MACOMB COUNTY COMMUNITY MENTAL HEALTH
PSYCHIATRIC EVALUATION

Program: ______________________ Date of Evaluation: __________ Patient

Name: ______________________ Guardian: ______________________

MCCMH Case No: __________

Insurance:
[ ] Indigent [ ] Caid [ ] Care/Caid [ ]Other

Referred By: ______________________
(print or type name of referring provider)

Evaluated By: ______________________
(print or type name)

Type of evaluation: [ ] Initial [ ] Upd ate

I. IDENTIFYING INFORMATION

Name: ______________________ DOB: . __________ Age: __________

Gender: [ ] Male [ ] Female Marital Status: [ ] Single [ ] Married [ ] Divorced

Other: ______________________

II. CHIEF COMPLAINT / PRESENTING PROBLEM (CC/PP)

If the above information has been provided by a third party, please state:
Name of third party: ______________________
Relationship to consumer: ______________________

III. PRESENT ILLNESS

CONSUMER: ______________________________ CASE NO:____________ DATE:_____________

IV. PERTINENT PAST HISTORY

Personal / Family : ______________________________

Occupational / Educational: ______________________________

Legal: ______________________________

Psychiatric: ______________________________

Substance Use: ______________________________

Non-Psychiatric Medical / Surgical: ______________________________

V. MENTAL STATUS EXAMINATION

Attitude/Behavior/Appearance: ______________________________

Affect: ______________________________

Stream of Mental Activity: ______________________________

Mood: ______________________________

Mental Trend and Content of Thought (examples of delusions/hallucinations if present): ______________________________

Sensorium, Mental Grasp, and Capacity: ______________________________

Assessment of Insight and Judgment: ____

Memory Functioning/Orientation With Methodology: ______________________________

VI. ASSESSMENT OF RISK FACTORS

VII. SUMMARY OF FINDINGS/BIOPSYCHOSOCIAL FORMULATION and PROGNOSIS

VIII. DIAGNOSIS

X. SUMMARY AND TREATMENT RECOMMENDATIONS

LENGTH of STAY: (when applicable)

X. -

XI. DISCHARGE CRITERIA (when applicable)

Licensed Prescriber: ______ Date: