MEDICAL/PSYCHIATRIC CONSULTATION

1. **Purpose:** This procedure establishes the protocol or process for obtaining consultation with medical/psychiatric specialists at Florida State Hospital to provide medical/psychiatric services and consultation in their area of expertise. It also establishes the review process following the consultation.

2. **Training Requirements:** Physicians and nurses will be trained on this operating procedure upon hire into the position during Discipline-Specific Education and by their supervisor each time the operating procedure is revised.

3. **Procedure:**

   a. **Medical Consultations.**

      (1) The physician/Advanced Registered Nurse Practitioner, in his/her medical judgment, determines that the service of a medical consultant is needed, will initiate and sign a Specialty Clinics Request/Report (Non-Florida State Hospital Providers) form (Form 187) (Attachment 1) and if applicable obtain signature of Attending Physician and forward to the Health Care Services Medical Service Director.

      (2) The Health Care Services Medical Service Director will then review the consult request and indicate approval or disapproval (stating rationale), with signature, on the Specialty Clinics Request/Report (Non-Florida State Hospital Providers) form.

         (a) Disapproved consults will be returned to the Unit Medical Service Director and the Unit Medical Service Director will notify the requester.

         (b) Approved consults will be forwarded to the appropriate specialty clinic.

         (c) The clinic staff receives the consult and pre-schedules an appointment.

         (d) The clinic staff finalizes the schedule for the clinic and notifies the unit two (2) days in advance by sending a master clinic list with appointment times via e:mail to the respective Unit Director or designee (it is the Unit Director’s responsibility to develop an in-house policy to assure residents are present for their appointment). If communication by e:mail is not feasible the clinic nurse will call the resident’s unit/ward with appointment date and time. The master list will identify preparatory procedures necessary for a successful clinic visit.

---

This operating procedure supersedes: Operating Procedure 151-13, dated June 19, 2008
Office of Primary Responsibility: Health Care Medical Service Director
Distribution: Florida State Hospital Computer Network Users
1. When a resident is added to the clinic after the distribution of the master list, the clinic nurse will notify the Unit Director or designee.

2. All residents must report to clinic with an escort, chart and MAR.

3. If consultation request is for procedure/surgery a completed Resident Transfer Information Form should be attached.

4. If consultation is for scan with contrast, note if resident is diabetic or has allergy to iodine or seafood.

(e) After the consultant has seen the resident, a completed and signed Form 187, will be forwarded to the requester and the original will be placed in the resident’s chart. When the consultant has recommendations requiring immediate action, the consultant will write an order on the physicians order sheet.

(f) When the resident returns to the unit, the nurse will review the consult, forward the consult to the appropriate physician/Advanced Registered Nurse Practitioner with physician’s order (if applicable) for co-signature of the physician/Advanced Registered Nurse Practitioner and carry out the orders according to the Unit Dose Policy.

(g) The requesting physician/Advanced Registered Nurse Practitioner will receive and review the report and indicate on the written or dictated consultation report and in the Progress Notes whether or not the recommendations will be followed.

(h) The completed original Specialty Clinics Request/Report form, along with the typewritten consultant’s report attached as applicable, will be filed by designated unit staff in the Consult section of the ward chart after all the required signatures are obtained. A copy of the consult will also be placed in the outpatient medical record in Unit 31.

(i) Internal consultations: The Consultation Referral/Report (In-House) (Florida State Hospital Form 29) (Attachment 2) will be used for in-house consultations; for example, emergency room consultations and dental clinic consults.

(j) The Unit Director will ensure that the consult recommendations followed will be tracked within each unit.

b. Psychiatric Consultations

(1) The psychiatrist/psychiatric Advanced Registered Nurse Practitioner, who, in his/her judgment, determines that the service of a psychiatric consultant is needed, will initiate and sign the Target Symptom Identification for Psychiatric Clinic form (Form 70) (Attachment 3) and forward to the Medical Staff Support Office.

