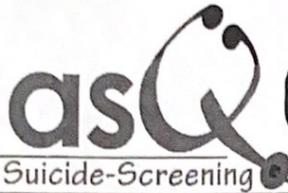


## Mental Status Exam

Client Name <u>L.L</u>	Date <u>3/8/24</u>
<b>OBSERVATIONS</b>	
Appearance	<input checked="" type="checkbox"/> Neat <input type="checkbox"/> Disheveled <input type="checkbox"/> Inappropriate <input type="checkbox"/> Bizarre <input type="checkbox"/> Other
Speech	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Tangential <input type="checkbox"/> Pressured <input type="checkbox"/> Impoverished <input type="checkbox"/> Other
Eye Contact	<input type="checkbox"/> Normal <input type="checkbox"/> Intense <input checked="" type="checkbox"/> Avoidant <input type="checkbox"/> Other
Motor Activity	<input type="checkbox"/> Normal <input checked="" type="checkbox"/> Restless <input type="checkbox"/> Tics <input type="checkbox"/> Slowed <input type="checkbox"/> Other
Affect	<input type="checkbox"/> Full <input checked="" type="checkbox"/> Constricted <input checked="" type="checkbox"/> Flat <input type="checkbox"/> Labile <input type="checkbox"/> Other
Comments: <u>Anxious, Sad, fidgeting</u>	
<b>MOOD</b>	
	<input type="checkbox"/> Euthymic <input checked="" type="checkbox"/> Anxious <input type="checkbox"/> Angry <input checked="" type="checkbox"/> Depressed <input type="checkbox"/> Euphoric <input type="checkbox"/> Irritable <input type="checkbox"/> Other
Comments:	
<b>COGNITION</b>	
Orientation Impairment	<input checked="" type="checkbox"/> None <input type="checkbox"/> Place <input type="checkbox"/> Object <input type="checkbox"/> Person <input type="checkbox"/> Time
Memory Impairment	<input checked="" type="checkbox"/> None <input type="checkbox"/> Short-Term <input type="checkbox"/> Long-Term <input type="checkbox"/> Other
Attention	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Distracted <input type="checkbox"/> Other
Comments:	
<b>PERCEPTION</b>	
Hallucinations	<input checked="" type="checkbox"/> None <input type="checkbox"/> Auditory <input type="checkbox"/> Visual <input type="checkbox"/> Other
Other	<input checked="" type="checkbox"/> None <input type="checkbox"/> Derealization <input type="checkbox"/> Depersonalization
Comments:	
<b>THOUGHTS</b>	
Suicidality	<input type="checkbox"/> None <input checked="" type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input checked="" type="checkbox"/> Self-Harm
Homicidality	<input checked="" type="checkbox"/> None <input type="checkbox"/> Aggressive <input type="checkbox"/> Intent <input type="checkbox"/> Plan
Delusions	<input checked="" type="checkbox"/> None <input type="checkbox"/> Grandiose <input type="checkbox"/> Paranoid <input type="checkbox"/> Religious <input type="checkbox"/> Other
Comments:	
<b>BEHAVIOR</b>	
<input checked="" type="checkbox"/> Cooperative	<input type="checkbox"/> Guarded <input type="checkbox"/> Hyperactive <input type="checkbox"/> Agitated <input type="checkbox"/> Paranoid
<input type="checkbox"/> Stereotyped	<input type="checkbox"/> Aggressive <input type="checkbox"/> Bizarre <input type="checkbox"/> Withdrawn <input type="checkbox"/> Other
Comments: <u>Hesitant to answer questions</u>	
<b>INSIGHT</b>	<input type="checkbox"/> Good <input checked="" type="checkbox"/> Fair <input type="checkbox"/> Poor    Comments:
<b>JUDGMENT</b>	<input type="checkbox"/> Good <input checked="" type="checkbox"/> Fair <input type="checkbox"/> Poor    Comments:



# Suicide Risk Screening Tool

## Ask Suicide-Screening Questions

### Ask the patient:

1. In the past few weeks, have you wished you were dead?  Yes  No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?  Yes  No
3. In the past week, have you been having thoughts about killing yourself?  Yes  No
4. Have you ever tried to kill yourself?  Yes  No

If yes, how? No but has self-harmed by "cutting wrists".

When? "Off and on" in the past. Recently a few weeks ago.

If the patient answers Yes to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now?  Yes  No

If yes, please describe: N/A

### Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (\*Note: Clinical judgment can always override a negative screen).
- If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:
  - "Yes" to question #5 = acute positive screen (imminent risk identified)
    - Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - "No" to question #5 = non-acute positive screen (potential risk identified)
    - Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient's care.

### Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

