

**Beebe Healthcare**  
**Margaret H. Rollins School of Nursing**  
**Nursing 201- Nursing Care of Special Populations**  
**DocuCare Mental Health Assessment**  
**Guidelines 2021**

**Instructions:** A Mental Health Assessment should be completed for the following mental health clinical experiences:

1. Dover Behavioral Health
2. Mental Health Simulation

Only the Mental Health Tab needs to be completed in DocuCare. Below are the detailed instructions.

**Complete the *Mental Health Tab* only**

- A. Behavior/ Affect:** Check appropriate box/s or check other and describe
- B. Stressors:** Check appropriate box/s or check other and describe
- C. Coping:** Check appropriate box/s or check other and describe
- D. Consult:** Would you recommend a consult for this patient? Check box and describe in the “additional notes” box
- E. Cognitive Impairment Screening Tab:** Not required
- F. Present Regimen Tab:** Describe the presenting problem, use patient’s own words as to why he/ she is seeking help
- G. Communication Tab:** Check the appropriate box
- H. Coping Style Tab:** Check the appropriate box
- I. Thoughts Exhibited Tab:** Check the appropriate box and secondary descriptor
- J. Reaction Tab:** Check the appropriate box
- K. Level of orientation Tab:** Check the appropriate box
- L. Treatment Tab:** What is your recommendation for further treatment?
- M. Mental Status Tab:**
  1. *General Observations*
    - a. Patient’s appearance: clothing, grooming (hair, nails, make-up), posture,
    - b. Affect: level of eye contact
    - c. Psychomotor activity: tremors, agitation, restlessness, aggressiveness, abnormal gait
    - d. Overall behavior
  2. *Orientation*
    - a. Date, time, and current location
  3. *Mood & Emotions:* Depressed, despairing, irritable, anxious, elated, euphoric, fearful, guilty, labile
    - a. Affect: congruence with mood, blunted, flat, appropriate/ inappropriate

4. *Speech*

- a. Verbal ability, speed, use of words correctly

5. *Thought Processes*

- a. Tangential, logic, repetition, rhyming of words, loose connections, disorganized
- b. Thought clarity: coherent, confused, vague
- c. Thought content: helplessness, hopelessness, worthlessness, suicidal/ homicidal

6. *Attention and Concentration*

- a. Poor, adequate, easily distracted, short attention span

7. *Abstract Reasoning and Comprehension*

- a. Capacity for abstract thought

8. *Recall, Short-Term, Recent, and Remote Memory*

9. *Insight and Judgment*

- a. Ability to solve problems and make decisions
- b. Awareness of consequences of actions, awareness of illness, awareness of own limitations

**N. CIWAA Score:** If your patient is withdrawing from alcohol, you must complete a CIWAA assessment/ score. Complete the Assessment and add the score to the “Additional Notes”

**THE CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT FROM ALCOHOL SCALE**

The CIWA-Ar measures 10 symptoms. Scores of less than 8 indicate minimal to mild withdrawal, scores of 8 to 15 indicate moderate withdrawal, and scores of 15 or higher indicate severe withdrawal (impending alcohol withdrawal delirium [delirium tremens]). The maximum score is 67. This assessment tool requires only about 5 minutes to administer.<sup>22</sup>

**Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-Ar)**

Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Nausea and vomiting**—Ask "Do you feel sick to your stomach? Have you vomited?" Observation.  
**0** no nausea with no vomiting  
**1** mild nausea with no vomiting  
**2**  
**3**  
**4** intermittent nausea with dry heaves  
**5**  
**6**  
**7** constant nausea, frequent dry heaves, and vomiting

**Tactile disturbances**—Ask "Have you any itching, pins and needles sensations, burning, numbness, or do you feel bugs crawling on or under your skin?" Observation.  
**0** none  
**1** very mild itching, pins and needles, burning or numbness  
**2** mild itching, pins and needles, burning or numbness  
**3** moderate itching, pins and needles, burning or numbness  
**4** moderately severe hallucinations  
**5** severe hallucinations  
**6** extremely severe hallucinations  
**7** continuous hallucinations

**Tremor**—Arms extended and fingers spread apart. Observation.  
**0** no tremor  
**1** not visible, but can be felt fingertip to fingertip  
**2**  
**3**  
**4** moderate, with patient's arms extended  
**5**  
**6**  
**7** severe, even with arms not extended

**Auditory disturbances**—Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.  
**0** not present  
**1** very mild harshness or ability to frighten  
**2** mild harshness or ability to frighten  
**3** moderate harshness or ability to frighten  
**4** moderately severe hallucinations  
**5** severe hallucinations  
**6** extremely severe hallucinations  
**7** continuous hallucinations

**Paroxysmal sweats**—Observation.  
**0** no sweat visible  
**1** barely perceptible sweating, palms moist  
**2**  
**3**  
**4** beads of sweat obvious on forehead  
**5**  
**6**  
**7** drenching sweats

**Visual disturbances**—Ask "Does the light appear to be too bright? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.  
**0** not present  
**1** very mild sensitivity  
**2** mild sensitivity  
**3** moderate sensitivity  
**4** moderately severe hallucinations  
**5** severe hallucinations  
**6** extremely severe hallucinations  
**7** continuous hallucinations

<p><b>Anxiety</b>—Ask "Do you feel nervous?" Observation.</p> <p>0 no anxiety, at ease</p> <p>1 mildly anxious</p> <p>2</p> <p>3</p> <p>4 moderately anxious, or guarded, so anxiety is inferred</p> <p>5</p> <p>6</p> <p>7 acute panic state, as seen in severe delirium or acute schizophrenic reactions</p>	<p><b>Headache, fullness in the head</b>—Ask "Does your head feel different? Does it feel like there is a band around your head?"</p> <p>Do not rate dizziness or light-headedness. Otherwise, rate severity.</p> <p>0 not present</p> <p>1 very mild</p> <p>2 mild</p> <p>3 moderate</p> <p>4 moderately severe</p> <p>5 severe</p> <p>6 very severe</p> <p>7 extremely severe</p>
<p><b>Agitation</b>—Observation.</p> <p>0 normal activity</p> <p>1 somewhat more than normal activity</p> <p>2</p> <p>3</p> <p>4 moderately fidgety and restless</p> <p>5</p> <p>6</p> <p>7 paces back and forth during most of the interview, or constantly thrashes about</p>	<p><b>Orientation and clouding of sensorium</b>—Ask "What day is this? Where are you? Who am I?" Observation.</p> <p>0 oriented and can do serial additions</p> <p>1 can't do serial additions or is uncertain about the date</p> <p>2 disoriented for date by no more than 2 calendar days</p> <p>3 disoriented for date by more than 2 calendar days</p> <p>4 disoriented for place or person</p>
<p>Total score: _____ (Maximum possible score 67)</p>	