Depression

FLOW SHEET/ ENCOUNTER FORM

CO-MORBID CONDITIONS AND OTHER FACTORS	
☐ *ALCOHOL OVERUSE	☐ *SUBSTANCE ABUSE
☐ ANXIETY	☐ *OTHER PSYCHIATRIC
☐ *BIPOLAR	
☐ PAST SUICIDE ATTEMPT	
☐ PRESENCE OF CHRONIC PHYSICAL CONDITION	

*** If these conditions or factors are checked off, treat this patient for these conditions or factors prior to beginning treatment for depression.**

♦ PATIENT NAME		
♦ HEALTH # (OR OTHER UNIQUE PATIENT ID)		♦ GENDER ☐ Undifferentiated ☐ Male ☐ Female
♦ PHONE (INCLUDE AREA CODE)		♦ BIRTHDATE (DD-MMM-YYYY)
CHART NUMBER	CITY	POSTAL CODE
♦ PROVIDER NAME		PROVIDER ID #

DIAGNOSTIC/ CLINICAL DATA, BY DATE REVIEW ♦ = MANDATORY FIELDS		MOST RECENT DATA			NEW DATA √ = RECALL DATE OF VISIT:
RELAPSE	♦ **DEPRESSION URGENT CARE SINCE LAST VISIT (Enter number of visits or admissions)**				**#ER VISITS: _____** **#HOSPITAL ADMISSIONS: _____** **# WALK INS: _____**
	RISK FACTORS FOR RELAPSE (check all that apply)				CHANGES IN: ☐MOOD ☐ENERGY ☐SLEEP ☐WORK ☐ENJOYMENT OF ACTIVITIES ☐INVOLVEMENT IN FAMILY ACTIVITIES ☐SIDE EFECTS FROM MEDICATION
PHQ-9 ©	♦ **RECOVERY PHASE (improving:** PHQ-9 is the same or lower in the last month; **not improving**: PHQ-9 increased by ≥ 2 in last month; **maintenance:** at target score and in ongoing treatment or support; **recovery:** PHQ-9 < 5)				☐ **IMPROVING** ☐ **NOT IMPROVING** ☐ **MAINTENANCE** ☐ **RECOVERY**
	♦ **SCORE FROM QUESTION 1-9**				**ENTER SCORE Q1-9: _____**
	♦ **RESULT FROM QUESTION 10**				☐ **NOT DIFFICULT** ☐ **SOMEWHAT DIFFICULT** ☐ **VERY DIFFICULT** ☐ **EXTREMELY DIFFICULT**
	REMISSION				☐ IN REMISSION (PHQ-9 © Q1 < 5)
SUICIDE RISK	ASSESSED (If positive, document management plan and refer to mental health specialist)				☐ POSITIVE SUICIDAL IDEATION ☐ NEGATIVE SUICIDAL IDEATION
	MANAGEMENT PLAN (DOCUMENTED)				☐ DOCUMENTED/REVIEWED
MEDS	ANTIDEPRESSANT MEDICATION				☐ YES ☐ TNS ☐ NO: ☐ CI ☐ PD ☐ OTHER: _____
	ANTIDEPRESSANT MEDICATION REVIEWED				☐ ADJUSTED ☐ REVIEWED DATE :
REFERRALS	MENTAL HEALTH SERVICES REFERRAL				☐ REFERRAL MADE ON WAIT LIST ☐ TREATMENT ONGOING ☐ TREATMENT COMPLETED ☐ NP ☐ PD ☐ OTHER _____
	PSYCHIATRY REFERRAL				☐ REFERRAL MADE ON WAIT LIST ☐ TREATMENT ONGOING ☐ TREATMENT COMPLETED ☐ NP ☐ PD ☐ OTHER _____
	PRIVATE PRACTICE PSYCHOLOGIST/SOCIAL WORKER				☐ REFERRAL MADE ON WAIT LIST ☐ TREATMENT ONGOING ☐ TREATMENT COMPLETED ☐ NP ☐ PD ☐ OTHER _____
	COMMUNITY SERVICE/OTHER PROGRAM REFERRAL				☐ REFERRAL MADE ON WAIT LIST ☐ TREATMENT ONGOING ☐ TREATMENT COMPLETED ☐ NP ☐ PD ☐ OTHER _____
GOALS AND FOLLOW-UP	EDUCATION – COMMUNITY RESOURCES AND SUPPORT (check all that apply)				REVIEWED: ☐WITH PATIENT ☐WITH FAMILY/SUPPORT NETWORK
	SELF-MANAGEMENT GOALS				☐SET/REVIEWED
	♦ **NEXT FOLLOW-UP VISIT (enter one)**				_____ ☐**DAYS** _____ ☐**WEEKS** _____ ☐**MONTHS** ☐**NO FOLLOW-UP PLANNED**
	IF NO FOLLOW-UP PLANNED, INDICATE REASON				REASON: _____

PD – patient declined **NP – no program available** **CI – contraindicated** **TNS – tried or not suitable**

Adapted from BCMA Flowsheet – October 28, 2009

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CHART NUMBER	CITY	POSTAL CODE
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COMMENTS

Date:

Date:

Date: