Vancouver CoastalHealth
Promoting wellness. Ensuring care.

PARIS
PRIMARY ACCESS
Regional Information System

MHA PSYCHIATRIC ASSESSMENT

Name:		**PARIS ID:**
DOB:	**Age:**	**PHN:**
Gender:		**Phone:**
Home Address:		

Assessment Start Date: **Assessment End Date:**

Reason For Assessment: **Carried Out By:**

Assessment Details

MHA Minimum Reporting Requirements [MRR]

Client has experienced violence/abuse towards them in the 12 months prior to referral or during service:

☐ Yes, indicated by client ☐ No

☐ Yes, indicated by other trusted source ☐ Unknown/not asked

Client has made a suicide attempt or engaged in significant intentional self-harm in the last 24 hours:

☐ Yes, indicated by client ☐ No

☐ Yes, indicated by other trusted source ☐ Unknown/not asked

MHA PSYCHIATRIC ASSESSMENT

Name:	PARIS ID:

Allergies - Current

Content may have been entered/updated after assessment completed.

Date Entered	Allergen	Category	Source	Reaction	Reaction Details

Diagnosis

Date	Diagnosis Type	Diagnosis	State	Aware?	Comments

Other People Involved

Copies To Be Sent To:

Other Authorizers

Other Authorizer: **Date:**

Other Authorizer: **Date:**

Authorization Details

Carried Out By: **Date:**

Closing Authorizer: **Date:**

Notes:

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

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