

PERT / Psychiatric Patient Assessment Form Emergency Department

To be completed for every ED patient before TOC to PERT / Psychiatry

Item	Check
1. Vital Signs (temp, pulse, RR, B/P, O-Sat plus Finger Glucose in altered patient):	
• Vital signs are normal / at baseline	<input type="checkbox"/>
• Vital signs are abnormal but appropriate for patient condition (appropriate testing that is clinically indicated has been completed). Nursing staff to continue to monitor Vital Signs. If they worsen or do not improve, inform MRP.	<input type="checkbox"/>
2. High Risk features have been reviewed and addressed as clinically indicated:	
• Acute / New onset	<input type="checkbox"/>
• Visual Hallucinations	<input type="checkbox"/>
• Inability to complete a reasonable history	<input type="checkbox"/>
• History suggestive of life-threatening ingestion / overdose	<input type="checkbox"/>
• First incidence of psychiatrically altered patient, especially over 55 years of age	<input type="checkbox"/>
• Medications reviewed especially for new medications	<input type="checkbox"/>
• Altered sensorium, especially fluctuation of delirium, unexplained	<input type="checkbox"/>
• Seizure, including tongue biting	<input type="checkbox"/>
• Recent trauma	<input type="checkbox"/>
• Concern for infection (including IVDU)	<input type="checkbox"/>
• Abnormal focused examinations	<input type="checkbox"/>
• Immunodeficiency	<input type="checkbox"/>
3. Investigations ordered have been reviewed:	
• Yes	<input type="checkbox"/>
• Some are pending (non-critical) and I will follow up on them	<input type="checkbox"/>
4. Interim orders for regular medications, NRT, chemical restraints etc. completed	
• Yes	<input type="checkbox"/>
5. This patient is:	
• SCS: Stable for transfer to PERT	<input type="checkbox"/>
• NFS, WS: Stable for PERT / Psychiatrist assessment	<input type="checkbox"/>

Comments from ED Physician:

NOTES:

- Initial Emergency Medicine assessment is not intended to rule out every concomitant medical condition. If the patient situation changes, please inform MRP.
- The psychiatrist is encouraged to consult any appropriate service (Emergency Medicine included) if clinically indicated at any time in the journey of the patient.

Emergency Physician Name / Signature

Date / Time
(dd/mm/yyyy hh:mm)



ASSMT103

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Name of physician _____ Physician Name
(print name of physician)

Physician address _____
(address of physician)

Telephone number () _____ Fax number () _____

On _____ I personally examined _____ Client / Patient Name
(date) (print full name of person)

whose address is _____
(home address)

*You may only sign this **Form 1** if you have personally examined the person within the past seven days.
In deciding if a Form 1 is appropriate, you must complete **either** Box A (serious harm test) **or** Box B (persons
who are incapable of consenting to treatment and meet the specified criteria test) below.*

**Box A – Section 15(1) of the Mental Health Act
Serious Harm Test**

The Past / Present Test (*check one or more*)

I have reasonable cause to believe that the person:

- ☐ has threatened or is threatening to cause bodily harm to himself or herself
- ☐ has attempted or is attempting to cause bodily harm to himself or herself
- ☐ has behaved or is behaving violently towards another person
- ☐ has caused or is causing another person to fear bodily harm from him or her; or
- ☐ has shown or is showing a lack of competence to care for himself or herself

I base this belief on the following information (*you may, as appropriate in the circumstances, rely on any
combination of your own observations and information communicated to you by others.*)

My own observations:

Facts communicated to me by others:

The Future Test (*check one or more*)

I am of the opinion that the person is apparently suffering from mental disorder of a nature or quality that
likely will result in:

- ☐ serious bodily harm to himself or herself,
- ☐ serious bodily harm to another person,
- ☐ serious physical impairment of himself or herself

Box A – Section 15(1) of the Mental Health Act
Serious Harm Test *(continued)*

I base this opinion on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations:

Facts communicated by others:

Box B – Section 15(1.1) of the Mental Health Act
Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria

Note: The patient *must* meet the criteria set out in *each* of the following conditions.

I have reasonable cause to believe that the person:

1. Has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in one or more of the following: *(please indicate one or more)*
 - ☐ serious bodily harm to himself or herself,
 - ☐ serious bodily harm to another person,
 - ☐ substantial mental or physical deterioration of himself or herself, or
 - ☐ serious physical impairment of himself or herself;

AND

2. Has shown clinical improvement as a result of the treatment.

AND

I am of the opinion that the person,

3. Is incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained;

AND

4. Is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

Box B – Section 15(1.1) of the Mental Health Act
Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria
(continued)

AND

5. Given the person's history of mental disorder and current mental or physical condition, is likely to: *(choose one or more of the following)*

- ☐ cause serious bodily harm to himself or herself, or
- ☐ cause serious bodily harm to another person, or
- ☐ suffer substantial mental or physical deterioration, or
- ☐ suffer serious physical impairment

I base this opinion on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations:

Facts communicated by others:

I have made careful inquiry into all the facts necessary for me to form my opinion as to the nature and quality of the person's mental disorder. I hereby make application for a psychiatric assessment of the person named.

Today's date _____

Today's time _____ HH : MM

Examining physician's signature _____
(signature of physician)

This form authorizes, for a period of 7 days including the date of signature, the apprehension of the person named and his or her detention in a psychiatric facility for a maximum of 72 hours.

For Use at the Psychiatric Facility

Once the period of detention at the psychiatric facility begins, the attending physician should note the date and time this occurs and must promptly give the person a Form 42.

(Date and time detention commences)

(signature of physician)

(Date and time Form 42 delivered)

(signature of physician)

(Disponible en version française)



Part I (complete only if appropriate)

To: _____
(name of person)

of _____
(home address)

This is to inform you that _____
(name of physician)

examined you on _____ and has made an application for you to
(date of examination) (day / month / year)

have a psychiatric assessment.

Part A and/or Part B must be completed

Part A

That physician has certified that he/she has reasonable cause to believe that you have:

Check
Box(es)

- ☐ threatened or attempted or are threatening or attempting to cause bodily harm to yourself;
- ☐ behaved or are behaving violently towards another person or have caused or are causing another person to fear bodily harm from you; or
- ☐ shown or are showing a lack of competence to care for yourself.

and that you are suffering from a mental disorder of a nature or quality that likely will result in:

Check
Box(es)

- ☐ serious bodily harm to yourself;
- ☐ serious bodily harm to another person; or
- ☐ serious physical impairment of you.

Part B

That physician has certified that he/she has reasonable cause to believe that you:

- a) have previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in
- ☐ serious bodily harm to yourself,
- ☐ serious bodily harm to another person,
- ☐ substantial mental or physical deterioration of you, or
- ☐ serious physical impairment of you;
- b) have shown clinical improvement as a result of the treatment;
- c) are suffering from the same mental disorder as the one for which you previously received treatment or from a mental disorder that is similar to the previous one;

Part B (continued)

d) given your history of mental disorder and current mental or physical condition, you are likely to

- ☐ cause serious bodily harm to yourself,
- ☐ cause serious bodily harm to another person,
- ☐ suffer substantial mental or physical deterioration, or
- ☐ suffer serious physical impairment;

e) have been found incapable, within the meaning of the Health Care Consent Act, 1996 of consenting to your treatment in a psychiatric facility and the consent of your substitute decision-maker has been obtained; and

f) you are not suitable for admission or continuation as an informal or voluntary patient.

The application is sufficient authority to hold you in custody in this hospital for up to 72 hours.

You have the right to retain and instruct a lawyer without delay.

(date)

(signature of attending physician)

Part II (complete only if appropriate)

To: _____
(name of person)

of _____
(home address)

This is to inform you that _____
(name of Minister of Health and Long-Term Care)

Minister of Health and Long-Term Care for the Province of Ontario, has reasonable cause to believe that you are suffering from mental disorder of a nature or quality that likely will result in:

Check
Box(es)

- ☐ serious bodily harm to yourself; or
- ☐ serious bodily harm to another person.

unless you are placed in the custody of a psychiatric facility and has by Order dated

_____, authorized your custody in a psychiatric facility for up to 72 hours.
(date of order) (day / month / year)

You have the right to retain and instruct a lawyer without delay.

(date)

(signature of attending physician)

Psychiatric patient journey flowchart in both ED and PERT by ED site:

