Partners in Care

Forms and Worksheets

MR-1198-AHRQ

RAND

Table of Contents

Partners in Care

INITIAL TELEPHONE CALL NOTES

(See suggested script in Guidelines and Resources for the Depression Nurse Specialist, *Section 2)*

Patient Name: _____ **Study ID:** _____

Primary Care Clinician: _____ Tel. №: (____) _____

Depression Nurse Specialist: _____ Tel. №: (____) _____

Patient Questions

1. _____
2. _____
3. _____

Scheduled Patient Visits

Initial Depression Nurse Specialist visit

Date of visit:___/___/___ Time of visit: ___:___ am / pm

Initial MD visit

Date of visit:___/___/___ Time of visit: ___:___ am / pm

☞ *Was patient given depression nurse specialist's telephone number?*

Record of Calls ☎

___/___/___ (date) Notes: _____

___/___/___ (date) Notes: _____

___/___/___ (date) Notes: _____

Notes

_____

_____

_____

_____

Recorded by: _____ *Phone number:* (____) _____

Reviewed by: _____ (Signature of MD/Primary Care Clinician)

ORIGINAL – **STUDY RECORD** *YELLOW* – **MD/PRIMARY CARE CLINICIAN** *PINK* – **PATIENT** *GOLDENROD* – **OTHER**

Healthform.1 –02/00

Initial Telephone Call Notes

Partners in Care

INITIAL VISIT WORKSHEET

Refer to Appendices A and B in *Guidelines and Resources for the Depression Nurse Specialist.*

To: *(Primary care clinician)* _____ **Today's date:** ___/___/___

Mr./Ms. _____ *(Study ID _____, MR# _____)* has been identified by the Partners in Care study team to have symptoms of depression. S/he attended an initial educational session on ____/____/____ and *(has / has not)* received the video tape and educational brochure in *(English / Spanish)*. Refer to step-by-step guide for Depression Nurse Specialist's initial visit assessment (Appendix A) and Depression Nurse Specialist initial assessment queries (Appendix B) in *Guidelines and Resources for the Depression Nurse Specialist.*

List 2 questions for the doctor or primary care clinician:

1. _____
2. _____

Symptoms *(Check all that apply, then circle the symptom that bothers the patient the most)*

- ❑ ✣ Sad or empty ✣
- ❑ ✣ Loss of interest ✣
- ❑ Poor concentration
- ❑ Poor energy
- ❑ Worthless/guilty
- ❑ Anxiety
- ❑ Hopelessness/poor future
- ❑ Drinks alcohol *(type(s)* _____ *drinks/day* _____*)*
- ❑ Thoughts of suicide or self-harm
- ❑ Sleep disturbance *(sleeps ____ hrs/night)*
- ❑ Appetite/weight change *(+ / - ___ lbs.)*
- ❑ Physical agitation or slowness
- ❑ Periods of over-excitement
- ❑ Sees/hears things not apparent to others
- ❑ Drug misuse/abuse
- ❑ Family history of depression
- ❑ Somatic/Other symptoms: *(list)*
  _____
  _____
  _____
  _____
  _____

NOTE: *The patient meets DSM-IV* major depression *criteria IF at least 5 of the 9 symptoms shown in the outlined box are present nearly every day for 2 weeks or more,* ***and*** *one of these symptoms is marked by a ✣ ✣. (Dysthymia has fewer/milder symptoms and lasts for 2 years or more.)*

Other Indicators for Depression:

(c h e c k a l l t h a t a p p l y)

a. Beck score: _____ **b.** Activities affected: ❑ social ❑ personal ❑ family ❑ work/school

c. Patient last felt good ___ *(wks / mos)* ago **d.** # bed days last month ____ **e.** # restricted days last month ____

Treatment:

a. Patient treated for depression *in the past?* ❑ Yes ❑ No ***Treated currently?*** ❑ Yes ❑ No

a.1 Any of these treatments? *(✓ if yes)* ❑ Psychotherapy ❑ Medication ❑ Electro-Convulsive Therapy

a.2 Was/is treatment helpful? ➔ ❑ Yes ❑ No ❑ Yes ❑ No ❑ Yes ❑ No

b. Patient wants: ❑ medication ❑ psychotherapy ❑ no strong preference

c. Patient is opposed to: ❑ medication ❑ psychotherapy ❑ no strong opposition

Current Medications

List both prescription & non-prescription medications

(Circle medications which may interact significantly with antidepressants)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Social Situation

Stressors: _____

Social support: _____

Assessed by: _____ *Phone number:* (____)_____

Reviewed by: _____ *(Signature of MD/Primary Care Clinician)*

ORIGINAL – **STUDY RECORD** *YELLOW* – **MD/PRIMARY CARE CLINICIAN** *PINK* – **PATIENT** *GOLDENROD* – **OTHER**

Healthform.2 –02/00

Initial Visit Worksheet

Partners in Care

POST-INITIAL VISIT EVALUATION

Patient Name: _____ **Study ID:** _____

Primary Care Clinician: _____ Tel. №: (____) _____

Depression Nurse Specialist: _____ Tel. №: (____) _____

This post-initial telephone call was *with*_____ *on* ___/___/___ *(date)*

Patient Questions

1. _____
2. _____
3. _____

Patient Handouts

Patient received:

- ❑ Your Personal Plan: *Medications*
- ❑ Your Personal Plan: *Psychotherapy*
- ❑ Your Personal Plan: *Watchful Waiting*
- ❑ Your Personal Plan: *Relapse Prevention*

Depression Phase of Patient *(at time of post-initial visit evaluation)*

✔ **Phase** (determined by primary care clinician)	**Follow-up**	**Next Visit**	**Handouts/Treatment**
❑ *Acute* • has not completed any treatment within the last 2 months ***OR*** • Beck score >9	Call next week	2 weeks	• Your Personal Plan: Medications • Your Personal Plan: Psycho-therapy • Other Your Personal Plans as appropriate
❑ *Continuation* • has been treated recently ***AND*** • Beck score <9	Call next week	3 months	• Your Personal Plan: Relapse Prevention • Other Your Personal Plans as appropriate
❑ *Maintenance* • has completed acute phase medications ***AND*** 6 months of continuation phase medications ***OR*** • has completed psychotherapy ***AND*** has had two or more prior episodes of major depression	Call in 1 month	3 months	• Your Personal Plan: Relapse Prevention • Other Your Personal Plans as appropriate • Consider continuing/starting antidepressants

➢**Next Primary Care Follow-up Appointment:** ___/___/___ **With:** _____

Assessed by: _____ *Phone number:* (____) _____

Reviewed by: _____ (Signature of MD/Primary Care Clinician)

Post-Initial Visit Evaluation

ORIGINAL – **STUDY RECORD** *YELLOW* – **MD/PRIMARY CARE CLINICIAN** *PINK* – **PATIENT** *GOLDENROD* – **OTHER**

Healthform.3 –02/00

Partners in Care

1 WEEK FOLLOW-UP TELEPHONE CALL WORKSHEET

Patient Name: _____ **Study ID:** _____

This follow-up telephone call was *with* _____ *on* ___/___/___ *(date)*

Attempted Calls: ___/___/___ *(date)* Notes: _____

___/___/___ *(date)* Notes: _____

___/___/___ *(date)* Notes: _____

Problems or Concerns with Treatment

_____

_____

_____

Improvement Status

a. Patient is feeling: *(check one)* ❑ better than before ❑ worse than before

b. ***If patient is worse***, is s/he considering suicide or self-harm? ❑ Yes ❑ No

Medications

a. List current medications:	**Taking as prescribed?**	**Side effects/Concerns**
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____

➢**Next Primary Care Follow-up Appointment:** ___/___/___ **With:** _____

Recorded by: _____ *Phone number:* (____) _____

Reviewed by: _____ (Signature of MD/Primary Care Clinician)

1 Week Follow-up Telephone Call Worksheet

Partners in Care

2 WEEK FOLLOW-UP TELEPHONE CALL WORKSHEET

Patient Name: _____ **Study ID:** _____

This follow-up telephone call was *with* _____ *on* ___/___/___ *(date)*

Attempted Calls: ___/___/___ *(date)* Notes: _____

___/___/___ *(date)* Notes: _____

___/___/___ *(date)* Notes: _____

Problems or Concerns with Treatment

_____

_____

_____

Improvement Status

a. Patient is feeling: *(check one)* ❑ better than before ❑ worse than before

b. ***If patient is worse***, is s/he considering suicide or self-harm? ❑ Yes ❑ No

Medications

a. List current medications:	**Taking as prescribed?**	**Side effects/Concerns**
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____

b. Is patient in psychotherapy? ❑ Yes ❑ No

If Yes, does patient attend every session? ❑ Yes ❑ No

Name of therapist: _____ Phone number: (____) _____

➢**Next Primary Care Follow-up Appointment:** ___/___/___ **With:** _____

Recorded by: _____ *Phone number:* (____) _____

Reviewed by: _____ (Signature of MD/Primary Care Clinician)

ORIGINAL – **STUDY RECORD** *YELLOW* – **MD/PRIMARY CARE CLINICIAN** *PINK* – **PATIENT** *GOLDENROD* – **OTHER**

Healthform.5 –02/00

2 Week Follow-up Telephone Call Worksheet

Partners in Care

4-6 WEEK FOLLOW-UP VISIT WORKSHEET

Patient Name: _____ **Study ID:** _____

This follow-up visit was ❑ in person ❑ by telephone *with* _____ *on* ___/___/___ *(date)*

Problems or Concerns

_____

_____

Symptoms *(Check all that apply, then circle the symptom that bothers the patient the most)*

❑ ✣ Sad or empty ✣	❑ Thoughts of suicide or self-harm	❑ Somatic/Other symptoms: *(list)*
❑ ✣ Loss of interest ✣	❑ Sleep disturbance *(sleeps ____ hrs/night)*	_____
❑ Poor concentration	❑ Appetite/weight change *(+ / - ___ lbs.)*	_____
❑ Poor energy	❑ Physical agitation or slowness	_____
❑ Worthless/guilty	❑ Periods of over-excitement	_____
❑ Anxiety	❑ Sees/hears things not apparent to others	_____
❑ Hopelessness/poor future	❑ Drug misuse/abuse	_____
❑ Drinks alcohol *(type(s)* _____ *drinks/day ____)*		_____

Improvement Status

a. Beck score: _____ **b.** *(check one)* ❑ **> 9**, no improvement ❑ **> 9**, some improvement ❑ **< 9**

(If no improvement, consider changing medications or adding psychotherapy or psychiatric consultation)

Social Situation

Stressors: _____

Social support: _____

Treatment

a. List current medications:	**Taking as prescribed?**	**Side effects/Concerns**
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____

b. Is patient in psychotherapy? ❑ Yes ❑ No

If Yes, does patient attend every session? ❑ Yes ❑ No

Name of therapist: _____ Phone number: (____) _____

➢**Next Primary Care Follow-up Appointment:** ___/___/___ **With:** _____

Assessed by: _____ *Phone number:* (____) _____

Reviewed by: _____ (Signature of MD/Primary Care Clinician)

ORIGINAL – **STUDY RECORD** *YELLOW* – **MD/PRIMARY CARE CLINICIAN** *PINK* – **PATIENT** *GOLDENROD* – **OTHER**

Healthform.6 –02/00

4-6 Week Follow-up Visit Worksheet

Partners in Care

10-12 WEEK FOLLOW-UP VISIT WORKSHEET

Patient Name: _____ **Study ID:** _____

This follow-up visit was ❑ in person ❑ by telephone *with* _____ *on* ___/___/___ *(date)*

Problems or Concerns

_____

_____

Symptoms *(Check all that apply, then circle the symptom that bothers the patient the most)*

❑ ✣ Sad or empty ✣	❑ Thoughts of suicide or self-harm	❑ Somatic/Other symptoms: *(list)*
❑ ✣ Loss of interest ✣	❑ Sleep disturbance *(sleeps ____ hrs/night)*	_____
❑ Poor concentration	❑ Appetite/weight change *(+ / - ___ lbs.)*	_____
❑ Poor energy	❑ Physical agitation or slowness	_____
❑ Worthless/guilty	❑ Periods of over-excitement	_____
❑ Anxiety	❑ Sees/hears things not apparent to others	_____
❑ Hopelessness/poor future	❑ Drug misuse/abuse	_____
❑ Drinks alcohol *(type(s) _____ drinks/day ____)*		_____

Improvement Status

a. Beck score: _____ **b.** *(check one)* ❑ **> 9**, no improvement ❑ **> 9**, some improvement ❑ **< 9**

(If no improvement, consider changing medications or adding psychotherapy or psychiatric consultation)

Social Situation

Stressors: _____

Social support: _____

Treatment

a. List current medications:	**Taking as prescribed?**	**Side effects/Concerns**
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____

b. Is patient in psychotherapy? ❑ Yes ❑ No

If Yes, does patient attend every session? ❑ Yes ❑ No

Name of therapist: _____ Phone number: (____) _____

➢**Next Primary Care Follow-up Appointment:** ___/___/___ **With:** _____

*(If acute phase completed, next contact is **3 month continuation visit.** If not, next contact is **16 week follow-up**)*

Assessed by: _____ *Phone number:* (____) _____

Reviewed by: _____ (Signature of MD/Primary Care Clinician)

ORIGINAL – **STUDY RECORD** *YELLOW* – **MD/PRIMARY CARE CLINICIAN** *PINK* – **PATIENT** *GOLDENROD* – **OTHER**

Healthform.7 –02/00

10-12 Week Follow-up Visit Worksheet

Partners in Care

16 WEEK FOLLOW-UP VISIT WORKSHEET

Patient Name: _____ **Study ID:** _____

This follow-up visit was ❑ in person ❑ by telephone *with* _____ *on* ___/___/___ *(date)*

Problems or Concerns

_____

_____

Symptoms *(Check all that apply, then circle the symptom that bothers the patient the most)*

❑ ✣ Sad or empty ✣	❑ Thoughts of suicide or self-harm	❑ Somatic/Other symptoms: *(list)*
❑ ✣ Loss of interest ✣	❑ Sleep disturbance *(sleeps ____ hrs/night)*	_____
❑ Poor concentration	❑ Appetite/weight change *(+ / - ___ lbs.)*	_____
❑ Poor energy	❑ Physical agitation or slowness	_____
❑ Worthless/guilty	❑ Periods of over-excitement	_____
❑ Anxiety	❑ Sees/hears things not apparent to others	_____
❑ Hopelessness/poor future	❑ Drug misuse/abuse	_____
❑ Drinks alcohol *(type(s)* _____ *drinks/day ____)*		_____

Acute Phase Status

a. Beck score: _____ **b.** *(check one)* ❑ **> 9**, no improvement ❑ **> 9**, some improvement ❑ **< 9**

(If still in acute phase, consider changing meds or adding psychotherapy or psychiatric consultation)

Social Situation

Stressors: _____

Social support: _____

Treatment

a. List current medications:	**Taking as prescribed?**	**Side effects/Concerns**
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____

b. Is patient in psychotherapy? ❑ Yes ❑ No

If Yes, does patient attend every session? ❑ Yes ❑ No

Name of therapist: _____ Phone number: (____) _____

➢**Next Primary Care Follow-up Appointment:** ___/___/___ **With:** _____

*(If acute phase completed, next contact is **3 month continuation visit**. If not, next contact is **20 week follow-up**)*

Assessed by: _____ *Phone number:* (____) _____

Reviewed by: _____ (Signature of MD/Primary Care Clinician)

ORIGINAL – **STUDY RECORD** *YELLOW* – **MD/PRIMARY CARE CLINICIAN** *PINK* – **PATIENT** *GOLDENROD* – **OTHER**

Healthform.8 –02/00

16 Week Follow-up Visit Worksheet

Partners in Care

20+ WEEK FOLLOW-UP VISIT WORKSHEET

Use for symptomatic acute phase patients

Week Number: _____

Patient Name: _____ **Study ID:** _____

This follow-up visit was ❑ in person ❑ by telephone *with* _____ *on* ___/___/___ *(date)*

