STANDARDIZED PROCEDURE FOR ASSESSMENT AND MANAGEMENT OF PATIENTS by the Psychiatric Nurse Practitioner

I. ACUTE PATIENTS

A. Definition: This procedure covers the management of common acute psychiatric disorders which may include but not be limited to: adjustment disorders, mood disorders, anxiety disorders, attention deficit hyperactivity disorder and schizophrenia and other psychotic disorders.

B. Data Base (may include but not be limited to):
1. Subjective Data:
   a. Brief history of chief complaint
   b. Past psychiatric history
   c. Past medical history
   d. Current medical problems
   e. Substance use history
   f. Family history
   g. Psychosocial history and current functioning

2. Objective Data (may include, but not be limited to):
   a. Mental status exam
   b. Vital signs
   c. Weight
   d. Diagnostic evaluation as appropriate:
      1) Complete blood count (CBC), liver function tests (LFTs), lipid profile studies, thyroid function tests (TFTs), metabolic panel
      2) Valproate, lithium, carbamazepine levels 5 days after start of or increase titration of medication; and every 6 months thereafter. Stat levels done for signs and symptoms of toxicity.
      5) ECG

C. Plan:
1. Diagnosis:
   Uses DSM IV Diagnostic criteria
2. Treatment Plan (may include one or more of the following):
   a. Initiates or adjusts medication (see Appendix A)
   b. Initiates diagnostic evaluations with other providers as indicated
   c. Monitors the effects of the prescribed psychotherapeutic agents and modifies treatment as indicated by the patient's response or laboratory results.
   d. Initiates psychotherapy

3. Education:
   Education is geared to patient and/or family readiness to learn and may include:
   a. Diagnosis
   b. Medications, including potential risks, benefits, and strategies to manage potential side effects
   c. Coping strategies
   d. Parameters for when patient/family should seek medical asistance.
4. Consultation is required with supervising psychiatrist for:
   a. Acute decompensation or deterioration of patient status.
   b. Failure of symptoms to improve within a reasonable time frame.
   c. Review of specific guidelines and possible complication related to treatment of mental illness less familiar to the psychiatric nurse practitioner.
   d. Review of specific guidelines and possible complications related to treatment of patients with co-morbid, non-stable medical problems.
5. Follow-up:
   a. Telephone contact or office visit as indicated.
   b. Contact with the primary medical provider, referral source or therapist as indicated for continuity of care (NOTE: "Release of Information" form must be signed by patient).

D. Documentation:
   1. Handwritten or typed documentation of all office visits, telephone management and prescriptions.

II. CHRONIC PATIENTS

A. Definition: This procedure covers the assessment and management of adult and adolescent patients with chronic psychiatric disorders such as, mood disorders, anxiety disorders, schizophrenia and other psychotic disorders, attention deficit hyperactivity disorder and mood symptoms related to personality disorders. The psychiatric nurse practitioner manages patients who are currently stable but whose chronic condition may require ongoing treatment.

B. Data Base (may include but not be limited to):
   1. Subjective Data:
      a. Relevant historical information including current medications

b. Current and past substance use
c. Present status of symptoms
d. Current management program
e. Past medical history

C. Plan:
1. Diagnosis: Uses DSM IV diagnostic criteria.
2. Treatment Plan (may include one or more of the following):
a. Initiates or adjusts medications
b. Orders diagnostic evaluation or medical referral as indicated
c. Monitors the effects of prescribed psychotherapeutic agents and modifies treatment as indicated by the patient's response and/or laboratory results
d. Initiates or continues psychotherapy
3. Education: is geared to the patient and/or family readiness to learn and may include but not be limited to:
a. Diagnosis
b. Medications, including potential risks, benefits and strategies to manage potential side effects
c. Coping strategies
d. Parameters for when patient/family should seek medical assistance
4. Consultation with supervising psychiatrist for:
a. Acute decompensation or deterioration of patient status.
b. Review of specific guidelines and possible complications related to treatment of mental illnesses less familiar to the psychiatric nurse practitioner
c. Review of specific guidelines and possible complications related to treatment of patients with co-morbid medical problems
5. Follow-up: Telephone contact or office visit indicated:
a. Telephone contact minimum of every three months
b. Office visit required minimum of every six months
c. No prescription shall be granted for patients who have not met these parameters

D. Documentation:
Handwritten or dictated documentation of all office visits, telephone management and prescriptions