HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

Patient Name Ronnie Today's Date 9/17

The HAM-D is designed to rate the severity of depression in patients. Although it contains 21 areas, calculate the patient's score on the first 17 answers.

0 1. DEPRESSED MOOD
(Gloomy attitude, pessimism about the future, feeling of sadness, tendency to weep)
0 = Absent
1 = Sadness, etc.
2 = Occasional weeping
3 = Frequent weeping
4 = Extreme symptoms

2 2. FEELINGS OF GUILT
0 = Absent
1 = Self-reproach, feels he/she has let people down
2 = Ideas of guilt
3 = Present illness is a punishment; delusions of guilt
4 = Hallucinations of guilt

0 3. SUICIDE
0 = Absent
1 = Feels life is not worth living
2 = Wishes he/she were dead
3 = Suicidal ideas or gestures
4 = Attempts at suicide

0 4. INSOMNIA - Initial
(Difficulty in falling asleep)
0 = Absent
1 = Occasional
2 = Frequent

0 5. INSOMNIA - Middle
(Complains of being restless and disturbed during the night. Waking during the night.)
0 = Absent
1 = Occasional
2 = Frequent

0 6. INSOMNIA - Delayed
(Waking in early hours of the morning and unable to fall asleep again)
0 = Absent
1 = Occasional
2 = Frequent

0 7. WORK AND INTERESTS
0 = No difficulty
1 = Feelings of incapacity, listlessness, indecision and vacillation
2 = Loss of interest in hobbies, decreased social activities
3 = Productivity decreased
4 = Unable to work. Stopped working because of present illness only. (Absence from work after treatment or recovery may rate a lower score).

0 8. RETARDATION
(Slowness of thought, speech, and activity; apathy; stupor.)
0 = Absent
1 = Slight retardation at interview
2 = Obvious retardation at interview
3 = Interview difficult
4 = Complete stupor

1 9. AGITATION
(Restlessness associated with anxiety.)
0 = Absent
1 = Occasional
2 = Frequent

0 10. ANXIETY - PSYCHIC
0 = No difficulty
1 = Tension and irritability
2 = Worrying about minor matters
3 = Apprehensive attitude
4 = Fears

HAMILTON DEPRESSION RATING SCALE (HAM-D)

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Gastrointestinal, indigestion
Cardiovascular, palpitation, Headaches
Respiratory, Genito-urinary, etc.
0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

0 12. SOMATIC SYMPTOMS - GASTROINTESTINAL
(Loss of appetite , heavy feeling in abdomen; constipation)
0 = Absent
1 = Mild
2 = Severe

0 13. SOMATIC SYMPTOMS - GENERAL
(Heaviness in limbs, back or head; diffuse backache; loss of energy and fatiguability)
0 = Absent
1 = Mild
2 = Severe

0 14. GENITAL SYMPTOMS
(Loss of libido, menstrual disturbances)
0 = Absent
1 = Mild
2 = Severe

0 15. HYPOCHONDRIASIS
0 = Not present
1 = Self-absorption (bodily)
2 = Preoccupation with health
3 = Querulous attitude
4 = Hypochondriacal delusions

0 16. WEIGHT LOSS
0 = No weight loss
1 = Slight
2 = Obvious or severe

1 17. INSIGHT
(Insight must be interpreted in terms of patient's understanding and background.)
0 = No loss
1 = Partial or doubtfull loss
2 = Loss of insight

TOTAL ITEMS 1 TO 17: _____
0 - 7 = Normal
8 - 13 = Mild Depression
14-18 = Moderate Depression
19 - 22 = Severe Depression
≥ 23 = Very Severe Depression

0 18. DIURNAL VARIATION
(Symptoms worse in morning or evening. Note which it is.)
0 = No variation
1 = Mild variation; AM ( ) PM ( )
2 = Severe variation; AM ( ) PM ( )

0 19. DEPERSONALIZATION AND DEREALIZATION
(feelings of unreality, nihilistic ideas)
0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

0 20. PARANOID SYMPTOMS
(Not with a depressive quality)
0 = None
1 = Suspicious
2 = Ideas of reference
3 = Delusions of reference and persecution
4 = Hallucinations, persecutory

1 21. OBSESSIONAL SYMPTOMS
(Obsessive thoughts and compulsions against which the patient struggles)
0 = Absent
1 = Mild
2 = Severe

* Adapted from Hamilton, M. *Journal of Neurology, Neurosurgery, and Psychiatry* 23:56-62, 1960.

NURSING SHIFT ASSESSMENT

DATE: 9/17/25 SHIFT: ☑ Day(7A-7P) ☐ Night(7P-7A)

OCEANS

Label
Name:
MR#: D.O.B.

Orientation ☑ Person ☑ Place ☑ Time ☑ Situation

Affect ☑ Appropriate ☐ Inappropriate ☐ Flat ☐ Guarded ☐ Improved ☐ Blunted

ADL ☑ Independent ☐ Assist ☐ Partial Assist ☐ Total Assist

Motor Activity ☑ Normal ☐ Psychomotor retardation ☐ Psychomotor agitation ☐ Posturing ☐ Repetitive acts ☐ Pacing

Mood ☐ Irritable ☐ Depressed ☑ Anxious ☐ Dysphoric ☐ Agitated ☐ Labile ☐ Euphoric

Behavior ☐ Withdrawn ☐ Suspicious ☐ Tearful ☐ Paranoid ☐ Isolative ☐ Preoccupied ☐ Demanding ☐ Aggressive ☐ Manipulative ☐ Complacent ☐ Sexually acting out ☑ Cooperative ☐ Guarded ☐ Intrusive

Thought Processes
☑ Goal Directed ☐ Tangential ☐ Blocking ☐ Flight of Ideas ☐ Loose association ☐ Indecisive ☐ Illogical ☐ Delusions:) (type)_____

Thought Content
☐ Obsessions ☐ Compulsions ☐ Suicidal thoughts ☐ Hallucinations:☐ Auditory ☐ Visual ☐ Olfactory ☐ Tactile ☐ Gustatory ☐ Worthless ☐ Somatic ☐ Assaultive Ideas ☑ Logical ☐ Hopeless ☐ Helpless ☐ Homicidal thoughts

Pain: Yes ☑ No Pain scale score 0 Locations_____
Is pain causing any physical impairment in functioning today ☐ No ☐ If yes explain_____

Nursing Interventions:
☑ Close Obs. q15 ☐ Ind. Support ☐ Reality Orientation ☐ Toilet Q2 w/awake ☐ 1 to 1 Observation _____ reason (specify)
☐ Milieu Therapy ☐ Monitor Intake ☐ Encourage Disclosure ☐ Neuro Checks ☐ Rounds Q2
☐ V/S ☐ O2 sat. ☐ Tx Team ☐ Wt. Monitoring ☐ Elevate HOB ☐ MD notified _____
☐ Nursing group/session (list topic): _____
☐ ADLs assist ☐ I&O ☐ PRN Med per order_____

☐ DOCUMENT ABNORMAL OCCURENCES IN MULTIDISCIPLINARY NOTES (violence, suicide, elope, fall, physical health) DAILY SUICIDE RISK ASSESSMENT* Note – for frequent assessment purposes, Question 1 has been omitted	Since Last Contact	
Ask Question 2*	YES	NO
2) Have you actually had thoughts about killing yourself?	LOW	
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Have you been thinking about how you might do this?	MOD	✓
4) Have you had these thoughts and had some intention of acting on them? E.g., "I thought about taking an overdose, but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."	LOW	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan? As opposed to "I have the thoughts, but I definitely will not do anything about them."		✓
6) Have you done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		✓

☐ Low Risk ☐ Moderate Risk ☐ High Risk

Nurse Signatures) Cynthia Rodriguez Date: 9/17/25 Time: 1100

REVIEW OF SYSTEMS

Cardio/Pulmonary:
☐ WNL ☐ Elevated B/P ☐ ↓ B/P ☐ Chest Pain ☐ Edema: ☐ upper ☐ lower

Respiratory/Breath sounds:
☐ Clear ☐ Rales ☐ Crackles ☐ Wheezing ☐ Cough ☐ S.O. B Other: _____ ☐ O2 @____ l/min ☐ Cont. ☐ PRN Via ☐ nasal cannula ☐ face mask

Neurological / L.O.C.:
☐ Unimpaired ☐ Lethargic ☐ Sedated ☐ Dizziness ☐ Headache ☐ Seizures ☐ Tremors ☐ Other_____

Musculoskeletal/Safety:
☐ Ambulatory ☐ MAE ☐ Full ROM ☐ Walker ☐ W/C ☐ Immobile ☐ Pressure ulcer ☐ Unsteady gait ☐ Risk for pressure ulcer ☐ Reddened area(s)

