Sheppard Pratt

Comprehensive Outpatient Psychiatric Evaluation Service
Confidential Comprehensive Consultation SAMPLE Evaluation Report

This is a sample report. The report will be tailored for the individual's evaluation needs and procedures.

Name:
Date of Birth:
Age:
Medical Record Number:
Dates of Evaluation:
Date of Report:
Report Prepared by:

Referred by:
Reason for Referral:

Goals:

Records Reviewed:

Collateral Sources Interviewed:

Informed Consent: Informed consent to conduct this evaluation was obtained and limits of confidentiality were discussed including obligation to report suspected previous or current child abuse or neglect or abuse or neglect of a vulnerable adult. The person demonstrated understanding and voluntarily consented to the evaluation and is not under guardianship. The person understands that raw testing data will only be released to a licensed psychologist. The person understands that this is a consultation and that the professionals conducting the evaluation are not providing treatment and are not to be considered their treatment providers. The person consents to all or part of this evaluation to be conducted via telehealth.

Evaluation Procedures (as clinically indicated):

Day 1	Day 2	Day 3
8:30 a.m. Check in and Paperwork with Administrative Coordinator	**9:00 a.m. - 12:00 p.m.** Other evaluations as indicated (Addiction, Neuropsychiatry, Geriatric, etc.)	**9:00 a.m. - 10:30 a.m.** Wellness Evaluation
9:00 a.m. Psychiatric Evaluation	**12:00 p.m. Lunch**	**10:30 a.m. - 12:00 p.m.** Diagnostic Conference with patient and family
10:30 a.m. Psychological Evaluation	**1:00 p.m.** Psychopharmacology Evaluation	**12:00 p.m. - 1:00 p.m.** Family Meeting
12:00 p.m. Lunch	**2:30 p.m.** Psychosocial Evaluation with Social Worker	**1:00 p.m. Depart**
1:00 p.m. Drawing Diagnostic Series	**4:00 p.m. Break**	
2:00 p.m. Break	**4:15 p.m.** Family Systems Evaluation with Family Therapist	
2:15 p.m. - 5:30 p.m. Psychological Testing		

Tests Administered: *A selection of objective and subjective tests will be administered to characterize the person's cognitive and personality functioning. Testing is administered to provide objective data related to the person's relative strengths and weaknesses.*

Sample tests include:

- Clinical Interviews (Psychiatric, Psychological, Psychosocial, Family)
- The Montreal Cognitive Assessment
- Shipley Institute of Living Scale
- Disability Rating Scale
- Hamilton Depression Inventory
- Cognistat

Sample tests include (continued):

- DSM-V Levels of Personality Functioning Questionnaire
- Personality Assessment Inventory
- Addiction Severity Index
- Drawing Diagnostic Series
- House Tree Person Test
- Thematic Apperception Test
- Clock Drawing Test
- Family Systems Assessment Tool
- Other tests as clinically indicated

Biopsychosocial History: *This section gathers information about the person's history across all aspects of human functioning including biological, developmental, social, emotional, academic, and occupational areas. History is gathered related to the person's and their family's medical, mental health, and substance abuse histories to inform diagnostic impressions and case formulation.*

History of Presenting Problem: what has led the person to seek an evaluation at this time?
Developmental History: maternal prenatal factors, perinatal events, birth trauma, developmental milestones and achievement of developmental tasks, relationship with parents, relationship with siblings, childhood trauma, childhood experiences
Academic History: academic performance and progression
Occupational History: occupational and employment history and functioning
Social History: friendships, romantic relationships, hobbies and recreation, marital history, psychosocial supports
Medical History: history of somatic illness and injuries, concussion or traumatic brain injury, history of surgeries, allergies (food and medication), medication history
Substance Abuse History and Treatment History: history of any and all substance use, misuse, and addiction. History of outpatient, intensive outpatient, inpatient, or rehabilitation treatment.
Psychiatric History and Treatment History: history of psychiatric symptoms, age of onset, precipitating factors, history of treatment including outpatient and inpatient. History of suicide attempts.
Family History (Neurological, Substance Abuse, Psychiatric): family history of neurological illness, psychiatric illness and treatment, and family history of substance use, misuse, and addiction.

Legal History: history of legal charges, incarcerations, custody matters, current legal issues pending
Strengths: person's strengths and abilities
Access to Firearms: does the person have access to firearms, and if so, what type and how are they stored?

Behavioral Observations: *This section documents how the person presented and how they interacted throughout the evaluation process. This provides essential clinical data regarding how the person approached the evaluation process and how they interact with others in the environment.*

Mental Status Examination: *This section of the report documents the person's mental status functioning during the evaluation process to include: orientation, speech, thoughts, mood, affect, suicidal ideation, homicidal ideation, appetite, sleep, perceptual disturbances, psychomotor functioning, memory, concentration, insight, and judgment.*

Clinical Findings: *This section documents summarizes findings from the evaluation procedures. Actual reports of various medical and psychological testing procedures will be attached as an addendum.*

Medical:

Somatic: This section summarizes the findings from the physical examination and nutrition consultation.

Imaging: This section summarizes findings from imaging studies such as MRI.

Laboratory values: This section summarizes laboratory findings from bloodwork.

Genomics: This section summarizes findings from genetic testing.

Psychiatric: This section summarizes the findings from the psychiatric and the psychopharmacological evaluations.

Wellness*:* *This section summarizes findings from the wellness assessment which includes fitness assessment, exercise, recreation, lifestyle habits, smoking, which will include all dimensions of wellness such as physical, emotional, occupational, environmental, social, spiritual, intellectual, and financial.*

Addiction: *This section will provide findings related to an evaluation of substance use and misuse. This section will document findings related to the assessment of an addiction.*

Cognitive Functioning: *This section includes an assessment of the person's cognitive functioning and relative strengths and weaknesses. Areas of cognitive functioning include attention, verbal and visual memory, executive functioning (insight, judgment, planning, decision making, mental flexibility, executive cognitive control, response inhibition, motivation), visuospatial skills, perceptual functioning, motor functioning, social comprehension, processing speed, information processing, and language.*

Personality Functioning: *This section includes an assessment of the person's personality functioning including self (identity and self-direction), interpersonal functioning, major anxieties and tensions, intrapsychic structure and conflicts, defense structure, neuroticism, self and emotional regulation, frustration tolerance, attachment style, coping style, vulnerability factors, protective factors, maintaining factors, controlling variables, motivation, reinforcements, locus of control, distress tolerance, reflective function, functional analysis of symptoms, psychological mindedness, perfectionism and need for control, social-emotional functioning (self-awareness, social comprehension, ability to express emotions), ego strength, and overall strengths.*

Family Systems: *This section will include an assessment of the family system functioning including genogram, family developmental stage, family emotional expression, processing, and regulation, family roles, identified patient, parent-child relationships, alliances, coalitions, history of interpersonal violence, safety assessment, family hierarchy structure, enmeshments, substance abuse in the family, attachment styles, impact of miscarriages, infertility, and adoption (as applicable), multigenerational conflicts and tensions, ethnic, cultural, and religious considerations in the family dynamics, how discipline was managed in the family, mental illness in the family, family problem solving approaches, family financial stressors, verbal and non-verbal communication patterns, and family strengths.*

Safety Assessment: *This section includes risk assessment for suicide, homicide, and violence. Evaluation will include an assessment of ideation, intent, plan, access to means, access to weapons, recent losses, major frustrations, substance use, previous attempts, and family history of suicide, homicide, or violence.*

Diagnostic Impressions: *This section will provide DSM-V diagnoses based on the finding of all of the data reviewed, collected, and analyzed. The rationale for the diagnoses made will be provided. Diagnostic specificity will be provided such that diagnostic clarification that are parsimonious.*

Differential Diagnosis: *This section will include other diagnoses considered, rationale for not including them as diagnoses, and documentation of any missing data needed to make further diagnoses or diagnostic clarifications.*

Formulation and Summary: *This section will provide the summary and case formulation integrating the biopsychosocial history, mental status examination, assessment of cognitive and personality functioning to explain the reciprocal biological-behavioral relationships accounting for the development and maintenance of psychiatric symptoms. The case formulation will discuss how the diagnoses are related, will describe the person's personality structure from a developmental perspective, and will discuss how the person sees her/him/themselves, the world, and the future, their major anxieties and tensions, patterns of behavior, controlling and maintaining factors, vulnerability and protective factors, sources of motivation, and strengths.*

Recommendations: *This section will document what level of care is recommended with justification and will make specific recommendations for treatment modalities with a treatment plan to address all diagnoses and to promote health, wellness, and resilience. Any barriers to care will be identified with suggestions for reducing factors that may interfere with the person following through on recommendations.*

Level of Care
Pharmacotherapy
Psychotherapy
Substance Abuse
Health and Wellness
Barriers to Care

Problem	Goal	Intervention	Metric	Professional
1.				
2.				
3.				

Referrals: ***This section will list recommendations for referral sources to pursue further evaluation and treatment as indicated.***

Report to be sent to the following providers with the person's signed consent:

Provider	Address	Phone	Email	Fax

The person was provided with the results and recommendations of this consultation. The person's questions were answered and psychoeducation was provided. The person demonstrated understanding of the findings and recommendations.

Signature

Addendum: