Alberta Health Services

Addiction and Mental Health Assessment

Important - Form is used for regular and downtime use.
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Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN / MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown	

Patient Demographics

Admission Date *(dd-Mon-yyyy)*	Patient Preferred Phone	Patient Alternate Phone
Admission Time *(hh:mm)*	Patient Address	
Mode of Transportation ☐ N/A	Observation Level on Admission ☐ N/A	
Admitting Physician	Attending Psychiatrist/Physician	Community Therapist ☐ N/A

1st Admission Certificate ☐ Yes ☐ No ☐ N/A	**2nd Admission Certificate** ☐ Yes ☐ No ☐ N/A
Date *(dd-Mon-yyyy)*	Date *(dd-Mon-yyyy)*
Time *(hh:mm)*	Time *(hh:mm)*
Expiration Date *(dd-Mon-yyyy)*	Expiration Date *(dd-Mon-yyyy)*

☐ Notification of Certification ☐ N/A ☐ Declined
Date *(dd-Mon-yyyy)* _____

Comments

Co-Decision Makers	Yes	No	In progress	On Chart	Release of Info
Goals of Care	☐	☐	☐	☐	☐
Personal Directive	☐	☐	☐	☐	☐
Guardianship in Place	☐	☐	☐	☐	☐
Trustee in Place	☐	☐	☐	☐	☐
Community Treatment Order	☐	☐	☐	☐	☐
PDD in Place	☐	☐	☐	☐	☐

☐ Service orientation provided to patient
☐ Patient informed of ***status*** and observation

Comments

Physical Description

Skin Colour	Hair Colour	Eye Colour	***Height*** ☐ cm ☐ in	***Weight*** ☐ kg ☐ lbs	Stature/Build

Other Distinguishing Characteristics *(e.g. scars, tattoos, piercings)*

Primary Language	**Aids / Activities of Daily Living** ☐ Not Applicable
☐ English ☐ Other *(specify)* _____ If other, are there language barrier issues ☐ Yes ☐ No	☐ Mobility issues ☐ Hearing issues ☐ Wheelchair ☐ Walker ☐ Cane ☐ Dentures ► ☐ Full ☐ Partial ☐ Top ☐ Bottom ☐ Vision issues ► ☐ Glasses ☐ Contact Lens
Comments	Comments

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Patient Demographics Continued

Education	**Employment**
Highest level of education completed	Employed ☐ Yes *(specify)* _____ ☐ No
☐ History of learning difficulties ☐ Difficulty with reading	☐ Other source of income *(specify)* _____

Marital/Family Status

☐ Children ► Number of children _____ Ages _____ ☐ Pets at home ► Number of pets _____ ☐ Dependents *(specify)* _____	☐ Married ☐ Common-Law ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

If checked above, is care in place for the children, pets and or dependents?
☐ Yes *(specify)* _____
☐ No

Comments *(Include information related to Children's Services involvement, custody issues, etc.)*

Emergency/Alternate Contact Details

Name of Emergency Contact	Relationship	Phone	☐ Consent provided ☐ Declined to provide ☐ Unable to provide
Name of Alternate Caregiver	Relationship	Phone	☐ Consent provided ☐ Declined to provide ☐ Unable to provide
Other Supports *(Guardian, Trustee, Next of Kin, etc.)*	Relationship	Phone	☐ Consent provided ☐ Declined to provide ☐ Unable to provide

Community Contact Details ☐

Name of Family Physician	Phone
Name of Psychiatrist *(If known)*	Phone
Name of Therapist/Counselor	Phone
Other	Phone

Referral Source ☐ N/A

☐ Self ☐ Significant Other ☐ Educational Facility	☐ Physician/Psychiatrist ☐ Hospital ☐ Community/Outpatient	Reason for Referral

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Presenting & Past Problems

Presenting Problem/Complaint ☐ complete-see Pt record

(Describe presenting concern, events leading up to the concern, current stressors, involvement in treatment, etc.)

Psychiatric History ☐ complete-see Pt record

(Describe history of hospitalizations/treatment, past response to therapeutic interventions, etc.)

