PURPOSE:

It is the policy of CHCS to provide all patients with an assessment when presenting as a ‘walk-in’ or as a ‘late arrival.’ Patients that call clinics between Provider visits may also necessitate an assessment over the phone. This assessment information is used by the medical team to decide on an appropriate course of action at that time which may include but is not limited to decisions to provide interim medication refills until the patient can get scheduled in with a Provider; to get placed into a Provider’s schedule for that day; or to be admitted to a hospital.

Background:

SBAR Reporting:

It is the specific goal of CHCS to have all staff members work at the top of their license in an effort to maximize resources while ensuring the safety of all patients. This Triage Form is one tool that allows this to occur in certain circumstances as listed above. This form aligns with the S.B.A.R. style of reporting as defined by the following:

S – Situation: The reasons for the request. What, when, why, and how the patient is requesting services.

B – Background: The pertinent clinical information about the patient that will impact how the Provider will decide the outcome of the request for care: diagnoses, age, compliance issues, recent dangerous behavior, recent abnormal labs, failure to come to appointments etc.

A – Assessment: The assessor’s specific appraisal of the patient’s situation based on information collected.

R – Recommendation: The assessor’s specific recommendation to the Provider. This recommendation will be included in the collaborative team approach to patient care with the Provider ultimately providing final decision.

REGULATORY REFERENCE: None.

UNIT(S) TO USE FORM: Initially Adult Behavioral Health Units will use the form. Other CHCS units will use the form in the future.

STAFF RESPONSIBLE FOR INITIATING AND/OR COMPLETING WITH SIGNATURE: Licensed Staff and QMHPs.
INSTRUCTIONS FOR COMPLETION:

**Triage Form:**

The content of the form serves to allow for high level SBAR reporting by the assessor to the Provider with the ultimate goal of providing an appropriate treatment plan around the current situation. The form includes condensed demographics field, condensed psychiatric review of systems, condensed mental status & behavioral assessments, condensed constitutional assessment, and areas for detailing relevant lab results, current medications, side effects, recent hospitalizations, new stressors, and recent drug or alcohol use. The triage form is only to be utilized by licensed staff and QMHPs. This form must be completed in its entirety as it is a part of the patient’s medical record.

**Clinic Procedure:**

**Walk-Ins:**

1. The patient arrives to the front desk and requests services.

2. If the patient is seeking an earlier appointment time, the front desk staff will work with the patient to find an acceptable appointment time.

3. If the patient is in need of refills or other medical attention, the patient will be instructed to sit in the waiting room to await assessment with the Case Manager.

4. The patient may be asked to provide a urine specimen for an Ingenuity Urinalysis

5. The Case Manager will use this Triage Form to start the initial assessment of the Walk-In patient. Case Manager is expected to fully complete the first page of this assessment. The second page is to be completed by nursing staff only.

   a. Case Manager will check ANSA/REC Plan and update if needed

6. Once the Case Manager has completed the first page of the assessment which includes providing a signature with his/her server ID # and date, the Case Manager will send the patient to the nurse to complete the assessment.

   NOTE: The Case Manager will sign, date, and list his/her server ID # on the first page of the assessment and the nurse will need to sign, date, and list his/her server ID # on the second page of the assessment.
7. After the Triage Assessment is complete, with the patient in a separate area away from the Provider, nursing staff will provide a SBAR report to the Provider.

8. The Provider will render a clinical decision to see the patient themselves, have the patient scheduled for a later date, or have the patient seen by the next available Provider.
   a. The assessor will document which Provider was consulted and include that Provider’s name on the form.
   b. If the patient will not be seen by the Provider, but will receive refills or other medical decisions are made, the nurse will complete the orders and will place the Triage Form into the message box of the Provider. The Provider will document the medical decision made with associated rationale in the Medical Follow-up Note section of the electronic medical record by the end of the clinic day. The Provider will send the Triage Form to Medical Records for scanning into the patient’s electronic medical record.
   c. If it is determined that the patient needs to be seen by a Provider, the patient will return to regular clinic flow (i.e.…reimbursement, ROS etc). The Provider will send the Triage Form to Medical Records for scanning into the patient’s electronic medical record.

**Late Arrivals:**

1. The patient arrives late to the front desk for scheduled services (services agreement defines a ‘late arrival’ as more than 10 minutes late to the clinic appointment).

2. The patient may be asked to provide a urine specimen for an Ingenuity Urinalysis.

3. Front desk staff will advise patient that he/she may or may not be seen by a Provider, due to late arrival, however, he/she will be asked to stay at clinic for assessment by the nursing staff.

4. The nurse will be informed of the late arrival. The nurse will assess the patient, develop a recommendation or opinion, and fully complete the Triage Form. With the patient in a separate area away from the provider, the nurse will provide a SBAR report to the Provider.

5. The nurse will link in with the Case Manager to ensure ANSA/recovery plan are up to date, no additional services are needed.
6. The Provider will render a clinical decision to see the patient themselves, have the patient rescheduled, or have the patient seen by the next available Provider. Providers are advised to accommodate late arrivals into that day’s schedule when possible.

   a. The nurse will document which Provider was consulted and include that Provider’s name on the form.

   b. If the patient is rescheduled, with no new orders, the nurse will send the Triage Form to Medical Records to be scanned into the patient’s electronic medical record.

   c. If the patient is rescheduled with new orders or refills, after the nurse has completed the orders, the Triage Form will be placed into the Provider’s box. The Provider will document the medical decision made with associated rationale in the Medical Follow-up Note section of the electronic medical record by the end of the clinic day. The Provider will send the Triage Form to Medical Records for scanning into the patient’s electronic medical record.

NOTE: The nurse will need to sign, date, and list his/her server ID # on BOTH pages of the assessment.

**Telephone Calls:**

1. All calls which are deemed as emergencies will be forwarded immediately to the nurse’s station for immediate attention. The nurse will triage the situation immediately.

2. The usual patient call is for an appointment. The new appointment should be made with sensitivity for the patient’s needs for refills or other time sensitive issues, so as not to cause a crisis for the patient in the future.

3. Telephone calls regarding paperwork will be fielded by the Case Managers and do not require a Triage Assessment.

4. If the call cannot be managed with the front desk, and/or the patient has clinical concerns i.e. potential side effects, needs refills or other medical problems, the front desk will instruct the patient that a nurse will assess the patient’s request on the phone.
5. The patient will be transferred to the nurse when possible, otherwise will be told that a nurse will call the patient back to collect information in the next 24 hours.

6. The nurse will be contacted by the front desk about the specific patients who need telephone calls back.

7. On the phone with the patient, the nurse will complete the Triage Form and using the nursing process will develop a recommendation or opinion.

8. Between patients or at a designated time, the nurse will provide an SBAR report to the Provider.

9. The Provider will render a clinical decision.
   a. The nurse will document which Provider was consulted and include that Provider’s name on the form.
   b. The nurse will then place the Triage Form into the Provider’s box. The Provider will document the medical decision made with associated rationale in the Medical Follow-up Note section of the electronic medical record by the end of the clinic day. The Provider will send the Triage Form to Medical Records for scanning into the patient’s electronic medical record.

**Form Instructions-Page 1:**

1. **Demographic Information** located at the top portion of the form along with today’s date, start time, age, and last date of service at CHCS. The last date of Service should pertain to last time patient was seen by a Provider.

2. Check off the **Type of Triage:** either Late Arrival, Walk-In, Phone or Other. The other category may include staff to staff interactions by e-mail, phone or in person wherein the data collected by the nurse or the Case Manager will result in medical decision making.

3. Assessor will document if the **ANSA and the Treatment Plan** are current by circling either “Y” for Yes or “N” for No in the appropriate box.

4. Assessor will document patient’s chief complaint.

5. Assessor will list current active diagnoses to include any pertinent medical diagnoses that would be relevant to action plan.
6. SLEEP PATTERN: Check “Normal” if applicable. Otherwise indicate:

   a. ____ Decreased need for sleep – sleeps fewer hours than typical sleep routine and says that they feel rested: i.e. sleeps less than 6 hours per day, but still feels rested

   b. ____ Hypersomnia – increased need for sleep: i.e. sleeps more than 10 hours per day and says they still need more sleep

   c. ____ Insomnia – unable to fall asleep or stay asleep or waking early and unable to go back to sleep.

7. ACTIVITY/ENERGY LEVEL: Check “Normal” if applicable. Otherwise indicate:

   a. ____ Doing more projects/activities – this is an indication of mania, and the patient is usually aware that they are doing more than usual and are either annoyed by it or taking pleasure in this increase in energy.

   b. ____ Unable to do routine activities – this is an indication of depression, and the patient is usually aware that they lack energy or drive to complete their usual chores and responsibilities.

   c. ____ High Energy – usually an indication of mania or agitation. The patient is often hyperactive and is sometimes aware of increased energy. The patient can be either dysphoric (unhappy) or euphoric (overly happy) and have high energy.

   d. ____ Low Energy – is usually an indication of depression or psychomotor slowing. The patient is often slow to speak or move. The patient is usually aware that their energy level is low and that they lack motivation and drive. Patients with schizophrenia may not be aware of low energy level.

   e. ____ Fatigue: tiredness can occur with medical illness, depression, severe anxiety or thought disorders such as schizophrenia. Fatigue may also occur due to medication side effects. Critical Thinking: when did this start, what is it associated with, is this sedation?

8. APPETITE: Check “Normal” if applicable. Otherwise indicate:

   a. ____ Poor appetite – is often associated with depressed mood.

   b. ____ Increased appetite can be associated with depression, anxiety, drug use of medication side effects, and is often a reason why patients stop medications without advising their doctor.
Critical Thinking: when did this start, what is it associated with, did the patient stop taking medications regularly due to concerns for weight gain?

c. ___ Indicate if the patient has gained or lost weight with a check mark in the correct space. You can indicate the amount of change in weight if more than 5 lbs.

9. GI: Check “Normal” if applicable. Otherwise indicate:

   a. ___ Nausea and Vomiting (N/V)
   b. ___ Diarrhea
   c. ___ Constipation

   Critical Thinking: when did this start, what is it associated with, did the patient stop taking medications regularly due to side effects.

10. THINKING: Check “Normal” if applicable. Otherwise indicate:

   a. ___ Inability to make decisions (associated often with depression, anxiety and mania)
   b. ___ Poor concentration (associated often with depression, anxiety, ADHD and mania)
   c. ___ Racing Thoughts (associated often with mania and psychosis)
   d. ___ thoughts going too slow (associated often with depression and psychosis)
   e. ___ Paranoid Thoughts: (associated often with psychosis)

11. HALLUCINATIONS: are associated with Psychosis. Check “Normal” if applicable. Otherwise indicate:

   a. ___ Visual Hallucinations – ask the patient if they see things they believe are not there.
   b. ___ Auditory Hallucinations – ask the patient if they hear voices or sounds that they believe may not be there.

   NOTE: Many patients hear voices or see shadows but only on rare occasion like when they are alone or at night when they feel vulnerable. Rare hallucinations like this may not require a change in medications. Some patients have tactile hallucinations; they feel something touching them. These are much rarer, however are particularly significant if also associated with visual hallucinations which may have a medical cause.
c. ____ Command Hallucinations – if the patient says they hear voices – they may be hearing voices telling them to harm themselves or others. Many patients are reluctant to discuss this as they fear they will be involuntarily committed to the hospital. Command auditory hallucinations are often dangerous.

12. **Depressed Mood:** Check “Euthymic” if the mood is normal. Otherwise indicate signs and symptoms of depression:
   
a. ____ Hopeless – having no expectation of wellness or improvement

b. ____ Helpless – having no confidence in self to create positive change

c. ____ Excessive Guilt – having exaggerated feelings of blame and guilt for past actions

d. ____ Anhedonia - Loss of pleasure in otherwise pleasurable activities

13. **Anxiety:** Check “LOW” if anxiety level is normal or tolerable. Otherwise indicate signs and symptoms of anxiety:
   
a. ____ Generalized Anxiety – a feeling of nervousness most of the time with NO PANIC

b. ____ Panic Attacks: - usually associated with “feelings of impending doom” with:
   
i. ____ SOB – shortness of breath – feeling as if they cannot breathe

   ii. ____ Chest pain or discomfort – feeling as if there is something wrong with the heart

   iii. ____ Palpitations – rapid pulse rate – feeling like their heart is beating at the throat

*Critical Thinking: Ask when the panic attacks started. Panic Attacks often are diagnosed initially in the ER. Panic attacks can be associated with medication reactions and legitimate heart disease. Ask the patient if they have gone to the ER due to the panic attacks. Ask the patient if an EKG was done to eliminate the possibility of heart disease.*

14. **Irritability:** Check “LOW” if irritability is normal or tolerable. Otherwise indicate signs and symptoms of irritability that may be associated with worsening of depression, mania and psychosis, and place the patient at a higher risk for acting out against themselves or others.
   
a. ____ Anger – ask if the patient has felt more angry than usual

b. ____ Loss of Temper – ask the patient if they have lost control over their anger recently resulting in rejection from others or more anger toward themselves.
15. SUICIDAL THOUGHTS:  Check “NONE” if applicable. Otherwise indicate:

a.____ Fleeting death wishes – wishing to die of natural or accidental causes – NO intention to harm themselves. This is called passive suicidal ideation.

b. ____ Suicidal thoughts with no plan – wishing to die of suicide but having no plan and no means with which to carry out an attempt.

c.____ Suicidal thoughts with a plan – the patient wants to die of suicide and has a plan and the means with which to act.

   Critical Thinking: Actively suicidal patients must be observed constantly while in the clinic and will require hospital admission. DO NOT promise secrecy or that the patient will not go to the hospital; however remain supportive of their fears to be hospitalized.

   d.____ History of Suicide Attempts – if yes give the most recent attempt and if possible estimate the lethality. Did this patient make a serious attempt with near lethal means?

   Critical Thinking: If the patient is actively suicidal and has a past history of attempts, the risk of suicide is high. Borderline Personality Disorder patients are frequently in this category and are often overlooked or underestimated by the treatment community just prior to an attempt.

16. HOMICIDAL THOUGHTS:  Check “NONE” if applicable. Otherwise indicate any intent. Actively homicidal patients most often target a family member, landlord, work mates or a boss. ASK about ideas to harm others. ASK about a plan and means.

   Thinking: Although homicidal ideation is much rarer than is suicidal ideation, remember to ask about intent to harm others. YOUR hunches matter.

17. OBSERVATIONS:  Check all that apply:

   a. ____ Grandiose: excessively grand or ambitious with their thoughts or perceptions of themselves.
b.____ Pressured Speech: accelerated pace that conveys urgency seemingly inappropriate to the situation. It is often difficult for listeners to interrupt pressured speech and the speech may be too rapid to understand.

c.____ Elevated Mood: Feelings of success, confidence, and well-being. Severely elevated mood is associated with mania or psychosis.

d.____ Flight of Ideas: nearly continuous flow of rapid speech that jumps from topic to topic, based on barely discernible associations, distractions, or play on words. It is most commonly seen in manic episodes.

e.____ Tangential speech: the train of thought wanders from one tangent to another, never returning to the initial topic of the conversation. It is less severe than Flight of Ideas, but more severe than circumstantial speech in which the speaker wanders, but eventually returns to the topic. This is also a symptom of mania or psychosis.

f.____ Bizarre Behavior: behavior that is very out of the ordinary or far from normal. Markedly unusual and unexpected behavior is often described as odd or strange. This is a symptom of schizophrenia or mania.

g.____ Delusional: Grandiose and paranoid delusions are typical. A person is delusional when they maintain false beliefs even when confronted with facts.

h.____ Irritable and rageful: Patients who are highly irritable may be depressed, manic or psychotic. Irritable patients may pace, curse, make provocative comments, and/or are defensive and disinterested in being at the session. Rage is often not reported by the patients but by the family members.

i.____ Psychomotor Agitation: unintentional and purposeless motion reflecting mental tension and anxiety. Examples include: pacing, wringing the hands, uncontrolled tongue movement, and taking on and off clothing. In more severe cases, the motions may become harmful, such as ripping, tearing or chewing at the skin around one's fingernails or lips to the point of bleeding. Psychomotor agitation may be a symptom of severe depression, OCD or mania. It can also be a result of an excess intake of stimulants or underlying general medical conditions such as hyponatremia.
j. ____ Psychomotor Slowing: slowing-down of thought and of physical movement and speech; associated with both major depression and bipolar depression and most prevalent in schizophrenia. Psychomotor slowing can also be associated with the adverse effects of certain drugs such as benzodiazepines.

k. ____ Poor concentration: short attention span, memory problems, and distractibility. Can be associated with mania and psychomotor agitation, or with depression or schizophrenia and psychomotor slowing.

l. ____ Disheveled: untidy, unkempt, scruffy, messy, disordered, disarranged, rumpled, bedraggled.

m. ____ Other: may be used to elaborate on observations above such as poor hygiene or the specific bizarre behavior. It may also be used to describe another observation that is pertinent, but not listed in the available descriptors.

18. Changes in the Home Environment or Losses: Has the patient moved or have more people moved in or out? Has someone died? Has the patient experienced an unacceptable loss? Events such as a miscarriage, a break-up, or a lost friendship can trigger severe depression or suicidal thoughts and are important to the clinical picture of the patient.

19. Alcohol, Drug or Prescription Use or Misuse: Is the patient using drugs or alcohol? If so, how much, how often, and how do they feel about the use? Is your patient taking pain medication? If so, do they take it as prescribed or do they find themselves running out too soon? Are they using the medications of a relative or a friend and if so, how much and how often?

    Critical Thinking: Most patients minimize the use of recreational drugs and alcohol. Some are afraid they will lose medical and social service benefits and some believe they will get into trouble with their probation or parole officer. Stay friendly and non-judgmental.

20. OTHER: A small segment in the middle of the page to write anything that does not fit somewhere on the Triage form.

Form Instructions-Page 2:

Note: Page 2 will only be completed by nursing staff.

1. Constitutional: Document the following:

   a. Vital signs: document actual values
b. Gait: circle “normal” – otherwise document comments with regard to the patient's balance and gait: one-sided weakness, dragging a limb, shuffling, scissor gait, poor balance, and staggering, or stomping gait.

c. Alertness: The patient is either:

   iv. Alert – normal

   v. Cloudy – inattention and reduced wakefulness

   vi. Somnolent – sleepy, groggy or drowsy

**Orientation:**

X1 – knows who they are

X2 knows where they are

X3 knows the day and date

X4 knows the situation and understands the circumstances

d. OTHER: (i.e. abnormal movements). If there are no abnormal movements circle N/A otherwise, write in a comment: pill rolling, lip smacking, grimacing etc.

e. Pregnancy Risk: Write in “N/A” if this is a male. Note the last Menstrual Period (LMP). Comment on the patient's method of birth control or hysterectomy etc.

2. **MEDICATIONS:**

   a. Medication Name: Brand or Generic

   b. Dose: Indicate the mg and if IM indicate such in this box

   c. Dosing Schedule: How often does the patient take this medication

   d. Last Use: When was the last time the patient took this medication

   e. PLAN: What are the new orders: refill, d/c or change

**Critical Thinking:** Remember the patient is often defensive about compliance irregularities. Most patients do not take their medications on time every day. Try to normalize their
experience of taking medications in order to illicit a realistic picture of what medications they take and how often.

**Recent Hospitalizations or New Medical Concerns:** Has the patient been in the hospital, and if so what was the reason and how long were they there? Has the patient been diagnosed with a new condition? What new medications is the patient taking? Is your patient being seen by a specialist?

*Critical Thinking: patients often compartmentalize their medical treatment and sessions. They often will remember that they wanted to tell us about a new medical problem, but they forgot until you asked.*

**RELEVANT LABS:** Check “N/A” if there are none; otherwise, look for drug level results for those patients taking Lithium, valproate (Depakote), or carbemazapine (Tegretol). In patients who take clozapine, look for repetitive and regular CBC lab results. In new patients, check to see that the patient did their initials labs. Locate the results of Ingenuity Testing.

*Critical Thinking: When giving report to a Provider, it is highly relevant to provide all the information you can with regard to the most recent lab results. Is the patient due for new labs? Is the patient positive for drugs or alcohol on their Ingenuity Test? Is the patient negative for medications they are supposed to take on their Ingenuity Test?*

**NOTE:** Ingenuity Tests that are “inconsistent” are relevant and may indicate that the patient is not taking medications as prescribed.

3. **Medication Concerns:** Please give data to elaborate upon the medication compliance, side effects etc. Note if the patient believes the meds are working, if the patient feels the meds need to be increased or if the patient is not taking them.

4. **TODAY’S PLAN of ACTION:** Please write a statement to indicate the disposition of your patient today. Will they be seen as a walk-in or rescheduled? Will medications be prescribed? Will the patient be scheduled for labs? Please note the name of the Provider you consulted to reach this medical decision in the box below.
GUIDELINES FOR BILLING SERVICE CODE 99211

Billing Procedure:

This is a billable service for nursing staff. Nurses need to consult with their clinical administrator(s) for proper coding and instruction that appropriately captures the assessment.

Guidelines for billing CPT code 99211 vary based on many factors including the insurance type and/or delivery area, etc. These are criteria for billing this CPT code from guidelines set forth by CMS.

1. When deciding whether it is appropriate to bill CPT code 99211 keep these things in mind:
   a. ALL 3 main criteria for an established patient office visit MUST be met: history, exam, and clinical decision making must be documented.
   b. Physician supervision is required and must be documented.

2. Typically the presenting problem is minimal.

3. Medically necessary decision-making by the provider which is communicated to the patient by the nurse, such as increasing or decreasing dosing on medications, is billable as 99211.

4. CPT code 99211 cannot be billed if an injection or lab draw is the main reason for the visit.

5. Routine picking up of a prescription is not billable as a 99211. If the patient must be evaluated before a prescription is given 99211 may be billed (See #1).

6. The physician does not need to see the patient.

2nd. Basic guidelines

The following guidelines can help you decide whether a service qualifies for 99211:

- The face to face provider must be an employee, contractor or leased employee.
- There must be direct supervision (i.e. a supervisor in the suite) for services.
- Service must be for an established patient.
- There must be an order for the service and the ordering Physician/Practitioner identified.
- The service must be some sort of evaluation and/or management and the actual evaluation or management must be documented to support the service.

- There must be a documented rationale for medical necessity.

- There must be a date and clear identifier/signature of the face to face provider.

- 99211 is a -25 modifier eligible code so that other services can be billed when the use of the modifier is allowable.

- 99211 can be used for a medication refill IF the Physician/Practitioner is providing on-going management for the patient.

- 99211 may be used for drawing labs for immediate in-house protocol or order AND a management change happens due to the lab testing. In this case, you would not use the lab draw codes (eg. 36415)

- 99211 can be used for short patient teaching sessions that are medically necessary or reflect a medication change and are not part of an earlier visit with the Physician/Practitioner.

- 99211 can be used to report a flush of a port when no therapy is done.

- 99211 can be used for blood pressure check that are ordered and are medically necessary. - See more at:

  http://codapedia.com/article_343_99211.cfm


ROUTING INSTRUCTIONS: The completed form will be given to unit medical records staff.

WHERE FILED IN CLINICAL RECORD: The completed form will be scanned into the EMR.
### Triage Form

**Consumer Name:**

**Case #:**

**Program/Unit #:**    **Sub Unit #:**

**Medicaid #:**

---

**Reason for Triage (check one):**

- [ ] Late Arrival/Time
- [ ] Walk-In
- [ ] Phone Call
- [ ] Other: (specify) __________________

**Date/Time:**

- Last Seen at CHCS: __________________
- CANS Current: Y N
- ANSA: Y N

**Age:**

- Pharmacy #: __________________

**Chief Complaint:**

<table>
<thead>
<tr>
<th>Sleep Pattern</th>
<th>Depressed Mood</th>
<th>OBSERVATIONS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] NORMAL</td>
<td>[ ] EUTHYMIC</td>
<td>[ ] grandiose</td>
</tr>
<tr>
<td>[ ] decreased need for sleep</td>
<td>[ ] hopelessness</td>
<td>[ ] pressured speech</td>
</tr>
<tr>
<td>[ ] hypsomnia</td>
<td>[ ] excessive guilt</td>
<td>[ ] elevated mood</td>
</tr>
<tr>
<td>[ ] insomnia</td>
<td>[ ] loss of pleasure in normally pleasurable activities</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity/Energy Level</th>
<th>Anxiety</th>
<th>[ ] LOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] NORMAL</td>
<td>[ ] generalized anxiety</td>
<td></td>
</tr>
<tr>
<td>[ ] doing more projects/activities</td>
<td>[ ] panic attacks</td>
<td></td>
</tr>
<tr>
<td>[ ] unable to do routine activities</td>
<td>[ ] SOB</td>
<td></td>
</tr>
<tr>
<td>[ ] increased</td>
<td>[ ] Chest Discomfort/Pain</td>
<td></td>
</tr>
<tr>
<td>[ ] wt loss</td>
<td>[ ] psychomotor agitation</td>
<td></td>
</tr>
<tr>
<td>[ ] increased</td>
<td>[ ] psychomotor slowing</td>
<td></td>
</tr>
<tr>
<td>[ ] wt gain</td>
<td>[ ] other:</td>
<td></td>
</tr>
</tbody>
</table>

**Appetite:**

- [ ] NORMAL
- [ ] poor appetite
- [ ] w t loss
- [ ] increased
- [ ] w t gain

**GI:**

- [ ] NORMAL
- [ ] n/v
- [ ] diarrhea
- [ ] constipation

**Suicidal Thoughts:**

- [ ] NONE
- [ ] fleeting death wishes (including Ingenuity)
- [ ] Yes, Specify Below

**Homicidal Thoughts:**

- [ ] NONE
- [ ] Yes, specify:

---

**Constitutional:**

<table>
<thead>
<tr>
<th>BP</th>
<th>Pulse</th>
<th>DOSE</th>
<th>DOSING SCHEDULE</th>
<th>LAST USE</th>
<th>PLAN (refill, d/c, change?)</th>
</tr>
</thead>
</table>

**Comments:**

- Gait: [ ] NORMAL
- Alertness: [ ] Alert [ ] Cloudy
- [ ] Somnolent
- Oriented x: 1 2 3 4
- Other (i.e. abnormal movements)
  - Specify:

---

**Pregnancy Risk:**

- L.M.P.:
- [ ] comments

**Recent Hospitalizations/New Medical Concerns:**

- If Yes, specify below

---

**Today’s Plan of Action:**

**Changes in Home Environment or Losses:**

- If Yes, specify below

**Alcohol/Illlicit Drug/Prescription Use:**

- If Yes, specify below

---

**Provider Consulted:**

---

**CHCS Case Manager Signature:**

- ____________________________
- ID# ____________________________
- Date: ____________________________

**Nurse M/A Signature:**

- ____________________________
- ID# ____________________________
- Date: ____________________________