## Psychiatric Medical Clearance by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(hospital/agency)

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Preliminary Diagnoses:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Confirmed as uninsured/no resources for payment for services (physician initials): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No**

1. Does the patient have new psychiatric condition?

2. Any history of active medical illness needing evaluation?

3. Any abnormal vital signs prior to transfer

Temperature >101F

Pulse outside of 50 to 120 beats/min

Blood pressure systolic <90 or >200; diastolic >120

Respiratory rate >24 breaths/min

4. Any abnormal physical exam (unclothed)

a. Absence of significant part of body, e.g. limb

b. Acute and chronic trauma (including signs of victimization/abuse)

c. Breathing Sounds

d. Cardiac *dysrhythmia*, murmurs

e. Skin and vascular signs: diaphoresis, pallor, cyanosis, edema

f. Abdominal distention, bowel sounds

g. Neurological with particular focus on:

h. Ataxia\_\_\_ pupil symmetry, size\_\_\_ nystagmus\_\_\_

 paralysis\_\_\_ meningeal signs\_\_\_ reflexes\_\_\_

i. Presence of prostheses, central lines, indwelling catheters, insulin pump, etc.

5. Any abnormal mental status indicating medical illness such as: lethargic, stuporous, comatose, spontaneously fluctuating mental status?

All patients are to have blood count (CBC), electrolytes, pregnancy test (if child-bearing age) and drug screen performed. If no to all of the above questions, no further evaluation is necessary. Go to question #9. If yes to any of the above questions go to question # 6, additional testing may be indicated.

6. Were any additional labs done? **Yes No**

7. What lab tests were performed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What were the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Possibility of Pregnancy **Yes No**

What were the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Were x-rays performed? **Yes No**

What kind of x-rays were performed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What were the results?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Was there any medical treatment needed by the patient prior to medical clearance? **Yes No**

What treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Has the patient been medically cleared in the ED? **Yes No**

11. Any acute medical condition that was adequately treated in the emergency department that allows transfer to a R1S/CCS service or state operated psychiatric facility (SOF)? **Yes No**

What treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Current medications and last administered? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Diagnoses: Psychiatric \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substance abuse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. Medical follow-up or treatment required in a R1S/CCS service or at state operated facility:

15. I have had adequate time to evaluate the patient and the patients medical condition is sufficiently stable that transfer to an alternative level of care does not pose a significant risk of deterioration.

Time Evaluator called: \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD/DO Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Physician Signature