GOVT. MEDICAL COLLEGE HOSPITAL, IDUKKI

(FORMER DISTRICT HOSPITAL)

VIMUKTHI INPATIENT

SUMMARY SHEET

Head of service (Dept. of Psychiatry)	Inpatient No.			
Name of Patient	Age	Sex	Religion	
Address:			Income	Date of admission with time
Phone (1):				
Name of Carer				
Phone (2):				
Final Diagnosis				Dg. Code No.
Mode of Admission				Date of discharge
☐ Independent☐ Supported				(with time)

Discharge Highlights

Form-C

സ്വമേധയാ അഡ്മിറ്റാകുന്നതിനുള്ള അപേക്ഷ

ലഹരി	ഉപയോഗ	ശീലം	മാറ്റുന്ന	തിലേക്ക	ായി	വിമുക്തി	വാർഡിൽ	അഡ്മിറ്റാകു	വാൻ	ഞാൻ
തയ്യാറാണ്.	ഇതുമായി	ബന്ധ	പ്പെട്ടുള്ള	മരുന്ന്	ചിക	റിത്സ/കൗദ	ൺസിലിംഗ്	എന്നിവയ്ക്ക്	തയ്യാ	റാണ്.
ഇതിലേക്കാ	യി സ്വമേധ	ായാ അ	ഡ്മിറ്റാ <i>ക</i>	കുവാനു	ള്ള ന	ന പേക്ഷ	സമർപിക്കു	ന്നു.		

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ഇതിലേക്കായി സ്വമേധയാ അഡ്മിറ്റാകുവാനുള്ള	അപേക്ഷ സമർപ്പിക്കുന്നു.
	എന്ന്
	തീയതി
Advance Directive Regarding Prefere	ence of Nominated Representative
അഡാൻസ് ര	-
അവ്മിറായിരിക്കെ ലഹരി വിടുതൽ ലക്ഷണം	ങ്ങളുടെ തീവ്രത കാരണം സ്വയം ചികിത്സാ തീരു
മാനങ്ങളെടുക്കാൻ വയ്യാത്ത സാഹചര്യമുണ്ടായാൽ	
എന്റെ നിർദ്ദിഷ്ട പ്രതിനിധിയായി ചികിത്സാ തീരു	
1.	
2.	
നിർദ്ദിഷ്ട പ്രതിനിധിയായി ഉത്തരവാദിത്വം ഏ	റ്റെടുത്ത് മെന്റൽ ഹെൽത്ത് ആക്ട്–2017 പ്രകാരം
എന്നിൽ ഏൽപ്പിച്ച ചുമതലകൾ നിർവ്വഹിച്ചുകൊള	ള്ളാം എന്ന് സമ്മതം നൽകുന്നു.
1. പേര്	
	. <u>-</u>
2. പേര്	ഒപ്പ്
Form	
പ്രതിനിധി സഹായത്തോടുകൂടി അ	രഡ്മിറ്റാവുന്നതിനുള്ള അപേക്ഷ
	എന്ന വൃക്തിയുടെ നിർദ്ദിഷ്ട പ്രതിനിധിയായ
	വ്യക്തിയെ ഇവിടെ അഡ്മിറ്റാക്കുന്നതിന്
വേണ്ടി അപേക്ഷ സമർപ്പിക്കുന്നു.	v
- വാരി വിവത്ത് വാധനത്തർ തീവരായ സ	ാഹചരൃത്തിൽ മരുന്ന് ചികിത്സകൾ ചെയ്യുന്നതി
നുള്ള സമ്മതം നൽകുന്നു.	ാഷാചര്യത്താത്ത് മരുന്ന ചിതിത്രത്തെ ചെയ്യുന്നത്ന
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പേര്	ഒപ്പ്

Name :					I.P. No. :
	(De	HIS ⁻ ocumented b	FORY y M.O. in-ch	narge)	
Subjective Report (0	Chief Complia	ants, Presentin	g history)		
Objective Findings (Past history,	Current MSE,	Relevant ph	ysical examina	tion findings)

