Behavioral Health / Psychiatry Patient Intake

MENTAL HEALTH & PSYCHIATRY PRACTICE PACK

Patient / DOB _____

Primary concerns _____

Current psychiatric medications _____

Other medications _____

Allergies _____

Prior diagnoses/treatment _____

Hospitalizations _____

Substance use _____

Primary care / other clinicians _____

- ■ Depression symptoms
- ■ Anxiety/panic
- ■ Mood elevation/irritability
- ■ Psychosis symptoms
- ■ Trauma symptoms
- ■ Sleep disturbance
- ■ Attention concerns
- ■ Eating concerns
- ■ Substance-use concern
- ■ Current suicidal thoughts
- ■ Current homicidal thoughts
- ■ Recent self-harm

Immediate risk assessment / action _____

Initial clinical plan _____

Patient/Staff Signature: _____ **Date:** _____

Reviewer / Clinician: _____ **Date:** _____

Behavioral Health Treatment Informed Consent

MENTAL HEALTH & PSYCHIATRY PRACTICE PACK

I consent to behavioral-health evaluation and treatment as clinically appropriate. Services may include diagnostic assessment, psychotherapy, medication management, care coordination, referrals, and follow-up.

I understand treatment benefits and risks vary, confidentiality has legal exceptions, and urgent safety concerns may require emergency intervention or disclosure permitted/required by law.

Services anticipated _____

Alternatives / limitations discussed _____

Confidentiality exceptions reviewed _____

Patient/Staff Signature: _____ **Date:** _____

Reviewer / Clinician: _____ **Date:** _____

Telepsychiatry / Telebehavioral Health Consent

MENTAL HEALTH & PSYCHIATRY PRACTICE PACK

I consent to behavioral-health services by telehealth when clinically appropriate. I understand limitations may include technology failure, privacy limitations, inability to perform certain in-person assessments, and the need to verify my physical location for emergency planning.

Patient physical location _____

Callback number _____

Emergency contact _____

Local emergency resource / plan _____

Patient/Staff Signature: _____ **Date:** _____

Reviewer / Clinician: _____ **Date:** _____

Psychotropic Medication Treatment Acknowledgment

MENTAL HEALTH & PSYCHIATRY PRACTICE PACK

I understand medication decisions are individualized and may require laboratory testing, vital signs, pregnancy/reproductive considerations, drug-interaction review, side-effect monitoring, and coordination with other clinicians.

Medication / class _____

Indication _____

Material risks discussed _____

Alternatives _____

Monitoring plan _____

Patient/Staff Signature: _____ **Date:** _____

Reviewer / Clinician: _____ **Date:** _____

Controlled Medication Safety Agreement - Behavioral Health

MENTAL HEALTH & PSYCHIATRY PRACTICE PACK

- ■ Use medication only as prescribed
- ■ Disclose controlled medications from other clinicians
- ■ Complete monitoring when clinically indicated
- ■ Report lost/stolen medication promptly
- ■ Avoid unsafe combinations as instructed
- ■ Do not share/sell/divert medication
- ■ Use designated pharmacy if required
- ■ Store medication securely
- ■ Understand early replacement is not guaranteed
- ■ Attend required follow-up

Medication/category _____

Pharmacy _____

Monitoring expectations _____

Patient/Staff Signature: _____ **Date:** _____

Reviewer / Clinician: _____ **Date:** _____

Template notice: General educational/operational starting point only. It is not legal, medical, billing, cybersecurity, or regulatory advice and does not guarantee compliance. Customize for the practice, patient population, technology, payer requirements, clinician scope, state/federal law, and current official agency guidance. Obtain qualified legal, privacy/security, billing, and clinical review as applicable.

Behavioral Health Safety / Crisis Plan Worksheet

MENTAL HEALTH & PSYCHIATRY PRACTICE PACK

Warning signs _____

Internal coping strategies _____

People/places for distraction/support _____

Trusted contacts _____

Professional/clinical contacts _____

Local emergency/crisis resources _____

Steps to make environment safer / reduce access to lethal means _____

Reasons for living / protective factors _____

This worksheet should be individualized by the patient and clinician. Emergency services should be used when immediate danger cannot be safely managed through an outpatient plan.

Patient/Staff Signature: _____ **Date:** _____

Reviewer / Clinician: _____ **Date:** _____

Care Coordination & Information Sharing Worksheet

MENTAL HEALTH & PSYCHIATRY PRACTICE PACK

Identify clinicians, family/support persons, schools, facilities, or other organizations relevant to care. Obtain legally sufficient authorization before disclosure when required.

Person/organization _____

Relationship/purpose _____

Contact _____

Information needed/shared _____

Authorization status / expiration _____

Patient/Staff Signature: _____ **Date:** _____

Reviewer / Clinician: _____ **Date:** _____

Psychiatry Medication Follow-Up Worksheet

MENTAL HEALTH & PSYCHIATRY PRACTICE PACK

Medication / dose _____

Adherence _____

Target symptoms _____

Sleep _____

Mood _____

Anxiety _____

Attention/function _____

Appetite/weight _____

Substance use changes _____

- ■ Sedation
- ■ GI effects
- ■ Movement symptoms
- ■ Suicidal thoughts
- ■ Activation/agitation
- ■ Sexual side effects
- ■ Cardiovascular symptoms
- ■ Other adverse effects

Clinical assessment _____

Medication plan _____

Monitoring / follow-up _____

Patient/Staff Signature: _____ **Date:** _____

Reviewer / Clinician: _____ **Date:** _____

High-Risk Outreach / Missed Appointment Documentation

MENTAL HEALTH & PSYCHIATRY PRACTICE PACK

Patient _____

Scheduled appointment _____

Risk context _____

Outreach date/time _____

Method _____

Outcome _____

Emergency contact attempted if authorized/appropriate _____

Welfare/emergency escalation considered _____

Clinician notified _____

Follow-up plan _____

Use practice policy and clinical judgment to determine appropriate outreach and escalation. Documentation should not imply that every missed appointment requires emergency intervention.

Patient/Staff Signature: _____ **Date:** _____

Reviewer / Clinician: _____ **Date:** _____

Behavioral Health Treatment Goals & Progress Review

MENTAL HEALTH & PSYCHIATRY PRACTICE PACK

Primary diagnosis/problem _____

Goal 1 _____

Goal 2 _____

Goal 3 _____

Interventions _____

Patient-reported progress _____

Functional change _____

Barriers _____

Updated plan _____

Next review date _____

Patient/Staff Signature: _____ **Date:** _____

Reviewer / Clinician: _____ **Date:** _____