

Georgia Department of Behavioral Health and Developmental Disabilities

Central State Hospital
Milledgeville, GA 31062

ADMISSIONS PRE-EVALUATION SCREEN: Adult Mental Health & Forensics

NAME:		DATE:	
DATE OF BIRTH:		TIME:	

SCREENING INFORMATION:

Vital Signs:	Temperature: _____°F Pulse: _____ Respiratory Rate: _____ Blood Pressure: _____		
	<input type="checkbox"/> unable to assess (reason): _____		
Right now, do you have any of the following:	Chest pain?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Trouble breathing?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Stomach pain?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Dizziness?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Any other medical/physical problems?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (describe): _____
Do you have:	High blood pressure?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Heart problems?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Breathing problems?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Diabetes?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Any other major illness?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (specify): _____

When was the last time that you ate anything?	_____
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PERSON COMPLETING SCREEN	_____	_____	_____
	PRINTED NAME	SIGNATURE	DATE AND TIME

ADMISSION PHYSICIAN REVIEW:

Based on this screening information -

Urgent/emergent evaluation due to medical condition or complaints.

Routine evaluation.

ADMITTING PHYSICIAN	_____	_____	_____
	PRINTED NAME	SIGNATURE WITH PROVIDER NUMBER	DATE AND TIME

The Individual's Identification