Vancouver CoastalHealth
Promoting wellness. Ensuring care.

PARIS
PRIMARY ACCESS
Regional Information System

MENTAL HEALTH CASE REVIEW

Name:		**Team:**
DOB:	**Age:**	**PARIS ID:**
Gender:		**PHN:**

Header Details

Date Started:
End Date:
Carried Out By:
Assessment ID:
Recorded By:
Assoc. Referral ID:

Client Profile Summary

Relapse Symptoms

Medications

Risk Assessment - Part 1

	Yes:	No:	Comments:
Medication, Side Effects:	☐	☐	
Allergies/Medication Contraindications:	☐	☐	**If Yes, please enter in Allergies grid section below (if not already entered)**

Allergies - Current *Content may have been entered/updated after assessment completed.*

Date Entered	Allergen	Category	Source	Reaction	Reaction Details

Lab Work/AIMS Test Required	☐	☐
Suicidal History/Potential	☐	☐
Alcohol/Drug Use:	☐	☐

Risk Assessment - Part 2

Assault History/Potential:	☐	☐
HIV/AIDS:	☐	☐
Safety Concerns (eg. home environment,driving ability)	☐	☐
Other (eg. Medical Risks):	☐	☐

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Major Changes In Client

	Yes:	No:	Comments:
Mental Status:	☐	☐	
Physical Health:	☐	☐	
Family/School:	☐	☐	
Housing:	☐	☐	
Finances:	☐	☐	
Relationships and Support Network:	☐	☐	
Roles:	☐	☐	
Spirituality:	☐	☐	
Vocational:	☐	☐	
Educational:	☐	☐	
Leisure:	☐	☐	
Personal Care:	☐	☐	
Hospitalizations:	☐	☐	
Legal Status:	☐	☐	
Sexuality:	☐	☐	
Other:	☐	☐	

Diagnosis

Date	Diagnosis Type	Diagnosis	State	Aware?	Comments

Key Problem Areas

Needs

Need	Post to C/P	Processed	Comments

Treatment Interventions During Review Period

Ongoing Treatment Plan

MENTAL HEALTH CASE REVIEW

Name:		**Team:**
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Gender:		**PHN:**

Comments

Other People Involved with Assessment

Who	Association	Comments

Copies To Be Sent To

Other Authorizers

Authorizer: Date:

Authorizer: Date:

Authorization Details

Carried Out By: Date:

Authorized by: Date:

Notes:

Casenote *May have been added after assessment completed.*

Note: Once downtime information from this form has been entered in PARIS, shred this working sheet.

---------- **End of Report** ----------