Problems or Concerns

_____

_____

Symptoms *(Check all that apply, then circle the symptom that bothers the patient the most)*

❑ ❖ Sad or empty ❖	❑ Thoughts of suicide or self-harm	❑ Somatic/Other symptoms: *(list)*
❑ ❖ Loss of interest ❖	❑ Sleep disturbance *(sleeps ____ hrs/night)*	_____
❑ Poor concentration	❑ Appetite/weight change *(+ / - ___ lbs.)*	_____
❑ Poor energy	❑ Physical agitation or slowness	_____
❑ Worthless/guilty	❑ Periods of over-excitement	_____
❑ Anxiety	❑ Sees/hears things not apparent to others	_____
❑ Hopelessness/poor future	❑ Drug misuse/abuse	_____
❑ Drinks alcohol *(type(s)* _____ *drinks/day ____)*		_____

Acute Phase Status

a. Beck score: _____ **b.** *(check one)* ❑ **> 9**, no improvement ❑ **> 9**, some improvement ❑ **< 9**

(If still in acute phase, consider changing meds or adding psychotherapy or psychiatric consultation)

Social Situation

Stressors: _____

Social support: _____

Treatment

a. List current medications:	**Taking as prescribed?**	**Side effects/Concerns**
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____

b. Is patient in psychotherapy? ❑ Yes ❑ No

If Yes, does patient attend every session? ❑ Yes ❑ No

Name of therapist: _____ Phone number: (____) _____

➢**Next Primary Care Follow-up Appointment:** ___/___/___ **With:** _____

*(If acute phase completed, next contact is **3 month continuation visit**. If not, next contact is **20+ week follow-up**)*

Assessed by: _____ *Phone number:* (____) _____

Reviewed by: _____ (Signature of MD/Primary Care Clinician)

ORIGINAL – **STUDY RECORD** *YELLOW* – **MD/PRIMARY CARE CLINICIAN** *PINK* – **PATIENT** *GOLDENROD* – **OTHER**

Healthform.9 –02/00

20+ Week Follow-up Visit Worksheet

Partners in Care

3 MONTH CONTINUATION PHASE VISIT WORKSHEET

Patient Name: _____ **Study ID:** _____

This continuation visit was ❑ in person ❑ by telephone *with* _____ *on* ___/___/___ *(date)*

Problems or Concerns

_____

_____

Symptoms *(Check all that apply, then circle the symptom that bothers the patient the most)*

❑ ✣ Sad or empty ✣	❑ Thoughts of suicide or self-harm	❑ Somatic/Other symptoms: *(list)*
❑ ✣ Loss of interest ✣	❑ Sleep disturbance *(sleeps ____ hrs/night)*	_____
❑ Poor concentration	❑ Appetite/weight change *(+ / - ___ lbs.)*	_____
❑ Poor energy	❑ Physical agitation or slowness	_____
❑ Worthless/guilty	❑ Periods of over-excitement	_____
❑ Anxiety	❑ Sees/hears things not apparent to others	_____
❑ Hopelessness/poor future	❑ Drug misuse/abuse	_____
❑ Drinks alcohol *(type(s)* _____ *drinks/day ____)*		_____

Relapse Status

a. Beck score: _____ **b.** *(check one)* ❑ **> 9**,worse than before ❑ **> 9**, same or some improvement ❑ **< 9**

(If patient is relapsing, strongly consider psychiatric consultation)

Social Situation

Stressors: _____

Social support: _____

Treatment

a. List current medications:	**Taking as prescribed?**	**Side effects/Concerns**
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____

b. Is patient in psychotherapy? ❑ Yes ❑ No

If **Yes**, does patient attend every session? ❑ Yes ❑ No

Name of therapist: _____ Phone number: (____) _____

c. Has patient been given *Your Personal Plan: Relapse Prevention*? ❑ Yes ❑ No

➢**Next Primary Care Follow-up Appointment:** ___/___/___ **With:** _____

Assessed by: _____ *Phone number:* (____) _____

Reviewed by: _____ (Signature of MD/Primary Care Clinician)

ORIGINAL – **STUDY RECORD** *YELLOW* – **MD/PRIMARY CARE CLINICIAN** *PINK* – **PATIENT** *GOLDENROD* – **OTHER**

Healthform.10 –02/00

3 MONTH Continuation Phase Visit Worksheet

Partners in Care

6 MONTH CONTINUATION PHASE VISIT WORKSHEET

Patient Name: _____ **Study ID:** _____

This continuation visit was ❑ in person ❑ by telephone *with* _____ *on* ___/___/___ *(date)*

Problems or Concerns

_____

_____

Symptoms *(Check all that apply, then circle the symptom that bothers the patient the most)*

❑ ❖ Sad or empty ❖	❑ Thoughts of suicide or self-harm	❑ Somatic/Other symptoms: *(list)*
❑ ❖ Loss of interest ❖	❑ Sleep disturbance *(sleeps ____ hrs/night)*	_____
❑ Poor concentration	❑ Appetite/weight change *(+ / - ___ lbs.)*	_____
❑ Poor energy	❑ Physical agitation or slowness	_____
❑ Worthless/guilty	❑ Periods of over-excitement	_____
❑ Anxiety	❑ Sees/hears things not apparent to others	_____
❑ Hopelessness/poor future	❑ Drug misuse/abuse	_____
❑ Drinks alcohol *(type(s)* _____ *drinks/day ____)*		_____

Relapse Status

a. Beck score: _____ **b.** *(check one)* ❑ **> 9**,worse than before ❑ **> 9**, same or some improvement ❑ **< 9**

(If patient is relapsing, strongly consider psychiatric consultation)

Social Situation

Stressors: _____

Social support: _____

Treatment

a. List current medications:	**Taking as prescribed?**	**Side effects/Concerns**
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____

b. Has patient been given *Your Personal Plan: Relapse Prevention*? ❑ Yes ❑ No

➢**Next Primary Care Follow-up Appointment:** ___/___/___ **With:** _____

Assessed by: _____ *Phone number:* (____) _____

Reviewed by: _____ (Signature of MD/Primary Care Clinician)

ORIGINAL – **STUDY RECORD** *YELLOW* – **MD/PRIMARY CARE CLINICIAN** *PINK* – **PATIENT** *GOLDENROD* – **OTHER**

Healthform.11 –02/00

6 MONTH Continuation Phase Visit Worksheet

Partners in Care

9 MONTH CONTINUATION PHASE VISIT WORKSHEET

Patient Name: _____ **Study ID:** _____

This continuation visit was ❑ in person ❑ by telephone *with* _____ *on* ___/___/___ *(date)*

Problems or Concerns

_____

_____

Symptoms *(Check all that apply, then circle the symptom that bothers the patient the most)*

❑ ✣ Sad or empty ✣	❑ Thoughts of suicide or self-harm	❑ Somatic/Other symptoms: *(list)*
❑ ✣ Loss of interest ✣	❑ Sleep disturbance *(sleeps ____ hrs/night)*	_____
❑ Poor concentration	❑ Appetite/weight change *(+ / - ___ lbs.)*	_____
❑ Poor energy	❑ Physical agitation or slowness	_____
❑ Worthless/guilty	❑ Periods of over-excitement	_____
❑ Anxiety	❑ Sees/hears things not apparent to others	_____
❑ Hopelessness/poor future	❑ Drug misuse/abuse	_____
❑ Drinks alcohol *(type(s)* _____ *drinks/day ____)*		_____

Relapse Status

a. Beck score: _____ **b.** *(check one)* ❑ **> 9**,worse than before ❑ **> 9**, same or some improvement ❑ **< 9**

(If patient is relapsing, strongly consider psychiatric consultation)

