Name/Address/DOB/Phone/PHN - label

Original Date:
Dates Revised:

CUMULATIVE PATIENT PROFILE – PSYCHIATRY

Name *(Last, First, M.I.)* ☐ M ☐ F ☐ transgendered					**DOB** *(DD/MM/YYYY)*	
Marital status ☐ Single ☐ Common-law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed						
Referring doctor (MSP)			**Date of last update** (q 6 months)			
Certification status			**Date of next certificate renewal**			
Financial status	☐ Employed	☐ Private disability	☐ PWD	☐ CPP/pension	☐ Income assistance	☐ Family
Med coverage	☐ Self-pay	☐ Private insurance	☐ Plan C	☐ Plan G		
Living situation	☐ Alone	☐ Family	☐ Roommate(s)	☐ Group home	☐ NFA/Shelter	☐ Other

Ongoing health conditions (Problem list - psychiatric and medical)			
ICD code	**Ongoing health conditions (Problem list - psychiatric and medical)**	**Date of onset**	**Date resolved/controlled**

Current (active) medication list				**Laboratory monitoring / health promotion**	
Name, dose, frequency	**Date started**	**Name, dose, frequency**	**Date started**	**Parameter**	**Date of most recent test**
				Height	
				Weight	
				Waist circumference	
				Fasting lipid profile (if on antipsychotics)	
				Fasting glucose / HbA1C (if on antipsychotics)	
				Abnormal involuntary movement scale (AIMS) (if on antipsychotics)	
				Medication level, if relevant	
				Screening for med-specific side effects	

Allergies (list name of drug + reaction)	☐ Yes ☐ No known drug allergies

Psychiatric history		
Year	Diagnosis	Hospital

Suicide attempts/gestures	☐ Yes	☐ No	Number	Method(s)
ECT	☐ Yes	☐ No	Date(s)	
Cognitive issues	☐ Yes	☐ No	Description or IQ	
Advance directive	☐ Yes	☐ No		

Past medication trials	Max dose	Date started	Date D/C	Why?	Past medication trials	Max dose	Date started	Date D/C	Why?

Medical/surgical/obstetrical history		Family history
Year	Diagnosis/procedure	

Other health care providers	Reason for involvement	Date(s)

Social history and habits								
Alcohol	Current alcohol use?			# of drinks per week?		☐ Yes	☐ No	
	Past alcohol use?			# of drinks per week?		☐ Yes	☐ No	
Tobacco	Smoking? Amt?		☐ # of years		☐ Or year quit	☐ Yes	☐ No	
Drugs	Current recreational drug use? Type/method of use?					☐ Yes	☐ No	
	Past recreational drug use? Type/method of use?					☐ Yes	☐ No	
Safety	Legal history					☐ Yes	☐ No	
	Date of offense	Date sentenced	Offense		Probation/Parole/NCR	P.O. + contact		
	History of abuse? ☐ Yes ☐ No				Current abuse?	☐ Yes	☐ No	