



Division of Public and Behavioral Health Policy

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1.0 Policy

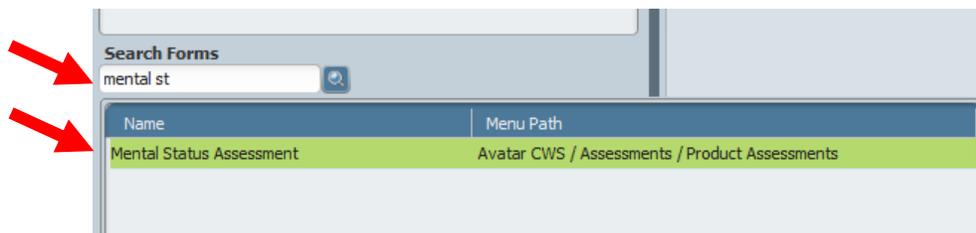
It is the Policy of the Division of Public and Behavioral Health (DPBH), Substance Abuse, Prevention, and Treatment Agency (SAPTA) that all providers, in accordance with 505 (a) of the Public Health Service Act (42 US code 290aa-4) which directs the Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), to collect items including admission and discharge data.

All providers will complete a mental status assessment on all clients.

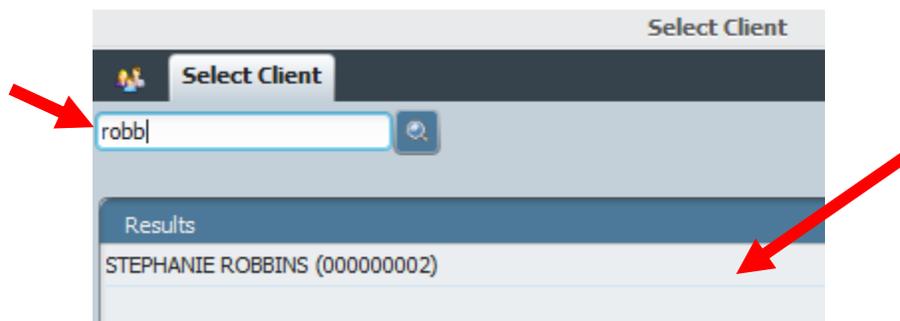
2.0 Procedure

NOTE: THIS POLICY AND PROCEDURE WILL NOT OUTLINE HOW TO ASSESS A CLIENT. INSTEAD, IT WALKS THROUGH THE PROCESS OF THE FORM IN AVATAR.

1. In the Search Forms field, type Mental Status Assessment.
 - a. Double-click on the Mental Status Assessment form.



2. The Search Client window will be displayed.
 - a. Search by Client ID # or Last Name.
 - b. Double-click the desired client.



2. The episode selection window will appear.
 - a. Double click on the episode you want to attach the Mental Status Assessment to.



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Name: STEPHANIE ROBBINS
ID: 2
Sex: Female
Date of Birth: 08/01/1995

Episode	Program
3	Residential
2	S1 Level 1 OP Adults-Indv~INACTIVE

3. The Mental Status Assessment form will be displayed.

Mental Status Exam

- Appearance and General Behavior
- Speech and Language
- Orientation and Affect
- Mood and Motor Activity
- Thought and Perceptual Disturbances
- Intelligence
- Suicidal and Homicidal Ass...

Assessment Status: Draft Final

Assessing Date: [Date Picker]

Assessing Clinician: [Text Field]

Assessment Time: [Time Picker]

Appearance and General Behavior

Appearance/General Behavior:

- Appearance: Well-Groomed Normal Weight Unkempt Bizarre
- Other: [Text Field]
- Comments: [Text Area]

Attitude:

- Cooperative Guarded
- Relates Well Evasive
- Accessible Negative Attitude
- Hostile Suspicious
- Good Eye Contact Uncooperative
- Avoids Eye Contact
- Other: [Text Field]
- Comments: [Text Area]

Speech and Language

Speech/Language:

- Speech: Normal Speech Slow Slurred Inappropriate Incoherent Rambling Unable to Talk
- Other: [Text Field]
- Comments: [Text Area]

Language:

- English-Speaking Poor Grammar
- Spanish-Speaking Limited Vocabulary
- Bilingual Interpreter Used
- Unusual Lang. Usage Other Lang. Spoken
- Other: [Text Field]
- Comments: [Text Area]

Orientation and Affect

Orientation/Affect:

- Orientation: Fully Oriented Disoriented to Time Disoriented to Place Person
- Other: [Text Field]
- Comments: [Text Area]

Affect:

- Appropriate Inappropriate Blunted
- Flattened Labile Passivity
- Restricted
- Other: [Text Field]
- Comments: [Text Area]

Mood and Motor Activity

Mood/Motor Activity:

- Mood: Anxious Irritable Depressed Angry



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4. The form consists of seven (7) parts.
 - Appearance and General Behavior
 - Speech and Language
 - Orientation and Affect
 - Mood and Motor Activity
 - Thought and Perceptual Disorder
 - Intelligence
 - Suicidal and Homicidal Assessment

Chart Mental Stat

▾ Mental Status Exam

- Appearance and General ...
- Speech and Language
- Orientation and Affect
- Mood and Motor Activity
- Thought and Perceptual D...
- Intelligence
- Suicidal and Homicidal Ass...

Submit

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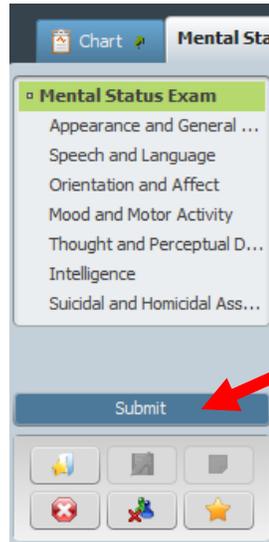
5. Choose whether the assessment is a draft or final by clicking on the radio buttons for **Assessment Status**.
6. Select the staff that you want to notify of this assessment in the search field for **Select Staff to Notify**.
 - a. Search for staff by last name.
7. Enter the **Assessing Date**.
 - a. T for today
 - b. Y for yesterday
 - c. Or Enter the date
8. Enter the **Assessing Clinician**.
 - a. Search by last name.
9. Enter the **Assessment Time**.
 - a. Click Current for the current time.
 - b. Enter time (ex: 5:00P will autocorrect to 5:00PM)
10. Complete the rest of the assessment.



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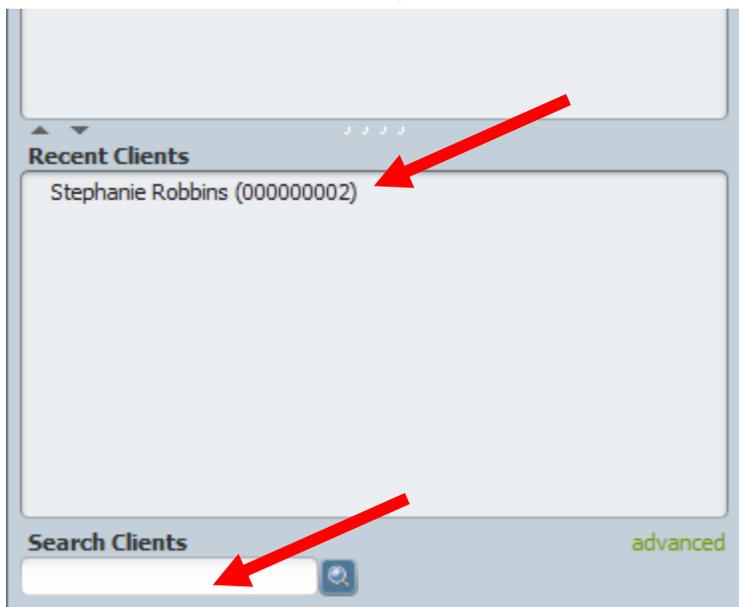
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11. When completed, click **Submit** in the upper left hand of the page. This will submit the Mental Status Assessment.



