* [NU672-7A](https://herzing.instructure.com/courses/27659)
* [Assignments](https://herzing.instructure.com/courses/27659/assignments)
* [Unit 4 Assignment - **Adult Psychiatric Initial Interview/Assessment**](https://herzing.instructure.com/courses/27659/assignments/785450)

Immersive Reader

Instructions

**In this assignment, you will complete a comprehensive psychiatric assessment interview of an adult/older adult.** You can use a patient you’ve seen in clinical or someone in your personal life. Your assessment should be comprehensive, and you should refer to course texts to inform items for inclusion in your assessment. Keep in mind that you will be responsible for covering those areas addressed in the reading assignments up to this point.

**Students always ask for a template.  Below is one that can be used to guide you in not forgetting any crucial information**. There are further pieces of this assessment to include in the first column of this template. Make sure all points are addressed in each section.   
At a minimum, 4 scholarly references should be included and cited in APA 7th Edition formatting. The references page should be set up similar to papers that are in full APA 7th edition formatting.

**The template that you are going to use for doing this assignment:**

**The template has answers that you have to alter or change.**

# **Initial Psychiatric Interview/SOAP Note Template**

There are different ways in which to complete a Psychiatric SOAP (Subjective, Objective, Assessment, and Plan) Note. This is a template that is meant to guide you as you continue to develop your style of SOAP in the psychiatric practice setting.

|  |  |
| --- | --- |
| **Criteria** | **Clinical Notes** |
|  |  |
| **Informed Consent** | Informed consent given to patient about psychiatric interview process and psychiatric/psychotherapy treatment. Verbal and Written consent obtained. Patient has the ability/capacity to respond and appears to understand the risk, benefits, and (Will review additional consent during treatment plan discussion) |
| **Subjective** | Verify Patient  Name:  DOB:  Minor:  Accompanied by:  Demographic:  Gender Identifier Note:  CC:  HPI:  Pertinent history in record and from patient: X  During assessment: Patient describes their mood as X and indicated it has gotten worse in TIME.  Patient self-esteem appears fair,no reported feelings of excessive guilt,  no reported anhedonia,does not report sleep disturbance, does not report change in appetite, does not report libido disturbances,does not report change in energy,  no reported changes in concentration or memory.  Patient does not report increased activity, agitation, risk-taking behaviors, pressured speech, or euphoria.Patient does not report excessive fears, worries or panic attacks.  Patient does not report hallucinations, delusions, obsessions or compulsions. Patient’s activity level, attention and concentration were observed to be within normal limits. Patient does not report symptoms of eating disorder. There is no recent weight loss or gain. Patient does not report symptoms of a characterological nature.  SI/ HI/ AV:Patient currently deniessuicidal ideation, deniesSIBx,denieshomicidal ideation, deniesviolent behavior, deniesinappropriate/illegal behaviors.  Allergies: NKDFA.  (medication & food)  Past Medical Hx:  Medical history: Denies cardiac, respiratory, endocrine and neurological issues, including history head injury.  Patient denies history of chronic infection, including MRSA, TB, HIV and Hep C.  Surgical history no surgical history reported  Past Psychiatric Hx:  **Previous psychiatric diagnoses**: none reported.  Describes stable course of illness.  **Previous medication trials**: none reported.  **Safety concerns:**  History of Violence to Self:none reported  History of Violence to Others: none reported  Auditory Hallucinations:  Visual Hallucinations:  **Mental health treatment history** discussed:  History of outpatient treatment: not reported  Previous psychiatric hospitalizations: not reported  Priorsubstance abuse treatment: not reported  **Trauma history:** Client does not report history of trauma including abuse, domestic violence, witnessing disturbing events.  **Substance Use:** Client denies use or dependence on nicotine/tobacco products.  Client does not report abuse of or dependence on ETOH, and other illicit drugs.  Current Medications: No current medications.  (Contraceptives):  Supplements:  Past Psych Med Trials:  Family Medical Hx:  Family Psychiatric Hx:  Substance use  Suicides  Psychiatric diagnoses/hospitalization  Developmental diagnoses  Social History:  Occupational History: currently unemployed. Denies previous occupational hx  Military service History:Denies previous military hx.  Education history: completed HS and vocational certificate  Developmental History: no significant details reported.  (Childhood History include in utero if available)  Legal History: no reported/known legal issues,no reported/known conservator or guardian.  Spiritual/Cultural Considerations: none reported.  ROS:  Constitutional: No report of fever or weight loss.  Eyes: No report of acute vision changes or eye pain.  ENT: No report of hearing changes or difficulty swallowing.  Cardiac: No report of chest pain, edema or orthopnea.  Respiratory: Denies dyspnea, cough or wheeze.  GI: No report of abdominal pain.  GU: No report of dysuria or hematuria.  Musculoskeletal: No report of joint pain or swelling.  Skin: No report of rash, lesion, abrasions.  Neurologic: No report of seizures, blackout, numbness or focal weakness. Endocrine: No report of polyuria or polydipsia.  Hematologic: No report of blood clots or easy bleeding.  Allergy: No report of hives or allergic reaction.  Reproductive: No report of significant issues. (females: GYN hx; abortions, miscarriages, pregnancies, hysterectomy, PCOS, etc…) |
| *Verify Patient:* Name, Assigned **identification** number (e.g., medical record number), Date of birth, Phone number, Social security number, Address, Photo.  *Include demographics, chief complaint, subjective information from the patient, names and relations of others present in the interview.*  *HPI:*  *, Past Medical and Psychiatric History,*  *Current Medications, Previous Psych Med trials,*  *Allergies.*  *Social History, Family History.*  *Review of Systems (ROS) – if ROS is negative, “ROS noncontributory,” or “ROS negative with the exception of…”* |
| **Objective** | **Vital Signs:** Stable  Temp:  BP:  HR:  R:  O2:  Pain:  Ht:  Wt:  BMI:  BMI Range:  LABS:  Lab findings WNL  Tox screen: Negative  Alcohol: Negative  HCG: N/A  Physical Exam:  MSE:  Patient is cooperative and conversant, appears without acute distress, and fully oriented x 4. Patient is dressed appropriately for age and season. Psychomotor activity appears within normal.  Presents with appropriate eye contact,euthymicaffect - full, even,congruent with reported mood of “x”. Speech: spontaneous, normal rate, appropriate volume/tone with no problems expressing self.  TC: no abnormal content elicited, denies suicidal ideation and denieshomicidal ideation. Process appears linear, coherent, goal-directed.  Cognition appears grossly intact with appropriateattention span & concentration and average fund of knowledge.  Judgment appears fair . Insight appearsfair  The patient is ableto articulate needs, is motivated for compliance and adherence to medication regimen. Patient is willing and able to participate with treatment, disposition, and discharge planning. |
| *This is where the “facts” are located.*  *Vitals,*  ***\*\*Physical Exam (if performed, will not be performed every visit in every setting)***  *Include relevant labs, test results, and Include MSE, risk assessment here, and psychiatric screening measure results.* |
| **Assessment** | DSM5 Diagnosis: with ICD-10 codes  Dx: -  Dx: -  Dx: -  Patient has the ability/capacity appears to respond to psychiatric medications/psychotherapy and appears to understand the need for medications/psychotherapy and is willing to maintain adherent.  Reviewed potential risks & benefits, Black Box warnings, and alternatives including declining treatment. |
| *Include your findings, diagnosis and differentials (DSM-5 and any other medical diagnosis) along with ICD-10 codes, treatment options, and patient input regarding treatment options (if possible), including obstacles to treatment.*  *Informed Consent Ability* |
| **Plan**  (Note some items may only be applicable in the inpatient environment) | Inpatient:  Psychiatric. Admits to X as per HPI.  Estimated stay 3-5days  Safety Risk/Plan: Patient is found to be stable and has control of behavior. Patient likely poses a minimal risk to self and a minimal risk to others at this time.  Patient denies abnormal perceptions and does not appear to be responding to internal stimuli.  Pharmacologic interventions: including dosage, route, and frequency and non-pharmacologic:   * No changes to current medication, as listed in chart, at this time * or…Zoloft is an excellent option for many women who experience any menstrual cycle complaints. I usually start at 50 mg and move to 100 week 6-8. f/u within 2 weeks initially then every 6-8 weeks.   + - Psychotherapy referral for CBT   Education, including health promotion, maintenance, and psychosocial needs   * + - Importance of medication     - Discussed current tobacco use. NRT not indicated.     - Safety planning     - Discuss worsening sx and when to contact office or report to ED   Referrals: endocrinologist for diabetes  Follow-up, including return to clinic (RTC) with time frame and reason and any labs that are needed for next visit 2 weeks  ☒> 50% time spent counseling/coordination of care.  Time spent in Psychotherapy 18 minutes  Visit lasted 55 minutes  Billing Codes for visit:  XX  XX  XX  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  NAME, TITLE  Date: Click here to enter a date.Time: X |

| NU672 Unit 4 Assignment - Adult Psychiatric Initial Interview/Assessment Rubric | | |
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| **Criteria** | **Ratings** | **Pts** |
| This criterion is linked to a Learning OutcomeSubjective Data | |  |  |  |  |  | | --- | --- | --- | --- | --- | | **20 pts**  **Exemplary Exceeds Expectations**  Includes all relevant subjective data necessary for differentiation of the client’s problem. Data is presented in systematic, organized manner consistently. | **17 pts**  **Advanced Meets Expectations**  Includes most subjective data with omission of two minor details or one major detail. Most data is presented in systematic, organized manner. | **15 pts**  **Intermediate Needs Improvement**  Includes subjective data but omits four minor details or two major details. Some data is presented in a systematic, organized manner. | **13 pts**  **Novice Inadequate**  Omits more than four minor details or more than two major details of the subjective data. Data is not presented in a systematic, organized manner. Lacking most or all subjective data. Submits assignment late. | **0 pts**  **Incomplete**  Assignment not completed. | | 20 pts |
| This criterion is linked to a Learning OutcomeObjective Data | |  |  |  |  |  | | --- | --- | --- | --- | --- | | **20 pts**  **Exemplary Exceeds Expectations**  Objective data is complete and consistently presented in an organized manner. | **17 pts**  **Advanced Meets Expectations**  Objective data is complete and presented in an organized manner most of the time. | **15 pts**  **Intermediate Needs Improvement**  Objective data is not complete or is not presented in an organized manner. | **13 pts**  **Novice Inadequate**  Objective data is not complete and is not presented in an organized manner. Lacking most or all objective data. Submits assignment late. | **0 pts**  **Incomplete**  Assignment not completed. | | 20 pts |
| This criterion is linked to a Learning OutcomeAssessment | |  |  |  |  |  | | --- | --- | --- | --- | --- | | **20 pts**  **Exemplary Exceeds Expectations**  Assessment, including differential and/or diagnosis (if appropriate), is complete and appropriate to client Diagnostics are complete and appropriate to client. | **17 pts**  **Advanced Meets Expectations**  Assessment, including differential and/or diagnosis (if appropriate), is complete but some may not be appropriate for client. | **15 pts**  **Intermediate Needs Improvement**  Assessment, including differential and/or diagnosis (if appropriate), is not complete but is appropriate. | **13 pts**  **Novice Inadequate**  Assessment, including differential and/or diagnosis (if appropriate), is not complete or appropriate, or it is not evident. Submits assignment late. | **0 pts**  **Incomplete**  Assignment not completed. | | 20 pts |
| This criterion is linked to a Learning OutcomePlan | |  |  |  |  |  | | --- | --- | --- | --- | --- | | **20 pts**  **Exemplary Exceeds Expectations**  Plan includes all relevant measures 95% to 100% Pharmacologic Non-pharmacologic Education Referral Follow-up. | **17 pts**  **Advanced Meets Expectations**  Plan includes all relevant measures 89% to 94% Pharmacologic Non-Pharmacologic Education Referral Follow-up. | **15 pts**  **Intermediate Needs Improvement**  Plan includes four of the five relevant measures, but the four are complete. | **13 pts**  **Novice Inadequate**  Plan is not complete and/or covers only three relevant measures. Plan and relevant measures are not evident. Submits assignment late. | **0 pts**  **Incomplete**  Assignment not completed. | | 20 pts |
| This criterion is linked to a Learning OutcomeProfessional Application | |  |  |  |  |  | | --- | --- | --- | --- | --- | | **10 pts**  **Exemplary Exceeds Expectations**  Case incorporates four evidence-based practice articles. | **8 pts**  **Advanced Meets Expectations**  Case incorporates three evidence-based practice articles. | **7 pts**  **Intermediate Needs Improvement**  Does not include an evidence-based practice article but has two or more advanced practice articles. | **6 pts**  **Novice Inadequate**  Does not include evidence-based practice article but has one advanced practice article or does not include evidence-based practice article or advanced practice article. | **0 pts**  **Incomplete**  Assignment not completed. | | 10 pts |
| This criterion is linked to a Learning OutcomeOrganization, APA, Grammar, and Spelling | |  |  |  |  |  | | --- | --- | --- | --- | --- | | **10 pts**  **Exemplary Exceeds Expectations**  Well organized content that is clear and concise. Correct APA formatting with no errors. The writer correctly identifies reading audience, as demonstrated by appropriate language (avoids jargon and simplifies complex concepts appropriately). There are no spelling, punctuation, or word-usage errors. | **8 pts**  **Advanced Meets Expectations**  Organized content that is informative and supportive of purpose. Correct and consistent APA formatting of references, and cites all references used. No more than one to two unique APA errors. There are minimal to no grammar, punctuation, or word-usage errors. | **7 pts**  **Intermediate Needs Improvement**  Poor organization and flow of ideas may distract from the content. Three to four unique APA formatting errors. The writer occasionally uses awkward sentence construction or overuses/inappropriately uses complex sentence structure. Problems with word usage (evidence of incorrect use of thesaurus) and punctuation persist, often causing some difficulties with grammar. Some words, transitional phrases, and conjunctions are overused. Multiple grammar, punctuation, or word usage errors. | **6 pts**  **Novice Inadequate**  Illogical flow of ideas. Many APA formatting errors, or no attempt to format in APA. The writer struggles with limited vocabulary and has difficulty conveying meaning–noting just the broadest of meanings. Grammar and punctuation are consistently incorrect. Spelling errors are numerous. Submits assignment late. | **0 pts**  **Incomplete**  Assignment not completed. | | 10 pts |
| Total Points: 100 | | |

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