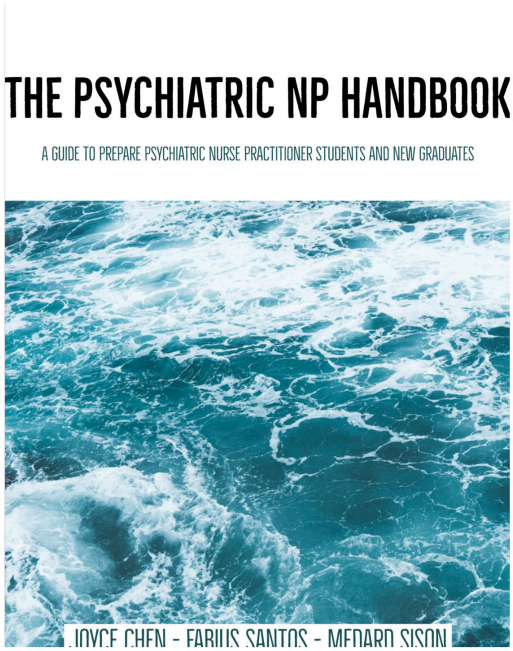


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volunteer groups that we are a member of. Our thoughts and opinions may change from time to time, as it is critical to stay current with the literature to be informed. The information provided in this guide or from our group should not be used as main resource, but used as a tool. Please always utilize current evidence-based practices as main resource. Our information and writings should not be construed as medical advice.

INTERVIEW & DOCUMENTATION

As a PMHNP, the interview and subsequent documentation that you do are two of the most important jobs that you perform for a variety of reasons. The interview is where you conduct your assessment of the patient, whether it be in an initial visit, or the follow-up. The questions that you ask during your interview are what guide you to diagnose, and then prescribe medications for the patient. By knowing the components of the psychiatric evaluation and which questions to ask, it can help you conduct a smooth interview and help elicit telling information that you might not otherwise obtain.

On the other hand, the documentation is important as it is the legal record that illustrates what care you are providing for a patient. It is important to document the information you have obtained during your interview as accurately as possible for a variety of reasons: another provider taking over your patient's care, to refresh your own memory, or to protect yourself in case of lawsuit or litigation. Always remember, your documentation is your final defense in legally protecting yourself.

As such, this section has melded both explanations for the interview and the documentation together. Without knowing what needs to be documented, you will not know which questions to ask. Likewise, conducting a thorough interview will give you the information needed to write a comprehensive note. This section contains explanations of all the different components of the psychiatric evaluation, for both initial and follow-up notes. There are also notes on what kind of questions to ask your patient in order to strengthen your documentation and treatment plan.

Finally, an initial and follow-up template have been included in this section, as well as a sample note so you can really see what is expected in your notes. (Please note that there are also differences in charting based on what

setting you are in. A county-based program will typically require significantly more charting than a private practice setting due to specific county requirements, for instance. The sample note will cover a generic outpatient clinic visit.)

INITIAL PSYCHIATRIC INTERVIEW

The initial psychiatric note is more in-depth than follow-up notes and provides more historical information that you can refer back to in subsequent sessions. Typical initial evaluations can take between 30 minutes to 2 hours, depending on your practice setting. While your individual practice setting's documentation requirements may vary slightly, the following are a list and explanation of the most vital components to add in your initial psychiatric evaluation:

Patient Identification: The patient identifier includes the patient's demographics (age, race, gender) and is typically found at the beginning of the note. This allows any other provider (or even yourself) to have a glimpse of the patient you are about to see and what special considerations that population might require. You might include things like sexual orientation or mixed race details if that is relevant to their symptomology/diagnosis. Your documentation should reflect ethical/cultural/religious considerations and it starts from the beginning of your note.

Chief Complaint: The chief complaint is found at the beginning of the note and this is always a quote that the patient provides as to what their understanding of their visit is and what symptoms they want to address. Typical chief complaints might include quotes such as the following: "I'm okay", "I'm very depressed", "I'm hearing voices", etc. The chief complaint gives you a clue as to how the rest of the session will go.

History of Present Illness: The history of present illness is essentially a short synopsis of the patient's symptomology, including its duration and impact to the patient. Here is where you put how or why they came to be assessed by you, whether or not they were referred by their PCP, or brought themselves in due to exacerbation in symptoms. It is helpful if you can put specific details, including age of onset, dates/duration of previous hospitalizations or treatment and why. If you perform diagnostic testing you can also put the results here. Typical tests include PQH-9, MDQ, SPMSQ, among others.

The purpose of the history of present illness is to inform you and anyone following this patient after you of this patient's history and any relevant treatments or triggers. This information is very valuable as oftentimes the patient may forget (or choose not to disclose) particular items which can help inform the course of treatment. Initial diagnostic testing included here can help inform you how severe and in what capacity the symptoms impact the patient. You can measure the patient's progress by providing diagnostic testing periodically throughout their treatment and comparing to the initial findings that you obtain during the initial psychiatric evaluation.

Subjective: The subjective note is the patient's interpretation of their symptoms and how much it impairs their life. It is important to note that even if their presentation is totally different from their self-report (eg they deny any hallucinations yet are actively responding), you document their responses and behavior objectively. There will be another section where you can document your professional interpretation of their presentation. You may use direct quotes from the patient, particularly if they say something memorable that informs their disease process. In the subjective, you should always include the following patient's responses: sleep, appetite, SI/HI/ AVH. It should also speak to any other symptoms that may not necessarily reflect your patient's symptomology, but should also be ruled out. For instance, if a patient clearly has MDD, your note should still speak to the fact that you have assessed the patient for and ruled out psychosis or mania. Most of the subjective information captured during the initial intake is then moved to the "History of Present Illness" note in subsequent follow-up documentation.

Past Psychiatric History: Most of the past psychiatric history is self-explanatory but there are a few points that should be taken into consideration. When asking about previous hospitalizations, try to obtain as much specific information as possible, including what were the circumstances leading to hospitalization, were they placed on a hold, how long they were hospitalized. It is important to ask similar questions for both suicide attempts and self-harm behavior.

- "When and how did you try to hurt yourself?"
- "What were the circumstances around these attempts?" (Drugs, relationship/financial stressors, mental illness exacerbation are common answers).
- "What stopped you from carrying out your attempt? What stops you now from acting on these urges?"

While it may be uncomfortable to ask these questions for both you and the patient, remind the patient that these answers will help you be able to tailor a better treatment plan as you will be cognizant of their triggers and what protective factors they may have. You can use this as an opportunity to discuss a safety plan should they feel an urge to hurt themself in any capacity. Finally, it is important to find out what medications they have trialed before. Unfortunately the reality is by the time your patient reaches you, chances are they have had numerous interactions with other mental-health professionals. Here is your opportunity to ask the patient which medications did they like? Which did they hate? And why? This is a great way to build rapport and trust with the patient, and by referring to this list in future sessions you can prevent the patient from trialing medications that are unlikely to be helpful, and maybe even harmful.

Substance Use: During the initial psychiatric assessment you will document historical substance use, not just the most current. Follow-up notes will likely include just the patient's most recent drug use, unless they have significant substance use history in which case you may find it helpful to leave historical information. As a note, you should ask the patient about each substance by name, not just "have you done any drugs?" because likely the patient will mis-report either due to not remembering or declining to report. It is much more illuminating to ask about specific drugs. Another helpful hint is to ask about drugs with specific questions, as oftentimes patients will deny drug use even if you ask by name directly. In order to circumvent this, it is helpful to ask specific questions.

- "When was the last time you smoked marijuana?"
- "When was the first time you drank alcohol?"
- "Have you ever needed to detox or go to rehab?"
- "What's your longest sobriety? What helps keep you sober?"

Patients will generally be much more forthcoming this way. For every positive drug interaction, it is helpful to know when they started, how often they use, what method they use, how much they use, and when the last time they used was.

This information is helpful for a variety of reasons-- it helps you understand how serious their drug use is, if there is any addiction, if any education needs to be provided (the answer is almost always yes!), and you can track their usage throughout the course of their treatment to see if it increases or decreases at all. If a patient has an increase in symptomology it is often helpful to ask about their current substance use as that can often be a

trigger and can be another educational opportunity. Finally, if a patient does have a history of substance use, it is useful to ask if the patient has ever had withdrawals, or has been to detox/rehab, and if so, if they completed their treatment. Ask if they have ever had periods of sobriety, and if so, how long and how they accomplished it. Ask what caused them to relapse. This information will help you as the prescriber tailor their treatment plan and watch out for triggers that may cause them to relapse, or it can help you suggest different treatment interventions if they were helpful before. If currently sober, it is helpful to document a sobriety date. Many who go through substance abuse programs will wear their sobriety date as a badge of pride and so documenting this and celebrating their anniversaries can be another avenue of building rapport and trust.

Past Medical History: The Past Medical History is important to document accurately what potential comorbid diagnoses/treatments that the patient has as this may impact what medication management you recommend. When documenting allergies, it is helpful to document what specific kind of reaction they have from their allergy, as sometimes their self-reported allergy may actually be a side-effect or a misunderstanding by the patient. As a healthcare provider, we should always try to encourage the patient to see their PCP on an annual basis, and obtain regular checkups. If your patient has not seen their PCP in some time, this can be used as another educational opportunity. The frequency that you ask for labs will vary by patient but generally all patients should have regular labwork done/recorded annually regardless of what medication they are taking, if any. This is also part of your metabolic monitoring for the patient. This is your opportunity to set that baseline expectation with the patient and can be used as a way to gauge the patient's ability to be treatment compliant in the future. Finally, it is important to gather an accurate and specific list as to what other medications or OTC treatments they are taking, including dosages, frequency, and indication. This is important as some medications may interact with psychotropic medications and so require careful monitoring and adjustment as necessary.

**The Birth/Milestones section does not have to be included if you are only treating adults. If you are treating children/adolescents, this information can be helpful particularly if your patient is autistic or on the spectrum to see exactly where their deficiencies lie and at what age-level they function at.*

AIMS Test: While your facility may not require the AIMS test yet, this is quickly becoming the new standard as treatments for tardive dyskinesia are becoming more mainstream. AIMS test should be conducted upon initial assessment, especially if the patient is coming to you already on an antipsychotic.

Vital Signs: Vital signs should be obtained every session as many psychotropic medications may potentially affect blood pressure/pulse.

Height/Weight: Height should be obtained on initial assessment. For children, height should be obtained every visit, particularly if the patient is on a stimulant medication due to potential height suppression. Weight should be obtained on every visit as this is part of regular metabolic monitoring for patients, which is important particularly if they are on an antipsychotic medication. Antipsychotic medications are notorious for potentially causing metabolic syndrome, so it is up to the practitioner's due diligence to monitor and intervene early should this be the case.

Family History: The Family History should include both medical and psychiatric past family history. It is helpful to ask the patient specific questions, rather than "Do you have any family history?" as very often the patient will deny any family history, yet upon closer assessment it turns out they do in fact do have a significant family history. Asking specifically if they have any family of cancer, diabetes, or heart conditions can lead to very informative responses. For mental health family history, try to obtain any previous medication trialed by these family members as very often what works for one family member will also work for that patient. Also document whether anyone in the family has attempted suicide, as that puts your patient at higher risk for the same. For any positive responses, ensure to document the family relation to the patient (maternal/paternal) as this can help you form a diagnosis and determine the severity of symptoms.

Psychosocial History: The Psychosocial History is where you document the patient's history starting from where they were born til the present. This information can be very telling as it informs if their mental illness has prevented them from making or keeping meaningful relationships or completing milestones including employment or education. By having them describe their childhood you can get a picture if they have any previous trauma that may help inform their current presentation. Asking about their current living situation can help identify supportive persons, if any. If they

have been homeless, it is helpful to understand what caused them to become homeless, how long they have been homeless, and what steps they have tried to take to obtain housing. While you may not be able to help, you can help link them to housing programs or social workers that can help guide them further. Remember, risk of homelessness drastically reduces treatment compliance, so it is in your best interest to give the patient the best chance for success through a variety of means including stable housing. If they never completed school, it is elucidating to ask why.

- "Do you have a learning disability? Have you ever had an IEP or had special needs classes?"
- "Did you have to support your family?
- "If you have never had a job or are in between jobs, why?"
- "Does your mental illness prevent you from working?"
- "Have you been fired for difficulty getting along with others?"

All of these answers can help inform how severe the patient's symptoms impact their lives, as well as tell you what the patient's motivations are. If the patient is unable to get a job due to their inability to concentrate or focus, but once stabilized on medication is able to hold a job for a year, that shows you that the treatment has been effective.

Review of Systems: Although the patient is seeing you for psychiatric-mental health services, as healthcare providers, it is our duty to also screen the patient for any physical symptoms that may be contributing to their symptomology. If they are positive, you can refer them back to their PCP or other healthcare provider. Only by working collaboratively with the healthcare team can the patient achieve total wellness.

Mental Status Exam: The Mental Status Exam is your descriptor of how the patient is presenting during the session. In this section you describe how the patient looks to you, from the clothes that they wear, to their hygiene, to their thought process and cognition. This is a way for you to describe objectively whether or not they are exhibiting symptoms of their disease process.

Diagnosis: The DSM-V took away the Diagnosis Axis categories, and there is now only a diagnosis. You may still hear people refer to the different axises colloquially (specifically Axis II personality disorders) but legally you do not need to include them. You do however need to include a diagnosis. If

you are unsure about what diagnosis to put, you may use diagnoses like “unspecified mood disorder” or “psychotic disorder, not otherwise specified”. It is important to include a diagnosis otherwise insurance will not pay-- after all, what are you treating them for then?

Assessment: The assessment is your time to write your interpretation of the member’s progress (good response, moderate response, fair response, poor response, etc) and what medication/ treatment interventions you will enact as a result.

- **Stable patient example:** “Patient reports good response to current medication regimen. Continue all medication as is.”
- **Unstable patient example:** “Patient reports poor response to current medication regimen, having breakthrough psychosis, residual anxiety. Add Haldol PRN to target breakthrough psychosis and increase Buspar to better target long-term anxiety management.”

It is important to note that even if the patient reports they are doing well (which you document under the “subjective” note), the “assessment” note should reflect your professional assessment of their presentation. This is also where you can specify if you are ordering labs, or sending the patient out for a referral, with rationale.

Risk Assessment: The Risk Assessment is legally important as this is where you document the patient’s acuity level and what protective factors or triggers that they have, and what interventions you have done to screen/protect them. If you deem the patient at higher risk, it is important to document not only why, but what interventions you are performing to address it. If you do deem the patient at higher risk, it is also important to document whether or not the patient meets criteria for a legal hold. If you let the patient out of your clinic without placing them on a hold although higher risk, you need to document the rationale for that otherwise should something happen, it could be seen as negligence on your part.

- **Stable patient example:** “Patient does not currently meet criteria for DTS, DTO, GD as not actively suicidal, homicidal, and has the ability to care for self, has stable housing, is willing to seek treatment.”
- **Unstable patient example:** “Will increase monitoring and have the patient return to clinic in 2 weeks” or “Discussed case with treatment team who will reach out to patient this week and assess for further decompensation”.

Plan: The plan is typically from a template form which you can ask for from your peers or clinic, as the information largely does not change every visit. In general, the plan should include the medication you are prescribing (including dosages and frequency), collaboration with a PCP, education provided on the medication and consent given to prescribe. It should also include any other interventions you have performed during the session, including psychotherapy or referrals. Finally, it should include when the patient should return to the clinic and what sort of follow-up care to expect.

INITIAL PSYCHIATRIC INTERVIEW TEMPLATE

Patient Identification: The patient is a ___ year-old, Caucasian male, presented alone to the office.

Chief Complaint: “I’m okay”

History of Present Illness: On initial evaluation, the patient reports ___.

Subjective: Patient eats and sleeps well. Denies any SI/HI/AVH, able to verbalize safety plan. Denies hx hypomania/mania, psychosis, PTSD, OCD, eating disorder, or conduct disorder.

Past Psychiatric History:
Prior Psychiatric Diagnosis:
Prior Hospitalizations: No
Prior Suicide Attempts: No
Episodes of Self-Harm: No
Previous Medication Trials:

Substance Use:
Tobacco: Denies
ETOH: Denies
Illicit drugs: Denies
Caffeine: Denies

AIMS:

Vital Signs: