HEALTH RECORD FOR PSYCHIATRIC VISIT

(To be completed and brought to each psychiatric hospital visit)

Name: _____ Likes to be called _____
D.O.B. _____ Soc. Sec. # _____Religion _____
Address: _____
_____
Tel. #_____

Provider Agency providing care:_____
Tel.#_____
Address:_____
Supports Coordinator: _____Tel#_____

Health Insurance(type and numbers)
Primary:_____
Secondary:_____

Documented level of MR: □ mild □ moderate □severe □ profound

Consent status: □ Can give own consent □ **Unable to give consent and no guardian**
□ Consent from guardian Name: _____Tel. #_____
Resuscitation □ DNR If DNR, is comfort care form available? □ Yes □ No □ Unknown
Status: □ Full resuscitation
Health Care Proxy: □ No □ Yes Name: _____Tel.#_____

Emergency contacts:
#1 Name: _____Relationship_____
Tel. #_____
#2 Name: _____Relationship_____
Tel. # _____

Communication
□Able to communicate
□Communication difficulties/Uses verbalizations
□Communication difficulties/Uses gestures
□Not able to communicate needs

Vision:
□Normal
□Low Vision
□Blind
□Wears glasses

Hearing:
□Normal
□HOH
□Deaf
□ Hearing aid

Supportive devices:
□Splints/braces
□Helmet
□Other

Toileting:
□ Continent
□ Incontinent
□Needs assistance

Ambulation:
□ Independent □ Steady □ Unsteady
□ Needs assistance □ 1 person □ 2 person
□ Ambulation aids □ Walker □ Cane □ Crutches
□ Wheelchair
□ Non-ambulatory

Personal hygiene: □ Independent □ Needs assistance
Oral hygiene: □ Independent □ Needs assistance □ Dentures
Head of bed elevated □yes □ No

Dietary: □ Regular Diet □ Special diet: _____
□Totally dependent □ Tube feed
□ Independent feed □ Needs assistance

Pain Response: □ Normal □ Unique (explain) _____

Special Needs:

Usual response to Medical Exams: □ Cooperates □ Partially cooperates □ Resistant

□Needs sedation for clinical visits □ Requires special positioning for examination

Medical Providers:

Primary Care Physician: _____Tel #_____
Address: _____

Neurologist _____Tel #_____
Address:_____

Behavior Psychologist/Consultant: _____Tel #_____
Address:_____

Other subspecialist/Type: _____Tel #_____
Address:_____

Living status: □ Group Home □ Own family □ Independent □ Shared home
□ Other _____

Nursing supports provided in home setting: □ Yes □ No

Marital status: □ Married □ Single □ Other

Work/Day Program Status: □ Community Day Support □ Day Habilitation
□ Regular Job □ Sheltered Workshop

Current medical problems & diagnoses:
(check) □Seizures □ Diabetes □ Asthma □ High blood pressure □ Hypothyroid
□ Hyperthyroid □ Gastro esophageal reflux diseases (GERD) □ Osteoporosis □ Dysphagia
List others:

_____
_____
_____
_____

Does the person have any implanted devices such as heart pacemaker or vagal nerve stimulator? □ Yes □ No
Type: _____

Past psychiatric diagnoses: (check)

- □ Intermittent explosive disorder
- □ Mood Disorder (Bipolar)
- □ Depression
- □ OCD (Obsessive compulsive disorder)
- □ ADD/ADHD) (Attention Deficit Disorder)
- □ Schizophrenia
- □ Schizoaffective Disorder
- □ Borderline Personality Disorder
- □ Other_____

_____

_____

_____

Has this person ever carried a diagnosis of Autism or Pervasive Developmental Disorder? □Yes □ No

Current behavior/mental health indicators:

Currently, does the person:	**Yes**	**No**	**Don't Know**	**Check if recent change**
Hurt himself/herself?				
Hurt others?				
Throw objects/destroy property?				
Appear unusually sad or depressed?				
Withdraw from others?				
Report hearing voices?				
Demonstrate paranoid thoughts?				
Display moodiness or irritability?				
Eat non-food items (pica)?				
Complain of pain- if so, where?				
Have recent history of personal losses or major life stressors?				
Have recent change in living or work environments? (including staff change)				
Display sexually inappropriate behavior?				
Run or wander away?				
Appear anxious (nervous, agitated, restless)?				
Appear forgetful, confused?				
Repeat words/actions again and again?				
Have difficulty sleeping?				
Have loss of appetite?				
Refuse medications?				
Have a Behavior Support Plan in place? **If so, please attach to form**				
Does the person follow the behavior support plan?				

*Attach Current Medication List to this Form

Allergies:

Medication/Response	Food/response	Environmental/Response

Food Likes/Dislikes

Food Likes	Food Dislikes

Preferred activities/hobbies:

□ Cards/Type_____
□ Games/Type_____
□ Music/Type_____
□ Puzzles
□ Drawing/Coloring
□ Prefers group activities/likes to be with others
□ Prefers to work/play alone
Other:_____
_____
_____
_____

Additional information/comments: