting a Behavioral Change Plan and In Session Practice: : *Begin to implement the specific behavioral change action plan, demonstrate relevant skills, and discuss specific options for homework practice. Focus on learning new information, developing new skills, overcoming barriers, solving problems, and/or developing confidence to make change**

-Uses evidence-based interventions for identified concerns*

-Handouts Given (education/activation):

ARRANGE

Specify plans for follow-up (visits/calls)*

RTC Follow-Up Arrangements: (additional referrals as needed- consults/meds):

Other : Give VCL number: 1-800-273-8255 (press 1)

Written Prescription of Next Steps: *Provide patient with a written prescription of next steps*

Patient agreed to plan.

MSE: Patient was dressed appropriately. Pt was O_x4 and cooperative during appointment. Pt's mood was euthymic and affect was congruent with mood. Pt maintained eye contact and was engaged throughout session. Pt displayed no evidence of a thought disorder; pt exhibited no psychotic or manic symptoms. Pt's speech was WNL. No indication of current or recent SI/HI, plan or intent.

*

Treatment Plan:

1. Description of identified problem:
2. Statement of treatment modality:
3. Anticipated goal and measurable change:

*

Diagnostic Impressions

**

Patient Education: Educated patient on the various resources available at this VAMC. Patient verbalized understanding of the information presented.

**

CCC Follow-Up Appointment CPRS Template

Example from Dr. Joe Barron, Bay Pines

PRIMARY CARE-MENTAL HEALTH INTEGRATION (PC-MHI)
FOLLOW-UP SESSION PROGRESS NOTE

Session #: {FLD:TEXT 10}
Length of Visit: {FLD:TEXT 10} minutes
Clinical Reminders Due: {FLD:00 YES/NO}

-Symptom Measurements:
PHQ9 (Depression):
(RANGES: 0-4 Minimal; 5-9 Mild; 10-14 Moderate; 15-19 Moderately severe; 20-27 Severe)

GAD7 (Anxiety):
(RANGES: 0-4 Minimal; 5-9 Mild; 10-14 Moderate; 15-21 Severe)

PCL-5 (Trauma-Related Symptoms):
(RANGES: 0-10: Minimal; 11-20: Mild; 21-40: Moderate; 41-60: Severe; 61-80: Very Severe symptoms)

Main Problem/Functional Review: {FLD:TEXTBOX}

Review of Previous Interventions/Homework: {FLD:TEXTBOX}

NEW ACTION PLAN: {FLD:TEXTBOX}

MENTAL STATUS:
{FLD:BUTTON []} Within normal limits
{FLD:BUTTON []} Other: {FLD:TEXTBOX}

LETHALITY ASSESSMENT:
{FLD:X BUTTON} Safety/Risk factors reviewed, unchanged. The veteran denied any urgent or emergent needs, or suicidal/homicidal ideation, plan, or intent. Veteran continues to be considered a LOW risk of harm to self or others.

{FLD:TEXTBOX}

DIAGNOSTIC IMPRESSIONS:

{FLD:TEXTBOX}

FOLLOW-UP PLANNING:

{FLD:BUTTON } Continue Care within PC-MHI. RTC: {FLD:TEXT 10} {FLD:TEXTBOX}

Changes in Care Plan, if applicable:

{FLD:BUTTON } Referral to Specialty Clinic or Program.

{FLD:BUTTON } Discontinue brief intervention services. Reason: {FLD:TEXTBOX}

Outcome and recommendations will be discussed with the referring provider and other relevant PACT team members as needed.

EDUCATION:

Veteran was provided with opportunity to address any questions or concerns.

The veteran is aware of the Suicide Prevention Hotline number (1-800-273-8255) in case of crisis. If experiencing a mental health emergency, the veteran should present to nearest emergency room or call 911 immediately.

Example from Dr. Kristen Perry, Seattle

Age: |PATIENT AGE| GENDER: |SEX| RACE: |RACE|
 |PRIMARY CARE TEAM|
 Current |PRIMARY CARE PROVIDER|
 Visit Duration: 20 min therapy (25 min face-to-face)

DIAGNOSES AND PROBLEMS TREATED THIS VISIT:

MEASUREMENT-BASED CARE:

PHQ-9 =
 GAD-7 =

HOMEWORK REVIEW:

FUNCTIONAL ASSESSMENT & SIGNIFICANT SYMPTOMS/ISSUES:

RISK ASSESSMENT:

No evidence SI/HI or change in risk. Denies urgent care needs.

MENTAL STATUS EXAMINATION:

Orientation and Consciousness: {FLD:MSE ORIENT}
 Appearance and Behavior: {FLD:MSE APPEAR}
 Mood and Affect: {FLD:MSE MOOD}
 Speech: {FLD:MSE SPEECH}
 Perceptual Disturbance: {FLD:MSE HALLUCINATE}{FLD:MSE PERCEPTUAL}
 Thought process: {FLD:MSE THOUGHT PRO}
 Insight: {FLD:MSE INSIGHT TEXT}{FLD:MSE INSIGHT}
 Judgment: {FLD:MSE JUDGE TEXT}{FLD:MSE INSIGHT}

INTERVENTION USED:

DISPOSITION/PLAN:

Veteran was provided with this writer's name and contact information and encouraged to make contact should any questions or concerns arise prior to the next appointment within the Mental Health Service Line. Veteran was also provided with instructions about how to access emergency services.

Clinical Reminders due: |REMINDERS DUE-MENTAL HEALTH|

Example from Dr. Peggy Arnott, Orlando

MH PC INITIAL ASSESSMENT

Veteran Identification: Patient is a xx year old, MALE.

Veteran is seen by PCMHI as part of the Patient-Aligned Care Team (PACT).

DATE: Feb 16,2018; VISIT DURATION (minutes): 25

Consent provided for participation by:

REFERRED BY:

REASON FOR REFERRAL:

Veteran's appraisal of the referral problem (duration, frequency, intensity, triggering events, etc.):

SCREENINGS ADMINISTERED:

PHQ9 (Depression): 2

PHQ9 was administered and score indicates minimal depression.

(RANGES: 0-4 Minimal; 5-9 Mild; 10-14 Moderate; 15-19 Moderately severe;
20-27 Severe)

GAD7 (Anxiety): 2

GAD7 was administered and score indicates minimal anxiety.

(RANGES: 0-4 Minimal; 5-9 Mild; 10-14 Moderate; 15-21 Severe)

No formal screening(s) completed

Brief summary of past mental health treatment (e.g. therapy, medication, hospitalization, inpatient treatment, etc.):

OR

Veteran denies any history of mental health treatment.

FUNCTIONAL ASSESSMENT:

Changes in relationships with family, friends, at work, etc.:

Changes in meaningful activities (e.g. social, recreational, etc.):

Changes in performance of responsibilities at work, school, home, etc.:

Changes in exercise or physical activity:

Changes in sleep, energy, concentration or appetite:

Mood during the past two weeks:

Veteran denies symptoms of psychosis and mania.

SUICIDE RISK SCREENING:

1. History of suicide attempt(s): No
2. Are you having thoughts today about killing yourself? No
3. Do you have a plan to kill yourself? No

Describe plan:

4. Do you have the means to carry out the plan? No
5. Risk level: Low (no suicide specific actions are needed)

Homicidal/violence risk? No

HEALTH BEHAVIORS:

Caffeine:

Alcohol:

Other substances:

Tobacco:

Health and medical concerns:

Strengths:

Relevant objective observations outside of normal limits:

VETERAN PROVIDED WITH:

Information about Veterans' Crisis Line and walk-in appointments with PCMHI

Literature:

Action plan with collaboratively developed activity goal:

DIAGNOSTIC IMPRESSIONS:

FOLLOW-UP PLAN:

Return for PCMHI follow-up:

PCMHI Psychologist to consult with PCP about medication or other management suggestions.

OR

Consult entered for General Mental Health for: Psychotherapy, Medication
Referral to BHL staff for: Referral Management, Antidepressant Monitoring,
Baseline Assessment, Telephone Care Management, Watchful Waiting

Referral to additional VA services (e.g. Social Work):

Veteran already established with General Mental Health services. Discussed scheduling/walk-in procedures for General Mental Health. No further PCMHI treatment planned.

No follow-up with PCMHI needed.

Veteran declines follow-up.

Veteran to return should treatment be needed/desired.

Feedback to PCP: View alert/Additional signer, In person, By phone, VISTA, GUI,
or Secured Messaging, Written note



MH PC INITIAL
ASSESSMENT 3.xml

Dr. Arnott's CPRS text file document:

Example from Dr. Rachel Colbert, Martinsburg

Intro script:

- Remind Veteran of 25 minute time
- Completion of self-report instruments (if not already done) and explains the use of instruments at each appointment*
- Informs Veteran further assessment will then occur with plan for adjustment of treatment as needed
- Informs communication will happen back to PCP

Primary Care Mental Health Integration Note

Procedure Code: 90832, 96152

Length of visit: 30 minutes

Referred by:

Referred for:

Session:

Identifying Information:

ASSESS

Self-Report Instruments and Risk Assessment

- Reviews results of brief self-report instruments*

Measurement-based care

PHQ-9:

GAD-7:

PCL:

BAM/AUDIT-C:

Other:

Risk Assessment (e.g., lethality, suicidality/homicidality):

- Appropriately assesses and manages risk of harm to self/others*

Homework Review

- Reviews any homework from prior session and incorporates this into the assessment

Other PCMH/PACT Members Input (care manager, PCP, RN, etc.)

Functional Assessment

- Reviews status of presenting problem and current impact on patient's functioning (physical, emotional, behavioral, environmental/social, cognitive) and any changes since the prior visit including progress towards goals

Positive/Negative Factors Impacting Functioning:

Assessment of Medication Adherence and Adverse Reactions (if applicable)

Review of active medication list

Suicide

Current Suicide Risk Factors

_____ Does not have thoughts of suicide or self-harm at this time

_____ Does not express feelings of hopelessness or helplessness at this time

Current Suicide Assessment

_____ Low: Patient judged NOT to be at significant risk for self-harm

_____ Moderate: Patient judged to be at increased risk for suicide but not imminently dangerous to self

_____ High: Patient judged to be at imminent risk for self-harm

ADVISE/AGREE

Goal Discussion

Collaboratively adjusts/revises change advise and goals based on self-report measures, brief assessment of progress toward goals, patient interest and motivation to change relative to progress and symptoms.*

**

ASSIST

Evidence-Based Intervention

Selects evidence-based interventions for use within session, appropriate for the concern and consistent with competency training. Continues behavioral change plan for addressing identified concerns and implementing next steps.*

Handouts Given (education/activation):

**

ARRANGE

Specify plans for follow-up (visits/calls)*

Provide patient with a written prescription of next steps

RTC Follow-Up Arrangements:

Additional Referrals (if indicated):

- * Referral to Care Management (if indicated)
- * Referral PACT Team Member (if indicated)
- * Referral to Specialty Mental Health (if indicated)

Written Prescription of Next Steps (including revision of SMART goals):

Patient agreed to plan.

**

Diagnostic Impressions

**

MSE: Patient was dressed appropriately. Pt was OX4 and cooperative during appointment. Pt's mood was euthymic and affect was congruent with mood. Pt maintained eye contact and was engaged throughout session. Pt displayed no evidence of a thought disorder; pt exhibited no psychotic or manic symptoms. Pt's speech was WNL. No indication of current or recent SI/HI, plan or intent.

*

Treatment Plan:

1. Description of identified problem:
2. Statement of treatment modality:
3. Anticipated goal and measurable change:

**

Patient Education: Educated patient on the various resources available at this VAMC. Patient verbalized understanding of the information presented.

**

Example from Dr. Joel Baskin, North Texas (Medication Review Visit for Psychiatrists/APRNs/PAs/Clinical PharmDs)

PCMHI PRESCRIBER NOTE

|TODAY'S DATE|

|PATIENT NAME|

DOB: |PATIENT DATE OF BIRTH|

HISTORY OF PRESENT ILLNESS: Completing medical portion of MH assessment documented by PCMHI staff today. See that note for details. In brief, their findings were as follows:

My additional findings are as follows:

MEDICATIONS:

|ALL ACTIVE MEDS COMBINED|

ALLERGIES:

|ALLERGIES/ADR|

PERTINENT MEDICAL HISTORY INCLUDING PROBLEM LIST FROM CPRS:

|ACTIVE PROBLEMS|

HISTORY OF SEIZURES:

BRIEF REVIEW OF SYSTEMS (if indicated):

MOST RECENT VITAL SIGNS:

T:|TEMPERATURE|

P:|PULSE|

BP:|BLOOD PRESSURE|

R:|RESPIRATION|

BMI: |BMI|

MENTAL STATUS EXAM:

LOC:

A:

B:
S:
M:
A:
TP:
TC:
P:
I:
J:
C/A:
M:
FoK:

RECENT PERTINENT LABS:

Thyroid function:
 |LR TSH|
Hepatic Panel:
 |LR AST|
 |LR ALT|
Electrolytes:
 |LR BUN|
 |LR CREATININE|
UDS:

IMPRESSION: |PATIENT NAME| is a |PATIENT AGE| year old |PATIENT SEX| veteran with

DSM-5 DIAGNOSES:

PLAN:
Reviewed diagnosis and treatment options.

Medications
=====

Consults

=====

Labs

=====

Follow-up

=====

-f/u as per PCMH staff

I have discussed risks, benefits, alternatives of treatments prescribed. I have warned patient not to drive or operate machinery if sleepy or otherwise impaired. Patient voiced understanding.

In case of an emergency, Vet knows to call 911, go to the nearest emergency room, or come directly to the VA, or call Crisis Line.