MENTAL HEALTH PROGRAMME: PSYCHIATRIC ASSESSMENT / REPORT



Please note: complete form in BLOCK CAPITALS Please return this form to: **mhnurses@cigna.com**

Hospital name					
Telephone number					
Fax number					
PATIENT DETAILS					
Name					
Member number					
Address					
Postcode					
Date of birth					
CONSULTANT DETAILS					
Name					
Email					
Telephone					
Diagnosis					
DSM V Code					
Brief description presenting problems/contextual situation:					
End description presenting problems/contextual studeton.					

PROPOSED TREATMENT PLAN				
Risk Assessment				
Suicide risk: Detail current and recent suicidal thoughts, plans or intent and how this is managed				
Aggressive behaviour: Leading to fear of injury to others or self				
Self-neglect: To the extent that it requires clinical management.				
Nutritional deficiency: Requiring restoration of body weight, hydration, and nutritional status				
Other: Provide details of other risks not already identified				

Please identify the number of ps diagnoses. Note that plan doesn must involve specifically identifie	't cover long ter	rm follow up and r	nonitoring over an ext	ended perio	od of time. These appointments			
Number of appointments requested		Frequency of appointments		Purpose(s)				
Psychopharmacology: Please detail all medications including start date and dosage.								
Date begun		Drug name		Dosage				
Psychotherapy: Please identify t sonal) and expected number of therapist at a time								
Therapist name	Format		Therapy modality		Number of sessions			
Other treatment(s)								
Information on this form will be re Further information may be requ Submission of this form does not	ested.							
Signature of consultant								
Date								

Together, all the way."



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