**BEHAVIORAL HEALTH INTAKE FORM**

This is a communication tool to ensure that all necessary safety precautions and screening has occurred. This checklist should be filled out when the patient first arrives and should be updated after mental health evaluation and as needed during their stay. It should be kept with the patient so that ED staff can use it as a reference tool for that patient. Please place check marks next to items as they are completed and complete form as instructed.

***Prior to patient placement into room:***

Clear room of potentially unsafe items (refer to Room Safety Checklist\*)

* *Please fill out date, time and staff initials when room cleared of hazards*

Date/Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Individual Completing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Garage Door Down (if using a designated “safe” room)

***Within the first (golden) hour of arrival:***

Patient placed in safe room

Patient changes into hospital gown or hospital safety gown

Collect Primary Information Intake

* **Past Medical Hx (e.g. asthma, depression):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **Chief Complaint:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **History of Present Illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Allergies (please circle)?** Yes /see chart No

Complete Patient Search with (if available) wand for metal devices

* *Please fill out date, time and staff initials when patient search completed*

Date/Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Individual Completing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete Belongings Search

* *Please fill out date, time and staff initials when belongings search completed*

Date/Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Individual Completing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Store/Secure belongings

* *Were any of the following items below found (circle one)? Yes No*

If yes, please circle all objects below found on patient

Insulin pump   Shoes   Sharps/sharp edge   Heavy Object Pens/pencils

Leggings/tights     Jewelry     Headphones/cords     Belts/laces/ties

Please fill out what happened with the items by circling one below:

Sent home Parent will hold Stored in ED (please fill out location of items)\_\_\_\_\_\_\_\_\_\_

* *Were any other items that are not allowed found (circle one)? Yes No*

Listitems here*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Please fill out what happened with the items by circling one below:

Sent home Parent will hold Stored in ED (please fill out location of items)\_\_\_\_\_\_\_\_\_\_

Remove Cell Phones/Electronics

* Please fill out what happened with the items by circling one below:

Sent home Parent will hold Stored in ED (please fill out location of items)\_\_\_\_\_\_\_\_\_\_

* Please check box if patient given permission to keep cell phone/electronics duration of the ED stay

Provide and Review What to expect education sheet\* if not already given

Provide and Review Restraint Information Sheet/Policy (if your ED has one)

Constant Observation assigned

Exam Room Door to remain Open (unless eval is in progress)

Complete Medication Reconciliation

* *Currently on Medications (circle one)?*Yes No
* *Any non-formulary home meds needed (circle one)*? Yes No
* *Please fill out date, time and staff initials when medication reconciliation completed*

Date/Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Individual Completing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Discuss de-escalation and coping strategies (Use Coping Tool\*)

* Top 3 coping strategies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Likes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Dislikes/Triggers:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Behavioral Health Assessment requested

***After evaluation by either MD or Behavioral Health team:***

Is the patient on an involuntary hold (circle one)? Yes No

Obtain medical testing (if any) for medical clearance

* *Fill in medical test here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time Completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*
* *Fill in medical test here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time Completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*
* *Fill in medical test here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time Completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Assessment of Observation for duration of ED stay

* *Does the patient require 1:1 observation for duration of stay (circle one)?*Yes No

*Reason for observation*(circle all that apply)**:**

Suicidal ideation  Elopement risk

Self-injurious behavior  Psychosis/hallucinations

Agitation/aggression  Homicidal ideation

* *Does the patient require video monitoring (circle one)?*Yes No

*Reason for video monitoring*(circle all that apply)**:**

Suicidal ideation  Elopement risk

Self-injurious behavior  Psychosis/hallucinations

Agitation/aggression  Homicidal ideation

Offer food/menu (if appropriate)

* *Does the patient have an eating disorder (circle one)?* Yes No

*If yes, will they need observation for meals(circle one)?* Yes No

Please fill out visitor restrictions (if any):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Fill out any other special considerations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_