Collateral/Other Information ☐ complete-see Pt record

(Supporting information regarding recent presentation and/or past history/current issues)

Past Primary Risk/Propensities *(Select **ALL** appropriate factors based on the patient's presenting complaint, psychiatric history, collateral/other information)*

- ☐ Addiction
- ☐ Aggression
- ☐ Cognition Limitations
- ☐ Command Hallucination
- ☐ Elopement/AWOL
- ☐ Personal/Financial Crisis
- ☐ Family History of Mental Illness/suicide
- ☐ History of Wandering
- ☐ Homicide
- ☐ Impulsiveness
- ☐ Legal Issues
- ☐ Medical Issues
- ☐ Suicide
- ☐ History of Leaving Against Medical Advice *(AMA)*
- ☐ Poor Insight/Judgment
- ☐ Post-Partum Depression
- ☐ Psychosis
- ☐ Recent Loss
- ☐ Self-harm
- ☐ Other *(specify)* _____

Comments

Name	Signature	Date *(dd-Mon-yyyy)*	Time *(hh:mm)*

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Mental Status

Appearance *(Check all that apply)*

Grooming
- ☐ Appropriate Dress
- ☐ Neat/Clean
- ☐ Poor Hygiene
- ☐ Unkempt

Manner
- ☐ Cooperative
- ☐ Pleasant
- ☐ Angry
- ☐ Guarded
- ☐ Seductive
- ☐ Suspicious

Alertness *(choose one)*
- ☐ Alert
- ☐ Confused
- ☐ Drowsy

Attentiveness to Interviewer
- ☐ Engaged
- ☐ Eye Contact
- ☐ Disinterested
- ☐ Distractible

Looks Stated Age
- ☐ Yes
- ☐ No

Describe/Summarize

Psychomotor Behavior *(Check all that apply)*

- ☐ Relaxed
- ☐ Agitated
- ☐ Compulsive
- ☐ Hyper vigilant
- ☐ Pacing
- ☐ Responding to unseen/ unheard stimuli
- ☐ Restless
- ☐ Retardation
- ☐ Rocking

Unusual Movements
- ☐ No
- ☐ Yes

specify,_____

_____

_____

Gait
- ☐ Smooth/Regular
- ☐ Limping
- ☐ Rhythmic
- ☐ Shuffling
- ☐ Symmetric

☐ Other *(specify)* _____

Describe/Summarize

Speech *(Check all that apply)*

Rate
- ☐ Appropriate
- ☐ Hesitation
- ☐ Long Pauses
- ☐ Pressured
- ☐ Rapid
- ☐ Slow

Rhythm
- ☐ Appropriate
- ☐ Monotonous
- ☐ Stuttering

Amount
- ☐ Appropriate
- ☐ Excessive
- ☐ Monosyllabic
- ☐ Mute

Articulation
- ☐ Appropriate
- ☐ Mumbled
- ☐ Slurred

Volume *(choose one)*
- ☐ Appropriate
- ☐ Loud
- ☐ Soft
- ☐ Whispered

Describe/Summarize

Mood/Affect *(Check all that apply)*

Stability
- ☐ Stable
- ☐ Fixed
- ☐ Labile

Range of Affect
- ☐ Restricted
- ☐ Broad

Intensity
- ☐ Appropriate
- ☐ Ambivalent
- ☐ Exaggerated

Congruency
- ☐ Congruent
- ☐ Incongruent

Affect
- ☐ Appropriate
- ☐ Anxious
- ☐ Blunted
- ☐ Bright
- ☐ Depressed
- ☐ Elated
- ☐ Euphoric
- ☐ Euthymia
- ☐ Flat
- ☐ Guilt/Shame
- ☐ Hostile
- ☐ Irritable
- ☐ Sad
- ☐ Tearful

Rate Mood *(Scale 1-10. 10 - best ever)* _____

Describe/Summarize

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Mental Status Continued

Perception *(Check all that apply)*

Perceptual Disturbances
- ☐ None noted
- ☐ Déjà vu
- ☐ Depersonalization
- ☐ Illusions
- ☐ Delusional
- ☐ Paranoid

Hallucinations
- ☐ None noted
- ☐ Auditory
- ☐ Command
- ☐ Gustatory
- ☐ Olfactory
- ☐ Tactile
- ☐ Visual

Describe/Summarize

Thought Content *(Check all that apply)*

- ☐ Appropriate
- ☐ Abstract
- ☐ Compulsions
- ☐ Concrete
- ☐ Delusional
- ☐ Grandiose
- ☐ Homicidal Ideations
- ☐ Hypochondriacal
- ☐ Obsessions
- ☐ Paranoid
- ☐ Persecutory
- ☐ Phobias
- ☐ Suicidal Ideations

Describe/Summarize

Vegetative Symptoms *(Choose One)*

Appetite
- ☐ No Change
- ☐ Decreased
- ☐ Increased

Duration of change _____

Motivation
- ☐ No Change
- ☐ Decreased
- ☐ Increased

Duration of change _____

Sleep
- ☐ No Change
- ☐ Early awakening
- ☐ Initial Insomnia
- ☐ Insomnia
- ☐ Interrupted
- ☐ Oversleeping

Duration of change _____

Weight
- ☐ No Change
- ☐ Decreased
- ☐ Increased

Duration of change _____

Amount of change _____

Energy
- ☐ No Change
- ☐ Decreased
- ☐ Increased

Duration of change _____

Concentration
- ☐ No Change
- ☐ Decreased
- ☐ Increased

Duration of change _____

Describe/Summarize

Thought Process *(Check all that apply)*

Stream *(Check all that apply)*
- ☐ Goal Oriented
- ☐ Organized
- ☐ Relevant
- ☐ Blocking
- ☐ Circumstantial
- ☐ Confabulation
- ☐ Confused
- ☐ Ideas of Reference
- ☐ Loose Association
- ☐ Perseveration
- ☐ Neologism
- ☐ Tangential
- ☐ Vague

Logic *(choose one)*
- ☐ Logical
- ☐ Illogical

Describe/Summarize

Insight/Judgement *(Check all that apply)*

Insight
- ☐ Poor
- ☐ Fair
- ☐ Good

Judgement
- ☐ Poor
- ☐ Fair
- ☐ Good

Describe/Summarize

Alberta Health Services

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Mental Status Continued

Cognition

Orientation	Written Comprehension	Memory	Verbal Comprehension
☐ Confused	☐ Appropriate	☐ Intact	☐ Appropriate
☐ Oriented	☐ Impaired	☐ Impaired	☐ Impaired

☐ Person
☐ Place
☐ Time

☐ Recent
☐ Remote
☐ Immediate

Cognitive Screen(s) Completed:
☐ SCIP ☐ SLUMS ☐ ACE-III ☐ RUDAS ☐ CogLog ☐ Oxford ☐ Other
Complete each tool's respective Flowsheet to document results when applicable.
For more information to support your clinical decision making regarding cognitive screening tool selection, see the Cognitive Screening webpage.

Other cognitive Screener(s) used *(specify)*

Name	Signature	Date *(dd-Mon-yyyy)*	Time *(hh:mm)*

Suicide Risk Assessment

Overall Risk of Suicide

All patients require a suicide risk screening.

☐ Completed *Once complete, record the identified level of risk below* ☐ Incomplete

☐ **High/Imminent** ☐ **Moderate** ☐ **Low**

Comments

Victim of Domestic Violence Assessmemt

Question	Yes	No
Is there a prior history or current concern of domestic violence *(physical, emotional, sexual, financial and/or neglect)* towards the patient and/or their children? ☐ Declined to provide information		

► If yes, describe:

► If yes and the abuse is current, how is the patient addressing safety for self, children and/or any dependents in the home? *(i.e. is there a safety plan or other measures in place?).*

► If yes, does the patient have or require connection with counseling, a shelter or social support services? *(If required, refer or provide resource)*.

Comments

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Aggression/Violence Risk Assessment

Question	Yes	No
Does the patient have a known prior history of aggression and/or violence towards others?	☐	☐
► If yes, is the aggression/violence directed at any one in particular? ☐ Declined to provide information	☐	☐

Based on the assessment thus far, check all the appropriate risk factors

☐ Attacking objects	☐ Boisterous	Comments
☐ Confusion	☐ History of violence	
☐ Irritable	☐ Physically threatening	
☐ Verbally threatening		

Overall Risk of Aggression/Violence *(The criteria below is just a guide - the level should be based primarily on best clinical judgment and does not require matching all elements of the criteria listed below)*

☐ **High/Imminent**	☐ **Moderate**	☐ **Low**
■ extremely aggressive	■ aggressive	■ non-aggressive
■ evidence of impaired self-control	■ some evidence of impaired self-control	■ good self-control
■ multiple risk factors present	■ some risk factors present	■ few risk factors

Comments

Homicide Risk Assessment

Has the patient ever had thoughts of killing anyone else? ☐ Declined to provide information
☐ Yes - continue with the assessment below
☐ No - move onto the next assessment

Question	Yes	No
Specify the target(s) of the homicidal thoughts:		
How often does the patient have thoughts of homicide?		
Do these thoughts intrude on their daily activity?	☐	☐
Ask the patient to rate the intensity of these thoughts on a scale of 1 to 5 *(5 - most intense)*		
Has the patient ever taken action in regards to these intrusive thoughts? Either positively *(sought help)* or negatively *(made a plan to harm or kill others)*.	☐	☐
Has the patient ever made a plan to commit homicide?	☐	☐
► If yes, describe details of the plan:		
Does the patient have access to the means to follow through with their plan to commit homicide? *(e.g. access to guns or other weapons)*	☐	☐
What has prevented the patient in the past from following through with their plans to commit homicide?		
Comments		

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Addiction and Mental Health Assessment

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Concurrent Disorders Assessment

Does the patient use substances *(alcohol, illegal or prescription drugs and/or tobacco)* **or gamble?**

☐ Yes - continue with the assessment below

☐ No - move onto the next assessment ☐ Declined to provide information

Question	Yes	No
Does the patient have concerns about their use of substances/gambling or other process addictions?	☐	☐
Has anyone ever suggested to the patient to get help for their substance use/gambling or other process addictions?	☐	☐
Has the patient's use of substances/gambling/identified addiction interfered with any major areas of their life, family, work, health etc.?	☐	☐
Has the patient ever participated in an addictions treatment program or concurrent disorder groups?	☐	☐
Is the patient interested in participating in an addictions program or concurrent disorder group?	☐	☐
When was the last time the patient has used substances or gambled? Date *(dd-Mon-yyyy)* _____ Time *(hh:mm)* _____		
Does the patient have a history of suffering from withdrawal symptoms *(e.g. seizures)*?	☐	☐

Describe the types of substances and/or types of process addiction *(i.e. gambling)* including details related to frequency, method of administration *(e.g. Alcohol-based hand rub, illicit substances, alcohol, etc.)* and quantity.

Comments

Brief Trauma History

Question ☐ Declined to provide information ☐ Not assessed, move onto the next assessment	Yes	No
Has the patient been a victim of physical, sexual and/or emotional abuse?	☐	☐
► If yes, the abuse is related to ☐ Physical ☐ Sexual ☐ Emotional ☐ Other _____		
► If yes, does this abuse continue to affect them emotionally?	☐	☐
Has the patient experienced any other type of traumatic event *(e.g. accident, witnessed death, recently diagnosed with a Terminal or Life Threatening Illnessmilitary service, fire, flood and/or sudden loss)* which is currently effecting them emotionally?	☐	☐
► If yes, specify:		

Comments

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Elopement Risk Assessment

Based on the assessment thus far, check all the appropriate risk factors related to elopement risk

- ☐ Cognitive impairment
- ☐ Cravings related to substances *(nicotine, drugs, alcohol)*
- ☐ History of leaving against medical advice (AMA)
- ☐ History of wandering/elopement
- ☐ Impaired insight/judgement
- ☐ Issues with being admitted
- ☐ Legal issues
- ☐ Mental illness diagnosis
- ☐ Responsibilities at home/work
- ☐ Restless/easily agitated

Comments

Overall Risk of Elopement *(The criteria below is just a guide - the level should be based primarily on best clinical judgment and does not require matching all elements of the criteria listed below)*

☐ High/Imminent
- frequent occurrences of prior elopement /wandering
- significant cognitive impairment
- significant cravings
- responsibilities at home/work
- high restlessness, etc
- history of premeditated elopement/leaving against medical advice (AMA)
- high impulsive behavior
- multiple risk factors present

☐ Moderate
- occasional occurrences of prior elopement/wandering/AMA
- moderate cognitive impairment
- moderate cravings
- some pressing responsibilities at home/work
- restlessness present
- some impulsive behavior
- some risk factors present

☐ Low
- no known history of elopement /wandering/AMA
- no evidence of cognitive impairment
- no known cravings
- no pressing responsibilities at home/work
- no visible signs of restlessness
- few risk factors present

Comments

For High/Imminent and Moderate Elopement Risk Only

Rate patient's level of risk of harm to themselves *(intentional or unintentional)*, if they were to elope *(Refer to Suicide Risk Assessment p.2A)*

☐ High/Imminent ☐ Moderate ☐ Low

Rate patient's level of risk of harm to others, if they were to elope *(Aggression/Violence Assessment and Homicidal Assessment p.4A)*

