Rainy Lake MEDICAL CENTER
In association with SMDC Health System

Mental Health Assessment

For patients being transferred to Hibbing,
Please complete and fax to 218-362-6702.

Original Date	07/2007	Revision Date	02/2010	Withdrawn Date	

Patient Name: _____ DOB: _____

Vitals: HR:_____ RR:_____ BP:_____ Temp:_____

General:

Appearance, distress: _____
(explanation)

Mental Status:

Oriented, cooperative, depressed, suicidal/homicidal, psychotic, dementia, MR/TBI: _____
(explanation)

ADL Function:

Independent, with assist, total assist: _____
(explanation)

Completed Labs: _____

Past Medical/Psych/Surgical History: _____

Home Medications: _____

Medications Given Today: _____

Cardiac: *Inspection:* heaves/lifts *Palpation:* thrills, PMI *Percussion:* heart span *Auscultation:* S_1, S_2, relative intensities, murmurs, rubs gallops (m/r/g), friction rubs, clicks *Peripheral Vascular:* varicose veins, pulses at cartoid, radial, femoral, popliteal, posterior tibial, & dorsalis pedis arteries, capillary refill in fingers and toes, hair on toes, edema.	**Heart:** *Eyes:* visual fields, EOMI, PERRLA, fundus *Ears:* exterior, hearing, Weber, Rinne, TM *Nose:* exterior, patency, septum, sinuses *Throat & mouth:* palate elevation, tongue mobility, tonsils *Neck:* trachea, JVD, lymph nodes, thyroid, ROM Shoulder shrug, carotids
Respiratory: *Inspection:* expansion, symmetry, use of accessory muscles *Palpation:* tenderness, tactile fremitus *Percussion:* CVA tenderness, lungs, diaphragmatic excursion *Auscultation:* breath sounds, voice sounds	**Neurological:** *Cranial nerves:* 2 – 12 grossly intact bilaterally (see HEENT). *Sensation:* light touch, vibration, position sense *Motor:* bulk, tone, strength 5/5 *Deep tendon reflexes:* biceps, triceps, brachioradialis, knee, ankle 2/4, Babinski *Cerebellar function:* posture, gait, Romberg, pronator drift, rapidly alternating tasks
Abdomen: *Inspection:* surgical scars, distention *Palpation:* tenderness, masses, organomegaly	 *Percussion:* liver span, ascites *Auscultation:* Bowel sounds, bruits

_____ ____/____/____ _____:_____
Physician Signature Date Time

PATIENT STICKER