KAISER PERMANENTE®

OUTPATIENT INITIAL ADULT DIAGNOSTIC EVALUATION AND TREATMENT PLAN

FAX TO: 877-608-0084 OR SEND VIA SECURE EMAIL TO:
PSYCH-OUTSIDE-REFERRALS@KP.ORG

Patient Name: enter text.	
MRN: enter text.	
Length of Session: enter text.	**Date:** _____/_____/_____
Informed Consent: Patient seen in the following Location: _____ ☐Clinic information, confidentiality policies, and emergency services reviewed. ☐Disclosure of clinician's credentials	
IDENTIFYING INFORMATION	
DOB _____/_____/___	**Age** enter text. **Occupation:** enter text.
Ethnicity: ☐ African-American ☐Asian ☐Caucasian ☐Eastern European ☐Hispanic ☐Middle Eastern ☐ Native American ☐Pacific Islander☐ South American ☐South East Asian☐ Unknown	
Patient's primary language: ☐English ☐ Other: enter text. ☐Spanish	**Relationship status:** ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Gay ☐Lesbian ☐Partnered ☐Other: enter text.
Patient Referred by: ☐Self ☐Primary Care MD ☐Primary Psychiatry Counselor/Therapist ☐Primary Psychiatrist ☐Primary Addiction MD Primary ☐RN ☐Case Manager Kaiser Permanente ☐Other: enter text.	
Attending Session: ☐Patient ☐Spouse/significant other ☐Father ☐Mother ☐Stepfather ☐Stepmother ☐Child / children ☐Sibling(s) ☐Friend ☐Legal guardian ☐Caretaker ☐Interpreter ☐Grandparent(s) ☐Clinician ☐Physician, ☐Nurse ☐Other: enter text.	
Source of information gathered during visit: ☐Patient ☐Spouse/significant other ☐Father ☐Mother ☐Stepfather ☐Stepmother ☐Child / children ☐Sibling(s) ☐Friend ☐Legal guardian ☐Caretaker ☐Interpreter ☐Grandparent(s) ☐Clinician ☐Physician, ☐Nurse ☐Other: enter text.	
Include Release of Information if applicable	enter text.
Chief Complaint: Click or tap here to enter text.	
Describe the onset, frequency & Duration of the Chief Complaint: Click or tap here to enter text.	
History of Chief Complaint: enter text.	
Why is Patient seeking help now? enter text.	
Additional Stressors enter text.	

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SYMPTOM EVALUATIONS

Depression: ☐Patient Denies ☐Depressed Mood ☐Sadness ☐Irritable Mood ☐Decreased interest or pleasure ☐Excessive Guilt ☐Feeling Worthless ☐Increased sleep ☐Decreased sleep ☐psychomotor agitation ☐psychomotor retardation ☐Increased appetite ☐Decreased Appetite ☐Weight Gain ☐Weight Loss when not dieting ☐Decreased concentration ☐Indecisiveness ☐Recurrent thoughts of Death ☐Feeling Hopeless ☐Low self-esteem ☐Tearfulness ☐ Anhedonia ☐Decreased Libido

Anxiety/Panic: ☐Patient Denies ☐Excessive worry or anxiety ☐Difficulty controlling worry ☐Restlessness ☐Feeling keyed up or on edge ☐Easily Fatigued ☐Difficulty concentrating ☐Mind going blank ☐Irritability ☐Muscle tension ☐Sleep disturbance ☐Panic ☐Obsessions ☐Panic attacks ☐Phobias ☐Compulsions

OCD: ☐Patient denies ☐Recurrent persistent thoughts, impulses or images that are disturbing intrusive and inappropriate and cause marked anxiety or distress ☐Thoughts/Impulses are not simply excessive worries about real-life problems ☐Attempts to ignore or suppress or neutralize the thoughts/impulse ☐Recognizes that the obsessional thoughts/impulse are a product of their own mind ☐Repetitive behaviors or acts that patient feels driven to perform in response to an obsession or according to rigid rules ☐Behaviors or acts are aimed at preventing or reducing distress or preventing some dreaded event ☐Able to recognize that the patterns are excessive and unreasonable ☐Obsessions or compulsions cause marked distress, are time consuming or significantly interfere with patients normal routine, functioning and relationships

Mania: ☐Patient Denies ☐Elevated mood Expansive mood ☐ Irritable mood ☐Inflated self-esteem ☐Grandiosity ☐Delusions ☐Decreased need for sleep ☐ Unusually talkative ☐Feeling pressured to talk ☐Flight of ideas ☐Racing thoughts ☐Difficulty concentrating ☐Distractibility ☐Psychomotor agitation ☐Increase in goal-directed activity ☐Excessive pleasurable activities with a high degree of risk ☐Psychosis

PTSD: ☐Patient denies ☐Experienced witnessed or was confronted with an event that involved death, serious injury, sexual violation or violent accident ☐Intrusive memories, dreams or nightmares ☐Dissociative reactions ☐Self-devaluation, shame and guilt ☐Unable to remember event or detail ☐Emotional constriction/avoidant of relationships ☐Significant challenges in relationships ☐Reenactment occurs in play (for children) ☐Response involved intense fear, hopelessness, horror or agitated behavior☐Persistent difficulty falling/staying asleep ☐ Irritability or outbursts of anger ☐Persistent difficulty concentrating ☐Hyper-vigilance ☐Exaggerated startle response

ADHD: enter text.

Inattentive sx: ☐Patient Denies ☐Poor attention to details ☐Making careless mistakes ☐Difficulty in maintaining attention ☐Not listening when spoken to ☐Poor follow through on instructions ☐Failing to complete school work ☐ Failing to complete chores ☐Failing to complete work duties ☐Difficulty with organizing ☐Avoiding tasks that require sustained

Patient Name: _____

Patient Medical Record Number:_____

concentration ☐Dislike for tasks that require sustained concentration ☐Losing things ☐Easily distracted ☐Forgetful
Hyperactive/Impulsivity sx: ☐Patient denies ☐Fidgeting with hands or feet ☐can't sit still ☐Can't remain seated ☐Running/climbing excessively ☐Feeling of restlessness ☐Excessively noisy during play/ activities ☐Always going non-stop ☐Talking excessively ☐Blurting out answers before question have been completed ☐Difficulty waiting for their turn ☐Interrupting others enter text.
Psychosis: ☐Patient Denies ☐Believes can control other's behavior ☐Believes can read other's mind ☐Believes others can control patients behavior ☐Believes others can read his/her mind ☐Believes without evidence ☐s/he has medical illness/symptoms ☐Catatonia ☐Disorganized thoughts ☐Feeling things that are not there ☐Paranoid untrue beliefs ☐Religious preoccupation ☐Seeing things that are not there ☐Smelling things that are not there ☐Thinks TV or radio are talking about him/her ☐Ideas of reference (TV or radio sending messages) ☐Thought broadcasting/thought insertion (people can read mind or patient can read mind of others)
What helps decrease or lessen severity of patient's symptoms? enter text.
PSYCHIATRIC TREATMENT HISTORY
Outpatient Treatment: ☐Patient Denies ☐Yes Dates: enter text.
Inpatient Treatment ☐ Patient Denies ☐Yes Dates: enter text.
History of Self Injury: ☐Patient Denies ☐Yes Dates enter text.
History of Suicide Attempts: ☐Patient Denies ☐Yes Dates: enter text.
History of Harm to Others: ☐Patient Denies ☐Yes Dates: enter text.
History of Eating Disorders: ☐Patient Denies ☐Yes Dates: enter text.
Family Psychiatric History: enter text.
Past Psychiatric Medications: enter text.
Current Medications: enter text.
Medical Problems: enter text.
Other significant medical history: enter text.
History of seizures: enter text.
History of head trauma: enter text.
Significant developmental issues: enter text.
Pregnant: ☐ **N/A** ☐ **No** ☐ **Yes:** Click or tap here to enter text.
SUBSTANCE USE
Current: ☐ Patient Denies ☐ Alcohol ☐ Amphetamines ☐ Anesthetic ☐ Barbiturates ☐ Caffeine ☐ Cannabis ☐ Club Drugs ☐ Cocaine ☐ Hallucinogens ☐ Opiates ☐ Psychomotor stimulants ☐ Sedative ☐ Hypnotics

Patient Name: _____

Patient Medical Record Number:_____

Past: ☐ Patient Denies ☐ Alcohol ☐ Amphetamines ☐ Anesthetic ☐ Barbiturates ☐ Caffeine ☐ Cannabis ☐ Club Drugs ☐ Cocaine ☐ Hallucinogens ☐ Opiates ☐ Psychomotor stimulants ☐ Sedative ☐ Hypnotics
Family Substance Abuse History: ☐ Patient Denies ☐ Yes: enter text.
SOCIAL HISTORY
Patient was born in: enter text.
Patient was raised by: enter text.
Patient has: enter text. **siblings** enter text. **brothers** enter text. **sisters**
Patient is the enter text. **in birth order.**
Patient described childhood as: enter text.
Patient indicates gets along with: Mother ☐ N/A ☐ No ☐ Yes, Father ☐ N/A ☐ No ☐ Yes, and Sibling(s) ☐ N/A ☐ No ☐ Yes
Patient has a support system: ☐ No ☐ Yes enter text.
Education: enter text.
Employment History: enter text.
Relationship History: enter text.
Lives with: ☐ alone ☐ with spouse ☐ with family ☐ with boyfriend ☐ with girlfriend ☐ in board care ☐ in skilled nursing facility ☐ in independent living facility/retirement home ☐ with caretaker
Religious Affiliation/spirituality: enter text.
Legal Issues: enter text.
HISTORY OF ABUSE: ☐ denied by patient ☐ physical ☐ sexual ☐ psychological ☐ emotional ☐ neglect
Was this reported: ☐ N/A ☐ NO: ☐ Yes: enter text.
RISK ASSESSMENTS/SAFETY
Suicidal

Ideation	☐ N/A ☐ Patient Denies ☐ Yes: enter text.
Plan	☐ N/A ☐ Patient Denies ☐ Yes: enter text.
Intent	☐ N/A ☐ Patient Denies ☐ Yes: enter text.
Means	☐ N/A ☐ Patient Denies ☐ Yes: enter text.

Patient Name: _____

Patient Medical Record Number:_____

Reason for not following through	☐N/A ☐ Other: enter text.
Self-Injury	☐ N/A ☐ Patient Denies ☐ Yes: enter text.
Homicidal	
Ideation	☐ N/A ☐ Patient Denies ☐ Yes: enter text.
Plan	☐ N/A ☐ Patient Denies ☐ Yes: enter text.
Intent	☐ N/A ☐ Patient Denies ☐ Yes: enter text.
Means	☐ N/A ☐ Patient Denies ☐ Yes: enter text.
Reason for not following through	☐ N/A ☐ Other: enter text.

Access to firearms or other weapon(s): ☐ Gun not accessible
☐ Gun in the home
☐ Familiarity with weapon(s)
☐ Intends to obtain gun / weapon(s)
☐ Recently obtained gun / weapon(s)
☐ Has agreed to remove gun / weapon(s) from availability
☐ Family/friend has agreed to remove gun/weapon(s) from availability
☐ Unable to assess

Domestic Violence: Did you come here today because you were hurt by your current/past husband/wife, boyfriend/girlfriend, and partner?

1. ☐ N/A ☐ Patient Denies ☐ Yes (answer questions below)
2. Within the last year, have you been pushed, shoved, hit slapped, kicked or otherwise physically hurt by your current/past husband/wife, boyfriend/girlfriend, partner: enter text.
3. Within the past year has your present or past husband/wife, partner, boyfriend/girlfriend forced you to have sexual activities: enter text.
4. Have you ever been emotionally or physically abused by our present/past husband/wife, boyfriend/girlfriend, or partner enter text.

MENTAL STATUS EXAM

Appearance: ☐No acute distress ☐Alert oriented x3 ☐Appropriate mood and affect ☐Well-nourished ☐Underweight ☐Overweight ☐Obese

BEHAVIOR: ☐ Normal ☐Cooperative ☐Agitated ☐Aggressive ☐Hostile ☐Impulsive ☐Intrusive ☐Negativistic ☐Resistant ☐Self-mutilates ☐Seductive ☐Unable to assess ☐Violent

Cognition ☐ alert ☐ clear ☐ oriented to person place time situation ☐ memory intact to immediate, recent and remote recall ☐ concentration normal ☐ clouded ☐ comatose ☐ confused ☐ distracted ☐ drowsy ☐ obtunded ☐ oriented to ☐ memory intact to ☐ stuporous ☐ unable to assess

Concentration: ☐ normal ☐ Mildly Impaired ☐ moderately Impaired ☐ Severely Impaired ☐ questionable ☐ unable to pay attention ☐ distractible ☐ unable to do simple math

Patient Name: _____

Patient Medical Record Number:_____

Eye contact: ☐ Appropriate ☐ Absent ☐ Avoidance ☐ Decreased ☐ excessive ☐ increased ☐ none ☐ Unable to assess
Mood: ☐ euthymic ☐ sustained emotional state ☐ anhedonic ☐ angry ☐ anxious ☐ apathetic ☐ bashful ☐ depressed ☐ euphoric ☐ expansive ☐ frightened ☐ grandiose ☐ hopeless ☐ irritable ☐ labile ☐ nihilistic ☐ unable to assess
Affect: ☐normal range ☐appropriate ☐mood congruent ☐mood incongruent ☐blunted ☐constricted ☐ flat ☐ inappropriate ☐ labile ☐ la bell indifference ☐ unable to assess
Thought Process: ☐ coherent ☐relevant ☐logical ☐concrete ☐circumstantial ☐clang associations ☐flight of ideas ☐illogical ☐incoherent ☐irrelevant ☐loose associations ☐perseverations ☐ poverty of content ☐racing ☐rambling ☐tangential thought blocking ☐unable to assess
Impulse control: ☐ unimpaired ☐ mildly impaired ☐ moderately impaired ☐ severely impaired ☐ unclear ☐ unable to assess
Judgment: ☐unimpaired ☐mildly impaired ☐moderately impaired ☐severely impaired ☐unclear ☐unable to assess
Insight: ☐excellent ☐good ☐average ☐fair ☐poor ☐limited ☐unclear ☐unable to assess
FUNCTIONAL IMPAIRMENT
Does the patient have a significant impairment in an important area of life functioning? ***In the past 3 months, how well has the patient been able to manage the following areas?*** 1. Impairment in maintaining age appropriate self-care: ☐ None ☐ Mild ☐ Moderate ☐ Severe 2. Impairment in performing routine daily tasks: ☐ None ☐ Mild ☐ Moderate ☐ Severe Impairment in performing work/school tasks: ☐ None ☐ Mild ☐ Moderate ☐ Severe 3. Impairment in participating in usual social/community activities: ☐ None ☐ Mild ☐ Moderate ☐ Severe ***Significant Deterioration: Please note if there is a reasonable probability of significant deterioration in an important area of life functioning.*** enter text.
DSM 5 Diagnosis: 1. enter text.
2. enter text.
3. enter text.
4.enter text.
TREATMENT PLANS & RECOMMENDATIONS:
(To be used to address goals) **NOTE: this evaluation may not be viewed upon receipt. When making a recommendation for treatment (other than individual treatment to continue), please**

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Patient Medical Record Number:_____

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contact Kaiser Permanente for assistance with scheduling
Hospitalization: ☐Not Applicable ☐Referral to MD for urgent evaluation ☐Patient sent to ER ☐Agrees to voluntary hospitalization☐Patient involuntarily hospitalized ***Patient is aware of post hospital protocol/options*** **☐Yes☐No**
Treatment Options: ☐ **1.** No follow up treatment indicated now.☐**2.** Psychiatric Medical Evaluation☐**3.** Individual Therapy☐**4.**Group Therapy/Classes☐**5.** Case Management☐**6.**Intensive Outpatient Program☐**7.**Other Treatment Recommendations: enter text. Send Request for Referral if items 4-7 are selected.
Treatment interventions used in the Session: ☐Diagnostic intake interview including assessment of symptoms, strengths/resources, risks and psychosocial and environmental challenges ☐Insight-Oriented, supportive therapy and empathetic listening☐Motivational Interviewing Strengths-based, solution-focused therapy☐Skills training (i.e. mindfulness, communication, limit-setting, relaxation, self-care, etc.)☐Pertinent Psycho-education (i.e. addiction, codependency, trauma, grief, etc.)☐Initial Goal Setting☐Safety Planning ☐Discussed and reviewed applicable treatment options and risks/benefits of each ☐Other: enter text.
Treatment goals agreed upon with patient: ☐Increase enjoyment in pleasurable activities☐ Decrease depression and/or hopelessness☐Improve sleep☐Increase energy ☐Stabilize appetite☐ Increase feelings of self-worth☐Improve concentration☐ Decrease agitation☐ Eliminate thought of wanting to die or of self-harm☐ Decrease anxiety/nervousness☐Decrease worry Improve productivity at home/work ☐ Stabilize mood/decrease mood swings ☐Decrease psychotic symptoms ☐Decrease drug/alcohol use ☐Achieve a safe environment/living situation
Recommended Treatment Intervals: enter text.
Verbal, physical, or sexual abuse or domestic violence reporting: *(notate any forms or filings done)* enter text.
Documentation of Medical Impairment: ☐Yes ☐ No
Treatment Consent: Patient understands and agrees to treatment goals and plans: ☐ Yes ☐ No Risks and benefits of psychotherapy reviewed with patient: ☐ Yes ☐ No
Safety: Patient advised of emergency procedures and phone numbers ☐ Yes ☐ No Kaiser Permanente Behavioral Healthcare Helpline: 800-900-3277.
Provider Name: enter text. **Date:** enter text. **License #:** enter text.

Patient Name: _____

Patient Medical Record Number:_____