Psychiatry - Inpatient Consultation Report
Initial Assessment

Patient Name:
Medical Record Number:
Date of Birth:

Date of Admission:
Date of Consultation:
Referring Provider and Service:

Reason for Consult:

Chief Complaint:

Summary of Current Medical/Surgical and Psychiatric Concerns:

Review of Systems:

Past Medical/Surgical History:
History pertinent to this consultation -

Past Psychiatric History:
Previous therapy -
Currently in treatment with -
Previous psychiatric treatment and medication trials -
Psychiatric hospitalizations -
Previous diagnoses -
Suicide attempts -
History of violence -
Self-Injurious Behavior -

Substance Use History:

Social History:
Living Situation -
Education -
Employment -
Hobbies/Interests -
Abuse and Trauma -
Firearms/Weapons Access -
Legal Guardian -
Legal/CPS Involvement -
Relationships/Marital Status -
Children -
Support System -

Military History -

Family Psychiatric History:
History of mood disorder -
History of psychotic disorder -
History of substance use disorder -
History of suicide attempt(s) -
History of completed suicide(s) -

Medications:

Allergies:

Vital Signs:

Mental Status Examination:
General Appearance -
Behavior -
Mood -
Affect -
Speech -
Language -
Thought Process/Associations -
Thought Content -
Cognition -
Sensorium/Orientation -
Recent, Remote Memories -
Attention Span and Concentration -
Fund of Knowledge -
Estimated Level of Intelligence -
Insight -
Judgment -
Executive Function -
Bedside Neuropsychiatric Testing -
- MMSE: /30
- MOCA: /30
- Clock Drawing:
- Luria Maneuver:
- Months Backwards:
- Digit Span Forwards:
- Digit Span Backwards:

Diagnostic Data Reviewed (including lab values, imaging results, and other pertinent diagnostics):

Safety Assessment:

Risk Factors -
Protective Factors -
Estimate of self-harm risk -

Impression/Assessment:

DSM-5 Diagnoses:

Recommendations/Treatment Plan:
1) Safety and other Critical Issues -
2) Non-Pharmacologic Recommendations -
3) Psychopharmacology -
4) Social Work Support -
5) Disposition -
6) Follow Up -

Please feel free to contact this examiner via (PAGER/PHONE NUMBER) if you have any questions or concerns. Thank you for allowing us to assist in the care of your patient.

PSYCHIATRIST NAME, MD
TIME, DATE

Time spent on review, patient examination, coordination, and documentation: ____ minutes. Total time spent counseling/coordinating care was greater than 50% of that time.