**EM Basic- Psychiatric Medical Screening**

(This document doesn’t reflect the views or opinions of the Department of Defense, the US Army, or the Fort Hood Post Command © 2012 EM Basic LLC, Steve Carroll DO. May freely distribute with proper attribution)

**First step- “scene safety”- safety of yourself, staff, and the patient**

 -Patient stripped down to underwear and in a hospital gown

 -Clothes and shoes stored outside the room

 -Powerful deterrent to the patient suddenly leaving

 -If necessary, have security/police search the patient

**Know your state’s laws on involuntary holds/emergency detention**

**Look at chart- address abnormal vitals**

 -Pay special attention to fever, tachycardia, low pulse ox

 -Read entire triage note for background on the patient

 -Is this suicidal ideation (SI) or more of the patient acting

bizarrely? (more altered mental status than SI)

**Introduce yourself to the patient, sit down and listen**

-For safety, stay in between the patient and the door

 -Don’t get trapped in the room

 -Ask the patient why they are in the ED

 -Be prepared to listen but be direct if the patient doesn’t talk

 -If they don’t volunteer it- ask the patient “do you want to hurt

yourself or anyone else”

 -If the patient has SI, ask them directly what their plan is

**PEARL**: You aren’t going to make a patient suicidal or give them ideas just by asking- you need to ask these questions directly to get the whole story

**Pay attention to the patient’s body language**

 -Are they being evasive?

-Are they hyper and on edge?

 -Are they somnolent and depressed?

-Are they blowing off your concerns about SI?

**If the patient has a plan to hurt themselves- how serious are they about carrying it out?**

-Method doesn’t matter- what matters is how much the patient believes it will hurt them

-Example- 10 motrin won’t kill an adult but if the patient believes that it will, take it seriously

**Ask about social and psychiatric history**

 -Social history- who does the patient live with? Support

structure? Drugs or alcohol use?

-Psych history- previous psych admission, medications

**Get full medical history**- meds, allergies, PMH, PSH

**Do a good review of symptoms**- focus on neuro and endocrine

**Do a good head to toe exam**- focus on the neuro exam and mental status

 -Some suggest doing a mini-mental status on every patient

 -Probably not necessary but make sure the patient has a clear

sensorium/mental status

-Pay attention to any confusion or fluctuating mental status

**Labs**- very low yield on young healthy patients but required by psych facilities/floors prior to admission- trying to catch undiagnosed medical conditions contributing/causing psych condition

**General lab workup with possible explanations**

CBC- anemia

Chem10- electrolyte disorders (hyponatremia, renal failure, etc.)

TSH- hypothyroidism (mimics depression)

Acetiminophen level- very important - OD is asymptomatic and lethal

ETOH level- general tox workup

Salicylate leve- same (but this is a recognizable toxidrome)

UA/Urine Drug Screen- UTI, drugs of abuse

Urine HCG- females= pregnant until proven otherwise

EKG- arrhythmias or prolonged arrhythmias (contraindication to some psych meds, can help you diagnose TCA overdose)

LFTs- optional- screen for liver disease?

**Catching the red flags**

-Most important part of this workup is to find those patients who have a medical condition causing their psychiatric illness

-Be careful in the young and the old and patients who all of the sudden have psychiatric problems without a previous history

**Example**- young patient starts suddenly acting bizarrely- could be herpes meningitis, older patient with SI with no stressors- could be a head bleed

**PEARL- Red Flags- Sudden onset of symptoms, age greater than 40, visual or tactile hallucinations, fluctuating level of consciousness**

**Patients with red flags should get a non-contrast head CT and a lumbar puncture looking for intracranial masses/bleeding or meningitis and any other indicated testing**

**Bottom line**- you have to pretend that you will be the last medical doctor that will see the patient- may be a long time before they see a doctor other than a psychiatrist

**Disposition**

Acting bizarrely with a known history of psychiatric illness- if history/exam, workup, and sensorium is normal may be able to discharge if the patient doesn’t want to stay (you have a right to act bizarrely on the streets as long as you aren’t hurting anyone or breaking any laws)- get social services help if you can

**SI/HI-** Should be evaluated by a psychiatrist in the ED

**Psychiatrist agrees with admission**- admit the patient to the psych floor/facility- may be a long wait- get the patient something to eat, make them comfortable, give benzos PRN for agitation

**Psychiatrist disagrees with admission**- make sure the patient hasn’t changed their story when they talked to the psychiatrist, make sure the psychiatrist has the whole picture/story

**Suicide Risk assessment**- at community EDs without ready access to psychiatry, may have to make SI low risk vs. high risk decision- go to blog.ercast.org/suicide for podcasts and other information on this topic

**Contact-** **steve@embasic.org** **Twitter- @embasic**