

Your
Hospital's
Logo
Here

PATIENT IDENTIFICATION

Integrated Biopsychosocial Summary

Psychiatric Unit

Section I: Diagnostic Impression / Indications for Hospitalization

Axis I

Axis II

Axis III

Axis IV

Axis V

Estimated Length of Stay

Current Problems - Indications for Hospitalization

<input type="checkbox"/> Evidence of current suicidal thinking, planning or attempt	<input type="checkbox"/> Danger to others (e.g., thought, threat, aggressive attempt)	<input type="checkbox"/> Inability to function outside of hospital	<input type="checkbox"/> Rapidly deteriorating psychiatric condition which fails to respond to outpatient treatment.
<input type="checkbox"/> Regression that needs to be treated in a hospital	<input type="checkbox"/> Need for continuous skilled observation of response to a newly initiated drug regimen	<input type="checkbox"/> Comprehensive therapy requiring close observation because of concomitant medical condition.	<input type="checkbox"/> Drug or alcohol abuse requiring detoxification and rehabilitation
<input type="checkbox"/> Severe withdrawal risk	<input type="checkbox"/> Unable to control use in less intensive treatment setting	<input type="checkbox"/> Severe withdrawal risk, can be managed in outpatient setting	<input type="checkbox"/> Resistance high enough to require structured program
<input type="checkbox"/> Requires 24-hour medical nursing care	<input type="checkbox"/> Environment dangerous for recovery	<input type="checkbox"/> Requires medical monitoring but not intensive treatment	<input type="checkbox"/> Environment unsupportive but with structure patient can cope

Signature and Printed Name of Physician Completing Section I

Date and Time

PART OF THE MEDICAL RECORD

Psychiatric Unit

Integrated Biopsychosocial Summary -- Psychiatry

Section II: Emotional / Behavioral Conditions

Include comments on cognitive impairment, persistency of symptoms, psychiatric condition, compounding additional behaviors, sexual preference and sexual abuse (victim or perpetrator).

Signature, Title and Credentials of Registered Nurse Completing Section II

Date and Time

Section III: Biomedical Conditions

Include comments on co-existing medical problems or referral for more intensive medical services.

Signature, Title and Credentials of Registered Nurse Completing Section III

Date and Time

Section IV: Withdrawal / Treatment Acceptance / Resistance and Relapse Potential

Include comments on withdrawal symptomology and post-withdrawal organicity. Include comments on the following: Does the patient recognize the severity of the illness? Does the patient show an understanding of the self-defeating nature of using chemicals? What will be the issues addressed in the therapeutic process? What are the cultural influences impacting on treatment?

Signature, Title and Credentials of Registered Nurse Completing Section III

Date and Time

PART OF THE MEDICAL RECORD

Integrated Biopsychosocial Summary -- Psychiatry

Section V: Recovery Environment/Discharge Planning

Include comments on the following: interpersonal lifestyle, social/interpersonal problems complicating treatment, occupational/legal/leisure situation, familial situation, spirituality considerations, potential discharge plans (e.g., outpatient AA, NA, etc.), involvement of significant others, involvement of employer and follow-up for medical/emotional concerns.

Patient Has:

Assess:

- | | | |
|--------------------------|---------------------------|--------------------------|
| <input type="checkbox"/> | Housing / Shelter | <input type="checkbox"/> |
| <input type="checkbox"/> | Case Management | <input type="checkbox"/> |
| <input type="checkbox"/> | Psychiatric After Care | <input type="checkbox"/> |
| <input type="checkbox"/> | Substance Abuse Aftercare | <input type="checkbox"/> |
| <input type="checkbox"/> | Structured Day Program | <input type="checkbox"/> |
| <input type="checkbox"/> | Legal Concerns | <input type="checkbox"/> |
| <input type="checkbox"/> | Domestic Violence | <input type="checkbox"/> |
| <input type="checkbox"/> | Other (Specify) | <input type="checkbox"/> |

Signature, Title and Credentials of Physician/Registered Nurse/Social Worker/Activity Therapist Completing Section V.

Date and Time

Psychiatric Unit
Psychiatry

Master Problem List

Date Identified	Problem Number	Problem	Address on Master Treatment Plan	Noted No Action Required
Section I: Emotional / Behavioral Conditions				
	1		<input type="checkbox"/>	<input type="checkbox"/>
	2		<input type="checkbox"/>	<input type="checkbox"/>
	3		<input type="checkbox"/>	<input type="checkbox"/>
Section II: Biomedical Conditions				
	4		<input type="checkbox"/>	<input type="checkbox"/>
	5		<input type="checkbox"/>	<input type="checkbox"/>
	6		<input type="checkbox"/>	<input type="checkbox"/>
Section III: Withdrawal / Treatment Acceptance / Resistance and Relapse Potential				
	7		<input type="checkbox"/>	<input type="checkbox"/>
	8		<input type="checkbox"/>	<input type="checkbox"/>
	9		<input type="checkbox"/>	<input type="checkbox"/>
Section IV: Recovery Environment / Discharge Planning				
	10		<input type="checkbox"/>	<input type="checkbox"/>
	11		<input type="checkbox"/>	<input type="checkbox"/>
	12		<input type="checkbox"/>	<input type="checkbox"/>

PART OF THE MEDICAL RECORD