Name :	I.P. No. :			
	HISTOR	Υ		
Assessment :				
Goal of treatment :	☐ Complete Abstinence	☐ Conditional Abstinence	☐ Controlled use	
Risk Assessment :	□ Low	☐ Intermediate	☐ High	
Diagnosis at first Asses	ssment :			
Plan of Management :				
Č				

Name :	I.P. No.
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RESIDENT REPORT

(4P Biopsychosocial matrix, Relapse prevention model, functional analysis, case formulation and other assessments)

Name: Age: I.P. No.:

RESIDENT REPORT

I.P. No. :

RESIDENT REPORT

Name: Age: I.P. No.:

RESIDENT REPORT

Name :	Age :	I.P. No. :
CLINICAL PSYCHOLOGY	- INTAKE NOTES	6
Description :		
Assessment :		
Plan :		
Tidit.		

Name :	Age :	I.P. No. :

CLINICAL PSYCHOLOGY - THERAPY PROGRESS NOTE

Date :	Session No. :	Patricipants :
Method of therapy : Individual	☐ Group	☐ Couple/Family
Issue/theme discussed :		
Therapeutic approach used :		
Techiniques:		
Treatment modality (MET, CBT):		
Observations/Reflections/Progress:		
Date :	Session No. :	Patricipants :
Method of therapy : Individual	☐ Group	☐ Couple/Family
Issue/theme discussed :		
Therapeutic approach used :		
Techiniques:		
Treatment modality (MET, CBT):		
Observations/Reflections/Progress:		
Date :	Session No. :	Patricipants :
Method of therapy : Individual	☐ Group	☐ Couple/Family
Issue/theme discussed :		
Therapeutic approach used :		
Techiniques:		
Treatment modality (MET, CBT):		
Observations/Reflections/Progress:		

Name :	Age :	I.P. No. :
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CLINICAL PSYCHOLOGY - THERAPY PROGRESS NOTE

Date :	Session No. :	Patricipants :
Method of therapy : Individual	☐ Group	☐ Couple/Family
Issue/theme discussed :		
Therapeutic approach used :		
Techiniques:		
Treatment modality (MET, CBT):		
Observations/Reflections/Progress:		
Date :	Session No. :	Patricipants :
Method of therapy : Individual	☐ Group	☐ Couple/Family
Issue/theme discussed :		
Therapeutic approach used :		
Techiniques:		
Treatment modality (MET, CBT):		
Observations/Reflections/Progress:		
Date :	Session No. :	Patricipants :
Method of therapy : Individual	☐ Group	☐ Couple/Family
Issue/theme discussed :		
Therapeutic approach used :		
Techiniques:		
Treatment modality (MET, CBT):		
Observations/Reflections/Progress:		

Name :	Age:	I.P. No. :
PSYCHIATRIC SOCIAL WOR	K – INTAKE NO	TE
Description:		
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Assessment :		
Assessment.		
Plan:		

Name:	Age :	I.P. No. :
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PSYCHIATRIC SOCIAL WORK - THERAPY PROGRESS NOTES

Date :	Session No. :	Patricipants :
Method of therapy : Individual	☐ Group	☐ Couple/Family
Issue/theme discussed :		
Therapeutic approach used :		
Techiniques :		
Treatment modality (MET, CBT):		
Observations/Reflections/Progress:		
Date :	Session No. :	Patricipants :
Method of therapy : Individual	☐ Group	☐ Couple/Family
Issue/theme discussed :		
Therapeutic approach used :		
Techiniques :		
Treatment modality (MET, CBT):		
Observations/Reflections/Progress:		
Date :	Session No. :	Patricipants :
Method of therapy : Individual	☐ Group	☐ Couple/Family
Issue/theme discussed :		
Therapeutic approach used :		
Techiniques:		
Treatment modality (MET, CBT):		
Observations/Reflections/Progress:		

Name :	Age :	I.P. No. :
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PSYCHIATRIC SOCIAL WORK - NOTES

