MACOMB COUNTY COMMUNITY MENTAL HEALTH

PSYCHIATRIC OUTPATIENT OFFICE VISIT - NURSE VERSION

FOCUS

Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Primary Program:

Address

Case Holder:

Disability Designation:

Index

1. **Chief Complaint / History**
2. Vital Signs & Labs
3. Send Copy to
4. Signatures

1. Psychiatric Outpatient Office Visit Nursing: Chief Complaint / History

WARNING: Once signed, information in this document will populate the next Psychiatric Outpatient Office Visit (DR/NP/PA version) document added for the same date of service.

Service Date **Start Time**

Use Current Date

○ Established patient

○ New patient (has never been seen or has not been seen in the past 3 years)

Attending Nurse lookup clear

Physicians Add Physician

lookup clear

☐ Primary Care Physician

Date of Last Visit

Name

Address

Specialty

Chief Complaint (symptom, problem, condition, diagnosis)

characters left: 8000

History (HPI, review of systems, PFSH)

characters left: 30000

Medical Co-morbidity (current status)

characters left: 30000

Run Maps: https://sso.state.mi.us/

Maps Report Run

Use Current Date

Prescribed Medications

	Medication	Dates	Prescribed By	Qty Prescribed	Number of Refills

Medication Compliance

○ Always (7days/week) ○ Mostly (4-6 days/week) ○ Sometimes (1-3 days/week) ○ Never (0 days/week)

Other Medications Add Other Medication

Medication lookup clear
Dosage
Qty
Medication Type
Start Date
End Date
Instructions
characters left: 512
Reason
characters left: 256
Physician Name
Prescribing Physician Type

Medication lookup clear
Dosage
Qty
Medication Type
Start Date
End Date
Instructions
characters left: 512
Reason
characters left: 256
Physician Name
Prescribing Physician Type

Adverse Reactions Add Adverse Reaction

Drug / Allergen lookup clear
Reported By
Severity
○ Not Assessed
○ Mild
○ Severe
○ Life-Threatening
☐ This is an Allergy
Reactions
characters left: 4096
Notes
characters left: 8192
Start

Drug / Allergen lookup clear
Reported By
Severity
○ Not Assessed
○ Mild
○ Severe
○ Life-Threatening
☐ This is an Allergy
Reactions
characters left: 4096
Notes
characters left: 8192
Start

Side Effects ☐ Consumer Denies

characters left: 4096

Record Added **Record Changed**

Save and Continue to Vital Signs & Labs | Save | Cancel

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2. Psychiatric Outpatient Office Visit Nursing: Vital Signs & Labs

Consumer's Vital Signs -

Collection Information

Collection Date | **Collection Time**

Use Current Date | Use Current Time

General Information

Height: ft in ☐ Declined ☐ No Information Collected

Weight: lbs oz ☐ Declined ☐ No Information Collected

Waist Circumference: in ☐ Declined ☐ No Information Collected

BMI:

Tobacco Use ☐ Declined ☐ No Information Collected

Smoking Status: **Effective:**

Provided Consumer with advice to quit smoking or tobacco use, or recommended or discussed smoking or tobacco use cessation, medications, methods, or strategies

○ Yes ○ No

Temperature ☐ Declined ☐ No Information Collected

Value:

Pulse ☐ Declined ☐ No Information Collected

Value:

Respiration ☐ Declined ☐ No Information Collected

Value:

Blood Pressure ☐ Declined ☐ No Information Collected

Value: Systolic mmHg / **Diastolic** mmHg

Comments

Reaction: ○ Cooperative ○ Declined ○ Resisted(Uncooperative)

Comments

characters left: 4096

Labs

Most Recent Labs (if none specify below)

characters left: 4096

Results Reviewed?

○ Yes ○ No

Last Menstrual Period

Month **Year** ☐ N/A

Abnormality found?

○ Yes ○ No

If Yes, describe abnormality

characters left: 1024

Action Taken

characters left: 1024

Lab Orders:

○ Yes ○ No

Other

characters left: 30000

Record Added **Record Changed**

Save and Continue to Send Copy to | Save | Cancel

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3. Psychiatric Outpatient Office Visit Nursing: Send Copy to

Instructions:
Once this document has been signed, it will be copied and sent to all parties listed below. For all documents that are to be sent outside of your agency, please be sure you have a valid Authorization for Release of Information before adding this copy request.
- To notify staff of document completion, click on **Send to Staff**.
- To send a copy of this document to a location outside of your agency, click on **Send External Copy**.

4 Document Copies Send to Staff Send External Copy

Send Copy To / Review By	Status
lookup clear	
lookup clear	
Location: lookup clear **Contact:** **Purpose:**	
Location: lookup clear **Contact:** **Purpose:**	

Record Added **Record Changed**

Save and Continue to Signatures | Save | Cancel

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Service Activity Logs

Staff:

Consumer:

If this is **not** the program providing the service, please use the LOOKUP button to select a new program

Date:
Start:
End:
SAL Spans Midnight

Contact Type
Attendance:
Place of Service:
StaffType:

IDDT

Interactive Complexity

Authorization: SAL Code: lookup clear

-

Please use the LOOKUP button to find an authorization and CPT code for the service provided

Physician On Site? Yes No

Physician on Site: lookup clear

Electronic Signatures

Instructions

When the form/document is completed, type in your password and click 'Sign and Save'. By entering your password you are electronically signing this form/document. Your signature represents your acceptance and approval of the records. Once signed, any future changes must be made via the 'Change Signed Document' option.

Nursing Signature Required By lookup

Enter your password to sign

Sign and Save

Record Added **Record Changed**

Save Cancel