

STANDARD PSYCHIATRIC HISTORY AND PHYSICAL

What follows are the essential elements of the initial psychiatric work-up. Although very similar to the evaluations performed by other fields of medicine, the history and physical (H&P) described below is modified and expanded in certain areas to meet the specific needs of psychiatry. Medicare also requires certain elements in a work-up. Most required elements are consistent with routine medical care. However, there are occasional required elements, which are not routinely done. These are bolded.

Some general information about the process:

- The H&P must be dictated at the time of hospital admission. Use the STAT dictation mode. Forms are available to facilitate completion of the examination, document that an examination was performed and serve as a template for dictation - but are not mandatory. Evaluations performed in outpatient settings are less urgent and frequently will not include a physical examination but should follow the same format otherwise.
- If a particular aspect of the examination is not performed, indicate, "not done". Do not write, "defer" unless you plan to document the examination later. It can be useful to elaborate on the reasons (e.g. "patient too somnolent to allow testing of cognition"). These occurrences should be rare. Examinations of the genitals and breasts may be skipped if the patient has had it done in the past year. However, this should not be an invariant practice and a sensible plan to address this portion of the physical examination seems prudent (e.g. "mammograms one year ago – unremarkable according to patient, she will follow-up with primary care doctor"). If an important portion of the examination is incomplete, attention should be given in the A/P to a sensible plan to complete the examination at a later date. If the patient is not admitted to your service, inform the resident about the aspects of the exam that could not be completed or, in the case of attendings without a resident, inform the admitting attending.
- Do not use descriptions such as "within normal limits". Instead, indicate the results.
- Each examination needs to uniquely reflect the person being examined. Comments made by the patient should be placed in quotation marks and can be a very effective way to document certain aspects about a patient's mental status.
- The dictation should be initiated in a standard manner - example: "This is Dr. (resident) dictating the STAT psychiatric admission note for patient (W), hospital name (X), floor (Y), attending physician (Z)."

I. "IDENTIFICATION":

"This is the ___ psychiatric admission of this ___ (age) year old, _____ (marital status, race, gender) who was brought to the hospital by _____ (relatives, police, self)". If in hospital, "He/she enters as a patient on Dr. _____'s service as a voluntary/involuntary patient".

II. "INFORMANTS":

Estimate the reliability of the source. Also include the relationship of the source to the patient and how well the source knows the patient. Because of HIPPA one should also note here that permission was obtained to talk with informants.

III. "CHIEF COMPLAINT":

The chief complaint should always be a quotation of the patient's own complaint, not the relative's or doctor's paraphrase.

Psychiatry History And Physical

**Allan Tasman, Jerald Kay, Jeffrey A.
Lieberman, Michael B. First, Michelle
Riba**

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Lorraine Loretz,2005-01-01 Designed to save time and assist busy practitioners this book guides standardized assessment and documentation of a patient s condition by providing ready to use forms that represent the gold standard of current practice **Psychiatry, 2 Volume Set** Allan Tasman,Jerald Kay,Jeffrey A. Lieberman,Michael B. First,Michelle Riba,2015-03-30 Now in a new Fourth Edition Psychiatry remains the leading reference on all aspects of the current practice and latest developments in psychiatry From an international team of recognised expert editors and contributors Psychiatry provides a truly comprehensive overview of the entire field of psychiatry in 132 chapters across two volumes It includes two new sections on psychosomatic medicine and collaborative care and on emergency psychiatry and compares Diagnostic and Statistical Manual DSM 5 and International Classification of Diseases ICD10 classifications for every psychiatric disorder Psychiatry Fourth Edition is an essential reference for psychiatrists in clinical practice and clinical research residents in training and for all those involved in the treatment psychiatric disorders Includes a a companion website at www.tasmanpsychiatry.com featuring PDFs of each chapter and downloadable images **The American Journal of Psychiatry**

,2009 **Atlas of Psychiatry** Waguih William IsHak,2023-02-27 This atlas is the first fully visual reference to cover psychiatry broadly appealing to psychiatric as well as non psychiatric clinicians and trainees who need an easy to use visual resource with holistic approach to patient care Written by expert clinicians and educators this text describes basic clinical and scholarly information across the field utilizing an easy to understand format The rich figures and tables describe etiology pathophysiology phenomenology and treatment even in areas that are difficult to illustrate including substance related disorders neurodegenerative diseases personality disorders and others The visual approach proves valuable to some of the most innovative techniques in psychiatry including implications for neuroimaging Comprehensive and unique Atlas of Psychiatry is a landmark reference for all medical practitioners looking for an intricate yet accessible visual resource

Psychiatry Allan Tasman,Jerald Kay,Jeffrey A. Lieberman,Michael B. First,Michelle Riba,2015-01-29 Now in a new Fourth Edition Psychiatry remains the leading reference on all aspects of the current practice and latest developments in

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