Involuntary Mental Hold Field Evaluation Form

CP#: MCU: MH# Time : Date: / /

Officer :	Incident #	Location of Eval:		
Patient Name: Last	First	Middle	DOB/Age	Gender M F
Physical Street Address	City	State	Zip Code	Phone #
Mailing address (if different)	City	State	Zip Code	Phone#
Insurance: Y N Company: ________________	Employed / Spouse employed: Y N			☐ VA Benefit eligible

Primary patient complaint

☐ Suicidal ☐ Homicidal ☐ Psychosis ☐ Gross disability

Exclusionary criteria

Criterion	Yes	No	
Age <18	☐ Yes	☐ No	
Persistently Combative	☐ Yes	☐ No	
Current Chest Pain	☐ Yes	☐ No	
Disoriented- person,place,time,event	☐ Yes	☐ No	
Signs of delirium / confusion	☐ Yes	☐ No	
Hx of medical diagnosis needing Eval.	☐ Yes	☐ No	Medical diagnosis:
New psychiatric symptoms	☐ Yes	☐ No	Existing Psychiatric diagnosis:
Physical symptoms / physical trauma	☐ Yes	☐ No	Physical symptoms:
PERRL	☐ Yes	☐ No	Pupils:
Blood pressure SBP >200, DBP >120	☐ Yes	☐ No	Blood pressure: / Repeat if needed /
Blood pressure SBP <100	☐ Yes	☐ No	
Pulse >120bpm or <50bpm	☐ Yes	☐ No	Pulse rate:
Respiratory rate >24bpm	☐ Yes	☐ No	Respiratory Rate:
Sp02 <94%	☐ Yes	☐ No	Sp02:
Blood Sugar >200, <70	☐ Yes	☐ No	BG:
Temperature >100.0 F or < 96.0 F	☐ Yes	☐ No	Temperature:
Abnormal lung sounds	☐ Yes	☐ No	Lung Sounds:
Cardiac Rhythm disturbances	☐ Yes	☐ No	3 lead interpretation:
Abnormal Skin signs or edema	☐ Yes	☐ No	Skin Signs:
Abdominal distention	☐ Yes	☐ No	
Absent bowel sounds	☐ Yes	☐ No	

A **YES** to any of the above questions results in a **failed** field ED diversion.

Discretionary criteria

Question	Yes	No	
Is there evidence of acute substance intoxication?	☐ Yes	☐ No	What is the substance?
Alcohol sensor test completed?	☐ Yes	☐ No	Results:
Oral swab test performed?	☐ Yes	☐ No	If no Why?
Any active infection/communicable disease?	☐ Yes	☐ No	
Any home medical equip/ports/pumps?	☐ Yes	☐ No	Type:
Requires home medical equipment i.e. 02	☐ Yes	☐ No	Type:
Needs Greater that partial assistance with ADL's	☐ Yes	☐ No	
Taken **more** than prescribed medications <24h?	☐ Yes	☐ No	Describe:
History of seizure with detox?	☐ Yes	☐ No	Describe:

Oral Swab test results

Amphetamine		Cocaine		Marijuana	
Methamphetamine		Opiates		Ketamine	

Medications

Medication	Dose	Medication	Dose	Medication	Dose

Allergies

Allergy	Reaction	Allergy	Reaction	Allergy	Reaction

Pharmacy Name:

Destination

☐ Intermountain	☐ SABH	☐ Safe Haven	☐ Allumbaugh House
☐ SLRMC	☐ SARMC	☐ SLMMC	☐ SAE

Additional Notes

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CP Signature____Print________________________________Date / /