Initials: ___________________ Last 4: ______________ Date: __________________

(Assess)

Referral Problem:

ETOH:

Tobacco:

Drugs:

Caffeine:

Clinical reminders:

Risks (e.g., lethality):

Problem hx:

Past tx:

Impression/Diagnosis

Better/worse:

Assessment Summary
Share summary and options (Advise)

➢ Strengths, concerns/needs

Other probs:

PHQ-9:

BAI:

PCL:

Other:

Pain (Source)

Today = __/10

High = __/10

Low = __/10

Avg = __/10

Personal Action Plan (Agree)
Patient’s goals for change:

PCP &/or PC-MH Team Input:

Tx Recommendations: (Pt and PCP) (Assist)

Functional Assessment/Typical Day

Sleep:

Work:

Close relationships:

Family:

Friends:

Recreation:

Physical:

Follow-Up Arrangements: (Arrange)

➢ RTC:

➢ Other:

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