*MENTAL HEALTH BOARDER STUDY*

# Data Abstraction Form

(SITE SPECIFIC)

Reviewer's Initials __ __ __

## SECTION 1: BASIC INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| 1. | **Site:** XXX | | | | |
| 2. | **Subject number:** (XXX) | | | | |
| 3. | **Age:** (XXXyrs) | | | | |
| 4. | **Sex:** | O Male | | O Female | |
| 5. | **Race/Ethnicity:** | O White<br>O Other: | O Black<br>O American Indian | O Hispanic<br>O Not documented | O Asian |
| 6. | **Mode of arrival:** | O Walk in/automobile<br>O EMS | | O Police | O No record |
| 7. | **Insurance**: (all that apply) | O Medicaid<br>O Mass Health | O Medicare<br>O Other, specify:<br>_____ | O HMO/Commercial | O None/Self-Pay |
| 8. | **Date/time of triage:** __ __/__ __/12 __ __:__ __ military time | | | | O No record |
| 9. | **Date/time med clearance completed:**<br>(i.e. mental health consult placed): __ __/__ __/12 __ __:__ __ military time | | | | O No record |
| 10. | **Date/time of arrival mental health:** __ __/__ __/12 __ __:__ __ military time | | | | O No record |
| 11. | **Date/time of bed request:**<br>*(mental health consult completed)* __ __/__ __/12 __ __:__ __ military time | | | | O No record |
| 12. | **Date/time of ED departure**: __ __/__ __/12 __ __:__ __ military time | | | | O No record |

## SECTION 2: MEDICAL ASSESSMENT AND TREATMENT

| | | | | |
|---|---|---|---|---|
| 13. | **Laboratory tests?** | O Yes | O No | |
| 14. | *If Yes, check all that apply* → | O CBC<br>O BMP<br>O Toxic screen | O BAC<br>O LFT's<br>O Pregnancy test | O Urinalysis<br>O Cardiac panel<br>O Other:_____ |
| 15. | **Other diagnostic tests?** | O Yes | O No | |
| 16. | *If Yes, check all that apply* → | O X-Ray<br>O CT | OEKG | O Other (specify): |
| 17. | **Active Alcohol Abuse?** | O Yes | O No | O Not documented |
| 18. | **Active Substance Abuse?** | O Yes | O No | O Not documented |

| | | | | |
|---|---|---|---|---|
| 19. | **Active Medical Problem?** | O Yes | O No | O Specify: _____ |

## SECTION 3: PSYCHIATRIC DIAGNOSTIC IMPRESSION

| | | | | |
|---|---|---|---|---|
| 20. | **Final Psychiatric Diagnosis?**<br>*Check all that apply:* | O Depression<br>O Schizoaffective<br>O Psychoses<br>O Not documented | O Suicidality<br>O Adjustment Disorder<br>O Borderline Personality | O Bipolar/Manic<br>O Agitation/Aggression<br>O Other :<br>_____ |
| 21. | **ICD 9 Code** | Primary: | Secondary: | |

## SECTION 4: PSYCHIATRIC AND BEHAVIORAL TREATMENT

| | | | |
|---|---|---|---|
| 22. | **Was close observation required?** | O Yes | O Not specified |
| 22a | **Did Patient require physical restraints?** | O Yes | O No |

## SECTION 5: DISPOSITION

| | | | | |
|---|---|---|---|---|
| 23. | **Was patient placed into observation status while in the Emergency Dept?** | O Yes | O No | |
| 24. | **Was patient transferred to outside psychiatric facility?** | O Yes | O No | |
| 25. | *If yes, name of psych facility* → | | | |
| 26. | *Location of psych facility* → | | | |
| 27. | **Type of facility?**<br><br>**Type of admission?** | O Adult O Adolescent O Geriatric<br><br>O Inpatient O Observation O CSU O Day care<br>O Other _____ | | |
| 28. | **Admitted to your hospital's psychiatric adult unit as inpatient or observation?**<br>(a) *If yes, type of admission:* | O Yes<br><br>O Inpatient O Observation | O No | |
| 29. | **Admitted to your hospital's geri-psych unit?**<br>(a) *If yes, type of admission:* | O Yes<br><br>O Inpatient O Observation | O No | |
| 30. | **Admitted to substance abuse facility?** | O Yes | O No | |
| 31 | **Discharged?** | O Yes | O No | |

| | | | | |
|---|---|---|---|---|
| 32. | **Discharge disposition?** | O Home<br>O Nursing home/assisted living | O Residential setting<br>O Safe house | O Other (specify):<br>_____ |

## SECTION 6: MISCELLANEOUS

| | | | | |
|---|---|---|---|---|
| 33. | **Primary mental health evaluator?** | O In-house resident psychiatrist<br>O In-house psychiatric social worker or nurse. | O In-house attending psychiatrist<br>O State mobile screening team (ESP) | O In-house clinical psychologist<br>O Outside contracted mental health clinician (non state ESP)<br>O Other:_____ |
| 34. | **Secondary mental health evaluator if applicable?** | O Yes | O No/No record | |
| 35. | *If Yes, check all that apply* → | O Resident psychiatrist<br>O Psychiatric social worker/Nurse | O Attending psychiatrist<br>O State's Mobile Screening team (ESP) | O Clinical psychologist<br>O Outside contracted mental health clinician (non state ESP)<br>O Other:_____ |

## SECTION 7: PAST MEDICAL HISTORY

| | | | | |
|---|---|---|---|---|
| 36. | **Past medical history?** | O COPD<br>O Currently Pregnant<br>O HIV/AIDS | O HTN<br>O Cardiac<br>O None | O Diabetes<br>O Other (specify):<br>_____ |
| 37. | **Past /current social history?** | O Aggression/Violence<br>O Recent psych admission (within one month) or three/year | O Incarceration<br>O Homeless<br>O Developmentally Disabled<br>O Insurmountable language barrier | O Sexual offender |
| 38. | **Did patient have a previously arranged bed at a receiving facility?** | O Yes | O No | |

**XXX**