Personal information and contact information

- Personal information that ensures correct identity and contact information, inclusive of phone numbers to relatives
- Patient data: Social security number, place of residence
- Information on the referring doctor, and contact information: phone number, where to reach him/her.
- If the referring doctor is not the patient's GP/family doctor, who is?

Important introductory information (check-off points)

- Is there an imminent danger for the need of compulsory care? ☐ Yes ☐ No
- Is the patient suicidal? ☐ Yes ☐ No
- Is the patient a threat to others? ☐ Yes ☐ No
- Is there an emergency situation? ☐ Yes ☐ No
- Is the patient responsible for the care of children? ☐ Yes ☐ No
- Do you suspect severe illness/psychosis? ☐ Yes ☐ No
- Does the patient have a drug problem or addiction? ☐ Yes ☐ No

Case history and social situation

- Case history. Focus on changes, e.g., worsening
- Development of psychiatric symptoms over time
- Duration of condition/chronic state
- Concrete information on any episodes of violence
- Concrete information on former suicidal risk
- Psychosocial situation (economics, employment, residence, social network, activities)

Present state and results

A. Function, symptoms and limitations
   - Present problem, present mental status
   - Level of function: present level, loss and duration of the loss
   - Present state of symptoms and duration of the symptoms

B. Somatic health
   - Somatic health and diseases
   - Other important conditions – comorbidity

C. Test results
   - When symptoms of depression: MADRS (Montgomery–Åsberg Depression Rating Scale)

D. Medications
   - Updated medication record
   - Side effects experienced from medications

Past and on-going treatment efforts, involved professional network

A. Tested interventions with assessment of the effect
   - What has the referring doctor tried so far?

B. Existing interventions/involved services with assessment of the effect
   - Other supportive services that the patient or the family uses

C. Existing plans

The patient's assessment

- The patient's experience of the situation/problems
- The patient's desire for and motivation for treatment
- The patient's thoughts or attitude towards the treatment intervention
- Has the patient induced self-treatment or complimentary medicine?

Reason for the referral

- «Order»/goal for the referral, what the referring doctor is asking of the specialist health care provider
- Reason for referral at this time