

**Innovate Treatment Services**

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**Regent House**

**Stockport, SK4 1BS**

**Telephone Assessment Form - Psychology**

**Please complete this form and email to** [**treatment@innovatehmg.co.uk**](mailto:treatment@innovatehmg.co.uk)**.**

**If you have any queries please contact Innovate Treatment Services on 0117 373 6171.**

**Patient name:**

**Date of birth:**

**Clinical Consultant:**

**Date of accident:**

**Date of assessment:**

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| **Patient Consent** | |
| **Has the patient given verbal consent for this assessment report to be passed to their solicitor, the treating therapist and the funding party?** | Yes  No |

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| **Patient Health Questionnaire (PHQ9)** | | | | |
| **Over the last 2 weeks, how often has the patient been bothered by any of the following problems?** | | | | |
|  | **Not at all**  **(1)** | **Several days**  **(2)** | **More than half of the days**  **(3)** | **Nearly every day**  **(4)** |
| **Little interest or pleasure in doing things** |  |  |  |  |
| **Feeling down, depressed, or hopeless** |  |  |  |  |
| **Trouble falling or staying asleep, or sleeping too much** |  |  |  |  |
| **Feeling tired or having little energy** |  |  |  |  |
| **Poor appetite or overeating** |  |  |  |  |
| **Feeling bad about yourself — or that you are a failure or have let yourself or your family down** |  |  |  |  |
| **Trouble concentrating on things, such as reading the newspaper or watching television** |  |  |  |  |
| **Moving or speaking so slowly that other people could have noticed?**  **Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual** |  |  |  |  |
| **Thoughts that you would be better off dead or of hurting yourself in some way** |  |  |  |  |
| **Have you felt any of these symptoms for longer than 2 weeks?** | Yes  No | | | |

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| **Total PHQ9 Score** |  |

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| **Severity of Depression Symptoms** | |
| **0-4** | **None** |
| **5-10** | **Mild** |
| **11-15** | **Moderate** |
| **16+** | **Severe** |

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| **Work and Social Adjustment (WSAS)** | |
| **Patient’s occupation:** |  |
| **Has the patient had any time off work?** | Yes  No |
| **If so, how many weeks have they been absent?** |  |
| **Has the patient returned to work?** | Yes  No |
| **Please rate the current impact of the symptoms on the patient’s daily life**  **(Please score 1-8)** | 1----------------------------------------4-----------------------------------------8  None Slight Definite Marked Severe |
| **Work** |  |
| **Home management** |  |
| **Social leisure activities** |  |
| **Private leisure activities** |  |
| **Family and relationships** |  |

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| **Total WSAS Score** |  |

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| **Generalised Anxiety Disorder (GAD7)** | | | | |
| **Over the last 2 weeks, how often has the patient been bothered by any of the following problems?** | | | | |
|  | **Not at all**  **(1)** | **Several days**  **(2)** | **More than half of the days**  **(3)** | **Nearly every day**  **(4)** |
| **Feeling nervous, anxious or on edge** |  |  |  |  |
| **Not being able to stop or control worrying** |  |  |  |  |
| **Worrying too much about different things** |  |  |  |  |
| **Trouble relaxing** |  |  |  |  |
| **Being so restless that it is hard to sit still** |  |  |  |  |
| **Becoming easily annoyed or irritable** |  |  |  |  |
| **Feeling afraid as if something awful might happen** |  |  |  |  |

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| **Total GAD Score** |  |

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| **Severity of anxiety symptoms** | |
| **0-4** | **None** |
| **5-10** | **Mild** |
| **11-15** | **Moderate** |
| **16+** | **Severe** |

**If the patient has scored 5 or above on the GAD scale above, please proceed with the additional screening prompts below:**

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| **IAPT Screening Prompts** | | | | |
| **Are there times when you are very frightened or anxious and feel very uncomfortable?** | Yes  No  (If yes then please continue below) | | | |
| If yes, please continue below.  Please explore any positive responses to these questions further as per the Telephone Assessment Guidance Notes | | | | |
| **Is it related to a specific situation or object?** | **Being in social situations** | **Being outside or in crowds** | **One particular activity / object** | **Undiagnosed health condition** |
| **Please detail** |  | | | |
| **Is it accompanied by recurrent thoughts, impulses, images or behaviour?** | Yes  No | | | |
| **Is it accompanied by physical symptoms?**  **(sweating, palpitations, trembling, dizziness etc)** | Yes  No | | | |
| **Do these symptoms come on quickly?** | Yes  No | | | |
| **Do these problems relate to a past traumatic event?** | Yes  No | | | |
| **Do you think your fear is excessive or unreasonable?** | Yes  No | | | |
| **Do you find it difficult to control these feelings?** | Yes  No | | | |

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| **Previous treatment / medication** | |
| **Has the patient suffered from any similar symptoms in the past?** | Yes  No |
| **If so, has the patient sought treatment for those symptoms?** | Yes  No |
| **If yes, please detail** |  |
| **Does the patient feel that treatment was beneficial?** | Yes  No |
| **Has the patient previously taken any medication?** | Yes  No |
| **Is the patient currently taking any medication?** | Yes  No |
| **If yes, please detail** |  |

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| **Provisional Diagnosis** | |
| **Depression** |  |
| **Generalised Anxiety Disorder** |  |
| **Social phobia** |  |
| **Specific phobia** |  |
| **Obsessive Compulsive Disorder** |  |
| **Health Anxiety (Hypochondriasis)** |  |
| **Post-Traumatic Stress Disorder** |  |
| **Agoraphobia** |  |
| **Panic Disorder** |  |

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| **Recommendation** | |
| **Which Care Pathway do you recommend?**  (please refer to the Telephone Assessment Guidance Notes) | Step 1  Step 2  Step 3  Step 4 |
| **Do you recommend Vocational Rehabilitation intervention?** | Yes  No |

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| **Additional information** |
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Signed………………………………………………………. Date…………………………………………………………

Print name………………………………………………..