Department of Corrections
WASHINGTON STATE

PSYCHIATRIC ASSESSMENT

PATIENT NAME:		
DOC NUMBER:		DATE OF BIRTH:
FACILITY:	UNIT (optional)	DATE:

Chief Complaint/Reason for Referral:

History of Present Illness (include level of function, test results, time course of symptoms):

Psychiatric History (include outpatient, inpatient, medications, danger to self, danger to others):

Substance Abuse History (include treatment):

Medical History:

Allergies:

Social, Developmental, and Family History (include abuse history):

Mental Status Examination:

Orientation and level of consciousness:

Appearance and behavior:

Speech:

Perception:

Thought process:

Thought content:

Affect/mood:

Vegetative function:

Department of Corrections
WASHINGTON STATE

PSYCHIATRIC ASSESSMENT

PATIENT NAME:		
DOC NUMBER:		DATE OF BIRTH:
FACILITY:	UNIT (optional)	DATE:

Danger to self/danger to others:

Memory/cognitive function:

Other/comments:

Clinical Formulation:

Diagnoses:

Plan:

Medications with target symptoms:

Additional testing:

Special watch or alerts:

Referral/follow-up:

PRACTITIONER'S PRINTED NAME AND TITLE

SIGNATURE