PATIENT STRESS QUESTIONNAIRE SCORING

PHQ-9 and PHQ Modified for Teens

- **Annual Depression Screening given at all physicals for patients 12 and older- Bill G0444**
- **Depression assessment and follow up (outside of annual physical) - Bill 96127**
  - **To assess major depression a 2 or a 3 must be score on one of the first 2 questions-**
    - **If a 2 or 3 is not indicated the patient may still be depressed (depression NOS or another depressive disorder), but it is not major depression.**

PHQ-9 Score	**Severity: Provisional Diagnoses***	**ORDERS NEEDED WHEN PT SCORES DEPRESSED- *One of the following orders must be completed***	**Proposed Actions/ Evidence-Based Treatment Considerations**
0-4	None: Minimal	✓ None	None
5 - 9	Mild: Minimal Depressive Symptoms Depression diagnosis may not be appropriate.	✓ **Referral Order** -Ref to psychiatry, psychology or behavior therapist ○ **OR** ✓ Referral Order -**Follow Up Adult Depression** to see you ○ **OR** ✓ **Prescribe** a Depression Medication	✓ Watchful waiting - provide support (e.g., educate patient to call if symptoms worsen; 0ffer self-management (books, websites) ✓ Have patient return in 1 month to repeat screening and reassess
10-14	Moderate: Minor Depression, or Dysthymia	✓ **Referral Order** -Ref to psychiatry, psychology or behavior therapist ○ **OR** ✓ Referral Order -**Follow Up Adult Depression** to see you ○ **OR** ✓ **Prescribe** a Depression Medication	✓ Develop treatment plan with consideration of counseling/psychotherapy, antidepressant medication and follow-up. ✓ Monitor with continued screenings over time
15-19	Moderately Severe: Depression	✓ **Referral Order** -Ref to psychiatry, psychology or behavior therapist ○ **OR** ✓ Referral Order -**Follow Up Adult Depression** to see you ○ **OR** ✓ **Prescribe** a Depression Medication	✓ Consider initiating anti-depressant medication and/or refer for psychotherapy and/or antidepressant medication ✓ Monitor with continued screenings over time
20 or greater	Severe: Major Depression	✓ **Referral Order** -Ref to psychiatry, psychology or behavior therapist ○ **OR** ✓ Referral Order -**Follow Up Adult Depression** to see you ○ **OR** ✓ **Prescribe** a Depression Medication	✓ Expedited referral to a mental health specialist for psychotherapy and/or antidepressant medication and collaborative management ✓ Consider Immediate initiation of anti-depressant medication ✓ Monitor with continued screenings over time

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GAD-7- Adult and bill 96127
Total Score: anxiety severity
A Score of **8** or greater indicates probable GAD or Panic disorder
A Score of **10** or greater warrants further evaluation

PC-PTSD- bill 96127
Yes to any **3** questions- Positive screen

Score	Risk	Provisional Dx	Follow up	Tx
Yes < 3 items	**Negative**	**None**	**None**	**None**
Yes > 3 items	**Positive**	**Possible PTSD**	**Structural Interview**	**RX medication Refer to BH/MH Refer to Psychiatry**

Score	Risk	Provisional Dx	F/u	Tx
0-5	Low	None or mild		
6-10	Moderate	Moderate Anxiety		
11-15	Moderate	Moderately Severe Anxiety	Further evaluation	Rx BH/MH Psych
16-21	high	Severe Anxiety	Further evaluation	Rx BH/MH Psych

AUDIT- bill 96217 or SBIRT codes if intervention/discussion was over 15 minutes

Score	Risk	Treatment
0-7	Low risk	• None or information about non-risky use
8-15	Risky or hazardous	• Brief intervention (BI) • Possible BH referral or counseling
16-19	High risk or harmful Assess for dependence	• BI • Counseling

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		• Possible referral to treatment
> 20	High risk Almost certainly dependent	• Further assessment with family and significant others • Substance use referral (medical specialist or substance use treatment) • Pharmacotherapy • Relapse prevention and support

Suicide Behaviors Questionnaire-Revised (SBQ-R)

Description	

Item 1: Taps into lifetime suicide ideation and/or suicide attempts

Selected Response 1	Non-Suicidal subgroup	1 point
Selected Response 2	Suicide Risk Ideation subgroup	2 points

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Selected Response 3a or 3b	Suicide Plan Subgroup	3 points	
Selected Response 4a or 4b	Suicide Attempt Subgroup	4 points	**TOTAL POINTS=** _________

Item 2: assesses the *frequency* of suicidal ideation over the past 12 months. Selected response:

Never	1 Point	
Rarely (1 time)	2 Points	
Sometimes (2 times)	3 Points	
Often (3-4 times)	4 Points	
Very often (5 or more times)	5 points	**TOTAL POINTS** =____________

Item 3: taps into the threat of suicide attempt

Selected Response 1	1 Point	
Selected Response 2a or 2b	2 Point	
Selected Response 3a or 3B	3 Points	**TOTAL POINTS** = ____________

Item 4: evaluates self-reported likelihood of suicidal behavior in the future. Selected Response:

Never	0 points	
No Chance at all	1 Point	
Rather unlikely	2 points	
Unlikely	3 points	
Likely	4 points	
Rather Likely	5 Points	
Very Likely	6 Points	**TOTAL POINTS=** ____________

TOTAL SCORE = ____________

Sum all of the scores circled / checked by the respondents. The total score should range from 3-18.

Interpretation for General Population:

Score	**Risk**	**Provisional Dx**	**Follow up**	**Tx**
Score < 7	**Low**			
Score >7	**High**			

Interpretation for Psychiatric Inpatients:

Score	**Risk**	**Provisional Dx**	**Follow up**	**Tx**
Score < 8	**Low**			
Score>8	**High**			