

Sending
Entity

(Insert Logo Here)

Patient's Name: _____




U.R. # _____ D.O.B. _____

MI-SMART Form

The workgroup developed the following guide for the assessment of patients presenting to the emergency department with psychiatric symptoms to determine the patient is medically stable and appropriate for transfer out of the emergency department to further psychiatric care. This guide is primarily intended for use in the medical assessment of patients who are age 12 or older.

No changes to this form are permitted.

Please make suggestions for form changes at: www.mpcip.org/mpcip/contact/

Description of Medical Clearance Status	
Status	Description
Green 	All responses to Part 1 of Medical Clearance Guide are negative. The individual is considered medically stable for inpatient psychiatric admission <u>without need for additional diagnostic studies.</u>
Yellow 	There are one or more positive findings to Part 1 and/or Part 2 of the Medical Clearance Guide, and the individual is determined to be medically stable for inpatient psychiatric admission based on the clinician's medical assessment with or without further diagnostic studies as medically indicated by the transferring clinician. The clinician is responsible for explaining all Part 1 and 2 abnormalities in Part 3 of the guide. Individuals with this status may have acute, chronic, or acute on chronic medical conditions but would otherwise be <u>considered appropriate for discharge from the emergency department</u> except for the behavioral health condition.
Red 	<p>This status is for patients <u>who meet criteria for medical admission.</u> The transfer of this individual to an inpatient psychiatric facility is inappropriate until the individual's underlying medical condition has been adequately treated. These patients include, but are not limited to:</p> <ul style="list-style-type: none">• Individuals with clinically unstable vital signs.• Individuals who have experienced a drug overdose and are in need of medical monitoring and/or treatment (consistent with poison control consultation).• Individuals who acutely require supplemental oxygen.• Individuals who require intravenous fluids and/or medications.• Individuals with other similar acute or acute exacerbations of chronic conditions.

Instructions for the Form

The clinician should enter the patient's demographic information and complete the Part 1 screen. Patients with negative findings ("No" selected for each item in Part 1) are considered medically stable and do not require further medical workup prior to inpatient psychiatric admission: the clinician should proceed to Part 4 and complete the attestation. Any positive finding ("Yes" selected in Part 1) **may** warrant further diagnostic studies (Part 2), and the clinician should proceed to Part 2. Any positive findings from Part 1 or Part 2 **require** a clinician explanation (Part 3) regarding the abnormal finding, the clinical significance, and the disposition plan before completing the attestation in Part 4. Please report any urgent technical issues to: www.surveymonkey.com/r/SZNZNJN

Sending
Entity

(Insert Logo Here)

Patient's Name: _____

U.R. # _____ D.O.B. _____

MI-SMART Form	No*	Yes	Time Resolved
Part 1(b) Adopted from the Sierra Sacramento Valley Medical Society SMART Project			
Suspect <u>New Onset</u> Psychiatric Condition?			
Medical Conditions that Require Screening?	2		
Diabetes (FSBS less than 60 or greater than 250)			
Possibility of pregnancy (age 12-50)			
Other complaints that require screening			
Abnormal:	3		
Vital Signs?			
Temp: greater than 38.0°C (100.4°F)			
HR: less than 50 or greater than 110			
BP: less than 100 systolic or greater than 180/110 (2 consecutive readings 15 min apart)			
RR: less than 8 or greater than 22			
O ₂ Sat: less than 95% on room air			
Mental Status?			
Cannot answer name, month/year and location (minimum A/O x 3)			
If clinically intoxicated, HII score 4 or more? (next page)			
Physical Exam (unclothed)?			
Risky Presentation?	4		
Age less than 12 or greater than 55			N/A
Possibility of ingestion (screen all suicidal patients)			
Eating disorders			
Potential for alcohol withdrawal (daily use equal to or greater than 2 weeks)			
Ill-appearing, significant injury, prolonged struggle or "found down"			
Therapeutic Levels Needed?	5		
Phenytoin			
Valproic acid			
Lithium			
Digoxin			
Warfarin (INR)			

* If ALL five SMART categories are checked "NO" then the patient is considered medically cleared and no testing is indicated. If ANY category is checked "YES" then appropriate testing and/or documentation of rationale must be reflected in the medical record and time resolved must be documented above.

Date: _____ Time: _____ Completed by: _____

Signature

Print

Sending
Entity

(Insert Logo Here)

Patient's Name: _____

U.R. # _____ D.O.B. _____

Part 2: Additional Diagnostic Studies (When Clinically Indicated)

Ordered	Abnormal*	Laboratory Study	Ordered	Abnormal*	Diagnostic	Detail
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	CBC	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	X-Ray	[Body Part]
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	CMP	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	CT/CTA	[Body Part]
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Urinalysis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	MRI/MRA	[Body Part]
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Urine Culture	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Ultrasound	[Body Part]
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Urine Drug Screen	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	EKG	[QTC Value]
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Urine Pregnancy	Ordered	Abnormal*	Diagnostic	Detail
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Beta hCG	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	[Name]	[Detail]
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	BAL	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	[Name]	[Detail]
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Liver Function Test	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	[Name]	[Detail]
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Ammonia	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	[Name]	[Detail]
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	TSH	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	[Name]	[Detail]
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Acetaminophen	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	[Name]	[Detail]
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Salicylate	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	[Name]	[Detail]
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Valproic Acid	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	[Name]	[Detail]
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Lithium	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	[Name]	[Detail]
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Phenytoin	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	[Name]	[Detail]
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Troponin	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	[Name]	[Detail]
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	CPK Levels	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	[Name]	[Detail]
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	ABG	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	[Name]	[Detail]

*Clinically Significant Abnormality

Part 3: Medical Clearance Explanation/Plan (Required for Positive Part 1 and Part 2 Findings)

<input type="checkbox"/>	See additional documentation in emergency department medical record

Part 4: Medical Clearance Attestation

This individual has undergone an emergency department medical screening evaluation and has been determined to be appropriate for inpatient psychiatric hospitalization. There is no indication for non- psychiatric hospitalization at this time. If there is a change in the individual's condition, further medical evaluation may be indicated.

Name		Organization	
Signature		Date and Time	

Please report any technical issues about form to www.surveymonkey.com/r/SZNZNJN

DIAGRAM OF THE WORKFLOW FOR THE MEDICAL ASSESSMENT FOR PSYCHIATRIC ADMISSION

