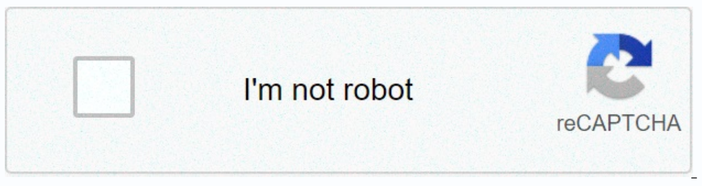

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Psychological testing report template

PSYCHOLOGICAL EVALUATION (device name here) Jane Smith Evaluation date: 9/12/96 Case No: 111,111 9/13/96 Building number: 11 Date of receipt: 9/2/96 Report date: 9/14/96 EVALUATION PURPOSE: Rather than Reason for referral the first part of the report is better called THE EVALUATION PURPOSE. This gives you much more flexibility. If you use reason for referral, you will pretty much need to copy what it says to consult. Unfortunately, many consultations ask questions that tests can not answer (otherwise they do not ask any question at all). In this section, briefly introduce the patient and the problem. Start with a brief demographic picture of the patient. (e.g., this is the third hospitalization for this 32 year old, single, white woman who has 13 years of formal education and is employed as a beautician. She was admitted due to symptoms of major depression with possible psychotic traits.) In this section, you can tell the reader what issues you'll be dealing with in the report body. In this way, it does not get to the end of your report, then you need to think about deciding whether your conclusions were supported by your data. He will know what questions to focus on, and he may be shaping his own impressions while he reads. (e.g. the purpose of the current evaluation was to examine evidence of psychosis and to clarify the nature of the underlying depressive disorder.) In short, use this section to ask a question that you will answer in the SUMMARY section. Finally, if the evaluation lasts more than 5 days, you should give a note on the progress in the patient chart, which provides preliminary test results. For example, you can close the PURPOSE FOR EVALUATION section of your report with: Preliminary results were reported in patient progress notes on 9/13/96. This report shall complement and elaborate these preliminary findings. ASSESSMENT PROCEDURES: In this section, the craft ASSESSMENT PROCEDURES and not THE TESTS ARE ADMINISTERED. This allows you to include a mental health exam and a clinical interview as two of your procedures. It also helps to communicate with reference sources that perform more than give some tests and copy interpretive commands from the manual. This will let them know that your rating is a professional integration of information from different sources. Do not forget to also note who gave the tests and how long it took. These questions are important if the case ever goes to trial. for example: Millon Clinical Multiaxial Inventory-III (MCMI-III) Minnesota Multiphasic Personality Inventory-2 (MMPI-2) Mental Status Examination of Prior Psychological Assessment of Prior Medical Records Clinical Interview This patient participated in 3 hours of testing and 1 hour diagnostic interview. The tests were administered by Jim Smith, MS and interpreted by John Jones, M.A. BACKGROUND INFORMATION: In this section you will discuss paragraphs related to family, social, legal, medical, family problems if necessary. Include only those questions that are relevant to the questions referred under THE EVALUATION PURPOSE. Excessive, unnecessary details distract the reader from the case you are trying to build to support your conclusions! If possible, maintain a chronological order when presenting basic information. Next, describe the patient's history of substance abuse/mental health issues and mental health care in chronological order. If possible, provide enough details about the previous intervention to clarify what they tried and whether it was successful. Your goal is to support replication of previous successes and/or prevent duplication of previous treatment failures. Also, be sure to describe the patient's behavior and the level of adaptive functioning between previous interventions. These details will help give the treatment team an idea of what the target level of adaptive functioning shoot in the current intervention. The following is a paragraph describing the onset and development of the current disease/ exacerbation. Let the reader get an idea of how current adoption compares to previous adoptions and what specific events have accelerated current adoption. End of this section with a short paragraph summarizing employee observations, patient behavior, level of motivation, etc. Keep in mind that objective observations of professional workers are one of your best data sources. Finally, a sentence indicating the drugs that were taken at the time of testing. MENTAL HEALTH EXAMINATION: Focus on your observations and impressions. This part of the report should focus on your objective assessment. Avoid quoting the patient's opinion on his own mood, influence, etc. It is also best to avoid mixing in basic information or test information with this part. A