FIRST PAGE TO BE COMPLETED WITH PATIENT AT FIRST VISIT

EXAMPLE ASSESSMENT

REFERRAL SOURCE: St. Francis Pathways (Palliative Care Program) Tiffany Graham
REASON FOR EVALUATION/ CHIEF COMPLAINT (Identify all specific symptoms that are the criteria for their diagnosis): Anxiety, Depression, Sleep disturbance *WHY WAS THE PATIENT REFERRED?*
HX OF PRESENT SYMPTOMS/PROBLEMS/CONDITIONS (relates to duration of symptoms):
Manifestation of pt's depression and/or anxiety has been ongoing 1 yr
per his wife and worsening x2-3 months (yelling, moaning, talking in his sleep); hx of anxiety d/o and depressive d/o *HOW LONG HAVE THESE CURRENT SYMPTOMS BEEN PRESENTING? (PREVIOUS LONG-STANDING SX'S CAN BE MENTIONED)*
STRENGTHS: Support of family, some caregivers in place, willing to engage in LCSW care
LIABILITIES: chronic and significant pain, prescription of numerous medications, depression
FAMILY/SOCIAL HISTORY: Pt was born in New Orleans, LA to both parents and having an older sister. They moved to MD when pt was 8 and he later graduated from high school. Later he graduated from Tulane Univ. (mechanical engineering degree). He served in the Navy ROTC and US Navy (6 yr). His primary career was as a rocket engineer. 51 years ago he married Joy and the couple had/have 2 sons. Pt's social contacts are few today. A CNA visits daily (bathing, cooking, cleaning, dressing him, sheet change); he resides with his wife. Pathways nursing visits 1x every 6-8 weeks; Kindred Care nurses visit re: catheter care. Pt speaks with his sister. His sons visit occasionally and sister-in-law visits the family often. He lives with wife Joy who is currently s/p shoulder surgery. *FAMILY OF ORIGIN; EDUCATION; WORK HISTORY; CURRENT FAMILY DYNAMIC; SOURCES OF SUPPORT?*

SIGNIFICANT MEDICAL HISTORY: asthmatic, COPD, 'cardiac condition,' cervical spondylosis, myopathy, COPD, osteoarthritis and osteoporosis, neuropathy, hx of r. CVA, HOH
MEDICATIONS: Med List on File
Maltreatment Risk identified requiring report to Authorities? __Yes _x_No
Depression Screen? __Yes _x_No Type: __GDS __BDI __PHQ-9 ___Other:
Result/Score/Severity:
MENTAL HEALTH HISTORY:
Involuntary hospitalization: __YES _x_NO Psychiatrist: __YES _x_No
Psychologist/LCSW: __YES _x_NO* Pt has hx of periodically seeing (his wife's) psychologist to learn coping strategies (per his wife; pt did not admit to this hx)
Hx of suicide attempts: __YES _x_NO * Admits to SI but due to religious beliefs denies any suicide plans
Current ideation or intent? _x_YES* __NO If YES, means for completing suicide? __YES _x_NO (no firearms)
MENTAL STATUS EXAM
APPEARANCE: Appropriate, Well groomed, Lying in hospital bed, oxygen cannula on/off of him during session
ORIENTATION: x- Person x- Place x-Time
ATTITUDE: Cooperative
SPEECH: Appropriate
AFFECT: Sad
MOOD: Depressed, slightly irritable
CONCENTRATION: Fair and Distracted (by electronic devices in the room)
THOUGHTS: Appropriate Coherent
MEMORY: Short term deficits and Long term deficits
INSIGHT: limited

SECOND PAGE TO BE DONE WITH SECOND PHONE SESSION W/BMSC (Please text/email Linda to set up appt. time when ready to enter your first assessment in Pimsy)

DIAGNOSTIC IMPRESSIONS & TREATMENT PLAN
ANTICIPATED DURATION: 3 months APPROX # OF SESSIONS: 12
Treatment of patient is medically necessary as patient has a diagnosis of: 309.0 Adjustment Disorders, Unspecified* (F43.20)
and presents with the following symptoms: sleep disturbance, depressed mood, significant emotional distress re: immobility
ASSESSMENT OF PROBLEM: _x_ Maladaptive Functioning _x_ Emotional Disturbance _x_ Inadequate Coping Methods _x_Other: increasing prevalence of sleep disturbance
METHOD/S OF MONITORING OUTCOME: _x_Patient self-report _x_Family report _x_Therapist observation
Pt presents with chronic mental health issues(intensifying x2-3 recent months) and stabilization of mental health status or functioning is expected as a result of treatment.
Pt has a diagnosis and/or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior or maladaptive functioning.
Pt has the capacity to actively participate in and benefit from psychotherapy.
Pt is amenable to allowing and participating in therapy in order for it to be effective.
METHODS OF THERAPY TYPE: _x_Behavioral _x_Cognitive _x_Cognitive-Behavioral _x_Reality Testing _x_Person-Centered _x_Validation _x_Other: Supportive, advocacy
The chosen therapy types are deemed to be the appropriate modalities based on the Patient's clinical symptoms, presentation and what Patient agrees would be most beneficial in creating therapeutic support and change.

PLANNED SPECIFIC, MEASUREABLE AND ACHIEVEABLE GOALS (e.g., Pt will reduce behavior by a certain %age or Pt will increase certain task/behavior 50% or Pt will complete a task 3x, 5x, 7x per week/month etc).
GOAL: Pt will work toward healthy adjustment to health status and stage in life, pt and/or family reporting at least a 50% reduction in incidence of sleep
disturbance sxs each week.
OBJECTIVES: Patient will explore thoughts and feelings related to his losses. Pt will explore barriers to adjustment. Pt will explore their understanding and perspective of accepting change. Pt will explore themes related to loss of independence and control. Pt will acknowledge their desire to overcome grief. Pt will explore sources of support. Pt will explore efficacy of past and current coping skills and learn new coping skills that are helpful. Pt will explore ways to promote meaning in daily life. Pt will attempt to create new positive relationships and/or activities and accept the “new normal.”

SAMPLE NOTE: Week #1 (10/12/2018)

NEXT TREATMENT PLAN REVIEW DATE: On or near 11/15/18
TREATMENT USED DURING SESSION: __Behavioral __Cognitive _X_Cognitive-Behavioral _X_Insight Oriented _X_Person-Centered __Reality Testing __Solution-Focused _X_Supportive __Validation __Other:
TECHNIQUES USED DURING SESSION: _X_Behavior Modification _X_Cognitive Modification X__Facilitation of coping skills __Testing _X_Encourage personality growth/development
The chosen therapy types are deemed to be the appropriate modalities based on the Patient's clinical symptoms, presentation and what Patient agrees would be most beneficial in creating therapeutic support and change.

SUMMARY OF SESSION
Patient presented AOx3, appropriately dressed, good eye contact, coherent speech. Pt verbalized feeling depressed.
Patient's participation was active. She was receptive and responsive.
Psychotherapy focused on the following goal: Pt will work toward healthy adjustment to new living environment and stage in life.
Pt processed thoughts and feelings related to gun shooting that occurred at facility the night before reportedly by a resident who lived upstairs. Pt had psychological catharsis during session. Pt worked on ways to reduce current anxiety and depression and promote feelings of comfort and normalcy. Pt gleaned new insight during session. Pt agreed this could be a time to connect with other residents and recommitted to attempting to bond with other residents. Pt agreed to specific steps she could take this day and this week to work on developing relationships with other residents after crisis occurred at ALF.

DIAGNOSTIC IMPRESSIONS & TREATMENT PLAN
ANTICIPATED DURATION FOR THIS TREATMENT PLAN PERIOD: 3 MONTHS # OF SESSIONS: APPROXIMATELY 6-8 or PRN
DSM-5/ICD-10 INITIAL DIAGNOSIS: Treatment of patient is medically necessary as patient has a diagnosis of Adjustment Disorder, With mixed anxiety and depressed mood, Acute* (F43.23) and Patient presents with the following depressive symptoms: depressed mood; disturbed sleep feelings of worthlessness or excessive or inappropriate guilt; indecisiveness; recurrent thoughts of death. Patient also presents with the following symptoms of anxiety: excessive anxiety and worry about a variety of events and situations; significant difficulty in controlling the anxiety and worry; feeling tense, problems with concentration; irritability; difficulty with sleep. The symptoms cause "clinically significant distress" or problems functioning in daily life.
ASSESSMENT OF PROBLEM: _X_Maladaptive Cognitions _X_ Maladaptive Functioning _X_ Emotional Disturbance _X_ Inadequate Coping Methods __ Inappropriate Behavior Patterns _X_Sudden/Rapid Change in Behavior __Other:
PROGNOSIS: Pt presents with acute symptoms and treatment is expected to improve the mental health status/ functioning of this patient. Pt has a diagnosis and/or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior or maladaptive functioning. Pt has the capacity to actively participate in and benefit from psychotherapy. Pt is amenable to allowing and participating in therapy in order for it to be effective.
PLANNED METHODS OF THERAPY TYPE: __Behavioral __Cognitive _X_Cognitive-Behavioral _X_Insight Oriented _X_Reality Testing _X_Solution-Focused _X_Person-Centered _X_Validation __Other:
The chosen therapy types are deemed to be the appropriate modalities based on the Pt's clinical symptoms, presentation and what Pt agrees would be most beneficial in creating therapeutic support and change.
METHOD/S OF MONITORING OUTCOME: _X_Patient self-report __Family report __Staff report _X_Therapist observation _X_GDS __Diagnostic testing

PLANNED MEASUREABLE AND ACHIEVEABLE GOALS AND PROGRESS:
1) GOAL: Pt will work toward healthy adjustment to new living environment and stage in life.

Pt will explore challenges and possible benefits of new living environment.

9/13/18: Pt agrees to tour other unit in same ALF within next 2 days and discuss with her daughter if she would be in support of this move which Pt identifies will help her better adapt and adjust to new living environment and feel less "imprisoned."

Patient will explore thoughts and feelings related to losses and verbalize a sense of closure and acceptance over losses.

9/29/18: Pt had discussion of reality regarding multiple layers of losses including not being able to order her own medication, drive to pharmacy, have control over her own medical issues and appointments and the related impact on her psychological state.

Pt will explore sources of support and attempt to engage in one activity per day at the ALF.

Pt will attempt to create new positive relationships (with at least 3 people) and accept the “new normal.”

10/12/18: Pt agreed to specific steps she could take this day and this week to work on developing relationships with other residents after crisis occurred at ALF.

2) GOAL: Pt will reduce depressive symptomology and strive to reduce score on GDS from 25 to 20 over next 3 months.

Pt will identify and explore depressive and or anxious symptomology and have catharsis as needed in sessions.

10/12/18: Pt processed thoughts and feelings related to gun shooting that occurred at facility the night before reportedly by a resident who lived upstairs.

Pt will target results from GDS during sessions in attempt to reduce overall depression score.

3) GOAL: Pt will take proactive steps to take care of medical conditions, make and keep all (100%) of medical appointments, take medication as ordered daily.

9/29/18: Pt expressed feelings and therapist provided supportive interaction as well as cognitive intervention to work on changing Pt's thought processes regarding 'loss' and behavioral modification with respect to reducing medication errors.