Date :	Session No. :	Patricipants :
Method of therapy : Individual	☐ Group	☐ Couple/Family
Issue/theme discussed :		
Therapeutic approach used :		
Techiniques:		
Treatment modality (MET, CBT):		
Observations/Reflections/Progress:		
Date :	Session No. :	Patricipants :
Method of therapy : Individual	☐ Group	☐ Couple/Family
Issue/theme discussed :		
Therapeutic approach used :		
Techiniques:		
Treatment modality (MET, CBT):		
Observations/Reflections/Progress:		
Date :	Session No. :	Patricipants :
Method of therapy : Individual	☐ Group	☐ Couple/Family
Issue/theme discussed :		
Therapeutic approach used :		
Techiniques:		
Treatment modality (MET, CBT):		
Observations/Reflections/Progress:		

Name :	Age :	I.P. No. :
Date	Progress	Doctor's order

Name :	Age :	I.P. No. :
Date	Progress	Doctor's order

Name :	Age :	I.P. No. :
Date	Progress	Doctor's order

Name :	Age :	I.P. No. :
Date	Progress	Doctor's order

Name :	Age :	I.P. No. :
Date	Progress	Doctor's order

Name :	Age :	I.P. No. :
Date	Progress	Doctor's order
-		

CONSULTATION

Name	Age	I. P. No.
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CONSULTATION

Name	Age	I. P. No.

				MEDI	CATI	ON (СНА	RT			
ALLE	RGIES	:									
			S	INGLE /	STA	ТМЕ	DICA	ATION			
Date		Drug		Dose	Time	e Ro	oute	Ordered by	Given by	Re	marks
			S	INGLE /	STA	ТМЕ	DICA	ATION			
Date	Time	Intravenous Fluid	Volume	Drug Ad & Dos	ded se	Drop/ ml	Orop/ ml Doctor's Na		Nurse N	ame	Time Ended

Name:

I.P. No. :

Age :

Name :	Age :	I.P. No. :
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Name of Medicine				
	24			

Name: Age: I.P. No.:

Name of Medicine				
	25			

Name:	Age :	I.P. No. :
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Name of Medicine					
	•	26			

Name :	Age :	I.P. No. :

Name of Medicine					
IVAILE OF MEGICILE					
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NURSING OFFICER'S RECORD Age : Name : I.P. No. : Hour Medicine Treatment & Remarks Date

NURSING OFFICER'S RECORD

Name : I.P. No. : Age : Hour Medicine Treatment & Remarks Date

NURSING OFFICER'S RECORD Age : Name : I.P. No. : Hour Medicine Treatment & Remarks Date

NURSING OFFICER'S RECORD

 Name :
 Age :
 I.P. No. :

 Date
 Hour
 Medicine
 Treatment & Remarks

Date	Hour	Medicine	Treatment & Remarks
	<u> </u>	31	<u> </u>

CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE (CIWA-Ar)

Assessment Protocol	Date						
(a) Vitals, Assessment							
(b) If initial score > 10 q1h×8 hrs., then if	stable						
q2h×8hrs., then if a q4h.	Pulse						
(c) If initial score < 10, a q4h×72 hrs. If scor for 72 hrs., d/c assess If score > 10 at any	e <10 sment. RR/Temp.						
go to (b) above. (d) If indicated, (see indic below) administe							
medications as ordere record on MAR and	ed and						
Assess and rate each of the fo	llowing (CIWA-Ar Scale) :						
Nausea/Vomiting (0 - 7) 0 - none; 1 - mild nausea, no							
nausea; 7 - constant nausea, freq Tremors (0 - 7)	uent dry neaves & vorniting.						
0 - no tremor; 1 - not visible but c arms extended; 7 - severe, eve							
Anxiety (0 - 7) 0 - none, at ease; 1 - mildly anxious or guarded; 7 - equiva							
Agitation (0 - 7) 0 - normal activity; 1 - some what							
ately fidgety/restless; 7 - paces or constantly thrashes about Paroxysmal Sweats (0 - 7)							
0 - no sweats; 1 - barely percept 4 - beads of sweat obvious on for	ible sweating, palms moist;						
Orientation (0 - 4) 0 - oriented; 1 - uncertain about date by no more than 2 days; > 2 days; 4 - disoriented to plate.							
Tactile Disturbances (0 - 7) 0 - none; 1 - very mild itch, P&N, numbeness; 2 - mild itch, P&N, burning, numbness; 3 - moderate itch, P&N, burning, numbness; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations							
Auditory Disturbances (0 - 7) 0 - not present; 1 - very mild harshness/ability to startle; 2 - mild harshness, ability to startle; 3 - moderate harshness, ability to startle, 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations.							
Visual Disturbances (0 - 7) 0 - not present; 1 - very mild sensitivity; 2 - mild sensitivity; 3 - moderate sensitivity; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations.							
Headache (0 - 7) 0 - not present; 1 - very mild; 2 - mild; 3 - moderate; 4 - moderately severe; 5 - severe; 6 - very severe; 7 - extremely severe							
Total CIWA - Ar score:							
PRN Med: (circle one) Diazepam Lorazepam	Dose given (mg):						
	Route:						
Time of PRN medication a	dministration:						
Assessment of response (Cominutes after medication a							
RN Initials							

CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE (CIWA-Ar)

