Annual Psychiatric Assessment

NAME / MRN

DATE: ______________

Facility Name: ______________________________ ID: ____________

Program Name: ______________________________ ID: ____________

Provider #: ______________ Min(s): _________ Code Activity: ☒361 EVAL/RX

Place of Service:

☐ Office	☐ Home	☐ Inpatient	☐ Telehealth – Pt Home
☐ Field	☐ School Satellite	☐ Other	☐ Telehealth – Other than Pt Home
☐ Phone	☐ Correctional Facility	______________	

Service Strategies: (Please check up to three, if applicable)

☐**50** Peer/Fam Deliv Svcs	☐**53** Supportive Education	☐**56** Ptnrshp:Soc Svcs	☐**59** Integrated Svcs:MH-Dvlp Disbled
☐**51** Psych Education	☐**54** Prtnrshp:LawEnfcmt	☐**57** Ptnrshp:Subs Abuse	☐**60** Ethnic-Specific Service Strategy
☐**52** Family Support	☐**55** Ptnrshp:Health Care	☐**58** IntSvcs:MH/Aging	☐**61** Age-Spec Svc Strategy ☐**99** Unknown

Is the client pregnant? ☐ **Yes** ☐ **No** **(If yes, please document how service was pregnancy-related)**

Language service provided in other than English: ☐ Spanish ☐ Other: ____________________

☐ **Interpreter** Name of Interpreter: ____

Description and Interim Psychiatric Treatment History (since last assessment)**:**

MENTAL STATUS EXAMINATION:

General (e.g., appearance, behavior):

Mood/Affect**:**

Perception**:**

Thinking**:**

Insight /Judgment**:**

Cognitive: ☐ WNL

Allergies or Adverse Reactions/Drug Intolerances: ☐ NKA

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Reviewed and Discussed: ☐ Pregnancy Risk ☐ Current Substance ☐ Current Suicide Risk

Details:

DIAGNOSIS: Include substance related diagnoses.

ICD-10 Code: ______________________ DSM-5 Diagnosis: __________________ (Primary)

DSM-5 Narrative Diagnosis: ____

ICD-10 Code: ______________________ DSM-5 Diagnosis: __________________ (Secondary)

DSM-5 Narrative Diagnosis: ____

Active Medical Problems:

PCP:	Date of last visit:

Current Psychiatric Medications:

Current Non-Psychiatric Drugs (incl OTC & herbal):

Changes in Treatment/ Recovery Plan:

☐ Treatment Plan/Partnership Plan signed by client.
☐ Drug information was provided and informed consent is current for each medication prescribed.
☐ The client appears to understand the information provided and was given opportunity to ask questions.

Client is able to manage own medication: ☐ YES ☐ NO Explain

MD Signature: ____ **Date:** ________________

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Data Entry Clerk Initials