

Monitoring Depression- Medical Record Form

Patient Name: _____ **Date of Birth:** _____

Initial Diagnosis Date: _____ **Referral Date to Mental Health Specialist:** _____

Name of Mental Health Specialist Referred To: _____

| Date | Symptoms (circle all applicable) | Medication | Notes | Reminders (Did you assess and document) |
|--|--|---|-------|---|
| Initial Visit _____ Next Visit in: _____ | <ul style="list-style-type: none"> ➤ Problems sleeping ➤ Changes in energy ➤ Anxiety ➤ Loss/gain appetite ➤ Difficulty Concentrating ➤ Anhedonia | Medication Name _____ Current Dose: _____ Sig: _____ Target Dose: _____ Sig: _____ | | Did you: <ul style="list-style-type: none"> ➤ Assess for Psychosis, Suicidal thoughts, Substance Abuse, Bipolar Illness ➤ Order a medical work-up ➤ Consider Behavioral Health Referral ➤ Prescribe Medication (Use lowest effective dose for appropriate length of time in elderly and patients with panic disorders. Gradually increase to therapeutic dose) ➤ Discuss possible risks, benefits, and side effects ➤ Give Patient Education Information ➤ Schedule follow-up visit (suggest 1 – 2 weeks) |
| Follow-up Visit #1 _____ Next Visit in: _____ | <ul style="list-style-type: none"> ➤ Problems sleeping ➤ Changes in energy ➤ Anxiety ➤ Loss/gain appetite ➤ Difficulty Concentrating ➤ Anhedonia | Medication Name _____ Current Dose: _____ Sig: _____ Target Dose: _____ Sig: _____ | | Did you: <ul style="list-style-type: none"> ➤ Assess for Suicidal thoughts ➤ Discuss response to medication ➤ Discuss side effects of medication ➤ Discuss importance of adherence to medication regimen ➤ Discuss length of time until full effects of medication ➤ Schedule follow-up visit(suggest 1 – 2 weeks) |

PERMANENT PART OF THE PATIENT MEDICAL RECORD

| Date | Symptoms (circle all applicable) | Medication | Notes | Reminders (Did you assess and document) |
|--|--|---|-------|---|
| Follow-up Visit #2 _____ Next Visit in: _____ | <ul style="list-style-type: none"> ➤ Problems sleeping ➤ Changes in energy ➤ Anxiety ➤ Loss/gain appetite ➤ Difficulty Concentrating ➤ Anhedonia | Medication Name _____ Current Dose: _____ Sig: _____ Target Dose: _____ Sig: _____ | | Did you: <ul style="list-style-type: none"> ➤ Assess for Suicidal thoughts ➤ Discuss response to medication ➤ Discuss side effects of medication ➤ Discuss importance of continuing medication ➤ Discuss length of time until full effects of medication ➤ Schedule follow-up visit (suggest 1 – 4 weeks) |
| Follow-up Visit #3 _____ Next Visit in: _____ | <ul style="list-style-type: none"> ➤ Problems sleeping ➤ Changes in energy ➤ Anxiety ➤ Loss/gain appetite ➤ Difficulty Concentrating ➤ Anhedonia | Medication Name _____ Current Dose: _____ Sig: _____ Target Dose: _____ Sig: _____ Changes: _____ | | Did you: <ul style="list-style-type: none"> ➤ Assess for Suicidal thoughts ➤ Discuss response to medication, if on target dose and only partial response, increase dose ➤ If no response to medication, consider changing medications and/or referral to psychiatrist ➤ If all symptoms resolved maintain on current dose for 6 – 12 months ➤ Discuss side effects of medication ➤ Discuss compliance with regimen ➤ Schedule follow-up visit (suggest 4 – 8 weeks if symptoms resolved, sooner if symptoms not resolved) |
| Follow-up Visit #4 _____ Next Visit in: _____ | <ul style="list-style-type: none"> ➤ Problems sleeping ➤ Changes in energy ➤ Anxiety ➤ Loss/gain appetite ➤ Difficulty Concentrating ➤ Anhedonia | Medication Name _____ Current Dose: _____ Sig: _____ Changes: _____ | | Did you: <ul style="list-style-type: none"> ➤ Assess for Suicidal thoughts ➤ Discuss response to medication ➤ Discuss side effects of medication ➤ Discuss importance of compliance ➤ Schedule follow-up visit (suggest 4 – 6 months, sooner if needed) |

PERMANENT PART OF THE PATIENT MEDICAL RECORD

| Date | Symptoms (circle all applicable) | Medication | Notes | Reminders (Did you assess and document) |
|---|--|---|-------|---|
| Follow-up Visit #5 _____ Next Visit in: _____ | <ul style="list-style-type: none"> ➤ Problems sleeping ➤ Changes in energy ➤ Anxiety ➤ Loss/gain appetite ➤ Difficulty Concentrating ➤ Anhedonia | Medication Name _____ Current Dose: _____ Sig: _____ Changes: _____ | | Did you: <ul style="list-style-type: none"> ➤ Assess for Suicidal thoughts ➤ Discuss response to medication ➤ Discuss side effects of medication ➤ Discuss importance of compliance ➤ Schedule follow-up visit (suggest 4 – 6 months) |
| Follow-up Visit #6 _____ Next Visit in: _____ | <ul style="list-style-type: none"> ➤ Problems sleeping ➤ Changes in energy ➤ Anxiety ➤ Loss/gain appetite ➤ Difficulty Concentrating ➤ Anhedonia | | | |
| Follow-up Visit #7 _____ Next Visit in: _____ | <ul style="list-style-type: none"> ➤ Problems sleeping ➤ Changes in energy ➤ Anxiety ➤ Loss/gain appetite ➤ Difficulty Concentrating ➤ Anhedonia | | | |

PERMANENT PART OF THE PATIENT MEDICAL RECORD