

Mental Status Exam

Client Name MT Date 3/8/24

OBSERVATIONS

Appearance Neat Disheveled Inappropriate Bizarre Other
 Speech Normal Tangential Pressured Impoverished Other
 Eye Contact Normal Intense Avoidant Other
 Motor Activity Normal Restless Tics Slowed Other
 Affect Full Constricted Flat Labile Other

Comments:

MOOD

Euthymic Anxious Angry Depressed Euphoric Irritable Other

Comments:

COGNITION

Orientation Impairment None Place Object Person Time
 Memory Impairment None Short-Term Long-Term Other
 Attention Normal Distracted Other

Comments:

PERCEPTION

Hallucinations None Auditory Visual Other
 Other None Derealization Depersonalization

Comments:

THOUGHTS

Suicidality None Ideation Plan Intent Self-Harm
 Homicidality None Aggressive Intent Plan
 Delusions None Grandiose Paranoid Religious Other

Comments:

BEHAVIOR

Cooperative Guarded Hyperactive Agitated Paranoid
 Stereotyped Aggressive Bizarre Withdrawn Other

Comments:

INSIGHT Good Fair Poor Comments: limited

JUDGMENT Good Fair Poor Comments:

1. Have you ever felt you ou
2. Have people **ANNOYED** yc
3. Have you ever felt **GUILTY**
4. Have you ever had a drink in symptoms, or get rid of a hangov

RING
r more positive responses

Did
have at
admission



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? _____

When? _____

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

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

If yes, please describe: _____

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

