State of Hawaii
Department of Health

Behavioral Health Administration
Adult Mental Health Division

Pre-Admission Screening / Resident Review
Psychiatric Evaluation Part I

_____ _____ ___/___/___ ____ ___
(Last Name) (First Name) (Middle) (Medicaid ID Number, if applicable) (Birthdate) (Age) (Sex)

_____ _____ _____ _____
(Home Address if applicable) City) (State) (Zip)

The psychiatric evaluation consists of two forms including: PSYCHIATRIC EVALUATION, PART I AND PART II: SERIOUS MENTAL ILLNESS CRITERIA. All forms must be completed. Please provide sufficient information to determine the patient's need for "active treatment/specialized services". Use the back of Part II form if additional space is needed to record your response.

1. Psychiatric History (including Drug History): Provide dates if known.

2. Current Psychiatric Condition:
   a. Is the patient a harm to self or others, i.e. suicidal or homicidal ideation, and/or exhibit externalizing and/or internalizing behaviors, i.e. physical violence, damage to property, sexually inappropriate, self abusive, or abuses unauthorized substances?

   b. Is patient delusional and/or has hallucinations?

3. Mental Status (appearance, orientation, affect and mood, thought, insight, organicity, etc.):

4. Describe Patient's Strengths and Weaknesses:

5. Estimated IQ Level:

6. Psychosocial Evaluation: Include current living arrangements, medical and support systems:

7. Recommendations / Plans of Service / Appropriate Placement:

8. Diagnosis: (A listing of applicable diagnoses is available on back of this form)

DSM – III – R	Axis I	Axis II	Axis IV	Axis V
Primary	_ _ _._ _	_ _ _. _ _	_____	___/___

_____ _____ _____
Psychiatrist/Psychologist Name and Title Signature Date