☐ High/Imminent ☐ Moderate ☐ Low

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Falls Risk

Falls Risk Screening

Was a **full** falls assessment completed upon admission?
☐ Yes - move onto *Overall Risk of Falls* section
☐ No - continue with the assessment below

Question	Yes	No
In the past 12 months has the patient fallen *(including a slip or trip)* where they lost their balance and ended up on a lower level?	☐	☐
► If yes, has this happened more than once in the past 12 months	☐	☐
► If yes, how many times?		
► If yes, was the patient hurt when they fell?	☐	☐
► If yes, describe their injuries:		

Has the patient experienced **more than one** injurious fall in the past 12 months?
☐ Yes - continue with the assessment below ▼
☐ No - move onto Overall Risk of Falls section

Falls Risk Assessment

■ A full falls risk assessment is required *(i.e. Schmid Falls Risk Assessment Tool, form # 103511)*

What are the results of the assessment? *(i.e. the SCHMID score)*

Is the completed falls risk assessment attached? ☐ Yes ☐ No

Overall Risk of Falls

☐ **High/Imminent** ☐ **Moderate** ☐ **Low**

Comments

Safety Plan

Has the patient been identified as a **High/Imminent or Moderate** level of risk in **1 or more** of the above assessments?

☐ **Yes** - must update/complete a new Safety Plan *(form # 19367)* for each identified risk factor

► If yes, specify
- ☐ Suicide ► ☐ attached
- ☐ Aggression/Violence ► ☐ attached
- ☐ Elopement ► ☐ attached
- ☐ Falls ► ☐ attached
- ☐ Other _____ ► ☐ attached

☐ **No** - move onto the Medications and Medical Conditions section

Comments

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Medications and Medical Conditions

Medications

☐ Complete - see Pt record

For a complete list of current medications refer to the MedRec form *(inclusive of Best Possible Medication History)*

Comments

Medical Conditions/Issues

Has a Physical Health Assessment been completed?
☐ Yes - see patient record
☐ No

Summarize all medical conditions or issues *(inclusive of extrapyramidal symptoms and seizures)*

☐ Acute Pain *(Describe Location, duration, intensity, date of injury, etc.)*

☐ Chronic Pain *(Describe Location, duration, intensity, date of injury, etc.)*

Allergies/Sensitivities

☐ Complete - see Pt record

Does the patient have any allergies/sensitivities?
☐ Yes - complete questions below ▼
☐ No - move onto Vital Signs section

List all allergies/sensitivities	Specify type of reactions *(e.g. hives, anaphylaxis)*

Comments

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Medications and Medical Conditions Continued

Vital Signs ☐ Complete - see Pt record

Temp	Pulse	Respirations	Blood Pressure	SpO_2

Additional Medical Information

Question	**Yes**	**No**
Does the patient require oxygen?		
► If yes, specify rate		
Does the patient have any skin integrity issues		
► If yes, does the patient require wound care?		

► If yes, specify:

location	
type	
size *(length, width, depth)*	
color of surrounding tissue	
exudate *(amount, color)*	

► If yes, has a BRADEN Scale *(form # 02134)* been completed?
☐ Attached

Is the patient Diabetic?
☐ Yes - complete questions below ▼
☐ No - move onto next section

☐ Type 1 ☐ Type 2 Insulin dependent ☐ Yes ☐ No	Frequency of Blood Glucose Monitoring	Most Recent Blood Glucose Result *(mmol/L)*	Result Date *(dd-Mon-yyyy)*	Result Time *(hh:mm)*

Comments

Female Patients Only

Currently ***Pregnant*** ☐ Yes ☐ No	Given birth in the last 12 months ☐ Yes ☐ No	Date of last menstrual cycle *(dd-Mon-yyyy)*

Name	Signature	Date *(dd-Mon-yyyy)*	Time *(hh:mm)*

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Additional Information

Question	Yes	No
Has there been a change in family composition in the last 12 months?	☐	☐
► If yes, describe changes:		
Does the patient relate to a specific ethnic / cultural group?	☐	☐
► If yes, specify:		
Does the patient have any religious affiliations?	☐	☐
► If yes, specify:		
Does the patient have any unique food restrictions / requirements either related to food allergies or religion?	☐	☐
► If yes, specify:		
Does the patient have any non-food related cultural or religious requirements	☐	☐
► If yes, specify:		

Client Goals for Treatment

☐ N/A
☐ See Treatment Plan

Disposition/Summary

Name	Signature	Date *(dd-Mon-yyyy)*	Time *(hh:mm)*