Behavioral Health

Social Worker Assessment

Social Work Scenario (5-10 minutes)

Type of referral: SW referral via EMR.

The PCP made the referral after discussion and agreement by the patient. The SW was seeing a patient at the time of the referral. An arrangement for a video call was scheduled for the following day.

Reason for referral: Positive screening on the PHQ9 with a score of 12. No indication of self-harm based on question #9(0 on #9).

Referral source: PCP referral to BHS/SW.

Significant Information from the PCP: The PCP notes indicate the following:

Reviewed results of the PHQ and provider assessment findings with the patient. The patient reveals her spouse became sick about 1 year ago and "things were really rough at the end". He died 6 months ago and she can't quite seem to get her life back together since. She declined to try medications but was agreeable to seeing the social worker.

Medical records indicate the patient was prescribed an anti-depressant 6 months ago, and spontaneously discontinued them. A note indicates the patient felt extremely restless and was having difficulty sleeping.

PCP indicates general dx of depression. (Where in scope of practice, the BHS will later refine and make the official diagnosis).

The patient would like to reengage with her sisters. She has become very isolated and has "pulled away" from her family and friends.

Video call goals of the initial assessment:

- Introduces SW/services
- Understanding of PCP concerns
- Understanding of diagnosis of depression
- Establish a productive relationship

SW assessment (20-25 minutes):

PHQ9= 12 yesterday **(see the screening test)**

Determine if there is a suicide risk (if #9 were positive they would use Columbia to screen further)

Review of Medications

- Past history, use
- Understanding of anti-depressants
- Willingness to consider medication treatment

Patient's greatest concern today?

Current stressors

Symptoms/effects of depression on function and health

Indicators of Depression Severity:

Family history

Relevant Developmental history (early childhood, adolescence, early adulthood, older adulthood

Activities effected

Last date remember feeling good

# of days in bed last month_____# of activity restricted days last month (by 50%)_____

Behavioral Health History:

Current treatment-where and what

Past treatment-where and what including any psychotropics

Past Suicide attempts

Social history and substance history:

Relationships/Social supports:

Employment, legal, education issues:

Religious orientation:

Sexual orientation:

Gender identification, (preferred pronouns):

Domestic/partner violence:

Tobacco use/Alcohol use/substance use:

SDOH:

Health history:

Current meds:

Stressors/treatment barriers

Coping strategies/strengths

- Behavioral Health observations
- Mental status exam

After the Visit – Preparing for the Case Review (5-10 minutes)

Situation:

Background:

BH/SW Assessment:

Patient goal(s)

Recommendations/Interventions

Follow up:

- Recommend a follow-up call in X_____
- Share recommendations of the team
- Begin X_____