(a) Upon receipt of Form 70, the Medical Staff Support Office Staff Assistant will place residents on a list to schedule for the Psychiatric Clinic.

(b) The Medical Staff Support Office Staff Assistant will prepare the schedule of residents to be seen; notify the Unit 31 Psychiatric Clinic nurse; collect Pharmacy Drug Profiles on each resident; and forward the Form 70 and pharmacy profiles to the Psychiatric Clinic nurse.
(c) The Medical Staff Support Office Staff Assistant will notify the requesting psychiatrist/psychiatric Advanced Registered Nurse Practitioner of the scheduled date and time of the consult, and the requesting psychiatrist/psychiatric Advanced Registered Nurse Practitioner will notify the ward staff.

(d) The ward staff will escort the resident to the Psychiatric Clinic in Unit 31, unless the resident refuses to attend.

(e) The requesting psychiatrist/psychiatric Advanced Registered Nurse Practitioner will attend the Psychiatric Clinic, along with the resident or without the resident if the resident refuses to attend.

(f) The requesting psychiatrist/psychiatric Advanced Registered Nurse Practitioner will discuss the issues with the consulting psychiatrist.

(g) The consulting psychiatrist will interview the resident, if present.

(h) The consulting psychiatrist will provide recommendations to the requesting psychiatrist/psychiatric Advanced Registered Nurse Practitioner.

(i) The consultation report will be dictated by the consulting psychiatrist.

(j) The dictated consultation will be transcribed by the Unit 31 medical transcriptionist and sent to the consulting psychiatrist for signature. An unsigned copy is sent to the requesting psychiatrist/psychiatric Advanced Registered Nurse Practitioner.

(k) The requesting psychiatrist/psychiatric Advanced Registered Nurse Practitioner will receive and review the report and indicate on the dictated report and in the Progress Notes whether or not the recommendations will be followed.

(l) The Unit Director will ensure that the consult recommendations followed will be tracked within each unit.

(Signed original on file in Central Health Services)

DIANE R. JAMES
Hospital Administrator

3 Attachments
1. Specialty Clinics Referral/Report (Non-FSH Providers) (Form 187)
2. Consultation Request/Report (In-House) (Form 29)
3. Target Symptom Identification for Psychiatric Clinic (Form 70)

SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL
This procedure was reviewed and there were no changes made.
PRIORITY: (Check One) _____ URGENT (Within 24 Hours) _____ AS SOON AS FEASIBLE _____ ROUTINE

REFERRED TO: ____________________________

VITAL SIGNS (If applicable): Blood Pressure _______ Pulse _______ Temperature _______ Respiration _______

DIABETIC: _____ Yes _____ No

ALLERGIES: __________________________________________________________

REASON FOR REFERRAL: Pertinent Background Information: __________________________________________

Brief Statement of Specific Advice Needed: ______________________________________________________

________________________________________________________

RECOMMENDATIONS ALREADY TAKEN TO RESOLVE CONDITION: __________________________________

________________________________________________________

REQUESTED PHYSICIAN/ARNP DATE SIGNATURE DATE

CONSULTATIVE REPORT: ____________________________________________________________

CONSULTANT’S SIGNATURE: ____________________________ DATE: ____________________________

HCMSD: _____ Approved _____ Disapproved

INSTRUCTIONS: Signatures of the Requesting Physician/ARNP, and Health Care Service MSD, as appropriate, must be obtained prior to consult. Signatures of the Requesting Physician and Attending/Medical Physician, as appropriate, must be obtained following review of consult.

After signing, forward directly to next required signer.

A copy to be placed in Consult section of the ward chart when initiated, to be replaced by the original form upon completion of consultation process.

Copies to: Outpatient Medical Records, and MSD after consultant completes.


