BEHAVIORAL HEALTH

Depression follow-up

Blank documentation outlines. Adapt to the encounter and your practice requirements; complete only findings and care actually documented.

ENCOUNTER

Patient name:

Date of birth:

Date and time of encounter:

Clinician:

INTERVAL HISTORY

Changes since the previous visit

Symptoms and functional impact as reported

Sleep, appetite and energy as reported

Stressors and supports

MEASURES

Screening tool used, score and date

Previous score and date for comparison

SAFETY

Suicide risk screening method and result

Safety plan reviewed or updated, if applicable

Access to lethal means discussed, if applicable

TREATMENT

Medication use as reported, response and adverse effects

Therapy or counseling engagement

ASSESSMENT AND PLAN

Current status and reasoning

Medication decisions and rationale

Therapy referral or coordination

Crisis resources provided

FOLLOW-UP

Follow-up timing and purpose

Return precautions discussed

Patient questions and understanding