Assessment Protocol (a) Vitals, Assessment Now (b) If initial score > 10 repeat q1n-8 hrs., then if stable q2n-8 hrs., then if stable q2n-8 hrs., then if stable q2n-8 hrs., then if stable q4n. Pulse (c) If initial score > 10 a sassas q4n+72 hrs. if score < 10 for 72 hrs., d/c assessment. If score > 10 at any time g1 or (b) above. RR/Temp. RR/Temp. G2 Sat. G3 Fare G4 for G4				-					•	,
(b) If initial score > 10 repeat q1h×8 hrs., then if stable q2h×6hrs., then if stable q4h. (c) If initial score < 10, assess q4h×72 hrs. If score < 10 for 72 hrs. Gore < 10 assessed q4h×72 hrs. If score < 10 for 72 hrs. Gore < 10 and my time, go to (b) above. (d) If iniciated, (see indications below) administer prin medications as ordered and record on MAR and below. Assess and rate each of the following (CIWA-Ar Scale): Nausea/Vomiting (0 - 7) O - none; 1 - mid nausea, no vomiting, 4 - intermittent nausea; 7 - contain nausea, required by newes 4 woming. Tremors (0 - 7) O - none; 1 - mid nausea, no vomiting, 4 - indernated ame extended; 7 - severe, even what more adminy a woming or guardet; 7 - equivalent to acute panic state. Anxiety (0 - 7) O - none at ease; 1 - mildly anxious; 4 - moderately amous or guardet; 7 - equivalent to acute panic state. Agitation (0 - 7) O - none admin; 1 - banky perceptible avealing, palms moist; 4 - beats of sweat obvious on forehead; 7 - directing sweat. Paroxysmal Sweats (0 - 7) O - no sweats; 1 - banky perceptible avealing, palms moist; 4 - beats of sweat obvious on forehead; 7 - directing sweat. D - on sweats; 1 - banky perceptible avealing palms moist; 4 - beats of sweat obvious on forehead; 7 - directing sweat. D - one; 1 - very mild list, P&N, numberses; 2 - mild, burning, numberses; 4 - moderate hallucinations; 5 - extremely severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations; 8 - severe hallucinations; 7 - continuous hallucinations; 8 - severe hallucinations; 7 - continuous hallucinations; 8 - severe hallucinations; 7 - continuous hallucinations; 9 - severe, 8 - very severe; 7 - extremely severe; 8 - evers extremely s	Assessment Protocol	Date								
Control of the first stable q2n×8ns. then if stable q2n×8ns. then if stable q2n×8ns. then if stable q2n×8ns. the is table q4h. Control of the first stable q4h. Control of the	(a) Vitals, Assessment No	w								
Q4h. Q2h.	q1h×8 hrs., then if sta	ble								
RR/Temp. RR/Temp. RR/Temp. RR/Temp. RR/Temp. RR/Temp. Go to b) above.	q4h.	Pulse								
Logical Delay Control of the following (ClWA-Ar Scale): Nausea/Nomiting (0 - 7) 0 - none; 1 - mid nausea, no vomiting; 4 - intermittent nausea, 7 - constainf nausea, frequent dy heaves & vomiting. Tremors (0 - 7) 0 - none; 1 - not visible but can be felt, 4 - moderate wis arms extended; 7 - severe, even wis arms not extended Anxioty (0 - 7) 0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute parinc state. Agitation (0 - 7) 0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute parinc state. Agitation (0 - 7) 0 - none; at ease; 1 - mildly anxious; a - moderately anxious or guarded; 7 - equivalent to acute parinc state. Agitation (0 - 7) 0 - none; at ease; 1 - mildly anxious; a - moderately anxious or guarded; 7 - equivalent to acute parinc state. Agitation (0 - 7) 0 - none; at ease; 1 - mildly anxious; a - moderately sweating, palms moist; 4 - beads of sweat obvious on forehead; 7 - direnching sweat. Orientation (0 - 4) 0 - oriented; 1 - uncertain about date; 2 - disoriented to date by 2 - 2 days; 4 - disoriented to date by 2 - 2 days; 4 - disoriented to date by 2 - 2 days; 4 - disoriented to place and / or person. Tactile Disturbances (0 - 7) 1 - none; 1 - very mild tich; P&N, burning, numbroness; 2 - mild itch; P&N, burning, numbroness; 3 - moderate lich, P&N, burning, numbroness; 4 - extremely severe hallucinations; 7 - continuous hallucinations. Visual Disturbances (0 - 7) 0 - not present; 1 - very mild seriently laterations. Headache (0 - 7) 0 - not present; 1 - very mild; 2 - mild; 3 - moderate; 4 - moderately severe; 5 - severe; 6 - very severe; 7 - extremely severe Total ClWA - Ar score:	q4h×72 hrs. If score for 72 hrs., d/c assessmelf score > 10 at any til	<10 RR/Temp.								
Assess and rate each of the following (CRWA-Ar Scale): Nausear/Nomiting (0 - 7) 0 - none: 1 mild nausea, no vomiting: 4 - intermittent nausea; 7 - constant nausea, frequent dry heaves & vomiting. Tremors (0 - 7) 0 - no terron; 1 - not visible but can be felt; 4 - moderate wis arms extended; 7 - severe, even wis arms not extended Anxiety (0 - 7) 0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute proteins and	below) administer	prn								
Nausea/Vomiting (0 - 7) 0 - none; 1 - mild nausea, no vomiting; 4 - intermittent nausea, 7 - constant nausea, frequent dry heaves & vomiting. Tremors (0 - 7) 0 - no remor; 1 - not visible but can be felt, 4 - moderate w/s arms extended; 7 - severe, even w/s arms not extended Anxiety (0 - 7) 0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute panic state. Agitation (0 - 7) 0 - none adativity; 1 - some what normal activity; 4 - moderately findly expensives; 7 - paces or constantly thrashes about dispelyiresitess; 7 - paces or constantly thrashes about a constant of the										
0 - none; 1 - mild nausea, no vomiting; 4 - intermittent nausea; 7 - constant nausea, requent dry heaves & vomiting. Tremors (0 - 7) 0 - no termor; 1 - not visible but can be felt; 4 - moderate ws arms extended; 7 - severe, even w/s arms not extended Anxiety (0 - 7) 0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute panic state. Agitation (0 - 7) 0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute panic state. Agitation (0 - 7) 0 - none and state; 1 - barry perceptible swealing, palms moist; 4 - beads of sweat obvious on forehead; 7 - denching sweat. Paroxysmal Sweats (0 - 7) 0 - no sweats; 1 - barry perceptible swealing, palms moist; 4 - beads of sweat obvious on forehead; 7 - denching sweat. Orientation (0 - 4) 0 - onemited; 1 - uncertain about date; 2 - disoriented to date by on more than 2 days; 3 - disoriented to date by 2 - 2 days; 4 - disoriented to place and / or person. Tactile Disturbances (0 - 7) 0 - none; 1 - very mild id; Paß, numbeness; 2 - mild itch, Paß, burning, numbness; 3 - moderate latch inclinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations Buditory Disturbances (0 - 7) 0 - not present; 1 - very mild harshness, ability to startle; 2 - mild harshness, ability to startle; 3 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations; 6 - extremely severe; 7 - extremely sever	Assess and rate each of the follow	wing (CIWA-Ar Scale) :								
