



CONSUMER ASSESSMENT

(Affix consumer identification label here)

URN:

Family name:

Given names:

Date of birth:

Sex: M F

Facility:

Date: / / Time:

Assessor's name: Team:

Information has been given to the consumer regarding:

- Their rights
- The Mental Health Service
- The *Mental Health Act 2000*

Persons present at interview:

REASON FOR REFERRAL / PRESENTING PROBLEMS

- Include additional information since initial intake.

HISTORY OF PRESENTING COMPLAINT

Specify:

- if notes relate to specific episode(s) / lifetime
- dates of assessments and investigations

Include:

- psychiatric history
- current mental health care treatment interventions
- impact of cultural and / or spiritual issues
- relationship and interpersonal issues and supports
- neurovegetative disturbance
- collateral since initial intake
- any family history of mental illness and suicide
- current family situation

DO NOT WRITE IN THIS BINDING MARGIN

CYMHHS - CONSUMER ASSESSMENT

Clinician's name:	Designation:	Signature:	Team:
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FAMILY HISTORY

Record three generations (if possible).

Include:

- year of birth/death
- cause of death

Genogram key

- Male
- Female
- Unknown
- Married
- Defacto
- Separated
- Divorced
- Adopted
- Death

Family history details

Include:

- psychiatric history
- family history of suicide
- illnesses
- substance use
- intellectual/physical disability
- family/carer's response to consumer's illness/ crisis

Family cultural issues

Include:

- language
- connection with community
- if migrant reason for migration etc.

CONSUMER DEVELOPMENTAL HISTORY (lifetime)

Include:

- ante-natal/peri-natal history
- milestones
- attachment/separation issues
- maternal substance use during pregnancy

PREMORBID FUNCTIONING

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MEDICATIONS

Allergies:

Current prescribed medication

For each medication list:

- name
- prescriber
- dose including frequency and route and
- duration

Other medications

Include:

- alternative medicines
- over the counter medications

Note response to medication/drug adherence/side effects.

Past medications

Include:

- any side effects
- reason for cessation

MEDICAL HISTORY

Current medical problems and treatment

Include:

- disabilities
- history of brain injuries; and
- eating disorders

Is a physical assessment required?

Mandatory if consumer is to be admitted to an inpatient unit

Yes No

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MENTAL STATE EXAMINATION

Appearance (physical development, nutrition body type and physique, skin, hair, clothing, grooming, hygiene distinguishing features)

Motor Behaviour (activity level, posture, gait, balance, co-ordination abnormal movements, startle response, habits, rituals, mannerisms)

Voice, Speech and Language (amplitude, pitch, tone, tempo, prosody, phonation, rhythm, fluency, articulation, accent, comprehension, vocabulary, syntax, conversational ability, use of gesture)

Interaction with Examiner (eye contact, cooperativeness, dependence, friendliness, withdrawal, evasiveness, fear, anxiety, hostility, suspiciousness, indifference, invasiveness, dramatism, suggestibility)

Mood and Affect (range, control, congruity, elevation, depression, suspicion, anxiety, fear, anger, issues related to particular affects)

Thought Processes (slowing, acceleration, interruptions, blocking, circumlocution, circumstantiality, perseveration, concreteness, flight of ideas, goal-direction, coherence, looseness of associations, tangential thinking)

Thought Content (obsession, compulsion, hallucination, delusion, illusion, depersonalisation, de-realisation, déjà vu, phobia, flashbacks [intrusive/traumatic/ imagery] abnormality of general or special sensation, abnormality of body image, distortion of the sense of time, confabulation, fabrication, preoccupation with identity, physical health, mental health, personal competence, or the past or future)

Cognitive Functioning (orientation, concentration, memory [immediate, recent, remote], general knowledge, social judgement abstracting ability, estimated intelligence)

Fantasy (dreams, wishes, drawings, free play: productivity, themes, capacity to distinguish fantasy from reality)

Concept of Self (dreams, wishes, drawings, free play, coherence, concepts of personal intelligence, strength, attractiveness, relationship with others)

Insight/Desire for Help (awareness of being unwell, awareness of nature of problem, desire for help, level of co-operation., awareness of impact of their behaviour on others)

Physiological Functions (energy, concentration, memory, interest in people and activities, appetite, weight, sleep, libido, sexual functioning, menstrual history, last menstrual period)

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Parent/Carer/Significant others drug and/or alcohol use:

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DRUG SCREEN

It is strongly recommended that the Drug Screen is completed with consumers of primary school age and above.

Clinicians may contact the Alcohol and Drug Information Service (ADIS) on 1800 177 833 for assistance in completing this form.

Drug name	Have you used? Y / N	Age first used	Date / time last used	Average amount	Frequency of use	Route of administration
Caffeine (tea / coffee / stimulant, energy, cola drinks)						
Nicotine (cigarettes / tobacco)						
Alcohol (including methylated spirits)						
Cannabis (marijuana / hash / bongs / ganja)						
Amphetamines (speed / goey / ice / cocaine)						
Opioids (methadone / heroin / morphine)						
Benzodiazepines (Temazepam / Diazepam / Valium / Normison)						
Designer drugs (MDA; ecstasy / MDMA)						
Inhalants (glue / petrol / paint / others)						
Others (pain killers / PCP / Ketamine / over the counter drugs etc.) Specify:						

Unable to complete due to consumer's circumstances? Yes No

Further drug screen required? Yes No

Further alcohol screen required? Yes No

Additional Information (Record current access to means/attitude of significant others/ effects of withdrawal if appropriate or other relevant information):

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Principal diagnosis: ICD10AM code:

Additional diagnoses: ICD10AM code:

..... ICD10AM code:

Mental Health Act (MHA) status: None Involuntary Assessment Involuntary Treatment Order

Justice Examination Order Emergency Examination Order Forensic Order

Special Notification Forensic Patient Classified

Conditions of order if appropriate:

Outcome Measures completed? Yes No Entered on CIMHA? Yes No

Outline significant clinical issues from HoNOSCA, SDQ and CGAS:

BRIEF SUMMARY FOR FOLLOW UP MANAGEMENT:

Is there a need for follow up / treatment?

Yes, from a Child and Youth Mental Health Service (CYMHS) (detail in CYMHS plan below)

Yes, from a service other than a CYMHS (detail follow-up with other agencies below)

No

Agency: Date: Time:

Agency: Date: Time:

CYMHS IMMEDIATE PLAN

Include any immediate actions required to maintain the consumer's safety (eg. aggressive behaviour management).

Consider:

- Treatment goals and location
- Recommended actions to manage / reduce risk
- Information / education
- Carer / family involvement
- Child protection issues
- Liaison with other service providers
- Cultural and language issues
- Medication changes
- Investigations
- Referrals

For inpatients, consider:

- Level of observations
- Early discharge requirements
- PRN medications

Information about consumer need and service response to be provided to:

Consumer Carer Referrer GP Other service provider (specify):

Information provided by (staff name): (date):

Information to be delivered: By telephone By email By fax By post In person

Additional forms, notes or information attached? Yes (specify:) No

Clinician's name:

Designation:

Signature:

Team:

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