Nutrition/Fluid:
☐ Adequate ☐ Inadequate ☐ Dehydrated ☐ Supplement ☐ Promoting ☐ Other_____ new onset of choking risks assessed

Skin:
☐ Bruises ☐ Tear ☐ No new skin issues ☐ Wound(s) (see Wound Care Packet) ☐ Abrasion ☐ Integumentary Assess ☐ Other: _____

Elimination:
☐ Continent ☐ Incontinent ☐ Catheter ☐ Diarrhea ☐ OTHER_____

Hours of Sleep: ____ Day Night

At Risk for Falls: ☐ Yes ☐ No

At Risk for FALL Precautions:
☐ Arm Band ☐ Nonskid footwear ☐ BR light ☐ ambulate with assist ☐ Call bell ☐ Clear path ☐ Edu to call for assist ☐ Bed alarm ☐ Chair alarm ☐ 1:1 observation level ☐ Assist with ADLs ☐ Gen Chair ☐ Ensure assistive devices near ☐ Other _____

Student Name: Cynthia Rodriguez Unit: _____ Pt. Initials: _____ Date: _____

Medication Worksheet – Current Medications & PRN for Last 24 Hours

Allergies: _____

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
	Isotonic/ Hypotonic/ Hypertonic			

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Correct Dose? If not, what is correct dose?	IVP – List solution to dilute and rate to push. IVPB – List mL/hr and time to give	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
trazodone HCL	atypical antidepressant	Depression	~~50mg~~ 25mg PO	(Y) N		drowsiness dry mouth	1. monitor cardiac – arrhythmias 2. orthostatic hypotension from ↓ in BP 3. Assess for sedation or drowsiness 4. watch for signs of serotonin syndrome ↑ level
hydroxyzine	antihistaminic	short term treatment of anxiety	50mg PO	(Y) N		drowsiness dry mouth Mild HA	1. monitor for respiratory depression (RR) 2. drowsiness - confusion 3. Assess skin for pruritis 4. mouth & mucous membranes (dry mouth) sugarless gum to help
				Y N			1. 2. 3. 4.
				Y N			1. 2. 3. 4.
				Y N			1. 2. 3. 4.

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Patient Name David **Today's Date** 9/16/25

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NURSING SHIFT ASSESSMENT

DATE: 9/16/25

SHIFT: ☑ Day(7A-7P) ☐ Night(7P-7A)

Label
Name: _____
MR#: _____ D.O.B. _____

Orientation
☑ Person
☑ Place
☑ Time
☑ Situation

Affect
☐ Appropriate
☐ Inappropriate
☐ Flat
☐ Guarded
☐ Improved
☐ Blunted

ADL
☑ Independent
☐ Assist
☐ Partial Assist
☐ Total Assist

Motor Activity
☑ Normal
☐ Psychomotor retardation
☐ Psychomotor agitation
☐ Posturing
☐ Repetitive acts
☐ Pacing

Mood
☐ Irritable
☐ Depressed
☐ Anxious
☐ Dysphoric
☐ Agitated
☐ Labile
☐ Euphoric

Behavior
☐ Withdrawn
☐ Suspicious
☐ Tearful
☐ Paranoid
☐ Isolative
☐ Preoccupied
☐ Demanding
☐ Aggressive
☐ Manipulative
☐ Complacent
☐ Sexually acting out
☑ Cooperative
☐ Guarded
☐ Intrusive

Thought Processes
☑ Goal Directed ☐ Tangential ☐ Blocking
☐ Flight of Ideas ☐ Loose association ☐ Indecisive
☐ Illogical ☐ Delusions:) (type)_____

Thought Content
☐ Obsessions ☐ Compulsions ☐ Suicidal thoughts
☐ Hallucinations: ☐ Auditory ☐ Visual ☐ Olfactory ☐ Tactile ☐ Gustatory
☐ Worthless ☐ Somatic ☐ Assaultive Ideas ☑ Logical
☐ Hopeless ☐ Helpless ☐ Homicidal thoughts

Pain: Yes **No** *Pain scale score* 0 *Locations* _____
Is pain causing any physical impairment in functioning today ☐ No ☐ If yes explain _____

Nursing Interventions:
☑ Close Obs. q15 ☐ Ind. Support ☐ Reality Orientation ☐ Toilet Q2 w/awake ☐ 1 to 1 Observation _____ reason (specify)
☐ Milieu Therapy ☐ Monitor Intake ☐ Encourage Disclosure ☐ Neuro Checks ☐ Rounds Q2
☐ V/S ☐ O2 sat. ☐ Tx Team ☐ Wt. Monitoring ☐ Elevate HOB ☐ MD notified _____
☐ Nursing group/session (list topic) _____
☐ ADLs assist ☐ I&O ☐ PRN Med per order _____

