N.J. DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
PSYCHIATRIC HOSPITAL

INITIAL
PSYCHIATRIC ASSESSMENT AND TREATMENT/STABILIZATION PLAN

Source of Information: ☐ Patient ☐ Family ☐ Significant Other ☐ Records

Language Line utilized to complete the Screening: ☐ (Check if applicable)

If checked, Name of Language Line Interpreter: __________________________

1. Admission Status (Legal Category):
☐ Involuntary  ☐ Voluntary  ☐ CEPP  ☐ CEPP/CR  ☐ IST Evaluation
☐ IST  ☐ Krol  ☐ Megan’s Law
☐ Other: ____________________________

2. Does the patient have a Mental Health Advance Directive?: ☐ Yes ☐ No ☐ Unable to answer

Is a physical copy of the Mental Health Advance Directive filed in chart?: ☐ Yes ☐ No

3. Chief Complaint: ____________________________

4. Current History and Assessment (Include onset of symptoms and circumstances leading to admission, assessment of data/symptom):

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

5. Past Psychiatric History/Current Treatment: ____________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________
### Suicide/Self Injurious/Foreign Body Ingestion/Risk and Protective Factors

**Instructions:** Check all that apply. Modified COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS) – Screen Version – Recent (S1)

<table>
<thead>
<tr>
<th>Suicidal Ideation – Ask Questions 1 and 2.</th>
<th>Past 1 Month</th>
<th>Past 6 Months</th>
<th>None Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Wish to be dead</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Suicidal thoughts</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If YES to 2, ask question 3, 4, 5 and 6. If NO, go directly to question 6.

<table>
<thead>
<tr>
<th>Suicidal thoughts with method (but without specific plan or intent to act)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Suicidal ideation with some intent but without specific plan</td>
<td></td>
</tr>
<tr>
<td>4. Suicidal ideation with specific plan and intent</td>
<td></td>
</tr>
</tbody>
</table>

**Suicide Behavior**

6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?

- [ ] Yes
- [ ] No

If YES, ask: How long ago did you do any of these?

- [ ] Over a year ago
- [ ] Between three months and a year ago
- [ ] Within the last three months

**Self-injurious behavior and foreign body ingestion**

<table>
<thead>
<tr>
<th>Past 1 Month</th>
<th>Past 6 Months</th>
<th>None Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Self-injurious behavior without suicidal intent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Foreign body ingestion</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Describe any suicidal, self-injurious or aggressive behavior (include dates)**

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### Modified COLUMBIA-SUICIDE SEVERITY RATING SCALE – Risk Assessment

#### Activating Events/Risk Factors

Check all that apply or:

- [ ] None

- [ ] Recent Loss(es) or other significant negative events (legal, financial, relationship, etc.)
- [ ] Social isolation/feeling alone
- [ ] Hopelessness
- [ ] Other:
  - [ ] Mixed affective (Bipolar)
  - [ ] Major depressive episode
  - [ ] Highly impulsive behavior
  - [ ] Command hallucinations to hurt self

#### Protective Factors (Recent)

Check all that apply:

- [ ] Identifies reason for living
- [ ] Responsibility to family or others; living with family
- [ ] Supportive social network
- [ ] Other
  - [ ] Substance abuse/dependence
  - [ ] Agitation or severe anxiety
  - [ ] Perceived burden on family or others
  - [ ] Sexual abuse (lifetime)
  - [ ] Chronic physical pain or other acute medical problem
  - [ ] Pending incarceration
  - [ ] Family history of suicide (lifetime)

#### Treatment History

Check all that apply:

- [ ] Previous psychiatric diagnoses and treatments
- [ ] Non-compliant with treatment
- [ ] Hopeless or dissatisfied with treatment
- [ ] No prior treatment
- [ ] Refused or unable to develop a safety plan

#### Estimated Risk Status

Acute:  
- [ ] Low Risk
- [ ] Moderate Risk
- [ ] High Risk

#### Description and Explanation of Risk

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**Referred to Psychologist for full C-SSRS Suicide Risk Assessment**

- [ ] Yes
- [ ] No
7. Trauma History

- Patient reports history of traumatic psychological (combat, physical/sexual assault) [☐ Yes ☐ No ☐ Incomplete event information]
- Reported intrusive thoughts or nightmares surrounding event [☐ Yes ☐ No ☐ Incomplete event information]
- Reports avoidant behaviors to minimize memory of event [☐ Yes ☐ No ☐ Incomplete event information]
- Reports being hyper vigilant and perpetually on alert for potential harm [☐ Yes ☐ No ☐ Incomplete event information]
- Expresses feelings of numbness, detached from others [☐ Yes ☐ No ☐ Incomplete event information]
- Reports that these dangerous or life threatening experiences are still occurring in their life [☐ Yes ☐ No ☐ Incomplete event information]
- There is history of significant physical, emotional abuse, neglect or sexual abuse as a child or adult that places this patient at increased risk if placed in restraint [☐ Yes ☐ No ☐ Incomplete event information]

Additional Comments: ____________________________

8. Medical History/Surgical History: ____________________________

9. Allergies/Adverse Drug Reaction (Include Food and Drug Allergies): ____________________________

10. Social and Family History: ____________________________

11. Substance Abuse: Has patient used in the past 12 months: ☐ No ☐ Yes

<table>
<thead>
<tr>
<th>Substance of Abuse</th>
<th>Quantity / Frequency / Route / Last Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiates/ Opioids/ Synthetic Opiates</td>
<td></td>
</tr>
<tr>
<td>Amphetamines</td>
<td></td>
</tr>
<tr>
<td>Cocaine</td>
<td></td>
</tr>
<tr>
<td>Cannabis/Marijuana</td>
<td></td>
</tr>
<tr>
<td>Synthetic Cannabis</td>
<td></td>
</tr>
</tbody>
</table>
Hallucinogens/Synthetic Hallucinogens
Dissociative Anesthetics
Sedatives/Tranquilizers/Hypnotics
Anabolic Steroids
Caffeine
Inhalants/Huffing
Alcohol
Over the Counter
Methyamphetamine
Synthetic Cathinone
Other:

Additional Comments:

12. **Alcohol Screening** (Circle answer & score): Each answer has 5 choices and points are allotted as follows:

   - **How often have you had a drink containing alcohol in the past year?** (If a. is circled, proceed to score and enter 0)
     a. Never (0 pts.)
     b. Monthly or less (1 pts.)
     c. 2-4 per month (2 pts.)
     d. 2-3 per week (3 pts.)
     e. 4 or more per week (4 pts.)

   - **How many standard drinks containing alcohol do you have on a typical day in the past year?**
     a. 1 or 2 (0 pts.)
     b. 3 or 4 (1 pts.)
     c. 5 or 6 (2 pts.)
     d. 7 to 9 (3 pts.)
     e. 10 or more (4 pts.)

   - **How often do you have six or more drinks on one occasion in the past year?**
     a. Never (0 pts.)
     b. Less than monthly (1 pts.)
     c. Monthly (2 pts.)
     d. Weekly (3 pts.)
     e. Daily or almost daily (4 pts.)

**Score:**

**Scoring:**
Men: A score of 4 or more is considered positive, optimal for identify hazardous drinking or active alcohol use disorders.
Women: A score of 3 or more is considered positive, optimal for identify hazardous drinking or active alcohol use disorders.

13. **Tobacco Use Screening**:  
   A. Tobacco Use/Smoking History:  
      ☐ Non User/ Smoker  ☐ Former Use/ Smoker  ☐ Current User/Smoker
   B. Have you used a tobacco in the last 30 days:  
      ☐ Yes (Answer C. through F.)  ☐ No
   C. Tobacco Products used:
      ☐ Cigarettes  ☐ Dry Snuff  ☐ Moist Snuff  ☐ Chewing/Plug/Twist Tobacco
      ☐ Smokeless Tobacco  ☐ Snus(moist powder tobacco)  ☐ Other: ______________________
   D. Volume:
      ☐ Heavy smoker: Patient has smoked 5 or more cigarettes per day and/or cigars daily and/or pipes daily during the past 30 days.
      ☐ Light smoker: Patient has smoked 4 or less cigarettes per day and/or used smokeless tobacco and/or smoked cigarettes but not daily and/or used cigars but not daily and/or pipes but not daily during the past 30 days.
E. Face-to-face, practical, tobacco use counseling provided:  ☐ Yes  ☐ No  ☐ Refused

F. Patient consented to treatment and FDA-approved tobacco cessation medication ordered:  ☐ Yes  ☐ No

If No, why not:  ☐ Refused  ☐ Allergy to Nicotine Replacement Therapies  ☐ Pregnant  ☐ Patient only uses smokeless tobacco  ☐ Drug Interaction  ☐ Patient has been at a non-smoking setting for the previous 30 days

14. **Legal History** (Include dates of incarceration, if any, and implications for treatment, as applicable): __________________________

15. **Violence Risk Assessment**

- Previous violence (verbal/physical):  ☐ No  ☐ Maybe/ moderate  ☐ Yes  ☐ Unable to obtain
- Current violence (verbal/physical) in the past 6 months:  ☐ No  ☐ Maybe/ moderate  ☐ Yes  ☐ Unable to obtain
- Previous substance abuse:  ☐ No  ☐ Maybe/ moderate  ☐ Yes  ☐ Unable to obtain
- Current substance abuse:  ☐ No  ☐ Maybe/ moderate  ☐ Yes  ☐ Unable to obtain
- Previous major mental illness:  ☐ No  ☐ Maybe/ moderate  ☐ Yes  ☐ Unable to obtain
- Current major mental illness:  ☐ No  ☐ Maybe/ moderate  ☐ Yes  ☐ Unable to obtain
- Personality disorder:  ☐ No  ☐ Maybe/ moderate  ☐ Yes  ☐ Unable to obtain
- Shows lack of insight into illness and/or behavior:  ☐ No  ☐ Maybe/ moderate  ☐ Yes  ☐ Unable to obtain
- Expresses suspicion/paranoia:  ☐ No  ☐ Maybe/ moderate  ☐ Yes  ☐ Unable to obtain
- Does patient have present or past history of sexual aggression:  ☐ No  ☐ Maybe /moderate  ☐ Yes  ☐ Unable to obtain
- Does the patient have a history of significant damage to property and/or arson:  ☐ No  ☐ Maybe /moderate  ☐ Yes  ☐ Unable to obtain
- Does patient pose a threat to a specific individual:  ☐ No  ☐ Maybe /moderate  ☐ Yes  ☐ Unable to obtain

If Yes, state name and relationship: __________________________

16. **Mental Status** (Check all application areas):

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Healthy</th>
<th>Unkempt</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Healthy</td>
<td>☐ Well groomed</td>
<td>☐ Tense</td>
</tr>
<tr>
<td>☐ Unkempt</td>
<td>☐ Tics</td>
<td>☐ Gesturing (odd)</td>
</tr>
<tr>
<td>☐ Other</td>
<td>☐ Sickly</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Appropriate</td>
</tr>
<tr>
<td>☐ Hostile</td>
</tr>
<tr>
<td>☐ Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Speech</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Soft</td>
</tr>
<tr>
<td>☐ Loud</td>
</tr>
<tr>
<td>☐ Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mood</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Euthymic</td>
</tr>
<tr>
<td>☐ Depressed</td>
</tr>
</tbody>
</table>
### Initial Psychiatric Assessment and Treatment/Stabilization Plan

**Anxious:**
- [ ] Yes
- [ ] No

**Affect**
- [ ] Anxious
- [ ] Other:

**Perceptual**
- [ ] None
- [ ] Other:

**Thought Process**
- [ ] Goal directed
- [ ] Distractibility
- [ ] Circumstantial

**Thought Content**
- [ ] Homicidal Ideation
- [ ] Suicidal Ideation
- [ ] Harm to others (Assault)
- [ ] Delusions
- [ ] Ideas of Reference

**Insight into illness:**

**Judgment (Evidenced by, i.e., plans for the future. Describe patient’s words and behavior):**

**Cognitive Registration (Ask the patient to repeat 3 words):**

**Attention/Concentration (Ask the patient to spell a 5 letter word backwards):**

**Orientation (Person, place time):**

**Memory (Recent/Remote):**

**Immediate Recall:**

**Abstract reasoning (Give the patient a proverb and ask him/her what it means; give the patient verbal similarities and difference and ask him/her to explain):**

**Cognitively Impaired:**
- [ ] Yes
- [ ] No

If Yes, will patient be cognitively impaired for at least 3 days:
- [ ] Yes
- [ ] No

17. **Admitting Diagnoses:**

**Psychiatric:**

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**INITIAL PSYCHIATRIC ASSESSMENT AND TREATMENT/STABILIZATION PLAN**

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18. Summary or Assessment:


19. Initial Psychiatric Treatment/Stabilization Plan:

- **Assets/Patient Strengths:**

  - Support: ____________________
  - Interests: ____________________
  - Talent/Skill sets: ____________________
  - Personal experiences: ____________________
  - Education: ____________________
  - Family/relationships: ____________________
  - Spiritual/religion: ____________________
  - Employment status: ____________________
  - Other: ____________________
  - Other: ____________________

- **Anticipated Discharge Plan:**

  - SERVICES
    - Outpatient Mental Health Treatment
    - PACT
    - Substance Abuse Treatment
    - Other: ____________________
  - PLACEMENT
    - Home/Family
    - Group home
    - Nursing home
    - Supportive housing
    - Boarding home/RHCF
    - Other: ____________________

- **Initial Justification for Hospitalization/Problems/Plan of Care:**

  - Problem(s) Related to Safety:
    - Unable to care for self, as evidenced by: ____________________
    - Danger to self, as evidenced by: ____________________
    - Danger to others, as evidenced by: ____________________
    - Danger to property, as evidenced by: ____________________
    - Other, as evidenced by: ____________________
  - Long Term Goal: Patient will remain free of injury to self, others, property during hospitalization.
  - Short Term Objective: Patient will remain free of injury to self, others, property for the next 7 days.
  - Intervention: Patient observation via: Every 15 minute safety check
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1:1 observation</td>
<td>Fall Risk</td>
</tr>
<tr>
<td>Assess safety risk daily</td>
<td>Refer for psychological risk assessment</td>
</tr>
<tr>
<td><strong>Other:</strong></td>
<td></td>
</tr>
</tbody>
</table>
### Problem(s) Related to Stabilization

- **Psychosis**, as evidenced by:
  - Hallucinations, specify: ____________________________
  - Delusions, specify: ____________________________
  - Other: ____________________________
- **Mood Disturbance**, as evidenced by: ____________________________
- **Substance Abuse**, as evidenced by: ____________________________
- Other: ____________________________, as evidenced by: ____________________________

**Long Term Goal:**
- Patient will demonstrate a reduction of psychiatric symptomology, ____________________________ (Specify) prior to discharge.
- Allow for placement in a less restrictive environment.
- Other: ____________________________

**Short Term Objective:**
- Patient will identify target symptoms contributing to hospitalization within 7 days.
- Patient will provide at least one benefit of medication/treatment within 7 days.
- Other: ____________________________

**Interventions:**
- Medication Management with ____________________________ for ____________________________ (Indication)
- Medication Management with ____________________________ for ____________________________ (Indication)
- Medication Management with ____________________________ for ____________________________ (Indication)
- Medication Management with ____________________________ for ____________________________ (Indication)
- Refer for drug use brief intervention
- Refer for alcohol use brief intervention
- Refer for psychology assessment
- Other: ____________________________

### Problem(s) Related to Engagement

- **Supports are insufficient to maintain safety and psychiatric stabilization in less restrictive environment**, as evidenced by: ____________________________
- Other, as evidenced by: ____________________________

**Long Term Goal:**
- Patient will utilize resources and supports to maintain their own safety and psychiatric stabilization prior to discharge.
- Other: ____________________________

**Short Term Objective:**
- Patient will successfully transition to therapeutic milieu/active treatment as demonstrated by appropriate social interactions, self-care medication adherence, participation in discipline specific assessments and review of recommended treatment mall programming within 7 days.
- Other: ____________________________

**Interventions:**
- Staff will provide the patient unit specific orientation to the therapeutic milieu.
- Treatment Team will collaborate with patient to identify initial Treatment Mall programs with a focus towards engagement.
- Social Service, Rehabilitation and other referred disciplines will complete assessments prior to day 7.
- Other: ____________________________