



0300002

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

PSYCHIATRIC CONSULT SERVICE

Date _____ Time _____ Requesting Physician _____ PIC _____

Reason for Consult _____ Patient Location: _____ Department _____

Chief Complaint	
History of Present Illness	
Psychiatric History	
Past Medical History	
Social History	
Family History	
Allergies	

PSYCHOACTIVE MEDS AND HISTORY OF FAILURE/SUCCESS	OTHER MEDICATIONS	REVIEW OF SYSTEMS		
		System	Normal	Abnormal (how?)
		Constitutional	<input type="checkbox"/>	<input type="checkbox"/>
		Eyes	<input type="checkbox"/>	<input type="checkbox"/>
		ENT	<input type="checkbox"/>	<input type="checkbox"/>
		Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>
		Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
		Skin	<input type="checkbox"/>	<input type="checkbox"/>
		GI	<input type="checkbox"/>	<input type="checkbox"/>
		GU	<input type="checkbox"/>	<input type="checkbox"/>
		Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
		Neurological	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> All other Systems Negative				

Physical Exam	Pulse: _____ bpm	BP: _____ / _____ mmHg	RR: _____ rpm	T: _____	PAIN _____ / 10	
	Skin	<input type="checkbox"/> Good skin turgor <input type="checkbox"/> Tattoos <input type="checkbox"/> Piercings <input type="checkbox"/> Lesions <input type="checkbox"/> No cyanosis <input type="checkbox"/> Other:				
	HEENT	<input type="checkbox"/> EOM intact <input type="checkbox"/> Anicteric sclera <input type="checkbox"/> Normal cornea <input type="checkbox"/> PERL <input type="checkbox"/> Normal fundi <input type="checkbox"/> Ears without erythema, exudates, or lesions <input type="checkbox"/> Moist mucous membranes <input type="checkbox"/> Dentition: _____ <input type="checkbox"/> Neck symmetrical, no masses, trachea midline <input type="checkbox"/> Thyroid not enlarged, non-tender <input type="checkbox"/> No palpable lymph nodes				
	CV	<input type="checkbox"/> RRR <input type="checkbox"/> Normal S1 & S2 <input type="checkbox"/> No murmurs <input type="checkbox"/> S3 or S4 <input type="checkbox"/> No JVD <input type="checkbox"/> No bruit <input type="checkbox"/> 2+ pulses BL				
	Pulm	<input type="checkbox"/> Clear to auscultation <input type="checkbox"/> Wheezes <input type="checkbox"/> Rales <input type="checkbox"/> Rhonchi <input type="checkbox"/> Other:				
	GI	<input type="checkbox"/> Abdomen soft <input type="checkbox"/> NT <input type="checkbox"/> ND <input type="checkbox"/> BS present <input type="checkbox"/> No masses <input type="checkbox"/> No organomegaly <input type="checkbox"/> Other:				
	MSK	<input type="checkbox"/> No clubbing <input type="checkbox"/> No edema <input type="checkbox"/> Normal spine curvature <input type="checkbox"/> Other:				
	Lymph	<input type="checkbox"/> No lymphadenopathy <input type="checkbox"/> Other:				
	Neuro	CN II-XII intact <input type="checkbox"/> Motor 5/5 in all 4 extremities <input type="checkbox"/> Sensation intact <input type="checkbox"/> Reflexes 2+ bilaterally & symmetric <input type="checkbox"/> No tremor, cogwheeling, or rigidity <input type="checkbox"/> Normal gait <input type="checkbox"/> Rapid alternating movements intact <input type="checkbox"/> Finger-to-nose intact <input type="checkbox"/> Heel-to-shin intact <input type="checkbox"/> Other:				
	GU	<input type="checkbox"/> No CVAT <input type="checkbox"/> Other:				
Mental Status Exam	Appearance	<input type="checkbox"/> Appropriate dress <input type="checkbox"/> Inappropriate dress <input type="checkbox"/> Well groomed <input type="checkbox"/> Hospital Gown <input type="checkbox"/> Unkempt <input type="checkbox"/> Disheveled <input type="checkbox"/> Bizarre				
	Behavior	<input type="checkbox"/> Awake, Alert, and Oriented <input type="checkbox"/> No behavior abnormalities <input type="checkbox"/> Drowsy <input type="checkbox"/> Confused <input type="checkbox"/> Tearful <input type="checkbox"/> Withdrawn <input type="checkbox"/> Intoxicated				
	Attitude	<input type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Redirectable <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile <input type="checkbox"/> Dramatic <input type="checkbox"/> Manipulative <input type="checkbox"/> Sarcastic				
	Eye Contact	<input type="checkbox"/> Direct <input type="checkbox"/> Darting <input type="checkbox"/> Averted gaze <input type="checkbox"/> Staring <input type="checkbox"/> Closed				
	Motor	<input type="checkbox"/> Appropriate <input type="checkbox"/> Retardation <input type="checkbox"/> Increased <input type="checkbox"/> Fidgety <input type="checkbox"/> Unsteady <input type="checkbox"/> Agitated <input type="checkbox"/> Rigid <input type="checkbox"/> Signs of EPS:				
	Mood	(patient quote)				
	Affect	<input type="checkbox"/> Congruent <input type="checkbox"/> Non-Congruent <input type="checkbox"/> Full Range <input type="checkbox"/> Labile <input type="checkbox"/> Shallow <input type="checkbox"/> Restricted <input type="checkbox"/> Blunted <input type="checkbox"/> Flat				
	Speech	<input type="checkbox"/> Normal Rate, Tone, Volume <input type="checkbox"/> Pressured <input type="checkbox"/> Hyperverbal <input type="checkbox"/> Slow <input type="checkbox"/> Slurred <input type="checkbox"/> Loud <input type="checkbox"/> Soft <input type="checkbox"/> Monotone <input type="checkbox"/> Latency				
	Thought Processes	<input type="checkbox"/> Linear <input type="checkbox"/> Tangential <input type="checkbox"/> Looseness of Associations <input type="checkbox"/> Flight Of Ideas <input type="checkbox"/> Word Salad <input type="checkbox"/> Echolalia <input type="checkbox"/> Logical <input type="checkbox"/> Illogical <input type="checkbox"/> Circumstantial <input type="checkbox"/> Circumferential <input type="checkbox"/> Perseveration <input type="checkbox"/> Blocking <input type="checkbox"/> Distractible <input type="checkbox"/> Goal directed <input type="checkbox"/> Slowed <input type="checkbox"/> Racing <input type="checkbox"/> Self-reference <input type="checkbox"/> Impoverished <input type="checkbox"/> Concrete <input type="checkbox"/> Intrusive Thoughts				
	Thought Content	<input type="checkbox"/> No SI <input type="checkbox"/> SI Plan: <input type="checkbox"/> No HI <input type="checkbox"/> HI <input type="checkbox"/> Toward:				
	Fund of Knowledge	Pt's awareness of current events, past history, and vocabulary: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor				
	Delusions	<input type="checkbox"/> None Evident <input type="checkbox"/> Persecutory <input type="checkbox"/> Grandiose <input type="checkbox"/> Ideas Of Reference <input type="checkbox"/> Persecutory <input type="checkbox"/> Somatic <input type="checkbox"/> Bodily Distortion				
	Perceptions	<input type="checkbox"/> Denies All <input type="checkbox"/> Visual Hallucinations <input type="checkbox"/> Auditory Hallucinations <input type="checkbox"/> A.H. Commanding Harm <input type="checkbox"/> Tactile Hallucinations				
	Memory	<input type="checkbox"/> Intact All Spheres <input type="checkbox"/> Impaired Short-Term <input type="checkbox"/> Impaired Intermediate <input type="checkbox"/> Impaired Long-Term		Insight	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
	Judgment	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		Impulse Control	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
MMSE TOTAL SCORE ____/____	Orientation /10	Attention/Concentration /5	Registration /3	Recall /3	Naming /2	Repetition /3
	Comprehension /1	Reading /1	Drawing /1	Sentence: /1	“ ”	
LABS	Na:	WBC:	PT:	ALT:	Other labs/imaging: (For all laboratory reference ranges and units of measure, refer to the electronic medical record on date of service.)	
	K:	HGB:	PTT:	AST:		
	CO2:	HCT:	INR:	ALP:		
	Cl:	PLT:	Ca:	Ethanol:		
	BUN:	TSH:	Mg:	Acetaminophen:		
	Creat:	DAU:	Phos:	Lithium:		
	Glu:					

IMPRESSION & RISK ASSESSMENT:

Risk of harm to self: High Medium Low (discuss)

Risk of harm to others: High Medium Low (discuss)

Risk of inability to care to self: High Medium Low (discuss)

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V: GAF:

Recommendations	

- I have personally interviewed and examined the patient and reviewed Dr. _____'s history, physical exam, assessment and management plan.
- I concur with all elements in the house officer's note (or)
- I agree with the house officer's note except as written, detailed on the following page.
- The resident has discussed the case with Attending Dr. _____ but the Attending has not seen the patient.

Resident Name: _____ Signature: _____ PIC#: _____ Date: _____ Time: _____

Attending Name: _____ Signature: _____ PIC#: _____ Date: _____ Time: _____

