



These questions are to assist in the assessment of people with potential mental health problems and to consider urgency of need for mental health referral and security measures.

Name:	Address:	DOB:
Next of Kin:	Telephone:	MCP:
<p>Commentary</p> <p>Use Mental Status Examination if deemed necessary.</p> <p>Consider safety issues for person and staff.</p> <p>Use prompts on next page to assess for suicide.</p> <p>*May need to institute measures to prevent inappropriate self-discharge prior to full assessment NOW.</p> <p>Is the person too sedated, sleepy or disoriented to give an adequate history?</p> <p>Does the person need an interpreter?</p> <p>Inquire about old notes/any existing mental health files.</p> <p>Start a problem list.</p> <p>Seek consent to contact family/friends.</p> <p>Check if they are from this area.</p> <p>Do you need to contact anyone immediately or can it wait until the following morning?</p>	<p>WHAT IS THE PROBLEM?</p> <p>Disorientation in:</p> <p><input type="checkbox"/> Time? <input type="checkbox"/> Place?</p> <p><input type="checkbox"/> Person?</p> <p><input type="checkbox"/> Suicidal ideation* <input type="checkbox"/> Anxiety/panic attacks</p> <p><input type="checkbox"/> Thoughts disordered <input type="checkbox"/> Bizarre behavior*</p> <p><input type="checkbox"/> Depressed <input type="checkbox"/> Intoxication*</p> <p><input type="checkbox"/> Hallucinating <input type="checkbox"/> Aggression*</p> <p><input type="checkbox"/> 'Stress' <input type="checkbox"/> Drug and alcohol withdrawal*</p> <p><input type="checkbox"/> Delusional <input type="checkbox"/> Agitation*</p>	
	<p>WHY NOW?</p> <p><input type="checkbox"/> Self-referral <input type="checkbox"/> Concern from others</p> <p><input type="checkbox"/> Personal crisis <input type="checkbox"/> Physician referral</p> <p><input type="checkbox"/> Person won't talk <input type="checkbox"/> Mental Health Care & Treatment Act</p> <p><input type="checkbox"/> Police presence <input type="checkbox"/> Deliberate self-harm</p>	
	<p>CAN I GET AN ADEQUATE HISTORY NOW? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
	<p>IS THERE A PSYCHIATRIC HISTORY? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, working diagnosis? _____</p> <p>Current medications? _____</p>	
	<p>Is there an existing treatment plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
	<p>WHAT DOES THE PERSON WANT?</p> <p><input type="checkbox"/> Someone to talk to <input type="checkbox"/> Hospitalization</p> <p><input type="checkbox"/> They don't know <input type="checkbox"/> Psychiatric referral</p> <p><input type="checkbox"/> Medication <input type="checkbox"/> Inpatient treatment (i.e. Humberwood)</p> <p><input type="checkbox"/> Detoxification <input type="checkbox"/> Outpatient treatment (i.e. Mental Health & Addictions)</p> <p><input type="checkbox"/> Other: _____</p>	
	<p>WHERE CAN I GET INFORMATION FROM? (note contact details)</p> <p><input type="checkbox"/> Family members or friends? <input type="checkbox"/> Physician?</p> <p><input type="checkbox"/> Community Clinic/Health Center? <input type="checkbox"/> Therapist/Counsellor?</p> <p><input type="checkbox"/> Psychiatrist? <input type="checkbox"/> Child, Youth & Family Services</p>	
	<p>IS ANYONE ELSE WITH THEM IN THE WAITING ROOM? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the person have children? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Where are they now? _____</p>	
	<p>CAN YOU TELL ME HOW YOU ARE FEELING AT THE MOMENT?</p> <p>_____</p> <p>_____</p>	

Adapted from Wilhelm, Kotze, Ballard and Hudson, Consultation Liaison Psychiatry and Emergency Departments, St. Vincent's Hospital, Sydney. 2001.

Commentary

Consider whether the person is safe to be alone.

Risk factors include:

- definite plan
- hopelessness
- severe depression
- psychotic symptoms
- recent discharge from a psychiatric unit
- use of alcohol and/or other drugs, particularly recent escalation
- recent suicide attempt
- Single men: young, elderly
- homelessness
- medical illness
- history of childhood abuse
- recent suicide attempt by a family member or a friend.

IF YOU SUSPECT A PERSON IS CARRYING A WEAPON, NOTIFY POLICE NOW

Predictors of violence include history of impulsivity and previous violence, alcohol and substance use, antisocial traits/behaviours.

Make triage decisions and decide whether to refer for a psychiatric assessment.

Does the Mental Health Care and Treatment Act need to be applied?

Do Child, Youth & Family Services need to be called (to offer 'care and protection' to under 16 yr. old)?

Involve social supports in discharge planning.

Complete a brief physical examination (*medical staff only*)

SUICIDE ASSESSMENT

Have you had thoughts that life is not worth living? Yes No

Have you thought of harming yourself? Yes No

Are you thinking of suicide? Yes No

Have you tried to harm yourself in the past? Yes No

If yes, how many times? _____

When was the most recent time? _____

How often are you having these thoughts? _____

Have you thought about how you would act on these thoughts (is there a plan)? (*Does this plan seem feasible? Are the methods available? Is it likely to be lethal?*)

Have you thought about when you might act on this plan? _____

Are there any things/reasons that stop you from acting on these thoughts?

Do you know anyone who has recently tried to harm themselves?

HAS A SUICIDE ATTEMPT BEEN MADE?

Yes No

If yes, when? _____

What method? _____

What did you hope would happen as a result of your attempt? (*Did they want to die, or end their pain?*) _____

Do you still have access to the method used? Yes No

Did you use alcohol or drugs (*prescription or illegal*) before the attempt? Yes No

What did you use? _____

Do you have easy access to a weapon? Yes No

HAVE YOU THOUGHT OF HURTING ANYONE ELSE? Yes No

If yes, have you acted on these thoughts? Yes No

Have you been involved in any fights recently? Yes No

If yes, were you using alcohol or drugs at the time? Yes No

DO YOU FEEL SAFE AT THE MOMENT? Yes No

WHO DO YOU LIVE WITH? _____

Is there anyone at home right now? Yes No

Is there anyone we need to call? _____

WHAT TRIGGERED THESE THOUGHTS/ACTIONS? (*what are key stressors for the person, e.g. financial, relationships, employment, bereavement?*)

What led you to try and take your life? _____

What led you to having these thoughts? _____

What has been going on in your life lately? Are there any things that have been worrying or upsetting you? _____

WHAT WOULD MAKE A DIFFERENCE AT THE MOMENT? (*can the person see anything changing in their situation?*)

Can we make a list of the main problems? _____

What can we do now? _____

What needs to be done later? _____

HOW IS YOUR GENERAL HEALTH? _____

Health Care Provider

Date