ADDRESSOGRAPH: Unit _______ Ward _______ Phone __________

** CONFIDENTIAL & PRIVILEGED INFORMATION *** FOR PROFESSIONAL USE ONLY **

Form 187, (Revised) Jul 04

SPECIALTY CLINICS REQUEST/REPORT

Office of Primary Responsibility: Health Care Medical Service Director

Operating Procedure 151-13
EACH NOTE MUST BE DATED AND SIGNED BY NAME AND TITLE OF PERSON MAKING THE NOTE.

PRIORITY: (Check One)  ☐ EMERGENCY (Immediately)  ☐ URGENT (Within 24 Hours)  ☐ ROUTINE (As Soon As Feasible)

DATE: ______________________________

REFERRED TO: ________________________________________________________________

REFERRED BY: ________________________________________________________________ (Include Unit, Ward, Telephone Number)

VITAL SIGNS (If applicable):  Blood Pressure _________  Pulse _________  Temperature _______  Respiration_______

REASON FOR REFERRAL:

Pertinent Background Information:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Brief Statement of Specific Advice Needed: ___________________________________________

_________________________________________________________________________

Actions already taken to resolve condition: _________________________________________

_________________________________________________________________________

SIGNATURE: ________________________________________________________________

CONSULTATIVE REPORT:

SIGNATURE: ________________________________________________________________

DATE: ______________________________

Recommendations Followed: ___ Yes ___ No  If no, date of Progress Note providing rationale: ________________

INSTRUCTIONS:  To be used to request a consultation or opinion from any staff members or departments except EEG, EKG, X-Ray, Laboratory, and Outpatient Clinics. This form should be used for immediate response of the consultant, and a more detailed, typewritten report, if necessary, may follow. DISTRIBUTION:

ORIGINAL -- To Addressee, to be placed in resident’s chart WHEN COMPLETED.

Copies To -- Resident’s chart when referral is made, to be REMOVED WHEN REPLACED BY ORIGINAL, COMPLETED FORM. Outpatient Medical Record when applicable.

ADDRESSOGRAPH:

** CONFIDENTIAL & PRIVILEGED INFORMATION *** FOR PROFESSIONAL USE ONLY **

FLORIDA STATE HOSPITAL, CHATTahooCHEE, FL 32324
1. CURRENT BEHAVIOR: __________________________________________
   _______________________________________________________________
   _______________________________________________________________
   _______________________________________________________________
   _______________________________________________________________
   _______________________________________________________________

   CARE MONITOR CODE: (Circle letter)
   (a) Problem in unresolved dx.
   (b) Unimproved resident
   (c) Dx. errors
   (d) Tx. failure
   (e) Complication in tx.
   (f) Other treatment issue

2. PRIMARY SYMPTOMS: __________________________________________
   A. Affect
   B. Autism
   C. Ambivalence
   D. Association

3. SECONDARY SYMPTOMS: _______________________________________
   A. Hallucinations
   B. Delusions
   C. Other

4. SLEEP PATTERN: _____________________________________________

5. EATING HABITS: _____________________________________________

6. ELIMINATION PATTERNS: _____________________________________

7. AGGRESSIVE/DESTRUCTIVE BEHAVIOR: __________________________
   _______________________________________________________________
   _______________________________________________________________

8. ORIENTATION: ______________________________________________

   _______________________________________________________________
   _______________________________________________________________

________________________________________  _______________________
DATE                                                                 SIGNATURE OF PROFESSIONAL

INSTRUCTIONS: This form, completed in duplicate should be
brought with the resident to the Psychiatric Clinic, together with the
most recent computerized lab reports (per Hospital procedure),
most recent MER, and most recent Dyskinesia Identification
System: Condensed User Scale (DISCUS). Only positive
symptoms should be reported (otherwise, leave blank).

DISTRIBUTION: Original--Ward chart
Copy--Outpatient Clinic.

To be filed in the Consult section of the ward chart.

** CONFIDENTIAL & PRIVILEGED INFORMATION *** FOR PROFESSIONAL USE ONLY **