PATIENT ASSESSMENT

POLICY

A complete bio-psychosocial assessment is a essential procedure for all patients presenting for psychiatric evaluation, adult as well as children and adolescents. Physicians are responsible for this assessment on the first visit and may have to schedule a second follow-up appointment within two weeks for the purpose of completing this evaluation. (Only then can a differential diagnosis and treatment plan be formulated). During this period, pertinent medical information will be obtained by laboratory examination, physical examination by the primary care physician, and also additional history extracted by obtaining medical records, conferring with other family members, teachers, etc.(with signed patient consent) to collaborate and verify obtained information from patient. Protecting patient's confidentiality is of the utmost importance.

PROCDURE

1. Patient referrals for psychiatric evaluation are accepted through the Electronic Health Record (EHR) [Psychiatry workqueue, Staff messages, and Referral messages] from all medical services at LSU-HSC. Self-referrals are also accepted as well as referrals from local community agencies (e.g. Mental Health Clinic, YWCA Counseling Services) and from the private medical community by paper referral fax to the clinic (318) 813-2447.

2. Consults or referrals that request a specific clinician are routed immediately to that clinician. All other referrals or consults are reviewed weekly by the Administrator Coordinator lll then forwarded to the Medical Director for approval and prioritized by provided information to be scheduled for assessment in one of the clinics as appropriate. We strive to schedule new evaluations within four to eight weeks of receiving the referrals. Any patient who is acutely suicidal, homicidal, or gravely disabled are referred to the Psychiatry Emergency Service for possible hospital admission.

3. Medical psychiatric assessments are performed on all patients (adults and children) scheduled for evaluation in the clinic.

   A. Responsible Staff

   Medical Staff refer to Medical doctors, either Faculty Psychiatrists or Psychiatry Residents with supervision. As a teaching clinic, medical students, physician assistants, students or Internal Medicine House staff may be involved in initial assessments under direct supervision of a Faculty Psychiatrist.

   B. Procedure

   1) Internal - The information is entered into the EHR.
   External – Information is received by FAX.

   2) Complete history of present illness, past psychiatric and medical history, family history, current and past medications, allergies, treatment response to previous treatment as well as social, educational, legal, spiritual, or religious, sexual, cultural occupational, substance, tobacco, alcohol, and gambling use and abuse history are illicit.

   3) Detailed history of any physical, emotional, verbal, or sexual abuse is also obtained and recorded.

4) Full mental status exam (MSE) is performed with MMSE in adults and geriatric patients.

5) Certain aspects of data collection including the psychosexual history, financial status, need for assistance with resources, legal status (e.g. probation), and recreational and leisure interests may be delegated to the Case Manager with review and supervision of the treating physician.

6) The initial assessment is documented in the EHR at the time of the patient's appointment by the treating physician.

a. The EHR shall minimally include essential information such as diagnostic impression, mental status exam, and initial treatment plan.

b. The remainder of the assessment will also be included in the EHR.

7) If additional time is needed to complete assessment (e.g. review records, evaluate requested lab and obtain presentation, a follow-up appointment will be scheduled within one to four weeks to further establish a diagnosis and treatment plan appropriate to the individual.

C. Special Population

1. **Children and adolescents** present a unique population that require, in conjunction to above assessment procedure, additional inquiries to develop an appropriately individualized treatment plan. These assessments include:

a. Daily activity and needs cognition, emotional, educational, communication and social

b. Developmental history and milestones

c. Measurements of height and weight are recorded in the EHR.

d. Systems evaluation, including roles in family, sibling rank, evaluation of primary care taker (e.g. foster parents, adoptive parents, juvenile detention or other relatives authorized as parent figures)

e. Immunization status record

f. Evaluation of general mental health of caregivers

g. Family or caregivers perception of problem and expectations of treatment as well as attitudes toward psychiatric disorders and treatments.

2. **Geriatric**

a. Assessments of functional status if warranted.

b. Assessments of nutritional status if indicated.

c. Assessment of relationship with caregivers and resources available to them.

d. Especially close attention to and referral for further treatment and evaluation for cancer work-up, medial illness, hearing, and vision loss

e. Assessment of dangerous behavior (e.g. wandering, confusion, compliance)

f. Minor mental status exam

3. **Assessment Forms**
   Assessment forms are mailed prior to the first appointment or given to patients on the first visit. Separate forms are utilized for adults and children. These forms are incorporated in the patient's medical record. Also, included are assessment forms for children and adolescents that are optional can be used at doctor's discretion.

4. **Testing and Consultation Requests**
   After the physician collects the initial information/data, further assessment may be warranted by requesting psychological/neuropsychological testing. Also, consultation requests may be made to various sub-specialists (e.g. neurology, pediatrics, endocrine) to assist with assessment.

5. **Reassessment**
   Reassessment is performed if there is:

   a. a significant change in the patient condition, unanticipated in the usual course of previously diagnosed illness and/or

   b. if there is no response to therapy or treatment.

   Reassessment is an ongoing process as additional subjective and causes of illness; the patient is reassessed and the physician reevaluates treatment at specific time intervals.

   a. With children and adolescents, reassessment occurs annually and attempts are made to minimize further exposure to psychotropic medication.

   b. Geriatric patients require even more frequent assessment due to multiple co-morbid illnesses. Reassessments are performed at least partially each visit.