☐ DOCUMENT ABNORMAL OCCURENCES IN MULTIDISCIPLINARY NOTES (violence, suicide, elope, fall, physical health) DAILY SUICIDE RISK ASSESSMENT* Note – for frequent assessment purposes, Question 1 has been omitted	Since Last Contact	
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If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Have you been thinking about how you might do this?	MOD	
4) Have you had these thoughts and had some intention of acting on them? E.g., "I thought about taking an overdose, but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."		
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan? As opposed to "I have the thoughts, but I definitely will not do anything about them."		
6) Have you done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		✓

☐ Low Risk ☐ Moderate Risk ☐ High Risk

Nurse Signature(s) Cynthia Rodriguez Date: 9/16/25 Time: 1030

REVIEW OF SYSTEMS

Cardio/Pulmonary:
☐ WNL ☐ Elevated B/P ☐ ↓ B/P
☐ Chest Pain
☐ Edema: ☐ upper ☐ lower

Respiratory/Breath sounds:
☐ Clear ☐ Rales ☐ Crackles ☐ Wheezing
☐ Cough ☐ S.O. B ☐ Other: _____
☐ O2 @ ____ l/min ☐ Cont. ☐ PRN
Via ☐ nasal cannula ☐ face mask

Neurological / L.O.C.:
☐ Unimpaired ☐ Lethargic ☐ Sedated
☐ Dizziness ☐ Headache ☐ Seizures
☐ Tremors ☐ Other _____

Musculoskeletal/Safety:
☐ Ambulatory ☐ MAE ☐ Full ROM
☐ Walker ☐ W/C ☐ Immobile
☐ Pressure ulcer ☐ Unsteady gait
☐ Risk for pressure ulcer
☐ Reddened area(s)

Nutrition/Fluid:
☐ Adequate ☐ Inadequate ☐ Dehydrated
☐ Supplement ☐ Prompting ☐ Other _____
new onset of choking risks assessed

Skin:
☐ Bruises ☐ Tear ☐ No new skin issues
☐ Wound(s) (see Wound Care Packet)
☐ Abrasion ☐ Integumentary Assess
☐ Other: _____

Elimination:
☐ Continent ☐ Incontinent ☐ Catheter
☐ Diarrhea ☐ OTHER _____

Hours of Sleep: ____ Day Night

At Risk for Falls: ☐ Yes ☐ No

At Risk for FALL Precautions:
☐ Arm Band ☐ Nonskid footwear
☐ BR light ☐ ambulate with assist
☐ Call bell ☐ Clear path
☐ Edu to call for assist ☐ Bed alarm
☐ Chair alarm ☐ 1:1 observation level
☐ Assist with ADLs ☐ Geri Chair
☐ Ensure assistive devices near
☐ Other _____

Cynthia Rodriguez

PMH Critical Thinking Sheet

DSM-5 Diagnosis and Brief Pathophysiology:

Multifactor
Neurobiological disorder
Neurotransmitter dysregulation
↑ cortisol ↓ Serotonin, Dopamine

DSM-5 Criteria for your patient's diagnosis:

diminished interest
Some activities
feelings of worthlessness

Psychosocial Stressors (Legal, Environmental, Relational, Developmental, Educational, Substance Use, etc.)

Limited provider options (VA insurance)
Financal Stress

Therapeutic Communication & Nurse Patient Relationship:

Communication strategy:
Simple, concrete language
Visual cues

Stage of nurse-patient relationship:
Orientation

Therapeutic communication techniques appropriate for this patient:
Validate feelings
Encourage autonomy

Communication approaches to avoid:
Rapid-fire questions
Minimizing their experience
Giving too much info

Plan of Care:

Patient problem: Mild depression + post stroke memory loss

Related to (etiology):
Hx of two strokes

As evidenced by (signs & symptoms):
frustration / inability to recall name of objects, letters

Outcome/Goal:
restore memory

Current Treatment & Interventions:

1. Group therapy

Rationale: express frustration and gain confidence

2.

Rationale: Occupational therapy

3. ADLs - not independence w/ mobility (Reading & writing)

Rationale:

4. Routine building strategies

Rationale:

Student name: