

Depression Flow Sheet

Name: _____ Preliminary Diagnosis: _____ DOB: __/__/__ Gender: M F

Intervention (circle all that apply): watch/wait medication ψ/therapy

Acute Phase Follow Up Visit (first 84 days)	Visit Information _____ _____	PHQ Scores _____	Self-Management & Educational Materials	Medication Management Consider med change if there is no response at four weeks or no partial response at 12 weeks Consider adding counseling Psychiatry /Psychotherapy Consider med change or addition of medication if no response at six weeks or only a partial response at 12 weeks Brief Visit Note
Initial Visit Best Practice SOC recommend 3 follow-up visits within the first 84 days of initiation of antidepressant medication	Visit Information Date_____ Provider_____	Index PHQ Score: _____ # SX: _____ Fnc: _____	Self Management [] Depression Action Plan Patient Education [] Depression and treatment information [] Anti-depressant prescription education	Medication Management Was there a new Rx or a change in current Rx? [] No [] Yes –explain _____ Psychiatry/Psychotherapy Was there a Counseling /Psychiatry referral? [] No [] Yes [] Patient refused Provider name: _____ Note: _____
Recommendation 1-2 weeks after initiation of antidepressant medication	Visit Information Date_____ Provider_____ [] Office visit [] Phone call	Repeat PHQ at 1-2 weeks if indicated. Score: _____ # SX: _____ Fnc: _____	Self Management [] Depression Action Plan Patient Education [] Depression and treatment information [] Anti-depressant prescription education	Medication Management Was there a new Rx or a change in current Rx? [] No [] Yes –explain _____ Psychiatry/Psychotherapy Was there a Counseling /Psychiatry referral? [] No [] Yes [] Patient refused Provider name: _____ Note: _____
Recommendation 4-6 weeks after initiation of antidepressant medication	Visit Information Date_____ Provider_____ [] Office visit [] Phone call	Repeat PHQ Score: _____ # SX: _____ Fnc: _____	Self Management [] Depression Action Plan Patient Education [] Depression and treatment information [] Anti-depressant prescription education	Medication Management Was there a new Rx or a change in current Rx? [] No [] Yes –explain _____ Psychiatry/Psychotherapy Was there a Counseling /Psychiatry referral? [] No [] Yes [] Patient refused Provider name: _____ Note: _____
Recommendation 6-8 weeks after initiation of antidepressant medication	Visit Information Date_____ Provider_____ [] Office visit [] Phone call	Repeat PHQ Score: _____ # SX: _____ Fnc: _____	Self Management [] Depression Action Plan Patient Education [] Depression and treatment information [] Anti-depressant prescription education	Medication Management Was there a new Rx or a change in current Rx? [] No [] Yes –explain _____ Psychiatry/Psychotherapy Was there a Counseling /Psychiatry referral? [] No [] Yes [] Patient refused Provider name: _____ Note: _____
Recommendation 8-12 weeks after initiation of antidepressant medication	Visit Information Date_____ Provider_____ [] Office visit [] Phone call	Repeat PHQ Score: _____ # SX: _____ Fnc: _____	Self Management [] Depression Action Plan Patient Education [] Depression and treatment information [] Anti-depressant prescription education	Medication Management Was there a new Rx or a change in current Rx? [] No [] Yes –explain _____ Psychiatry/Psychotherapy Was there a Counseling /Psychiatry referral? [] No [] Yes [] Patient refused Provider name: _____ Note: _____



Continuation Phase (180 days) Maintenance Phase (12-24 months)	Visit Information	PHQ Scores	Self-Management & Educational Materials	Medication Management <ul style="list-style-type: none"> Continuation Phase: tries to prevent return of symptoms in current episode (180 days) Maintenance Phase: tries to prevent return of symptoms within 2 years (12-24 months) Keep same dose of antidepressant Rx for at least 6-9 months after return to well state Psychiatry /Psychotherapy <ul style="list-style-type: none"> Ensure ongoing communication with behavior health specialist Brief Visit Note
Treatment Phase <input type="checkbox"/> Continuation Phase <input type="checkbox"/> Maintenance Phase	Visit Information Date _____ Provider _____ <input type="checkbox"/> Office visit <input type="checkbox"/> Phone call	Repeat PHQ Every 4-6 months Score: _____ # SX: _____ Fnc: _____	Self Management <input type="checkbox"/> Depression Action Plan Patient Education <input type="checkbox"/> Depression and treatment information <input type="checkbox"/> Anti-depressant prescription education	Medication Management Was there a new Rx or a change in current Rx? <input type="checkbox"/> No <input type="checkbox"/> Yes –explain _____ Psychiatry/Psychotherapy Was there a Counseling /Psychiatry referral? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Patient refused Provider name: _____ Note: _____ _____ _____
Treatment Phase <input type="checkbox"/> Continuation Phase <input type="checkbox"/> Maintenance Phase	Visit Information Date _____ Provider _____ <input type="checkbox"/> Office visit <input type="checkbox"/> Phone call	Repeat PHQ Every 4-6 months Score: _____ # SX: _____ Fnc: _____	Self Management <input type="checkbox"/> Depression Action Plan Patient Education <input type="checkbox"/> Depression and treatment information <input type="checkbox"/> Anti-depressant prescription education	Medication Management Was there a new Rx or a change in current Rx? <input type="checkbox"/> No <input type="checkbox"/> Yes –explain _____ Psychiatry/Psychotherapy Was there a Counseling /Psychiatry referral? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Patient refused Provider name: _____ Note: _____ _____ _____
Treatment Phase <input type="checkbox"/> Continuation Phase <input type="checkbox"/> Maintenance Phase	Visit Information Date _____ Provider _____ <input type="checkbox"/> Office visit <input type="checkbox"/> Phone call	Repeat PHQ Every 4-6 months Score: _____ # SX: _____ Fnc: _____	Self Management <input type="checkbox"/> Depression Action Plan Patient Education <input type="checkbox"/> Depression and treatment information <input type="checkbox"/> Anti-depressant prescription education	Medication Management Was there a new Rx or a change in current Rx? <input type="checkbox"/> No <input type="checkbox"/> Yes –explain _____ Psychiatry/Psychotherapy Was there a Counseling /Psychiatry referral? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Patient refused Provider name: _____ Note: _____ _____ _____
Treatment Phase <input type="checkbox"/> Continuation Phase <input type="checkbox"/> Maintenance Phase	Visit Information Date _____ Provider _____ <input type="checkbox"/> Office visit <input type="checkbox"/> Phone call	Repeat PHQ Every 4-6 months Score: _____ # SX: _____ Fnc: _____	Self Management <input type="checkbox"/> Depression Action Plan Patient Education <input type="checkbox"/> Depression and treatment information <input type="checkbox"/> Anti-depressant prescription education	Medication Management Was there a new Rx or a change in current Rx? <input type="checkbox"/> No <input type="checkbox"/> Yes –explain _____ Psychiatry/Psychotherapy Was there a Counseling /Psychiatry referral? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Patient refused Provider name: _____ Note: _____ _____ _____

