

PSYCHIATRIC REPORT



NAME:	
ADDRESS:	
DATE OF BIRTH:	

MARK WITH AN (X) WHERE APPLICABLE

1. IN-PATIENT		OUT-PATIENT	
PERIOD OF TREATMENT			

2. MENTAL HEALTH	
Schizophrenia, including hallucinations	
Schizophrenia, incl. delusions/paranoid thoughts	

External symptoms

3. ANXIETY DISORDERS	
Psychosomatic	
Obsessive-compulsive	
Hysteria	
Phobia	

External symptoms

4. DEPRESSION	
Severe/mild	
Psychotic depressive	
Bipolar disorder	

5. ACUTE DISORDERS	
Delirium/confusional state	
Chronic dementia	

Severity

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6. PERSONALITY DISORDERS	
Passive dependence	
Passive aggressive	

7. ALCOHOL PROBLEM	
Social	
Chronic	
Brain damage	

8. EPILEPSY	YES	NO

Remarks

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9. MENTALLY RETARDED	
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10. DRUG DEPENDENT	
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11. **PRESENT FUNCTIONING**

11.1 Selfcare:

11.2 Orientation with regard - one self, other people, environment:

11.3 Ability to communicate:

11.4 Emotions/Alertness:

11.5 Behaviour:

AGGRESSIVE	PHYSICAL ABUSE	RESTLESS	INCONTINENCY	OTHER

12. **PROGNOSIS**

13. **MEDICATION**

14. **TREATMENT**

AUTHORITY

SIGNATURE

DATE