typical MSE for a 'normal' patient could read: The results of a mental state examination revealed a record of an attentive individual who showed no signs of excessive distractibility and watched the conversation well. The patient was casually dressed and groomed. Orientation was intact for person, time and place. Eye contact was appropriate. There was no abnormality of gait, posture or deportation. Speech functions were suitable for speed, volume, prosody and fluency, without evidence of paraphasic errors. Vocabulary and grammar skills indicated intellectual functioning within the average range. The patient's attitude was open and cooperative. His mood was euthymic. The effect was suitable for verbal content and showed a wide range. The memory functions were grossly intact with respect to immediate and remote downloads of events and de facto information. His thought process was intact, purposefully oriented and well organized. The thought content revealed no signs of delusions, paranoia or suicidal/murderous thoughts. There were no signs of impaired perception. His level of personal insight seems to be good, as evidenced by his ability to present his current diagnosis ability to identify specific stressors with precipitated simultaneous exacerbation. Social judgment seemed to be good, as evidenced by appropriate interactions with staff and other patients in the ward and cooperative efforts to achieve the treatment goals needed for discharge. EVALUATION RESULTS: There are several models for writing test reports. A hypothesis testing model is recommended for most MSH evaluations. In this model, the results are focused on possible answers to questions of recommendations(questions). The aim is to present the hypothesis in the SECTION PURPOSE FOR EVALUATION, then systematically present data to support or refute the hypothesis. Separate paragraphs in the EVALUATION RESULTS section deal with theoretical/ conceptual issues by integrating data from history, mental health testing and behavioral observation with data from all tests. Specific tests are rarely listed by name. For example, information from scale 2 to MMPI-2 can be combined with interpretive data from the MCMI-III dysthymia scale. If the integration of this information is consistent with the history and examination of mental state, it is included in the paragraph dealing with depression. The strength of this model lies in its effectiveness and brief focus on referral problem. The reader is not distracted by unrelated details. The primary weakness of the model is that you do not have to report some information that is not related to THE EVALUATION PURPOSE, but that could potentially be useful for other disciplines. SUMMARY/RECOMMENDATION: Start by specifically answering the questions you have asked in the EVALUATION PURPOSE section. Then elaborate as much as it takes to present your conceptualization of the case. It is ok to include diagnostic impressions of DSM, but your summary of the psychological composition of the patient is much more important. If you specify DSM labels, make sure that you have provided enough detail in the report text to support diagnostic criteria as described in dsm. Any recommendation for treatment can also go here. For example: The results of the psychological evaluation reveal an extended history of alcohol abuse and psychotic disorders characterized primarily by disruption of thought content, relative integrity of the thought process and no clear indication of perception of the disorder. The current clinical presentation seems to represent an acute exacerbation of a chronic psychotic disorder that had its onset approximately 8 years ago. At the moment, Mr Jones seems to remain very desperate, anxious, paranoid and deceptive, despite self-reports to the contrary. It lacks sufficient capacity/motivation to rely on external supports and lacks sufficient personal insight to cope independently at present. It seems that the patient is trying to cope with his disease with the help of extreme guarding and withdrawal. In recent months, he has shown no signs of aggressive thoughts and is not considered a physical risk to himself or others It is recommended that efforts to establish a trusting relationship with this patient continue to help him cultivate a more adaptable coping/defensive formula. Individual therapy will be more productive than group interventions. Once his guarding is released, it will probably be beneficial to examine the psychosocial problems present at the time Mr. Jones lost his job, as they seem to have partially accelerated the current psychotic exacerbation. In addition, the patient will benefit from encouragement to explore the social and adaptive importance of his substance abuse history. Please let me know if further information is needed regarding the results of this evaluation. _____ ____ ___