

# Physical Assessment for Mental Health Patients Form



## Patient's Details (or sticker)

Name _____
Age _____
DOB _____
Address _____

## Brief description of presenting problem

---

---

---

## Physiological Observations

Heart rate	BP	Temp.	Resp. Rate	O2Sats	BSL

### Meets low risk criteria (all required) - may be referred to mental health service

- Age 15-65 years
- No acute physical health problems (including trauma, ingestion or drug side-effects)
- No altered level of consciousness (GCS 15, no delirium)\*
- No evidence of physical cause for the acute presentation
- Not the first or significantly different psychiatric presentation
- Not delusional or psychotic

\*Alcohol ingestion does not preclude mental health assessment if patient meets low risk criteria

### Doesn't meet low risk criteria (write in notes)

- Urgent resuscitation/sedation alert senior ED, NUM, security if required
- Further medical review based on observations discuss with senior ED
- Investigations done based on clinical findings
- Chronic medical issue identified, note for psychiatric services to follow up

Transfer to Mental Health Services?  Yes  No

Referred to \_\_\_\_\_ for \_\_\_\_\_  N/A

Is the Mental Health Services aware of the patient?  Yes  No

---

ED Doctor's Name Printed                      Signed                      Date and Time