Geri Psych Clinic Templates

**Movement Disorder Psychiatry Clinic NEW CONSULT**

Movement Disorders Psychiatric Consult

Patient seen at the request of Movement Disorders Clinic to evaluate movement

disorder-associated psychiatric symptoms.

ID: |PATIENT AGE| yo |PATIENT SEX| with

-----------------------------------------------------------------------

S:

----------------------------------------------------------------------------

O:

PRESENCE OF NONMOTOR SIGNS:

UPDRS

UNIFIED PARKINSON'S DISEASE RATING SCALE

I. MENTATION, BEHAVIOR AND MOOD

1. Intellectual Impairment

0 = None.

1 = Mild. Consistent forgetfulness with partial recollection of events and no

other difficulties.

2 = Moderate memory loss, with disorientation and moderate difficulty handling

complex problems. Mild but definite

impairment of function at home with need of occasional prompting.

3 = Severe memory loss with disorientation for time and often to place. Severe

impairment in handling problems.

4 = Severe memory loss with orientation preserved to person only. Unable to make

judgements or solve problems.

Requires much help with personal care. Cannot be left alone at all.

2. Thought Disorder (Due to dementia or drug intoxication)

0 = None.

1 = Vivid dreaming.

2 = "Benign" hallucinations with insight retained.

3 = Occasional to frequent hallucinations or delusions; without insight; could

interfere with daily activities.

4 = Persistent hallucinations, delusions, or florrid psychosis. Not able to care

for self.

3. Depression

1 = Periods of sadness or guilt greater than normal, never sustained for days or

weeks.

2 = Sustained depression (1 week or more).

3 = Sustained depression with vegetative symptoms (insomnia, anorexia, weight

loss, loss of interest).

4 = Sustained depression with vegetative symptoms and suicidal thoughts or

intent.

4. Motivation/Initiative

0 = Normal.

1 = Less assertive than usual; more passive.

2 = Loss of initiative or disinterest in elective (nonroutine) activities.

3 = Loss of initiative or disinterest in day to day (routine) activities.

4 = Withdrawn, complete loss of motivation.

OTHER:

40. Does the patient have anorexia, nausea, or vomiting?

0 = No

1 = Yes

41. Any sleep disturbances, such as insomnia or hypersomnolence?

0 = No

1 = Yes

42. Does the patient have symptomatic orthostasis? ( Record the patient's blood

pressure, height and weight on the scoring form)

0 = No

1 = Yes

DRIVING SAFETY STATUS:

---------------------------------------------------------------------------

PAST MEDICAL HISTORY:

|ACTIVE PROB LIST-SHORT|

OUTPATIENT MEDICATIONS:

|ACTIVE OUTPATIENT MEDICATIONS|

MEDICATIONS RECONCILIATION:

I have reviewed the patient's outpatient medications with

the patient or caregiver and the list above accurately

reflects the medications that the patient is currently

taking including any that may be provided from non-VA

sources, over the counter medications, nutritional or

other supplements.

OR:

MEDICATIONS RECONCILIATION:

The patient and/or his/her caretaker were unable to participate in the

medication reconciliation at this time due to:

However, I have reviewed the patient's outpatient medication list

on record.

ALLERGIES: |ALLERGIES/ADR|

VITAL SIGNS:

|VITALS-LAST|

LABORATORY DATA:

TSH: |LR TSH NEW|

Free T4: |HSO FREE T4|

Vit D: |LR 25-VITD|

B12: |LR VIT B12|

Folate: |LR FOLATE|

MMA  |LR MMA SERUM|

Thiamine B1 |LR VIT B1|

RPR: |LR RPR|

CD4: |LR CD4+/3+ LY(T-4) #|

HIV VL: |LR HIV PCR ULTRA SENSITIVE|

RBC: |LR RBC|

Hgb: |LR HEMOGLOBIN|

Hct: |LR HEMATOCRIT|

MCV: |LR MCV|

MCH: |LR MCH|

MCHC: |LR MCHC|

WBC: |LR WBC|

RDW: |LR RDW|

Neutrophil: |NEUTROPHIL # (AUTO)|

Platelet: |LR PLATELET COUNT|

LDL: |LR LDL CHOLESTEROL, CALCULATED (WLA)|

HDL: |LR HDL CHOLESTEROL-WLA|

TG: |LR TRIGLYCERIDE-WLA|

Tot cholesterol: |LR CHOLESTEROL|

A1c: |LR HGBA1C 3,2|

Na: |LR SODIUM|

K: |LR POTASSIUM|

GLU: |LR GLUCOSE|

BUN: |LR UREA NITROGEN|

CREAT: |LR CREATININE|

CREAT IDMS: |LR CREATININE IDMS|

CO2: |LR CO2|

CC: |LR CREATININE CLEARANCE|

Urine C&S: |HSO URINE C&S|

Urine Toxicology:

Amphetamines:    |AMPHETAMINES (QUAL/URINE)|

Benzodiazepines: |BENZODIAZEPINES (QUAL/URINE)|

Cocaine:         |COCAINE (QUAL/URINE)|

Opiates:         |OPIATES (QUAL/URINE)|

Cannabinoids:    |CANNABINOIDS (QUAL/URINE)|

|HSO MRI BRAIN + CT HEAD|

-------------------------------------------------------------------------------

MENTAL STATUS EXAMINATION:

- Appearance:

- Behavior:

- Speech:

- Mood:

- Affect:

- Thought process:

- Thought content:

- Insight/Judgment:

- Cognition:

MOCA DEMENTIA SCALE:

Visuo-spat/Exec:   /5

Naming:            /3

Attn:              /6

Lang:              /3

Exec(Abstract):    /2

Recall:            /5    (with cues: /5)

Orientn:           /6

              ------------

TOTAL MOCA SCORE:            (<26 CI)

MMSE Scale:

Orientn:            /10

Immed Recall:       /3

Attn:               /5

Lang:               /8

Delayed Recall:     /3

Visuo-spat:         /1

            ------------------

TOTAL MMSE SCORE:

    2. Word lists

      Animals: (18+/-6): {FLD:COMMENTS 40}

      F-words: (15+/-5): {FLD:COMMENTS 40}

  Memory:

    Shopping list

    Trial   Correct        Intrusions         Perseverations

      1.    {FLD:COMMENT 10}   {FLD:COMMENTS 40}

      2.    {FLD:COMMENT 10}   {FLD:COMMENTS 40}

      3.    {FLD:COMMENT 10}   {FLD:COMMENTS 40}

      4.    {FLD:COMMENT 10}   {FLD:COMMENTS 40}

      5.    {FLD:COMMENT 10}   {FLD:COMMENTS 40}

      15 min. recall: {FLD:COMMENT 30} /10

      Recognition: {FLD:COMMENT 30} /10 with {FLD:COMMENT 6} intrusions

      Remote: {FLD:COMMENTS INDENT 6}

Neurologic Exam (Optional):

Motor -  muscle wasting, mild cogwheeling rigidity of the upper

extremity bilaterally, resting tremor of the \_\_\_\_\_\_\_ that diminishes

significantly with purposeful movement.

