PSYCHIATRIC ASSESSMENT ANNUAL UPDATE

Date of Service:____________________________________________ RU:__________________
Staff #: __________________ Hours: ______ Mins: _____
Code Activity: 361 EVAL/RX Location: 1 Office 2 Field 4 Home 5 School Satellite 18 Other

Service Strategies: (Please check up to three, if applicable)
☐ 51 Psych Education ☐ 54 Ptnrshp:LawEnfcmty ☐ 57 Ptnrshp:Subs Abuse ☐ 60 Ethnic-Specific Service Strategy

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

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

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
**DIAGNOSIS:** Include substance related diagnoses.

| DSM-5 Code: | _________ (Primary) AND ICD-10 Code: | _________ |
| DSM-5 Diagnosis Title/Narrative: |

| DSM-5 Code: | _________ (Secondary) AND ICD-10 Code: | _________ |
| DSM-5 Diagnosis Title/Narrative: |

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 consumer.

- [ ] Drug information was provided and informed consent is current for each medication prescribed.
- [ ] The consumer appears to understand the information provided and was given opportunity to ask questions.

Consumer is able to manage own medication:  [ ] YES  [ ] NO  Explain

Assessment in language other than English:  [ ] Spanish  [ ] Other ________________________________

[ ] Interpreter  Name of Interpreter: ________________________________

**MD Signature:** ________________________________  **Date:** __________________

Data Entry Clerk Initials