12. To pull a Mental Status Assessment report, go to the client's chart by double-clicking on the client name on the home screen in Recent Clients.

a. If the client is not there, use the Search Clients field to find the client.



13. Double-clicking the client name will open up the Chart View.



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The screenshot shows a patient chart interface with a left-hand navigation menu and several main content panels. The 'Service History' panel displays a table of services:

Date	Status	Start Time	End Time	Staff Name	Program	Service Code	Duration	Cost	Location
07-31-2015	No Entry			FEDOR, BETSY	Residential	90792	60	115.76	3500 Lakeside Court Ste 101, Reno
06-16-2015	No Entry			furlong,kendra	S1 Assessment Adult Pre-Admit--INACTIVE	90837	60	108.15	3500 Lakeside Court Ste 101, Reno
06-16-2015	No Entry			furlong,kendra	S1 Assessment Adult Pre-Admit--INACTIVE	908	30	0	3500 Lakeside Court Ste 101, Reno
06-15-2015	No Entry			furlong,kendra	S1 Level 1 OP Adults Indv--INACTIVE	90847	60	97.85	3500 Lakeside Court Ste 101, Reno
06-15-2015	Scheduled	09:00 AM	09:30 AM	DRUCKER, LAURIE	S1 Level 1 OP Adults COO-Indv--INACTIVE	90837	30	108.15	3500 Lakeside Court Ste 101, Reno

The 'Client Episodes' panel shows a list of episodes with columns for Episode Number, Program, Admit Practitioner, Attending Practitioner, and Admit Date.

14. If the Chart View is set up similar to the one shown above, find and click on Mental Status Assessment on the left hand side. This is referred to the Chart Design.

This image is a close-up of the left-hand navigation menu from the screenshot above. The menu items are listed in a vertical column. The item 'Mental Status Assessment' is highlighted with a red rectangular box, and a red arrow points to it from the left.

- Pre-Admit
 - Pre Admit
 - Screening
 - ASAM
 - Pre Admit Discharge
- Client Profile
 - Update Client Data
 - Client Consents
 - Emergency Contact Information
 - Next of Kin
 - Legal Status
 - Drug Test Results
- Financial Information
 - Financial Investigation
 - Cross Episode Financial Eligibility
 - Cross Episode Managed Care Authori
- Client Charges
- Admission
 - Admission
 - Admission Referral Information
 - Diagnosis
- Assessments
 - ASI Input
 - ASAM
 - Diagnosis
 - Mental Status Assessment**
 - Substance Abuse History
 - Drug Test Results
- Progress Notes
 - Ambulatory Progress Notes
 - Progress Notes (Group and Individual)
- Treatment Plan
 - ASAM
 - Treatment Plan
- Discharge
 - Update Client Data
 - Treatment/Discharge Summary
 - Discharge

15. The chart view of the Mental Health Assessment will be displayed reflecting the data.



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Submitted 07/31/2015 at 07:34 PM by ADMIN,SAPTA

Mental Status Exam...
Assessment Status: Draft
Select Staff To Notify: ROBBINS,STEPHANIE (000032)
Assessing Date: 07/31/2015
Assessing Clinician: FEDOR,BETSY (000041)
Assessment Time: 04:34 PM

16. In the upper right hand corner of this screen, in yellow, is **Report**. Click on **Report**.

Sticky Notes (0) Edit Print **Report**

17. A Crystal Report will generate and show the data on the Mental Status Assessment.

essment.rpt

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Run Date: 7/31/2015 04:46 PM

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Quest Counseling and Consulting, Inc.
3500 Lakeside Court, Suite 101
Reno, NV 89509-4846

Mental Status Assessment
Assessment Date: 7/31/2015

Client: ROBBINS,STEPHANIE (2)

Appearance:
Intelligence: Unknown
Judgment: Unknown
Memory:
Motor Activity:
Orientation:
Speech:
Thought Process:

Comment:

electronically signed

FEDOR,BETSY 7/31/2015 04:34 PM

18. When completed, close out of the report.