Sensory -

Romberg

Coordination -

Intact FTN, HTS. notably bradykinetic with RAM and FFM

Gait -

patient posture:

Turning radius-

Pull test-

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Diagnostic Impression/Assessment:

|PATIENT AGE| yo |PATIENT SEX| with history of

1. Intellectual Impairment:

2. Thought Disorder (primary or secondary to iPD):

3. Depression:

4. Motivation/Initiative:

5. Impulse control impairment:

5. Sleep disturbances:

PSYCH PLAN/RECs:

NEURO PLAN:

RTC in

**Movement Disorder Psychiatry Clinic FOLLOW UP (Note it is not so different from new consult but this is the one sent by clinic)**

Movement Disorders Psychiatry Outpatient Follow-up

Pt. seen at the request of Movement Disorders Clinic to evaluate movement

disorder-associated

psychiatric symptoms.

PROGRESS NOTE

ID: |PATIENT AGE| yo |PATIENT SEX| with

-----------------------------------------------------------------

Last visit plan:

-----------------------------------------------------------------

S:

-----------------------------------------------------------------

O:

PRESENCE OF NONMOTOR SIGNS:

UPDRS

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problems.

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judgements or solve

problems.

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activities.

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weeks.

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interest).

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0 = No

1 = Yes

41. Any sleep disturbances, such as insomnia or hypersomnolence?

0 = No

1 = Yes

42. Does the patient have symptomatic orthostasis? ( Record the patient's blood

pressure, height and

weight on the scoring form)

0 = No

1 = Yes

DRIVING SAFETY STATUS:

---------------------------------------------------------------------

MEDICAL PROBLEM LIST

|ACTIVE PROB LIST-SHORT|

VITALS:

|VITALS-LAST|

ALLERGIES: |ALLERGIES/ADR|

OUTPATIENT MEDICATIONS:

|ACTIVE OUTPATIENT MEDICATIONS|

Non-VA Medications:   {FLD:TEXTBOX}

Over the Counter Medications:{FLD:TEXTBOX}

Nutritional or Supplements:{FLD:TEXTBOX}

"MEDICATIONS RECONCILIATION:

I have reviewed the patient's outpatient medications with

the patient or caregiver and the list above accurately

reflects the medications that the patient is currently

taking including any that may be provided from non-VA

sources, over the counter medications, nutritional or

other supplements.

OR:

MEDICATIONS RECONCILIATION:

The patient and/or their caretaker were unable to participate in the

medication reconciliation at this time due to:

However, I have reviewed the patient's outpatient medication list

on record."

LABORATORY DATA:

TSH: |LR TSH NEW|

Free T4: |HSO FREE T4|

Vit D: |LR 25-VITD|

B12: |LR VIT B12|

Folate: |LR FOLATE|

MMA  |LR MMA SERUM|

Homocysteine:|LR HOMOCYSTENE|

Thiamine B1 |LR VIT B1|

RPR: |LR RPR|

CD4: |LR CD4+/3+ LY(T-4) #|

HIV VL: |LR HIV PCR ULTRA SENSITIVE|

RBC: |LR RBC|

Hgb: |LR HEMOGLOBIN|

Hct: |LR HEMATOCRIT|

MCV: |LR MCV|

MCH: |LR MCH|

MCHC: |LR MCHC|

WBC: |LR WBC|

RDW: |LR RDW|

Neutrophil: |NEUTROPHIL # (AUTO)|

Platelet: |LR PLATELET COUNT|

LDL: |LR LDL CHOLESTEROL, CALCULATED (WLA)|

HDL: |LR HDL CHOLESTEROL-WLA|

TG: |LR TRIGLYCERIDE-WLA|

Tot cholesterol: |LR CHOLESTEROL|

A1c: |LR HGBA1C 3,2|

Na: |LR SODIUM|

K: |LR POTASSIUM|

GLU: |LR GLUCOSE|

BUN: |LR UREA NITROGEN|

CREAT: |LR CREATININE|

CREAT IDMS: |LR CREATININE IDMS|

CO2: |LR CO2|

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Urine C&S: |HSO URINE C&S|

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Cocaine:         |COCAINE (QUAL/URINE)|

Opiates:         |OPIATES (QUAL/URINE)|

Cannabinoids:    |CANNABINOIDS (QUAL/URINE)|

EKG:

QTc interval

-------------------------------------------------------------------

MOCA DEMENTIA SCALE:

Visuo-spat/Exec:   /5

Naming:            /3

Attn:              /6

Lang:              /3

Exec(Abstract):    /2

Recall:            /5    (with cues: /5)

Orientn:           /6

              ------------

TOTAL MOCA SCORE:            (<26 CI)

MENTAL STATUS EXAMINATION:

- Gen/Appearance:

- Behavior:

- Speech:

- Mood:

- Affect:

- Thought Process:

- Thought Content:

- Cognition:

- Insight/Judgment:

SUICIDAL IDEATION: Denies

HOMICIDAL/AGGRESSIVE IDEATION: Denies

OVERALL SUICIDE RISK ASSESSMENT

Despite chronic risk factors that include chronic mental illness ,

and substance use/abuse, patient is future-oriented, engaged in treatment,

demonstrating intact reality testing, has no hx of active suicide attempts,

denies access to firearms, and denies all passive/active suicidal ideation, and

as such is at low acute risk of imminent self-harm.

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Diagnostic Impression/Assessment:

|PATIENT AGE| yo |PATIENT SEX| with history of

1. Intellectual Impairment:

2. Thought Disorder (primary or secondary to iPD):

3. Depression:

4. Motivation/Initiative:

5. Impulse control impairment:

5. Sleep disturbances:

PSYCH PLAN/RECs:

NEURO PLAN:

RTC in

Pt was seen and discussed with attending physician, Dr. \_\_\_\_\_, and the above

assessment and plan were jointly formulated.

**WLA VA Psych Inpatient New Consult**

CONSULTATION-LIAISON PSYCHIATRY AT THE WEST LOS ANGELES VA MEDICAL CENTER

MENTAL HEALTH INITIAL ASSESSMENT

REASON FOR CONSULT:

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:

Pertinent ED course(if applicable):

Pertinent medical course:

Discussion with RN and/or sitter:

PAST PSYCHIATRIC HISTORY:

Diagnosis:

Inpatient psych hosp:

Suicide attempts:

Psychiatric med history:

Access to firearms:

SUBSTANCE ABUSE HISTORY:

|ACTP|

Allergies/ADR: |ALLERGIES/ADR|

|ACTIVE MEDICATIONS|

SOCIAL HISTORY:

Housing:

Employment:

Relationship/Marital status:

Military:

FAMILY HISTORY:

Severe persistent mental illness in first degree relative:

Completed suicide in first degree relative:

Vitals:

T: |TEMPERATURE|

P: |PULSE|

R: |RESPIRATION|

BP:|BLOOD PRESSURE|

Pulse Ox: |PULSE OXIMETRY|

Ht: |PATIENT HEIGHT|

Wt: |PATIENT WEIGHT|

BMI:|BMI|

ASSESSMENT OF VIOLENCE RISK TO SELF

RISK FACTORS - ACTIVE

Current suicidal ideation: Present/absent

Plan or intention to attempt suicide/self-harm: Present/absent

RISK FACTORS DURING THE PAST 6 MONTHS

Prior suicidal ideation: Present/absent

Prior suicide attempts (even if aborted): Present/absent

Plans/preparations for suicide: Present/absent

Intent to act upon plans for suicide: Present/absent

Inability/unwillingness to commit to contacting staff in event of increase in

suicidality: Present/absent

Treatment or medication non-adherence: Present/absent

Substance use disorder: Present/absent

Insomnia: Present/absent

Anhedonia: Present/absent

Hopelessness: Present/absent

Homicidal ideation: Present/absent

Available means, including access to firearms: Present/absent

Upcoming anniversary date(s) (e.g. anniversary of spouse's death, traumatic

event): Present/absent

Worsening medical problems: Present/absent

Cognitive impairment: Present/absent

PROTECTIVE FACTORS DURING THE PAST 6 MONTHS (STRENGTHS)

Social/Family Support: Present/absent

Pregnancy: not applicable

Religiosity/Cultural Beliefs: Present/absent

Positive Life satisfaction: Present/absent

Children in the home/responsibility to family: Present/absent

Intact Reality testing: Present/absent

Coping skills/Problem Solving Skills (strong): Present/absent

Planning for the future: Present/absent

Established positive therapeutic alliance: Present/absent

MENTAL STATUS EXAM:

Appearance:

Behavior/motor:

Speech:

Mood:

Affect:

Thought Process:

Thought Content:

Auditory Hallucinations:

Visual Hallucinations:

Suicidal ideation/intent/plan:

Homicidal ideation/intent/plan:

Cognition: Alertness, orientation, attention, memory

Insight:

Judgment:

RELEVANT LABS:

Na:          |LR SODIUM|

K:           |LR POTASSIUM|

Magnesium:   |LR MAGNESIUM|

Urea Nitrogen: |LR UREA NITROGEN|

Estimated GFR: |LR EGFR|

Hemoglobin:    |LR HEMOGLOBIN|

MCV:              |LR MCV|

Platelet Count: |LR PLATELET COUNT|

WBC:              |LR WBC|

Neutrophil #: |NEUTROPHIL # (AUTO)|

Sed Rate: |SED RATE|

ALT SGPT: |LR ALT (SGPT)-WLA|

AST SGOT:  |LR AST (SGOT)-WLA|

Free T4:  |HSO FREE T4|

TSH:         |LR TSH.T3|

Vitamin B12:  |LR VIT B12|

RPR:           |LR RPR|

Metabolic Review:

BMI: |BMI|

Weight: |PATIENT WEIGHT|

HbA1c: |LR HEMOGLOBIN A1C|

Lipid Panel:

CHOLESTEROL : |LR CHOLESTEROL|

TRIGLYCERIDE : |LR TRIGLYCERIDE-WLA|

         HDL : |LR HDL CHOLESTEROL-WLA|

LDL, direct : |LR LDL CHOLESTEROL, DIRECT|

   LDL, calc : |LR LDL CHOLESTEROL, CALCULATED (WLA)|

Head Imaging:

|HSO MRI BRAIN + CT HEAD|

EKG:

DIAGNOSTIC IMPRESSION:

ASSESSMENT:

PLAN:

Pharmacologic Recommendations:

Diagnostic Recommendations:

Safety Assessment:

Based on the above safety assessment, patient’s risk of imminent self harm is:

low/moderate/high

Based on the above safety assessment, patient risk of chronic self harm is:

low/moderate/high

[if risk is moderate/high, document attempt to complete safety plan/date of

safety plan with corresponding note]

[If CSRE indicated aka ANY consult for safety assessment, then document the date

of most recent CSRE]

Legal:

Delirium precautions: Blinds up/light on during the day, lights and television

off at night, space vitals checks overnight as appropriate for sleep hygiene

2200-0600, frequent reorientation, baseline sensory aides(glasses, hearing aids)

should be in place on the patient as much as possible during waking hours,

incorporation of familiar items/stimuli into hospital environment to the extent

possible, adequate pain management per primary team. Avoid deliriogenic

medications, such as benzodiazepines and anticholingerics.

EKG monitoring guidelines for antipsychotics

--Baseline EKG on \_\_\_\_ shows QTc \_\_\_ HR\_\_\_ NSR

--Recommend checking EKG at minimum on weekly basis or within 24 hours after

giving IM/IV antipsychotics

--If QTc interval greater than 500 ms, recommend holding antipsychotics, page

psychiatry

--Recommend repleting K>4, Mg>2 to optimize QTc interval

The above recommendations were discussed with the primary team. The case was

discussed with Attending psychiatric, Dr. \_\_\_ who agrees with the assessment and

plan.

[ ] CL psychiatry will continue to follow

[ ] CL psychiatry signing off, please call/page with any additional

questions/concerns.

-Daytime Psychiatry Non-ER Consult (M-F, 8AM-4PM) PAGER UCLA 89289

-Overnight/Weekend On Call Resident for ER and Non-ER Consults (M-F 4PM-8AM

Sat/Sun/Holidays) PAGER UCLA 94883

**WLA VA Psych Inpatient Follow up Progress note**

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CONSULTATION LIAISON PSYCHIATRY PROGRESS NOTE

-------------------------------------------------------------------------

Reason for Consult:

ID:

Include brief pertinent medical course:

-------------------------------------------------------------------------

SUBJECTIVE

-------------------------------------------------------------------------

Include discussion with RN and/or sitter:

=========================================================================

|ACTP|

Allergies/ADR: |ALLERGIES/ADR|

|ACTIVE MEDICATIONS|

VITAL SIGNS

T: |TEMPERATURE|

P: |PULSE|

R: |RESPIRATION|

BP:|BLOOD PRESSURE|

Pulse Ox: |PULSE OXIMETRY|

Ht: |PATIENT HEIGHT|

Wt: |PATIENT WEIGHT|

BMI:|BMI|

-------------------------------------------------------------------------

MENTAL STATUS EXAM

-------------------------------------------------------------------------

Appearance:

Behavior/Motor:

Speech:

Mood:

Affect:

Thought process:

Thought content:

Cognition: Alertness, orientation, attention, memory

Insight/Judgment:

LABS

Na:          |LR SODIUM|

K:           |LR POTASSIUM|

Magnesium:   |LR MAGNESIUM|

Urea Nitrogen: |LR UREA NITROGEN|

Estimated GFR: |LR EGFR|

Hemoglobin:    |LR HEMOGLOBIN|

MCV:              |LR MCV|

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Free T4:  |HSO FREE T4|

TSH:         |LR TSH.T3|

Vitamin B12:  |LR VIT B12|

RPR:           |LR RPR|

IMAGING

|HSO MRI BRAIN + CT HEAD|

EKG:

-------------------------------------------------------------------------

DIAGNOSTIC IMPRESSION:

ASSESSMENT:

PLAN:

Pharmacologic Recommendations:

Diagnostic Recommendations:

Legal:

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**Memory Clinic New Consult**

MEMORY/NEUROBEHAVIOR CLINIC NEW CONSULTATION

Choose One Modality Foreword:

///[Face-to-Face] I reviewed the procedures necessary for in person visits. This

included negative COVID screen by both the patient and provider, need for all

parties to wear masks at all times, need to maintain 6 feet of distance between

us as much as possible, need to use hand sanitizer/wash hands before and after

the visit, and attention to not touching our faces.  Patient/caregiver expressed

understanding and was in agreement with these procedures.

///[Video] Due to the COVID-19 pandemic, this visit was conducted via video-

conference with audio and visual components. Patient/caregiver understood and

agreed to terms, risks, and benefits of visit conducted by telehealth.

Address & Phone#:

|PATIENT ADDRESS|

|PATIENT PHONE|

Emergency Contact:

|EMERGENCY CONTACT|

///[Telephone] Due to the COVID-19 pandemic, this visit was conducted via

telephone with audio components. Patient/caregiver understood and agreed to

terms, risks, and benefits of visit conducted by telehealth.

Address & Phone#:

|PATIENT ADDRESS|

|PATIENT PHONE|

Emergency Contact:

|EMERGENCY CONTACT|

Length of call: ///

ID

|PATIENT NAME| is a |PATIENT AGE| year old |PATIENT SEX| with pertinent history

of ///

presenting to memory/neurobehavior as a new consultation.

I explained the purpose of this evaluation and addressed questions related to

the risks/benefits of completing the assessment.  The patient/surrogate provided

oral informed consent

REASON FOR EVALUATION (Consult request reason & requester):

///

HPI (e.g. onset of cognitive symptoms, associated behaviors, specific examples,

functional impairments, stressors/contexts, timeline, contributing

biopsychosocial conditions):

///

Collateral information obtained from caregiver/family member:

///

Driving status (e.g. drivers license status, accidents or near misses, moving

violations, concerns from family/friends):

///

PERTINENT REVIEW OF SYSTEMS:

- Depression/Apathy/Mood/Agitation:

- Sleep (e.g. snoring, dream enactment, gasping, insomnia):

- Hallucinations (visual/sensory/perceptual illusions):

- Gait changes:

Constitutional/Medical ROS:

Denies fevers, chills, nausea, vomiting, headache, abdominal pain, genitourinary

issues, shortness of breath, chest pain, vision changes, skin changes.

Functional Activities Questionnaire (FAQ):

Writing checks, paying bills, balancing a checkbook.

(3) [] Dependent

(2) [] Requires Assistance

(1) [] Has difficult but does by self

(1) [] Never did the activity but would have difficulty now

(0) [] Normal

(0) [] Never did the activity but could do now

Assembling tax records, business affairs, papers.

(3) [] Dependent

(2) [] Requires Assistance

(1) [] Has difficult but does by self

(1) [] Never did the activity but would have difficulty now

(0) [] Normal

(0) [] Never did the activity but could do now

Shopping alone for clothes, household necessities, groceries.

(3) [] Dependent

(2) [] Requires Assistance

(1) [] Has difficult but does by self

(1) [] Never did the activity but would have difficulty now

(0) [] Normal

(0) [] Never did the activity but could do now

Playing a game of skill, hobbies.

(3) [] Dependent

(2) [] Requires Assistance

(1) [] Has difficult but does by self

(1) [] Never did the activity but would have difficulty now

(0) [] Normal

(0) [] Never did the activity but could do now

Heating water, making coffee, turning off stove.

(3) [] Dependent

(2) [] Requires Assistance

(1) [] Has difficult but does by self

(1) [] Never did the activity but would have difficulty now

(0) [] Normal

(0) [] Never did the activity but could do now

Preparing a balanced meal.

(3) [] Dependent

(2) [] Requires Assistance

(1) [] Has difficult but does by self

(1) [] Never did the activity but would have difficulty now

(0) [] Normal

(0) [] Never did the activity but could do now

Keeping track of current events.

(3) [] Dependent

(2) [] Requires Assistance

(1) [] Has difficult but does by self

(1) [] Never did the activity but would have difficulty now

(0) [] Normal

(0) [] Never did the activity but could do now

Paying attention to, understanding, discussing - TV, books, magazines.

(3) [] Dependent

(2) [] Requires Assistance

(1) [] Has difficult but does by self

(1) [] Never did the activity but would have difficulty now

(0) [] Normal

(0) [] Never did the activity but could do now

Remembering appointments, family occasions, holidays, meds.

(3) [] Dependent

(2) [] Requires Assistance

(1) [] Has difficult but does by self

(1) [] Never did the activity but would have difficulty now

(0) [] Normal

(0) [] Never did the activity but could do now

Traveling out of neighborhood, driving, arranging bus transportation.

(3) [] Dependent

(2) [] Requires Assistance

(1) [] Has difficult but does by self

(1) [] Never did the activity but would have difficulty now

(0) [] Normal

(0) [] Never did the activity but could do now

Total Score: ///

SOCIAL HISTORY:

- living situation [residence, who lives in home/caregiver]:

- educational status:

- occupation (past or present):

- financial/caregiver stressors:

- contributing cultural/religious/racial/sexual/gender/trauma contextual issues:

- childhood/developmental issues:

PSYCHIATRIC HISTORY (e.g dx, medication trials, current MH providers,

hospitalizations, suicidality)

///

FAMILY HISTORY (e.g. dementia, psychiatric d/o, neuro d/o)

///

SUBSTANCE USE HISTORY:

(Type, Last use, age of onset, amount & frequency, longest period of sobriety)

- Alcohol:

- Tobacco:

- Cannabis:

- Other illicit substances:

- Prescription medications (beyond prescribed amount or frequency:

PAST NEUROLOGICAL HISTORY:

- Head Trauma/TBI:

- Stroke/Aneurysm:

- Seizures:

- CNS Infection:

- Sleep apnea screen:

Does the patient have a diagnosis of OSA?

  []Yes

  []No

     If Yes, does the patient adhere to treatment?

          []Yes

          []No – address why, and if indicated, refer back to sleep medicine

     If No, has the patient completed a sleep study through sleep medicine?

          []Yes – review and document results

          []No – order sleep study through e-consult menu if indicated

(cognitive complaints/impairment, depression, sleep symptoms)

PAST MEDICAL HISTORY:

|ACTIVE PROB LIST-SHORT|

OUTPATIENT MEDICATIONS:

|ACTIVE OUTPATIENT MEDICATIONS|

///MEDICATIONS RECONCILIATION:

[] I have reviewed the patient's outpatient medications with

the patient or caregiver and the list above accurately

reflects the medications that the patient is currently

taking including any that may be provided from non-VA

sources, over the counter medications, nutritional or

other supplements.

[] Unable to complete medication reconciliation due to:

Allergies:|ALLERGIES/ADR|

OBJECTIVE

Vitals: |VITALS-LAST|

///MENTAL STATUS EXAM

General appearance:

Behavior:

Speech:

Motor:

Mood:

Affect:

Thought process:

Thought content:

Perceptual disturbances:

Cognition:

Insight:

Judgment:

MOCA DEMENTIA SCALE:

Visuo-spat/Exec:   /5

Naming:            /3

Attn:              /6

Lang:              /3

Exec(Abstract):    /2

Recall:            /5 (with cues: /5)

Orientn:           /6

<13 years ed.?    +0 or +1

               ------------

TOTAL MOCA SCORE: ///

Prior MOCA scores:

NEUROBEHAVIOR EXAM:

  Attention:

     1. Digit span

       Forward:

       Reverse:

     2. "A" test

       Omissions:

       Intrusions:

  Mental Control:

     1. Months in reverse:

     2. Serial 3's:

  Language:

     1. Fluency:

       Spontaneous:

       non-fluent:

       paraphasic errors:

     2. Word lists

       Animals: (18+/-6):

       F-words: (15+/-5):

     3. Comprehension

       Pointing:

       Yes/No:

       Passive/Possessive:

       Objects in array:

     4. Repetition

     5. Naming

       Mini-BNT (pictures):

       Other missed words on confrontation:

     6. Reading

       Aloud:

       Comprehension:

     7. Writing (sentence):

     8. Non-propositional communication:

  Memory:

       Shopping list

    Trial   Correct    Intrusions     Perseverations

     1.

     2.

     3.

     4.

     5.

     15 min. recall: ///10

     Recognition: ///10 with /// intrusions

     Remote [document patient’s response]:

       “JFK”:

       “Watergate”:

       “9/11”:

       “Katrina”:

       Current President:

       Recent news event:

  Spatial Orientation/Construction:

     SHAPE             COPY     SPON. RECALL     MULT. CHOICE

       Simple:

       Complex:

       3D (3 planes):

  Calculations:

     Single-digit addition:

     Double-digit addition:

     Multiplication:

  Similarities:

     Painting and Music:

     Bicycle and Train:

     Watch and Ruler:

  Praxis:

     Buccofacial ("blow-out match"):

     Limb ("brush your teeth"):

     Trunk ("take a bow"):

  R/L orientation:

  Finger identification:

  Frontal system tasks:

     Alternating programs:

     Repeating loops:

     Go/No-Go:

     Alternate tapping:

     Luria Hand Sequences:

     Clock construction ("10 after 11"):

NEURO EXAM

  Cranial nerve exam (eye movements, nystagmus, facial asymmetry & involuntary

movements, gag/cough response, shrugging, SCM, tongue movement):

  Motor:

      Bulk:

       Tone:

       Fine finger movement/tapping:

  Sensory:

       General:

       Romberg:

  Coordination:

       Finger-to-nose:

       Heel-to-knee-to-shin:

       Rapid alternating mov'ts:

  Posture:

  Gait:

  Reflexes:

  Frontal release signs (e.g. glabellar tap, palmomental, rooting, grasp, jaw

jerk):

LABORATORY DATA:

             TSH: |LR TSH NEW|

         Free T4: |HSO FREE T4|

             B12: |LR VIT B12|

          Folate: |LR FOLATE|

             MMA: |LR MMA SERUM|

    Homocysteine: |LR HOMOCYSTENE|

     Thiamine B1: |LR VIT B1|

           Vit D: |LR 25-VITD|

             RPR: |LR RPR|

             CD4: |LR CD4+/3+ LY(T-4) #|

          HIV VL: |LR HIV PCR ULTRA SENSITIVE|

             LDL: |LR LDL CHOLESTEROL, CALCULATED (WLA)|

             HDL: |LR HDL CHOLESTEROL-WLA|

              TG: |LR TRIGLYCERIDE-WLA|

Tot cholesterol: |LR CHOLESTEROL|

             A1c: |LR HGBA1C 3,2|

              Na: |LR SODIUM|

               K: |LR POTASSIUM|

             GLU: |LR GLUCOSE|

             BUN: |LR UREA NITROGEN|

           CREAT: |LR CREATININE|

      CREAT IDMS: |LR CREATININE IDMS|

             CO2: |LR CO2|

              CC: |LR CREATININE CLEARANCE|

|HSO MRI BRAIN + CT HEAD|

EKG: ///

QTc interval

///OVERALL SUICIDE RISK ASSESSMENT

Risk factors:

[] older adult

[] male

[] Veteran

[] chronic mental illness

[] prior suicide attempt

[] history of substance abuse, past or present

[] access to firearms

[] history of impulsive behaviors

[] economic/housing instability

[] passive or active suicidal ideation

Protective factors:

[] future-oriented

[] engaged in treatment

[] social support

[] demonstrating intact reality testing

[] no prior suicide attempts

[] no active substance use

[] no access to firearms

[] no history of impulsive behaviors

[] stable housing/finances

[] denies passive or active suicidal ideation

///Based on the above, patient is deemed to be at

[] low

[] moderate

[] high

acute risk of imminent self-harm.

///[Complete CSSRS for initial intake]

ASSESSMENT

Memory/Neurobehavior diagnoses:

#

Pertinent medical/psychiatric diagnoses:

#

Pertinent psychosocial/contextual issues:

#

Discussion/Formulation:

///

PLAN

///

- Provided education with regards to diet, sleep, exercise, and lifestyle

modifications as appropriate in the context of memory and cognition

Medical

- Management per primary care team and appropriate sub-specialties

- Encouraged to f/u as recommended by those providers

Social

- Veteran does not meet criteria for 5150 LPS hold for DTS, DTO, or GD

- Emergency services reviewed with veteran.  Informed him/her to return to

clinic if symptoms worsen and/or with questions, and/or if side effects develop.

Patient has been provided information to VA Crisis Hotline (1800-273-TALK), WLA

ER for emergency matters.

- Pt educated regarding risks/benefits of any meds prescribed, verbalized

understanding. Provided supportive therapy and psychosocial resources.

RTC in \_\_ months

Modality:

[] face-to-face

[] VVC

Pt was seen and discussed with attending physician, Dr. ///, and the above

assessment and plan were jointly formulated.

**Memory Clinic Follow up Progress note**

MEMORY/NEUROBEHAVIOR CLINIC PROGRESS NOTE

Choose One Modality Foreword:

///[Face-to-Face] I reviewed the procedures necessary for in person visits. This

included negative COVID screen by both the patient and provider, need for all

parties to wear masks at all times, need to maintain 6 feet of distance between

us as much as possible, need to use hand sanitizer/wash hands before and after

the visit, and attention to not touching our faces.  Patient/caregiver expressed

understanding and was in agreement with these procedures.

///[Video] Due to the COVID-19 pandemic, this visit was conducted via video-

conference with audio and visual components. Patient/caregiver understood and

agreed to terms, risks, and benefits of visit conducted by telehealth.

Address & Phone#:

|PATIENT ADDRESS|

|PATIENT PHONE|

Emergency Contact:

|EMERGENCY CONTACT|

///[Telephone] Due to the COVID-19 pandemic, this visit was conducted via

telephone with audio components. Patient/caregiver understood and agreed to

terms, risks, and benefits of visit conducted by telehealth.

Address & Phone#:

|PATIENT ADDRESS|

|PATIENT PHONE|

Emergency Contact:

|EMERGENCY CONTACT|

Length of call: ///

ID

|PATIENT NAME| is a |PATIENT AGE| year old |PATIENT SEX| with history of ///

presenting to memory/neurobehavior clinic for follow-up visit.

PLAN LAST VISIT & INTERVAL EVENTS:

///

SUBJECTIVE

///

Collateral information obtained from caregiver/family member:

///

Driving status:

///

Pertinent Review of Systems:

- Depression/Mood:

- Sleep:

- Psychosis:

- Headaches:

- Urinary incontinence:

- Gait instability:

ADL’s:

[Mark if patient is independent of activity. Comment if assistance is needed.]

BADL'S

[] Bathing

[] Dressing

[] Grooming

[] Mouth care

[] Toileting

[] Transfering from bed

[] Walking

[] Climbing Stairs

[] Eating

IADL's

[] Shopping

[] Cooking

[] Managing medications

[] Using the phone

[] Doing housework

[] Doing laundry

[] Driving/using public transportation

[] Managing finances

Medical ROS:

[] constitutional symptoms (fevers, chills, etc.)

[] falls

[] medication side effects

ALLERGIES

|ALLERGIES/ADR|

OUTPATIENT MEDICATIONS:

|ACTIVE OUTPATIENT MEDICATIONS|

///MEDICATIONS RECONCILIATION:

[] I have reviewed the patient's outpatient medications with

the patient or caregiver and the list above accurately

reflects the medications that the patient is currently

taking including any that may be provided from non-VA

sources, over the counter medications, nutritional or

other supplements.

[] Unable to complete medication reconciliation.

OBJECTIVE:

Vitals: |VITALS-LAST|

MENTAL STATUS EXAM

General appearance:

Behavior:

Speech:

Motor:

Mood:

Affect:

Thought process:

Thought content:

Perceptual disturbances:

Cognition:

Insight:

Judgement:

MOCA DEMENTIA SCALE:

Visuo-spat/Exec:   /5

Naming:            /3

Attn:              /6

Lang:              /3

Exec(Abstract):    /2

Recall:            /5 (with cues: /5)

Orientn:           /6

<13 years ed.?    +0 or +1

               ------------

TOTAL MOCA SCORE:

Prior MOCA scores:

LABORATORY DATA:

             TSH: |LR TSH NEW|

         Free T4: |HSO FREE T4|

             B12: |LR VIT B12|

          Folate: |LR FOLATE|

             MMA: |LR MMA SERUM|

    Homocysteine: |LR HOMOCYSTENE|

     Thiamine B1: |LR VIT B1|

           Vit D: |LR 25-VITD|

             RPR: |LR RPR|

             CD4: |LR CD4+/3+ LY(T-4) #|

          HIV VL: |LR HIV PCR ULTRA SENSITIVE|

                Cr: |LR CREATININE IDMS|

     Cr. Clearance: |LR CREATININE CLEARANCE| ml/min

Neuroimaging

|HSO MRI BRAIN + CT HEAD|

EKG: ///

QTc interval

///OVERALL SUICIDE RISK ASSESSMENT

Risk factors:

[] older adult

[] male

[] Veteran

[] chronic mental illness

[] prior suicide attempt

[] history of substance abuse, past or present

[] access to firearms

[] history of impulsive behaviors

[] economic/housing instability

[] passive or active suicidal ideation

Protective factors:

[] future-oriented

[] engaged in treatment

[] social support

[] demonstrating intact reality testing

[] no prior suicide attempts

[] no active substance use

[] no access to firearms

[] no history of impulsive behaviors

[] stable housing/finances

[] denies passive or active suicidal ideation

///Based on the above, patient is deemed to be at

[] low

[] moderate

[] high

acute risk of imminent self-harm. (If moderate or high, complete CSSRS.)

ASSESSMENT

Memory/neurobehavior diagnoses:

#

Pertinent psychiatric/medical diagnoses:

#

Pertinent psychosocial/contextual issues:

#

Discussion:

///

PLAN

///

- Provided education with regards to diet, sleep, exercise, and lifestyle

modifications as appropriate in the context of memory and cognition

Medical

- Management per primary care team and appropriate sub-specialties

- Encouraged to f/u as recommended by those providers

Social

- Veteran does not meet criteria for 5150 LPS hold for DTS, DTO, or GD

- Emergency services reviewed with veteran.  Informed him/her to return to

clinic if symptoms worsen and/or with questions, and/or if side effects develop.

Patient has been provided information to VA Crisis Hotline (1800-273-TALK), WLA

ER for emergency matters.

- Pt educated regarding risks/benefits of any meds prescribed, verbalized

understanding. Provided supportive therapy and psychosocial resources.

RTC in \_\_ months

Modality:

[] face-to-face

[] VVC

Pt was seen and discussed with attending physician, Dr. ///, and the above

assessment and plan were jointly formulated.

**GeriPsych Clinic New Consult**

GERIATRIC PSYCHIATRY OUTPATIENT NEW CONSULTATION

Choose One Modality Foreword:

///[Face-to-Face] I reviewed the procedures necessary for in person visits. This

included negative COVID screen by both the patient and provider, need for all

parties to wear masks at all times, need to maintain 6 feet of distance between

us as much as possible, need to use hand sanitizer/wash hands before and after

the visit, and attention to not touching our faces.  Pt expressed understanding

and was in

agreement with these procedures.

///[Video] Due to the COVID-19 pandemic, this visit was conducted via video-

conference with audio and visual components. Patient/caregiver understood and

agreed to terms, risks, and benefits of visit conducted by telehealth.

Address & Phone#:

|PATIENT ADDRESS|

|PATIENT PHONE|

Emergency Contact:

|EMERGENCY CONTACT|

///[Telephone] Due to the COVID-19 pandemic, this visit was conducted via

telephone with audio components. Patient/caregiver understood and agreed to

terms, risks, and benefits of visit conducted by telehealth.

Address & Phone#:

|PATIENT ADDRESS|

|PATIENT PHONE|

Emergency Contact:

|EMERGENCY CONTACT|

Length of call: ///

I explained the purpose of this evaluation and addressed questions related to

the risks/benefits of completing the assessment.  The patient/surrogate provided

oral informed consent.

ID

|PATIENT NAME| is a |PATIENT AGE| year old |MARITAL STATUS| |PATIENT SEX| with

pertinent psychiatric and medical history of /// presenting to geriatric

psychiatry for new visit.

CHIEF COMPLAINT

///

HPI

///

Collateral information obtained from caregiver/family member:

///

PSYCHIATRIC REVIEW OF SYSTEMS

Depression

[] None

[] Depressed mood

[] anhedonia

[] appetite changes

[] sleep disturbances

[] decreased energy

[] decreased concentration

[] feelings of guilt

[] psychomotor changes

[] suicidality

Anxiety

[] None

[] anxiety

[] difficulty controlling worry

[] restlesness

[] muscle tension

[] irritability

[] fatigued

[] sleep disturbance

PTSD

[] None

[] Exposure to traumatic event directly or by proxy [Describe Event: ]

[] Intrusion symptoms: nightmares, flashbacks

[] Avoidance symptoms: avoidance of triggering thoughts or actions

[] Depressive symptoms: depression, anhedonia, changes in

mood, and changes in cognition

[] Hyperstartle symptoms: hypervigilance, elevated startle response

Mania

[] None

[] distractibility

[] impulsivity

[] grandiosity

[] flight of ideas

[] increased activities

[] decreased need for sleep

[] talkativeness

Psychosis

[] None

[] auditory hallucinations

[] visual hallucinations

[] paranoia

[] delusions

[] disorganized thoughts or speech

[] alogia

[] anhedonia

[] anergy

[] apathy

[] flat affect

Functional/Cognitive

[] None

[] Subjective concerns about memory from patient or caregiver

[] Specific examples of memory lapses:

[] Impairment in any IADL’s (managing finances, managing meds, getting around,

shopping, cooking).

[] Impairment in any BADL’s (toileting, grooming, bathing, dressing, eating).

ADL’s

[Mark if patient is independent of activity. Comment if assistance is needed.]

BADL'S

[] Bathing

[] Dressing

[] Grooming

[] Mouth care

[] Toileting

[] Transfering from bed

[] Walking

[] Climbing Stairs

[] Eating

IADL's

[] Shopping

[] Cooking

[] Managing medications

[] Using the phone

[] Doing housework

[] Doing laundry

[] Driving/using public transportation

[] Managing finances

Driving status: ///

///PSYCHIATRIC HISTORY

- Previous diagnoses:

- Psychiatric hospitalizations:

- Previous medication trials:

- Previous or current engagement with psychotherapy:

- Previous or current interventional trials (ECT, TMS, ketamine):

LIFETIME HISTORY OF SUICIDAL ACTS AND SELF HARM:

///

LIFETIME HISTORY OF VIOLENCE/ASSAULTING OTHERS/LEGAL PROBLEMS:

(including charges, convictions, incarcerations, probation or parole, domestic

violence)

///

///FAMILY HISTORY

- Psychiatric diagnoses:

- Suicide attempts:

- Cognitive impairment/dementia:

- Substance use:

///SUBSTANCE USE HISTORY:

(Type, Last use, age of onset, amount & frequency, longest period of sobriety)

- Alcohol:

- Cannabis:

- Other illicit substances:

- Prescription medications (beyond prescribed amount or frequency:

- Nicotine/Tobacco:

- Caffeine:

///SOCIAL HISTORY:

- current living situation [type of home, who with]:

- relationships, marital status, children, family constellation:

- educational status:

- occupation (past or present):

- financial status or stressors:

- religion/spirituality:

- childhood/developmental history [where they grew up, home environment, etc]:

- past trauma/sexual/physical abuse:

- legal history or stressors:

///MILITARY HISTORY:

- Branch:

- Years active:

- Combat:

///PERTINENT MEDICAL HISTORY:

- Head Trauma/TBI:

- Stroke/Aneurysm:

- Falls:

- Seizures:

- Pain:

- Nutritional assessment (food allergies, weight loss or gain of ten pounds or

more in the last 3 months, decrease in food intake and/or appetite, dental

problems, unusual eating habits or behaviors including restricting, binging, or

inducing vomiting):

- Sleep apnea screen:

///Does the patient have a diagnosis of OSA?

  []Yes

  []No

     If Yes, does the patient adhere to treatment?

          []Yes

          []No – address why, and if indicated, refer back to sleep medicine

     If No, has the patient completed a sleep study through sleep medicine?

          []Yes – review and document results

          []No – order sleep study through e-consult menu if indicated

(cognitive complaints/impairment, depression, sleep symptoms)

PAST MEDICAL HISTORY:

|ACTIVE PROB LIST-SHORT|

ALLERGIES

|ALLERGIES/ADR|

|ACTIVE OUTPATIENT MEDICATIONS|

///MEDICATIONS RECONCILIATION:

[] I have reviewed the patient's outpatient medications with

the patient or caregiver and the list above accurately

reflects the medications that the patient is currently

taking including any that may be provided from non-VA

sources, over the counter medications, nutritional or

other supplements.

[] The patient and/or caregiver were unable to participate in the medication

reconciliation at this time due to \*\*\*. However, I have reviewed the patient’s

outpatient medication list on record.

OBJECTIVE

|VITALS-LAST|

///MENTAL STATUS EXAM

General appearance:

Behavior:

Speech:

Motor:

Mood:

Affect:

Thought process:

Thought content:

Perceptual disturbances:

Cognition:

Insight:

Judgement:

MOCA DEMENTIA SCALE:

Visuo-spat/Exec:   /5

Naming:            /3

Attn:              /6

Lang:              /3

Exec(Abstract):    /2

Recall:            /5 (with cues: /5)

Orientn:           /6

<13 years ed.?    +0 or +1

               ------------

TOTAL MOCA SCORE: \*\*\*

Prior MOCA scores:

LABORATORY DATA:

             TSH: |LR TSH NEW|

         Free T4: |HSO FREE T4|

             B12: |LR VIT B12|

          Folate: |LR FOLATE|

             MMA: |LR MMA SERUM|

    Homocysteine: |LR HOMOCYSTENE|

     Thiamine B1: |LR VIT B1|

           Vit D: |LR 25-VITD|

             RPR: |LR RPR|

             CD4: |LR CD4+/3+ LY(T-4) #|

          HIV VL: |LR HIV PCR ULTRA SENSITIVE|

             RBC: |LR RBC|

             Hgb: |LR HEMOGLOBIN|

             Hct: |LR HEMATOCRIT|

             MCV: |LR MCV|

             MCH: |LR MCH|

            MCHC: |LR MCHC|

             WBC: |LR WBC|

             RDW: |LR RDW|

      Neutrophil: |NEUTROPHIL # (AUTO)|

        Platelet: |LR PLATELET COUNT|

             LDL: |LR LDL CHOLESTEROL, CALCULATED (WLA)|

             HDL: |LR HDL CHOLESTEROL-WLA|

              TG: |LR TRIGLYCERIDE-WLA|

Tot cholesterol: |LR CHOLESTEROL|

             A1c: |LR HGBA1C 3,2|

              Na: |LR SODIUM|

               K: |LR POTASSIUM|

             GLU: |LR GLUCOSE|

             BUN: |LR UREA NITROGEN|

           CREAT: |LR CREATININE|

      CREAT IDMS: |LR CREATININE IDMS|

             CO2: |LR CO2|

              CC: |LR CREATININE CLEARANCE|

|HSO MRI BRAIN + CT HEAD|

///EKG

QTc interval:

///ASSESSMENT OF SUICIDE RISK FACTORS

[] older adult

[] male

[] Veteran

[] chronic mental illness

[] prior suicide attempt

[] history of substance abuse, past or present

[] access to firearms

[] history of impulsive behaviors

[] economic/housing instability

[] passive or active suicidal ideation

///ASSESSMENT OF VIOLENCE RISK FACTORS

[] homicidal/violent ideation

[] homicidal/violence plan

[] access to firearms

[] sense of hopelessness

[] history of violence

[] history of impulsivity

[] history of substance abuse

///PROTECTIVE FACTORS:

[] access to housing/residential stability

[] steady employment

[] job skills

[] financial stability

[] active involvement in treatment

[] strong therapeutic alliance

[] religious/spiritual alliance

[] involvement in community

[] hopefulness about change

[] motivation and readiness for change

[] ability to set and pursue goals

[] ability to manage surrounding demands and opportunities

[] self-direction

[] resilience

[] intelligence

[] engagement with hobbies or pastimes

[] supportive family and/or friends

[] insight regarding mental health and substance use issues

[] knowledge of medications

[] other:

///Based on the above, patient is deemed to be at

[] low

[] moderate

[] high

acute risk of imminent self-harm, and

[] low

[] moderate

[] high

acute risk of imminent harm to others.

///[Complete CSSRS for initial intake]

ASSESSMENT

Psychiatric diagnoses:

#

Pertinent medical diagnoses:

#

Pertinent psychosocial/contextual issues:

#

Discussion & Formulation:

///

PLAN

///

- Provided supportive therapy and cognitive restructuring in the time allotted

- Provided psychoeducation with regards to diet, sleep, exercise, relaxation

techniques, pain management, lifestyle modifications, on the mind and body as

appropriate

Medical

- ///Patient has had a primary care visit in the past year:

[] Yes, date: \*\*\*

[] No, discuss referral to primary care

- Management per primary care team and appropriate sub-specialties

- Encouraged to f/u as recommended by those providers

Social

- Veteran does not meet criteria for 5150 LPS hold for DTS, DTO, or GD

- Emergency services reviewed with veteran.  Informed him/her to return to

clinic if symptoms worsen and/or with questions, and/or if side effects develop.

Patient has been provided information to VA Crisis Hotline (1800-273-TALK), WLA

ER for emergency matters.

- Pt educated regarding risks/benefits of any meds prescribed, verbalized

understanding. Provided supportive therapy and psychosocial resources.

RTC: ///

Pt was seen and discussed with attending physician, Dr. ///, and the above

assessment and plan were jointly formulated.

**GeriPsych Clinic Follow up**

GERIATRIC PSYCHIATRY PROGRESS NOTE

Choose One Modality Foreword:

///[Face-to-Face] I reviewed the procedures necessary for in person visits. This

included negative COVID screen by both the patient and provider, need for all

parties to wear masks at all times, need to maintain 6 feet of distance between

us as much as possible, and need to use hand sanitizer/wash hands before and

after the visit. Patient/caregiver expressed understanding and was in agreement

with these procedures.

///[Video] Due to the COVID-19 pandemic, this visit was conducted via video-

conference with audio and visual components. Patient/caregiver understood and

agreed to terms, risks, and benefits of visit conducted by telehealth.

Address & Phone#:

|PATIENT ADDRESS|

|PATIENT PHONE|

Emergency Contact:

|EMERGENCY CONTACT|

///[Telephone] Due to the COVID-19 pandemic, this visit was conducted via

telephone with audio components. Patient/caregiver understood and agreed to

terms, risks, and benefits of visit conducted by telehealth.

Address & Phone#:

|PATIENT ADDRESS|

|PATIENT PHONE|

Emergency Contact:

|EMERGENCY CONTACT|

Length of call: ///

ID

|PATIENT NAME| is a |PATIENT AGE| year old |PATIENT SEX| with pertinent history

of ///

presenting to geriatric psychiatry for follow-up visit.

CHIEF COMPLAINT:

///

PLAN LAST VISIT & INTERVAL EVENTS:

///

SUBJECTIVE

///

Collateral information obtained from caregiver/family member:

///

Pertinent Psychiatric Review of Systems:

- Depression:

- Anxiety:

- Psychosis:

- Mania:

- Sleep:

- Changes in memory/cognition/IADLs/BADLs since initial assessment:

Pertinent Medical ROS:

[] constitutional symptoms (fevers, chills, etc.)

[] falls

[] medication side effects

ALLERGIES

|ALLERGIES/ADR|

|ACTIVE OUTPATIENT MEDICATIONS|

///MEDICATIONS RECONCILIATION:

[] I have reviewed the patient's outpatient medications with

the patient or caregiver and the list above accurately

reflects the medications that the patient is currently

taking including any that may be provided from non-VA

sources, over the counter medications, nutritional or

other supplements.

[] Unable to complete medication reconciliation.

OBJECTIVE

|VITALS-LAST|

///MENTAL STATUS EXAM

General appearance:

Behavior:

Speech:

Motor:

Mood:

Affect:

Thought process:

Thought content:

Perceptual disturbances:

Cognition:

Insight:

Judgement:

MOCA DEMENTIA SCALE:

Visuo-spat/Exec:   /5

Naming:            /3

Attn:              /6

Lang:              /3

Exec(Abstract):    /2

Recall:            /5 (with cues: /5)

Orientn:           /6

<13 years ed.?    +0 or +1

               ------------

TOTAL MOCA SCORE:

Prior MOCA scores:

PERTINENT LABORATORY DATA:

             TSH: |LR TSH NEW|

         Free T4: |HSO FREE T4|

             B12: |LR VIT B12|

          Folate: |LR FOLATE|

             MMA: |LR MMA SERUM|

    Homocysteine: |LR HOMOCYSTENE|

     Thiamine B1: |LR VIT B1|

           Vit D: |LR 25-VITD|

             RPR: |LR RPR|

             CD4: |LR CD4+/3+ LY(T-4) #|

          HIV VL: |LR HIV PCR ULTRA SENSITIVE|

                Cr: |LR CREATININE IDMS|

     Cr. Clearance: |LR CREATININE CLEARANCE| ml/min

|HSO MRI BRAIN + CT HEAD|

///EKG

QTc interval:

///OVERALL SUICIDE RISK ASSESSMENT

Risk factors:

[] older adult

[] male

[] Veteran

[] chronic mental illness

[] prior suicide attempt

[] history of substance abuse, past or present

[] access to firearms

[] history of impulsive behaviors

[] economic/housing instability

[] passive or active suicidal ideation

Protective factors:

[] future-oriented

[] engaged in treatment

[] social support

[] demonstrating intact reality testing

[] no prior suicide attempts

[] no active substance use

[] no access to firearms

[] no history of impulsive behaviors

[] stable housing/finances

[] denies passive or active suicidal ideation

///Based on the above, patient is deemed to be at

[] low

[] moderate

[] high

acute risk of imminent self-harm. (If moderate or high, complete CSSRS.)

ASSESSMENT

Psychiatric diagnoses:

#

Pertinent medical diagnoses:

#

Pertinent psychosocial/contextual issues:

#

Discussion:

///

PLAN

///

- Provided supportive therapy and cognitive restructuring in the time allotted

- Provided psychoeducation with regards to diet, sleep, exercise, relaxation

techniques, pain management, lifestyle modifications, on the mind and body as

appropriate

Medical

- ///Patient has had a primary care visit in the past year:

[] Yes, date: \*\*\*

[] No, discuss referral to primary care

- Management per primary care team and appropriate sub-specialties

- Encouraged to f/u as recommended by those providers

Social

- Veteran does not meet criteria for 5150 LPS hold for DTS, DTO, or GD

- Emergency services reviewed with veteran.  Informed him/her to return to

clinic if symptoms worsen and/or with questions, and/or if side effects develop.

Patient has been provided information to VA Crisis Hotline (1800-273-TALK), WLA

ER for emergency matters.

- Pt educated regarding risks/benefits of any meds prescribed, verbalized

understanding. Provided supportive therapy and psychosocial resources.

RTC: ///

Pt was seen and discussed with attending physician, Dr. ///, and the above

assessment and plan were jointly formulated.