PBHCI Clinical Registry Form – All Providers Except Nurse CM and PC ARNP

Patient Name (last, first, middle) _____ **Client ID** _____

Provider Name (last, first) _____

Visit Date _____ **Site** ☐ DESC ☐ HMHS

RESPONSES IN THIS SECTION SHOULD BE SPECIFIC TO THIS VISIT

Provider Seen	**Yes**
Psychiatrist/ Psychiatric Nurse Practitioner	
Psychiatric Nurse	
Case Manager	
Psychologist	
Peer Counselor	
Psychiatry Resident	
Substance Abuse Counselor	
Employment/ Vocational Specialist	

Physical Health	**Yes**
Screened/Assessed	
Referral	
Treatment planning	
Medication management	
Hospitalized for physical health since last visit	

Mental Health	
Screened/Assessed	
Referral	
Treatment planning	
Medication management	
Hospitalized for mental health since last visit	
CBT	
Interpersonal Psychotherapy	
DBT	
CCM[1]	
IDDT[2]	

Substance Use	
Screened/Assessed	
Referral	
Treatment planning	
Medication management	
Hospitalized for substance use since last visit	
Counseling	
SBIRT	
MI/MET[3]	
Peer support	
IDDT[2]	

Wellness	
Referral	
Smoking cessation	
Nutrition education	
Healthy cooking	
Diabetes education	
Hypertension education	
Physical activity education	
Exercise	
Yoga	
Stress management	
Illness self-management	
Recovery activities	
Peer support	
Spirituality	
Medication management	
Vocational/ Pre-Vocational	
Other, specify:	

[1] Comprehensive Case Management [2] Integrated Dual Diagnosis Treatment [3] Motivational Interviewing/ Motivational Enhancement Techniques