Social Situation

Stressors: _____

Social support: _____

Treatment

a. List current medications:	**Taking as prescribed?**	**Side effects/Concerns**
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____

b. Has patient been given *Your Personal Plan: Relapse Prevention*? ❑ Yes ❑ No

➢**Next Primary Care Follow-up Appointment:** ___/___/___ **With:** _____

Assessed by: _____ *Phone number:* (____) _____

Reviewed by: _____ (Signature of MD/Primary Care Clinician)

ORIGINAL – **STUDY RECORD** *YELLOW* – **MD/PRIMARY CARE CLINICIAN** *PINK* – **PATIENT** *GOLDENROD* – **OTHER**

Healthform.12 –02/00

9 MONTH Continuation Phase Visit Worksheet

Partners in Care

MAINTENANCE VISIT WORKSHEET

Patient Name: _____ **Study ID:** _____

This maintenance visit was ❑ in person ❑ by telephone *with* _____ *on* ___/___/___ *(date)*

Problems or Concerns

_____

_____

Symptoms *(Check all that apply, then circle the symptom that bothers the patient the most)*

❑ ✣ Sad or empty ✣	❑ Thoughts of suicide or self-harm	❑ Somatic/Other symptoms: *(list)*
❑ ✣ Loss of interest ✣	❑ Sleep disturbance *(sleeps ____ hrs/night)*	_____
❑ Poor concentration	❑ Appetite/weight change *(+ / - ___ lbs.)*	_____
❑ Poor energy	❑ Physical agitation or slowness	_____
❑ Worthless/guilty	❑ Periods of over-excitement	_____
❑ Anxiety	❑ Sees/hears things not apparent to others	_____
❑ Hopelessness/poor future	❑ Drug misuse/abuse	_____
❑ Drinks alcohol *(type(s)* _____ *drinks/day _____)*		_____

Relapse Status

a. Beck score: _____ **b.** *(check one)* ❑ **> 9**,worse than before ❑ **> 9**, same or some improvement ❑ **< 9**

(If patient is relapsing, strongly consider psychiatric consultation)

Social Situation

Stressors: _____

Social support: _____

Treatment

a. List current medications:	**Taking as prescribed?**	**Side effects/Concerns**
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____
_____	❑ Yes ❑ No	_____

b. Has patient been given *Your Personal Plan: Relapse Prevention*? ❑ Yes ❑ No

➢**Next Primary Care Follow-up Appointment:** ___/___/___ **With:** _____

Assessed by: _____ *Phone number:* (____) _____

Reviewed by: _____ (Signature of MD/Primary Care Clinician)

Maintenance Visit Worksheet

Partners in Care

MD/RN STUDY RECORD NOTES

Use one form per visit/contact, as needed.
Place in chronological order in patient's study record.

Patient Name: _____ **Study ID:** _____

Primary Care Clinician: _____ Tel. Nº: (____) _____

Depression Nurse Specialist: _____ Tel. Nº: (____) _____

Visit/Contact	**Notes**
___/___/___ *(date)*	
(check one)	
❑ **Telephone**	
❑ **In person**	

MD/RN Study Record Notes

Recorded By: _____ *Phone number:* (____) _____

Reviewed By: _____ (Signature of MD/Primary Care Clinician)

ORIGINAL – **STUDY RECORD** *YELLOW* – **MD/PRIMARY CARE CLINICIAN** *PINK* – **PATIENT** *GOLDENROD* – **OTHER**

Healthform.14 –02/00

Partners in Care

YOUR PERSONAL PLAN: Medications

Patient Name: _____ **Study ID#:** _____

CONTACT/APPOINTMENT INFORMATION

Primary Care Clinician: _____ Tel. Nº: (____)_____

Depression Nurse Specialist: _____ Tel. Nº: (____)_____

➢**Next appointment:** *Date* ___/___/___ *Time:* ____:____ *(circle one) am / pm*

YOUR MEDICATION SCHEDULE

Name of medication: _____ **From:** **To:**

	1st	Take ____ tablet(s) of _____ mg every morning/evening for _____ days	___/___	___/___
THEN	2nd	Take ____ tablet(s) of _____ mg every morning/evening for _____ days	___/___	___/___
THEN	3rd	Take ____ tablet(s) of _____ mg every morning/evening for _____ days	___/___	___/___
THEN	4th	Take ____ tablet(s) of _____ mg every morning/evening for _____ days	___/___	___/___

NOTE: *The medication is started at a low dose to give your body time to adapt. If you are having side effects, you can stay at a lower dose for a little longer and then increase the amount.* ***Remember: It may take a few weeks before you experience the medication's full effect, so don't get discouraged.***

✷ IMPORTANT!!! ✷
DON'T STOP THE MEDICATION BEFORE CALLING YOUR DOCTOR

SYMPTOMS TO MONITOR

✔ if you are having this symptom:

- ❑ Anxiety attacks
- ❑ Aches and pains
- ❑ Problems with sleep
- ❑ Trouble thinking, concentrating, or deciding
- ❑ Decreased or increased appetite
- ❑ Feeling slowed down or sped up/jittery
- ❑ Feelings of worthlessness or guilt
- ❑ Wishing you were dead or thinking about suicide
- ❑ Feeling depressed or sad
- ❑ Loss of interest or pleasure
- ❑ Nervousness or tension
- ❑ Fatigue or loss of energy
- ❑ Others: _____

YOUR QUESTIONS/CONCERNS

Bring this form to your next visit. Record any questions, problems, or concerns you may have about your current treatment here:

1. _____
2. _____
3. _____

Your Personal Plan: Medications

INFORMATION ABOUT ANTIDEPRESSANT MEDICATIONS

How do antidepressants work?

Both life stresses and medical problems can deplete the amount of chemical messengers in the nervous system that maintains the balance in how you feel emotionally and physically. This chemical imbalance results in some of the common symptoms of depression such as sleep and appetite problems, loss of energy, loss of concentration, and increased sensitivity to pain. Antidepressant medications help restore a normal balance of these chemical messengers, which helps to relieve emotional and physical symptoms.

Antidepressants can take up to 6 weeks to work. It usually takes one to four weeks until people start feeling better emotionally and physically. The improvement may be gradual, and oftentimes family members or friends may notice a difference in how you are doing before you do. Your sleep and appetite may improve first, then your mood and energy. Negative thinking may take some more time to decrease.

Once you are feeling better, do not stop the medication right away. Your doctor may recommend taking the medication for six to nine months or longer to prevent a relapse of the depression.

How to find an antidepressant that works for you?

Scientific studies show that antidepressant medications do not differ in the percentage of patients that get better. However, different medications are effective for different people, and the side effects of the medications differ. Some medications also cost more than others. Your doctor can help you decide which medication may be best for you.

About 70% of patients will get better after 4 to 6 weeks on an antidepressant medication. By working together, you and your doctor can decide during that six-week period whether the medication you started is the right one for you. If you need to switch to another antidepressant because of side effects or because you are not significantly improved after six weeks, chances are still excellent that you will improve on this second medication.

What about side effects?

Some people may experience side effects when taking antidepressant medications. While these side effects can be annoying, they are rarely dangerous to your health. They usually occur in the first few weeks and then gradually decrease as your body adapts to the medication. Because of these early side effects, patients sometimes feel a little worse before they start getting better and may give up too soon. If you have side effects that are bothering you, discuss these with your doctor. Your doctor will help you determine if these side effects will decrease over time or if you should decrease or switch your medication.

Some of the side effects that can occur with antidepressants:

- nausea
- headaches
- jitteriness
- weight gain
- diarrhea
- insomnia
- sedation
- urinary hesitancy
- dizziness
- rapid heart rate
- temporary difficulty in achieving orgasm
- blurred vision
- dry mouth
- constipation
- *other:* _____

Remember:

- Antidepressants are not addicting or habit forming. They do not make people 'high', and they do not lead to serious withdrawal symptoms once you stop them.
- Take the medications daily.
- Keep track of side effects and problems and discuss them with your physician.
- **Do not stop the medication before talking with your doctor.**

Partners in Care

YOUR PERSONAL PLAN: Psychotherapy

Patient Name: _____ **Study ID:** _____

CONTACT INFORMATION

Primary Care Clinician: _____ Tel. Nº: (____) _____

Depression Nurse Specialist: _____ Tel. Nº:(____) _____

Psychotherapist: _____ Tel. Nº:(____) _____

YOUR NEXT APPOINTMENTS

With Primary Care Physician: *Date* ___/___/___ *Time:* ____:____ *(circle one) am / pm*

With Psychotherapist: *Date* ___/___/___ *Time:* ____:____ *(circle one) am / pm*

SYMPTOMS TO MONITOR

✔ if you are having this symptom:

- ❑ Anxiety attacks
- ❑ Aches and pains
- ❑ Problems with sleep
- ❑ Trouble thinking, concentrating, or deciding
- ❑ Decreased or increased appetite
- ❑ Feeling slowed down or sped up/jittery
- ❑ Feelings of worthlessness or guilt
- ❑ Wishing you were dead or thinking about suicide
- ❑ Feeling depressed or sad
- ❑ Loss of interest or pleasure
- ❑ Nervousness or tension
- ❑ Fatigue or loss of energy
- ❑ Others: _____

_____

YOUR QUESTIONS/CONCERNS

Bring this form to your next visit. Record any questions, problems, or concerns you may have about your current treatment here:

1. _____
2. _____
3. _____

Your Personal Plan: Psychotherapy

Partners in Care

YOUR PERSONAL PLAN: Watchful Waiting

(For patients not started on medication or psychotherapy treatment plan)

Patient Name: _____ **Study ID:** _____

CONTACT INFORMATION

Primary Care Physician: _____ Tel. Nº: (____) _____

Depression Nurse Specialist: _____ Tel. Nº:(____) _____

Psychotherapist: _____ Tel. Nº: (____) _____

YOUR NEXT APPOINTMENTS

		(circle one)
With Primary Care Physician:	*Date* ___/___/___	*Time:* ____:____ *am / pm*
With Depression Nurse Specialist:	*Date* ___/___/___	*Time:* ____:____ *am / pm*
With: _____	*Date* ___/___/___	*Time:* ____:____ *am / pm*

SYMPTOMS TO MONITOR

✔ if you are having this symptom:

- ❑ Anxiety attacks
- ❑ Aches and pains
- ❑ Problems with sleep
- ❑ Trouble thinking, concentrating, or deciding
- ❑ Decreased or increased appetite
- ❑ Feeling slowed down or sped up/jittery
- ❑ Feelings of worthlessness or guilt
- ❑ Wishing you were dead or thinking about suicide
- ❑ Feeling depressed or sad
- ❑ Loss of interest or pleasure
- ❑ Nervousness or tension
- ❑ Fatigue or loss of energy
- ❑ Others: _____ _____

YOUR QUESTIONS/CONCERNS

Bring this form to your next visit. Record any questions, problems, or concerns you may have about your current treatment here:

1. _____
2. _____
3. _____

Partners in Care

YOUR PERSONAL PLAN: Relapse Prevention

Patient Name: _____ **Study ID:** _____

CONTACT INFORMATION

Primary Care Physician: _____ Tel. Nº: (____) _____

Depression Nurse Specialist: _____ Tel. Nº:(____) _____

Psychotherapist: _____ Tel. Nº: (____) _____

PERSONAL WARNING SIGNS

1. _____
2. _____
3. _____

STRESSFUL LIFE EVENTS AND HOW TO MINIMIZE THEM

Event: _____ How to minimize: _____

_____ _____

Event: _____ How to minimize: _____

_____ _____

Event: _____ How to minimize: _____

_____ _____

MEDICATIONS

Name of antidepressant: _____ **Dose:** _____

Take medication until: ___/___/___

Questions: Call your **primary care clinician** or your **depression nurse specialist.**

(See Contact Information, above)

WHAT YOU SHOULD DO IF SYMPTOMS OF DEPRESSION RECUR

1. _____
2. _____
3. _____

Reviewed by: _____ ___ *(Signature of MD/Primary Care Clinician)*

ORIGINAL – **STUDY RECORD** *YELLOW* – **MD/PRIMARY CARE CLINICIAN** *PINK* – **PATIENT** *GOLDENROD* – **OTHER**

Healthform.18 –02/00

Your Personal Plan: Relapse Prevention

Partners in Care

MEDICATION-ENHANCED CLINIC

REGISTER AND ACTIVITY SUMMARY

ALL STUDY PATIENTS

Depression Nurse Specialist: _____ **Clinic:** _____

Line #	A	B	C	D	E	F	G	H	I	J
				Enter Dates				Enter Dates		
	Study ID *(ODD & EVEN)*	**Patient Name** Last, First ✓ = *Patient Index Card filed*	**Medical Record №**	**Initial Call**	**Initial Assessment Visit**	**Post-Initial Visit Assessment**	**Type of Therapy Started on Initial Visit*** *(circle one)*	**Patient Started Psycho-therapy✣**	**Patient Started Medication✣**	**End of Follow-up period** *(6 or 12 months after initial visit)*
1		❑		/ /	/ /	/ /	M P N	/ /	/ /	/ /
2		❑		/ /	/ /	/ /	M P N	/ /	/ /	/ /
3		❑		/ /	/ /	/ /	M P N	/ /	/ /	/ /
4		❑		/ /	/ /	/ /	M P N	/ /	/ /	/ /
5		❑		/ /	/ /	/ /	M P N	/ /	/ /	/ /
6		❑		/ /	/ /	/ /	M P N	/ /	/ /	/ /
7		❑		/ /	/ /	/ /	M P N	/ /	/ /	/ /
8		❑		/ /	/ /	/ /	M P N	/ /	/ /	/ /
9		❑		/ /	/ /	/ /	M P N	/ /	/ /	/ /
10		❑		/ /	/ /	/ /	M P N	/ /	/ /	/ /

* **M = Medication or medication plus psychotherapy**; if **'M'** circled, enter dates as appropriate in Columns H & I.
  P = Psychotherapy only; if **'P'** circled, enter date as appropriate in Column H.
  N = None; if **'N'** circled, enter line number, Study ID and name of patient on *Follow-up Log for Patients Not Started on Treatment* (Healthform.21 –02/00). If patient begins treatment at a later date, enter dates as appropriate in Columns H & I.

✣ If patient has not started on this treatment, leave blank.

Suggested Codes for Results

31 Initial therapy appointment pending
32 Patient met w/ study psychotherapist
33 Made appt. w/ primary care clinician
34 Started on depression medication
35 Started treatment *outside of* study clinic
36 Depression improved
37 Refused treatment
38 Unable to contact after repeated attempts
39 Other - *Specify*

Partners in Care

MEDICATION-ENHANCED CLINIC
FOLLOW-UP LOG
FOR PATIENTS
STARTED ON PSYCHOTHERAPY ONLY*

Notes:

Depression Nurse Specialist: _____ **Clinic:** _____

Line #	Study ID *(ODD & EVEN)*	Patient Name	Tel No	Date of Contact	Results CODE	Results COMMENTS	Date of Contact	Results CODE	Results COMMENTS
				1.			3.		
				2.			4.		
				1.			3.		
				2.			4.		
				1.			3.		
				2.			4.		
				1.			3.		
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				1.			3.		
				2.			4.		
				1.			3.		
				2.			4.		

* Record information on patients for whom psychotherapy **only** *(i.e., no medication)* has been prescribed as treatment. ***Reminder.*** Transfer Line Number from *Register* (Healthform.19 –02/00).

The patient should be contacted 8 to 12 weeks after the initial assessment visit to see if therapy is working. If the patient has not adhered to therapy regimen, or if therapy is not working, consult with the primary care clinician. *This form provides additional spaces for optional contacts.*

Suggested Result Codes

21 Made appt. w/ primary care clinician
22 Started on depression medication
23 Initial therapy appointment pending
24 Started CBT therapy *at this clinic*
25 Started treatment at *outside* clinic
26 Patient considering treatment
27 Depression improved
28 Refused treatment
29 Unable to contact after repeated attempts
30 Other - *Specify*

Partners in Care

MEDICATION-ENHANCED CLINIC
FOLLOW-UP LOG
FOR PATIENTS
NOT STARTED ON TREATMENT – TREATMENT INDICATED*

Notes:

Depression Nurse Specialist: _____ **Clinic:** _____

Line #	Study ID *(ODD & EVEN)*	Patient Name	Tel №	Date of Contact	Results CODE	Results COMMENTS	Date of Contact	Results CODE	Results COMMENTS
				1.			3.		
				2.			4.		
				1.			3.		
				2.			4.		
				1.			3.		
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				1.			3.		
				2.			4.		

* Record information on patients for whom treatment is indicated, but who were not started on treatment at time of initial visit. ***Reminder.*** Transfer Line Number from *Register* (Healthform.19 –02/00).

About 4 weeks after the initial assessment visit, the patient should be contacted for reevaluation and to encourage treatment. If patient is still depressed and <u>not</u> willing to see the primary care clinician, consider recontacting in another 4 weeks. If treatment is started, record date(s) as appropriate in columns H and/or I of the *Register and Activity Summary--ALL Study Patients* (Healthform.19 –02/00). *This form provides additional spaces for optional contacts.*

Suggested Result Codes

21 Made appt. w/ primary care clinician
22 Started on depression medication
23 Initial therapy appointment pending
24 Started CBT therapy *at this clinic*
25 Started treatment at *outside* clinic
26 Patient considering treatment
27 Depression improved
28 Refused treatment
29 Unable to contact after repeated attempts
30 Other - *Specify*

Partners in Care

MEDICATION-ENHANCED CLINIC
FOLLOW-UP LOG

FOR PATIENTS NOT REQUIRING PSYCHOTHERAPY OR MEDICATION*

Notes:

Depression Nurse Specialist: _____ **Clinic:** _____

Line #	Study ID *(ODD & EVEN)*	Patient Name	Tel No	Date of Contact	Results CODE	Results COMMENTS	Date of Contact	Results CODE	Results COMMENTS
				1.			3.		
				2.			4.		
				1.			3.		
				2.			4.		
				1.			3.		
				2.			4.		
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				2.			4.		
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				1.			3.		
				2.			4.		
				1.			3.		
				2.			4.		
				1.			3.		
				2.			4.		

* Record information on patients for whom treatment has been neither indicated **nor** prescribed. ***Reminder***: Transfer Line Number from *Register* (Healthform.19 –02/00).

About 3months after the initial assessment visit, the patient should be contacted to reassess or educate. If the depression has worsened, notify the primary care clinician. *This form provides additional spaces for optional contacts.*

Partners in Care

MEDICATION-ENHANCED CLINIC

BECK DEPRESSION INVENTORY (BDI) TRACKING FORM

12 MONTH FOLLOW-UP PATIENTS

(ODD-Numbered Study IDs)

Depression Nurse Specialist: _____ **Clinic:** _____

Line #*	Study ID (ODD ONLY)	Patient Name Last, First	1st Date	1st BDI Score	2nd Date	2nd BDI Score	3rd Date	3rd BDI Score	4th Date	4th BDI Score	5th Date	5th BDI Score
			/ /		/ /		/ /		/ /		/ /	
			/ /		/ /		/ /		/ /		/ /	
			/ /		/ /		/ /		/ /		/ /	
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* ***Reminder:*** Transfer Line Number from *Register* (Healthform.19 –02/00).

Partners in Care

MEDICATION-ENHANCED CLINIC

BECK DEPRESSION INVENTORY (BDI) TRACKING FORM

12 MONTH FOLLOW-UP PATIENTS (for information OVERFLOW+)

(ODD-Numbered Study IDs)

Depression Nurse Specialist: ______________________ **Clinic:** ______________________

Line #*	Study ID (ODD ONLY)	6th		7th		8th		9th		10th		11th		12th	
		Date	BDI Score	Date	BDI Score	Date	BDI Score	Date	BDI Score	Date	BDI Score	Date	BDI Score	Date	BDI Score
___		/ /		/ /		/ /		/ /		/ /		/ /		/ /	
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+ Continue to record scores on this form for patients who have been given the BDI more than 5 times.

*Transfer Patient Line Number and Study ID from the page of the BDI Tracking Form on which the patient was originally listed (Healthform.23a –02/00).

***Overflow* Page** ___

Partners in Care

MEDICATION-ENHANCED CLINIC

BECK DEPRESSION INVENTORY (BDI) TRACKING FORM

6 MONTH FOLLOW-UP PATIENTS

(EVEN-Numbered Study IDs)

Depression Nurse Specialist: _____ **Clinic:** _____

Line #*	Study ID (*EVEN ONLY*)	Patient Name Last, First	1st		2nd		3rd		4th		5th	
			Date	BDI Score	Date	BDI Score	Date	BDI Score	Date	BDI Score	Date	BDI Score
			/ /		/ /		/ /		/ /		/ /	
			/ /		/ /		/ /		/ /		/ /	
			/ /		/ /		/ /		/ /		/ /	
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* ***Reminder.*** Transfer Line Number from *Register* (Healthform.19 –02/00).

Partners in Care

PSYCHOTHERAPY-ENHANCED CLINIC
REGISTER AND ACTIVITY SUMMARY
ALL STUDY PATIENTS

Depression Nurse Specialist: _____ **Clinic:** _____

Line #	A **Study ID** *(ODD & EVEN)*	B **Patient Name** Last, First	C **Medical Record №**	D **Enter Dates** **Initial Call**	E **Initial Assessment Visit**	F **Post-Initial Visit Assessment**	G **Type of Therapy Started on Initial Visit*** *(circle one)*	H **Patients Started on Psychotherapy** ***Scheduled Date*** **Initial Psych Appointment**	I ***Actual Date*** **Initial Psych Appointment**	J **Date Study Record Given to Therapist**
1				/ /	/ /	/ /	P B N	/ /	/ /	/ /
2				/ /	/ /	/ /	P B N	/ /	/ /	/ /
3				/ /	/ /	/ /	P B N	/ /	/ /	/ /
4				/ /	/ /	/ /	P B N	/ /	/ /	/ /
5				/ /	/ /	/ /	P B N	/ /	/ /	/ /
6				/ /	/ /	/ /	P B N	/ /	/ /	/ /
7				/ /	/ /	/ /	P B N	/ /	/ /	/ /
8				/ /	/ /	/ /	P B N	/ /	/ /	/ /
9				/ /	/ /	/ /	P B N	/ /	/ /	/ /
10				/ /	/ /	/ /	P B N	/ /	/ /	/ /

*__P = Psychotherapy only__; if **'P'** circled, enter dates as appropriate in Columns H, I & J.
B = Both psychotherapy and medications; if **'B'** circled, enter dates as appropriate in Columns H, I & J.
N = None; if **'N'** circled, enter patient's name on *Follow-up Log for Patients Not Started on Treatment* (Healthform.21 –02/00). If patient begins psychotherapy at a later date, enter dates as appropriate in Columns H, I & J.

Suggested Result Codes

1 Made appt. w/primary care clinician
2 Started on depression medication
3 Initial therapy appointment pending
4 Started CBT therapy *at this clinic*
5 Started treatment at *outside* clinic
6 Patient considering treatment
7 Depression improved
8 Refused treatment
9 Unable to contact after repeated attempts
10 Other - *Specify*

Partners in Care

PSYCHOTHERAPY-ENHANCED CLINIC
FOLLOW-UP LOG
for patients
NOT STARTED ON TREATMENT – **TREATMENT INDICATED***

Notes:

Depression Nurse Specialist: _____ **Clinic:** _____

Line #	Study ID *(ODD & EVEN)*	Patient Name	Tel №	Date of Contact	Results CODE	Results COMMENTS	Date of Contact	Results CODE	Results COMMENTS
				1.			3.		
				2.			4.		
				1.			3.		
				2.			4.		
				1.			3.		
				2.			4.		
				1.			3.		
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				1.			3.		
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				1.			3.		
				2.			4.		
				1.			3.		
				2.			4.		
				1.			3.		
				2.			4.		

* Record information on patients for whom treatment is indicated, but who were not started on treatment at the initial visit. ***Reminder***: Transfer Line Number from *Register* (Healthform.19 –02/00).

About 4 weeks after the initial assessment visit, patient should be contacted for reevaluation and to encourage treatment. If the patient is still depressed and *not* willing to see the primary care clinician, consider recontacting in another 4 weeks. If psychotherapy is started, record date in the *Register and Activity Summary--ALL Study Patients* (Healthform.19 –2/00). *This form provides additional spaces for optional contacts.*

Suggested Result Codes

51 Made appt. w/primary care clinician
52 Started on depression medication
53 Initial therapy appointment pending
54 Started CBT therapy *at this clinic*
55 Started treatment at *outside* clinic
56 Patient considering treatment
57 Depression worsened
58 Refused treatment
59 Unable to contact after repeated attempts
60 Other - *Specify*

Partners in Care

PSYCHOTHERAPY-ENHANCED CLINIC
FOLLOW-UP LOG
for patients
NOT REQUIRING PSYCHOTHERAPY OR MEDICATION *

Notes:

Depression Nurse Specialist: _____ **Clinic:** _____

Line #	Study ID *(ODD & EVEN)*	Patient Name	Tel №	Date of Contact	Results CODE	Results COMMENTS	Date of Contact	Results CODE	Results COMMENTS
				1.			3.		
				2.			4.		
				1.			3.		
				2.			4.		
				1.			3.		
				2.			4.		
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				1.			3.		
				2.			4.		

* Record information on patients for whom treatment has been **neither** *indicated* **nor** *prescribed.* ***Reminder***: Transfer Line Number from *Register* (Healthform.19 –02/00).

About 3 months after the initial assessment visit, the patient should be contacted to reassess or educate. If the depression has worsened, notify the primary care clinician. ***This form provides additional spaces for optional contacts.***

Partners in Care

PATIENT INDEX CARD*

Patient Name: _____

Last, *First,* *MI*

Study ID:_____ **Medical Record No:**_____ **Line No*:** _____

CONTACT INFORMATION

Patient Tel No: (___) _____

Primary Care Clinician: _____ **Tel No:** (___) _____

Emergency Contact_____ **Tel No:** (___) _____

Patient Address:_____

Street

_____ ____ _____

City *State* *Zip*

* *For use in alphabetical file for assigned patients*

* From *Register and Activity Summary* (Healthform.19 -02/00)

Healthform.28 –02/00

Partners in Care

TRACKING CARD FOR PATIENTS ON MEDICATION

(See reverse for Acute and Continuation/Maintenance Phases)

Patient Name: _____ ***Phone:*** (___)_____

Emergency Contact: _____ ***Phone:*** (___)_____

Primary Care Clinician: _____ ***Phone:*** (___)_____

Medical Record No: _____ ***Study ID:*** _____

ASSESSMENT

	Date Scheduled ✓*	*on meds?*	*in psychotherapy?*	*BDI administered?*
Initial Phone Call	___/___/___ ❑	❑	❑	❑
Initial Visit	___/___/___ ❑	❑	❑	❑
Post-Initial Visit Evaluation	___/___/___ ❑	❑	❑	❑
		6 month	*12 month*	
Last Follow-up Scheduled	___/___/___	❑	❑	

* *Check box if completed*

Healthform.29 –02/00

Patient Name: ***Study ID:***

ACUTE PHASE

			Date Scheduled	✓	*on meds?*	*in psychotherapy?*	*BDI administered?*
1	Wk Follow-up Call		___/___/___	❑	❑	❑	❑
		(circle one)					
2	Week	Visit / Call	___/___/___	❑	❑	❑	❑
4-6	Week	Visit / Call	___/___/___	❑	❑	❑	❑
10-12	Week	Visit / Call	___/___/___	❑	❑	❑	❑
16	Week	Visit / Call*	___/___/___	❑	❑	❑	❑
20	Week	Visit / Call*	___/___/___	❑	❑	❑	❑
___	Week	Visit / Call*	___/___/___	❑	❑	❑	❑

CONTINUATION/MAINTENANCE PHASE

		Date Scheduled *21 item Beck score*	✓	*on meds?*	*relapse prevention?*
3 Month	Visit / Call	___/___/___	❑	❑	_____
6 Month	Visit / Call	___/___/___	❑	❑	_____
9 Month	Visit / Call	___/___/___	❑	❑	_____
Maintenance	Visit / Call	___/___/___	❑	❑	_____

Partners in Care

CBT SESSION RECORD

*(Fill out one for **each** patient for **each** session)*

Patient Name: _____ **Study ID:** _____

Therapist Name: _____ **Study ID:** _____

Patient Participation

Patient attended? ☐ Yes ☐ No

If NO, was patient contacted? ☐ Yes ☐ No

Reason for absence: _____

Patient participated: ☐ Fully ☐ Partially ☐ Not at all

Completed homework? ☐ Yes ☐ No

Module/Session Information

Type of therapy: ☐ Individual ☐ Group № of patients attending this session _____

This session was: *(check one)*

Full CBT			Brief CBT	Motivational
Thoughts	*Activities*	*People*		
1st ☐	1st ☐	1st ☐	1st ☐	☐
2nd ☐	2nd ☐	2nd ☐	2nd ☐	
3rd ☐	3rd ☐	3rd ☐		
4th ☐	4th ☐	4th ☐		

Treatment Progress

BDI score: _____

Treatment plan: _____

_____

Comments: _____

_____

_____

_____ Date: ___/___/___

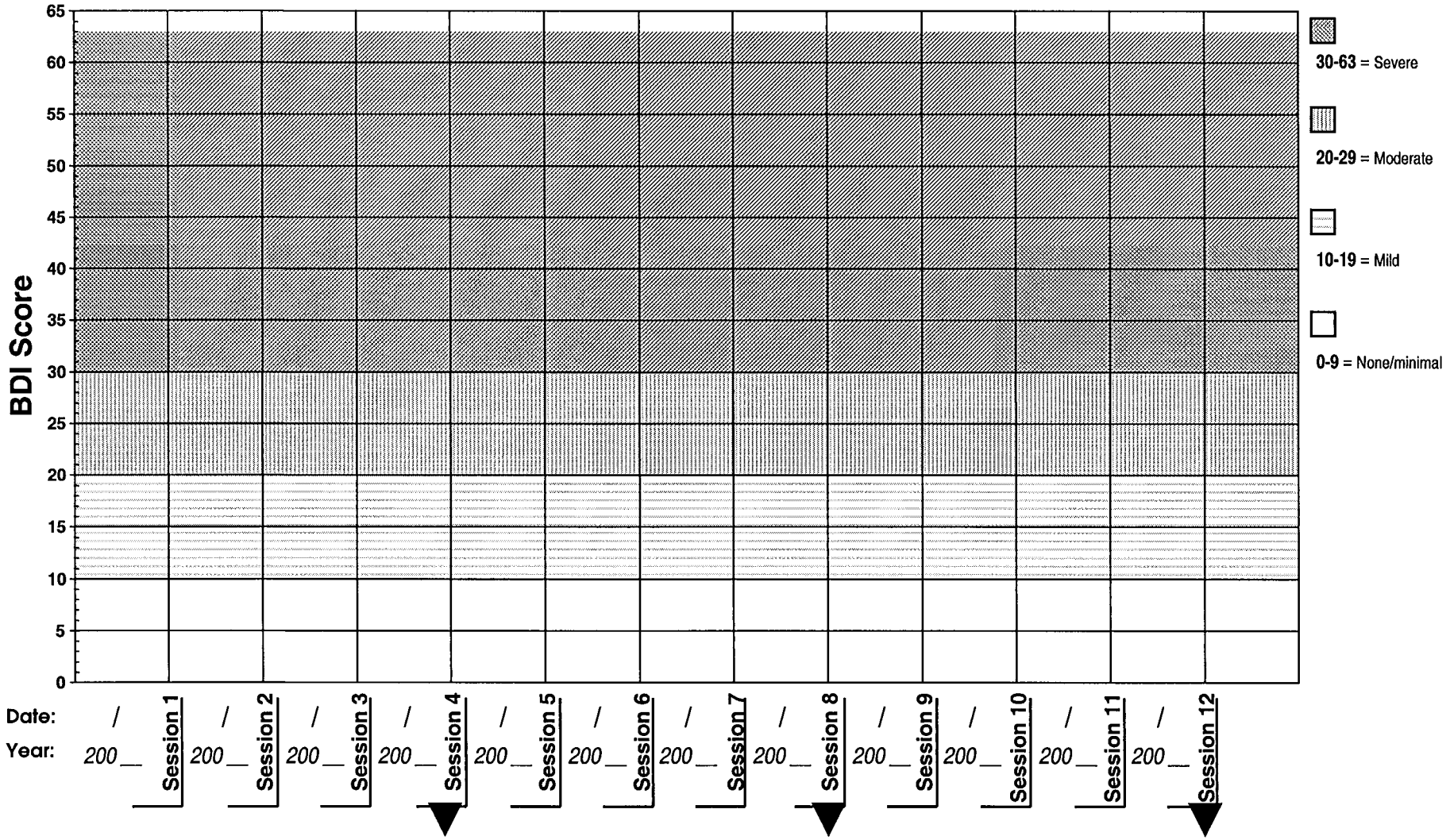
Signature of Therapist

Partners in Care

Individual Patient BDI Progress Graph

Therapist: _____

Patient: _____ **Primary Care Clinician:** _____



Give an NCR copy of this Progress Graph to the Primary Care Clinician after recording sessions 4, 8, and 12.

Healthform.31 –02/00

ORIGINAL - **STUDY RECORD** YELLOW - **MD/PRIMARY CARE CLINICIAN** PINK - **EXPERT PSYCHOTHERAPIST**

Partners in Care

COMMUNICATION FORM

Patient Name: _____ **Study ID:** _____

Therapist: _____ Date of Session: ___/___/___

Primary Care Clinician: _____ Tel. No: (____) _____

This is a(n): ❑ Initial Report ❑ Progress Report ❑ Final Report

The patient is now having the following symptoms:

❑ Sad or empty	❑ Thoughts of suicide or self-harm	❑ Somatic symptoms: *(list)*
❑ Loss of interest	❑ Sleep disturbance *(sleeps ____ hrs/night)*	_____
❑ Poor concentration	❑ Appetite/weight change *(+ / - ___ lbs.)*	_____
❑ Poor energy	❑ Physical agitation or slowness	_____
❑ Worthless/guilty	❑ Periods of over-excitement	❑ Other symptoms: *(list)*
❑ Anxiety	❑ Sees/hears things not apparent to others	_____
❑ Hopelessness/poor future	❑ Drug misuse/abuse	_____
❑ Drinks alcohol *(type(s)* _____ *drinks/day _____)*		_____

Progress of patient: _____

_____

_____

Recommended treatment plan: _____

_____

_____

Comments/consultation requested: _____

_____

_____

Please contact me ❑ Yes ❑ No

at: (___) _____ (___) _____ _____

phone beeper e-mail

Signature of Therapist: _____ Date___/___/___

ORIGINAL – **STUDY RECORD** *YELLOW* – **MD/PRIMARY CARE CLINICIAN** *PINK* – **EXPERT PSYCHOTHERAPIST** *GOLDENROD* – **OTHER**

Healthform.32 –02/00

Partners in Care
PSYCHOTHERAPY-ENHANCED CLINIC
CLIENT REGISTER AND INITIAL CONTACT SUMMARY
ALL Study Patients

Therapist:________________________________ **Clinic:**________________________________

	A	B	C	D	E	F	G	H	I	J
								Treatment Assignment		
Line #	**Study ID**	**Patient Name** *(last, first)*	**Medical Record No.**	**Clinic Where Patient Enrolled**	**Patient's Primary Care Clinician**	**Initial Contact** *(date & type)*	**Start Date of Treatment** *(scheduled)*	**Group or Individual** *(✓ one)*	**Brief or Full** *(✓ one)*	**English or Spanish** *(✓ one)*
___						/ / Call in person	/ /	☐ Group ☐ Individual	☐ Brief ☐ Full	☐ English ☐ Spanish
___						/ / Call in person	/ /	☐ Group ☐ Individual	☐ Brief ☐ Full	☐ English ☐ Spanish
___						/ / Call in person	/ /	☐ Group ☐ Individual	☐ Brief ☐ Full	☐ English ☐ Spanish
___						/ / Call in person	/ /	☐ Group ☐ Individual	☐ Brief ☐ Full	☐ English ☐ Spanish
___						/ / Call in person	/ /	☐ Group ☐ Individual	☐ Brief ☐ Full	☐ English ☐ Spanish
___						/ / Call in person	/ /	☐ Group ☐ Individual	☐ Brief ☐ Full	☐ English ☐ Spanish
___						/ / Call in person	/ /	☐ Group ☐ Individual	☐ Brief ☐ Full	☐ English ☐ Spanish
___						/ / Call in person	/ /	☐ Group ☐ Individual	☐ Brief ☐ Full	☐ English ☐ Spanish
___						/ / Call in person	/ /	☐ Group ☐ Individual	☐ Brief ☐ Full	☐ English ☐ Spanish
___						/ / Call in person	/ /	☐ Group ☐ Individual	☐ Brief ☐ Full	☐ English ☐ Spanish
___						/ / Call in person	/ /	☐ Group ☐ Individual	☐ Brief ☐ Full	☐ English ☐ Spanish

* Allocate a sequential Line Number for each patient as he/she is registered on this form. Continue sequential numbering for each subsequent page.

Healthform.33 –02/00

Partners in Care
PSYCHOTHERAPY-ENHANCED CLINIC
THERAPY SESSION RECORD AND BDI SCORE SHEET
For ALL Patients

Therapist: ____________________ **DNS:** ____________________ **Clinic:** ____________________

Line #*	Study ID	Patient Name *(last, first)*	Date	Type of Session[+] *(circle one)*	BDI Score	Date	Type of Session[+] *(circle one)*	BDI Score	Date	Type of Session[+] *(circle one)*	BDI Score	Date	Type of Session[+] *(circle one)*	BDI Score
___			1st / /	I G N		2nd / /	I G N		3rd / /	I G N		4th / /	I G N	
	Comments:		5th / /	I G N		6th / /	I G N		7th / /	I G N		8th / /	I G N	
			9th / /	I G N		10th / /	I G N		11th / /	I G N		12th / /	I G N	
			13th / /	I G N		14th / /	I G N		15th / /	I G N		16th / /	I G N	
___			1st / /	I G N		2nd / /	I G N		3rd / /	I G N		4th / /	I G N	
	Comments:		5th / /	I G N		6th / /	I G N		7th / /	I G N		8th / /	I G N	
			9th / /	I G N		10th / /	I G N		11th / /	I G N		12th / /	I G N	
			13th / /	I G N		14th / /	I G N		15th / /	I G N		16th / /	I G N	
___			1st / /	I G N		2nd / /	I G N		3rd / /	I G N		4th / /	I G N	
	Comments:		5th / /	I G N		6th / /	I G N		7th / /	I G N		8th / /	I G N	
			9th / /	I G N		10th / /	I G N		11th / /	I G N		12th / /	I G N	
			13th / /	I G N		14th / /	I G N		15th / /	I G N		16th / /	I G N	
___			1st / /	I G N		2nd / /	I G N		3rd / /	I G N		4th / /	I G N	
	Comments:		5th / /	I G N		6th / /	I G N		7th / /	I G N		8th / /	I G N	
			9th / /	I G N		10th / /	I G N		11th / /	I G N		12th / /	I G N	
			13th / /	I G N		14th / /	I G N		15th / /	I G N		16th / /	I G N	

[+] **I** = Individual Therapy Session; **G** = Group Therapy Session; **N** = 'No Show'

* ***Remember***: For each patient, transfer the corresponding Line Number from the *Client Register and Initial Contact Summary* (Healthform.33 –02/00).

Healthform.34 –02/00