Tremors (0 - 7) 0 - no tremor, 1 - not visible but can be felt; 4 - moderate w's arms extended; 7 - severe, even w/s arms not extended Anxiety (0 - 7) 0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute paine state. Agitation (0 - 7) 0 - normal activity; 1 - some what normal activity; 4 - moderately fidgely/restless; 7 - paces or constantly thrashes about Paroxysmal Sweats (0 - 7) 0 - no sweats; 1 - barely perceptible sweating, palms moist; 4 - beads of sweat obvious on forehead; 7 - derenching sweat. Orientation (0 - 4) 0 - oriented; 1 - uncertain about date; 2 - disoriented to date by no more than 2 days; 3 - disoriented to date by > 2 days; 4 - disoriented to place and / or person. Tactile Disturbances (0 - 7) 0 - none; 1 - very mild itch, PaRN, numbeness; 2 - mild itch, PaRN, burning, numbness; 3 - moderate itch, PaRN, burning, numbness; 6 - extremely severe hallucinations; 7 - continuous hallucinations Auditory Disturbances (0 - 7) 0 - not present; 1 - very mild harshness/ability to starfle; 2 - mild harshness, ability to starfle; 2 - mild harshness, ability to starfle; 2 - mild harshness, ability to starfle; 3 - moderate hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations. Visual Disturbances (0 - 7) 0 - not present; 1 - very mild sensitivity, 2 - mild sensitivity, 3 - moderate sensitivity, 4 - moderate hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations. Headache (0 - 7) 0 - not present; 1 - very mild; 2 - mild; 3 - moderate; 4 - moderately severe; 5 - severe, 6 - very severe; 7 - extremely severe Total CIWA - Ar score:	0 - none; 1 - mild nausea, no voi									
0 - no tremor, 1 - not visible but can be feft, 4 - moderate ws arms extended; 7 - severe, even w/s arms not extended arms extended; 7 - severe, even w/s arms not extended arms extended; 7 - severe, even w/s arms not extended arms extended; 7 - severe, even w/s arms not extended arms extended; 9 - on, one, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute panic state. Agitation (0 - 7) 0 - normal activity, 1 - some what normal activity, 4 - moderately fideptivesties; 7 - paces or constantly threathes about the part of the par		t dry neaves & vorniting.								
0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute panic state. Agitation (0 - 7) 0 - normal activity; 1 - some what normal activity, 4 - moderately fidgety/resitess; 7 - paces or constantly thrashes about Paroxysmal Sweats (0 - 7) 0 - no sweats; 1 - barely perceptible sweating, palms mois; 4 - beads of sweat obvious on forehead; 7 - denorhing sweat. Orientation (0 - 4) 0 - oriented; 1 - uncertain about date; 2 - disoriented to date by no more than 2 days; 3 - disoriented to date by no more than 2 days; 3 - disoriented to date by no more than 2 days; 3 - disoriented to date by by 2 days; 4 - disoriented to place and / or person. Tactile Disturbances (0 - 7) 0 - none; 1 - very mild itch, P&N, numbeness; 2 - mild itch, P&N, burning, numbness; 3 - moderate itch, P&N, burning, numbness; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations Auditory Disturbances (0 - 7) 0 - not present; 1 - very mild sensitivity; 2 - mild sensitivity; 3 - moderate sensitivity; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations. Visual Disturbances (0 - 7) 0 - not present; 1 - very mild sensitivity; 3 - moderate sensitivity; 4 - moderate hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations. Headache (0 - 7) 0 - not present; 1 - very mild; 2 - mild; 3 - moderate; 4 - moderately severe; 5 - severe; 6 - very severe; 7 - extremely severe; 7 - extremely severe; 5 - severe; 6 - very severe; 7 - extremely seve	0 - no tremor; 1 - not visible but can be felt; 4 - moderate w/s arms extended; 7 - severe, even w/s arms not extended									
0 - normal activity; 1'- some what normal activity, 4 - moderately fidgety/restless; 7 - paces or constantly thrashes about Paroxysmal Sweats (0 - 7) 0 - no sweats; 1 - barely perceptible sweating, palms moist; 4 - beads of sweat obvious on forchead; 7 - dienching sweat. Orientation (0 - 4) 0 - oriented; 1 - uncertain about date; 2 - disoriented to date by no more than 2 days; 3 - disoriented to date by yo more than 2 days; 3 - disoriented to date by yo no more than 2 days; 3 - disoriented to date by yo no more than 2 days; 3 - disoriented to date by yo no more than 2 days; 3 - disoriented to place and / or person. Tactile Disturbances (0 - 7) 0 - none; 1 - very mild itch, P&N, burning, numbness; 3 - moderate itch, P&N, burning, numbness; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations Auditory Disturbances (0 - 7) 0 - not present; 1 - very mild harshness/ability to startle; 2 - mild harshness, ability to startle; 3 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations. Visual Disturbances (0 - 7) 0 - not present; 1 - very mild sensitivity; 2 - mild sensitivity; 3 - moderate sensitivity; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations. Headache (0 - 7) 0 - not present; 1 - very mild; 2 - mild; 3 - moderate; 4 - moderately severe; 5 - severe; 6 - very severe; 7 - extremely severe Total ClWA - Ar score:	0 - none, at ease; 1 - mildly anxious; 4 - moderately									
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	0 - not present; 1 - very mild; 2 - mild; 3 - moderate; 4 - moderately severe; 5 - severe; 6 - very severe;									
PRN Med: (circle one) Dose given (mg):	· · · · · · · · · · · · · · · · · · ·									
Diazepam Lorazepam	PRN Med: (circle one) Diazepam Lorazepam	Dose given (mg):								
Route:										
Time of PRN medication administration:	Time of PRN medication adm	inistration:								
Assessment of response (CIWA-Ar score 30 - 60	minutes after medication adm									
	RN Initials									

CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE (CIWA-Ar)

Assessment Protoco	I	Date							
(a) Vitals, Assessment	Now								
(b) If initial score > 10 re q1h×8 hrs., then if s q2h×8hrs., then if s q4h.	stable	Time							
	stable	Pulse							
(c) If initial score < 10, q4h×72 hrs. If sco for 72 hrs., d/c asses If score > 10 at an go to (b) above.	ore <10 ssment.	RR/Temp.							
(d) If indicated, (see indi	ications er prn	O₂ Sat.							
medications as order record on MAR and		ВР							
Assess and rate each of the f	ollowing ((CIWA-Ar Scale) :							
Nausea/Vomiting (0 - 7)	,	•							
0 - none; 1 - mild nausea, no nausea; 7 - constant nausea, fre									
Tremors (0 - 7) 0 - no tremor; 1 - not visible but arms extended; 7 - severe, ev									
	Anxiety (0 - 7) 0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or quarded; 7 - equivalent to acute panic state.								
Agitation (0 - 7) 0 - normal activity; 1 - some who stelly fident (rootless; 7 - pages)	at normal a	activity; 4 - moder-							
ately fidgety/restless; 7 - paces or constantly thrashes about Paroxysmal Sweats (0 - 7)		lly thrashes about							
0 - no sweats; 1 - barely perceptible sweating, palms moist; 4 - beads of sweat obvious on forehead; 7 - drenching sweat. Orientation (0 - 4) 0 - oriented; 1 - uncertain about date; 2 - disoriented to date by no more than 2 days; 3 - disoriented to date by > 2 days; 4 - disoriented to place and / or person. Tactile Disturbances (0 - 7) 0 - none; 1 - very mild itch, P&N, numbeness; 2 - mild itch, P&N, burning, numbness; 3 - moderate itch, P&N, burning, numbness; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations									
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hallucinations; 7 - continuous hallucinations. Visual Disturbances (0 - 7)									
0 - not present; 1 - very mild sensitivity; 2 - mild sensitivity; 3 - moderate sensitivity; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations.									
Headache (0 - 7) 0 - not present; 1 - very mild; 2 - mild; 3 - moderate; 4 - moderately severe; 5 - severe; 6 - very severe; 7 - extremely severe									
Total CIWA - Ar score:									
PRN Med: (circle one) Diazepam Lorazepam	Dos	e given (mg):							
,		Route:							
Time of PRN medication	administi								
Assessment of response (CIWA-Ar score 30 - 60 minutes after medication administered)									
RN Initials									
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HEALTH SERVICE DEPARTMENT, KERALA GOVT. MEDICAL COLLEGE HOSPITAL, IDUKKI

DISCHARGE SUMMARY

	Head of Service Department of Psychiatry	Department/Specialty Vimukthi Deaddiction Ward	Head of Institution			
j 						
 	Name of Patient :	Sex : Male / Female				
\ \ \ \ \	Address:		IP No			
		Date of Admission/20				
			Date of Discharge/20			
 	Mode of Admission : Indepe	endent 🗆 Supported				
 	Final Diagnosis (ICD 11):		(Psychosocial)			
*						
 	Brief history and clinical notes :					
* ·	Treatment :					
, ,	Advice on Discharge :					
1 · -	(Follow up Advise/Appointmen	t	1			
* 	(1 onow-up Advice/Appointmen	Signature :				
		Name :				
	Design	ation of Medical Officer in-charge :				
 	Please Contact : ① 623860025 (8.00 AM – 8.00 PM					

HEALTH SERVICE DEPARTMENT, KERALA GOVT. MEDICAL COLLEGE HOSPITAL, IDUKKI

DISCHARGE SUMMARY

Head of Service Department of Psychiatry	Department/Specialty Vimukthi Deaddiction Ward	Head of Institution
Name of Patient :	Age :	Sex : Male / Female
Address:		IP No
		Date of Admission/20
		Date of Discharge/20
Mode of Admission : Independent	endent 🗆 Supported	
Final Diagnosis (ICD 11):		(Psychosocial)
Brief history and clinical notes :		
Treatment:		
Advice on Discharge :		
7 ta 30 on 2 to 3 ta .go .		
(Follow-up Advice/Appointmen	t)
	Signature :	
	Name :	
Design	ation of Medical Officer in-charge :	
Please Contact : ① 623860025 (8.00 AM – 8.00 Pl		

DISCHARGE PLANNING NOTES						
Form – G						
ഡിസ്ചാർജിനുള്ള അപേക്ഷ						
ആരോഗ്യസ്ഥിതി ഭേദമായിട്ടുള്ളതിനാൽ ഡിസ്ചാർജിനുള്ള അപേക്ഷ സമർപ്പിക്കുന്നു.						
എന്ന്						

Name :	Age :	I.P. No. :

INVESTIGATIONS

Name :			Age :	I.P. No. :	
		DIET SHE	ET		
IP No. :			Ward :		
Name & Address	3 :		D.O.A. :		
			D.O.D. :		
			Diagnosis	3:	
Age:	Sex:		Religion	:	
Occupation :			Monthly I	ncome :	
Date		Diet		Sign. of M.C	—).
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