**The University of Texas at Arlington**

**College of Nursing and Health Innovation**

**N5424 Psychiatric Mental Health Nursing**

**Fall 2015**

**Instructor(s):**

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| **Diane Snow, PhD, RN, PMHNP-BC, FAANP, FIAAN**  ***Clinical Professor***  Director, PMHNP Program  Office Number: Pickard Hall Rm. # 627  Office Phone: (817) 272-7087  Office Hours: By Appointment  E-mail: [snow@uta.edu](mailto:snow@uta.edu)  Faculty Profile: <https://www.uta.edu/mentis/profile/?357> |
| **Carol Lieser, PhD, RN, PMHNP-BC, MTS, OFS**  ***Assistant Clinical Professor***  Office Number: Pickard Hall Rm. # 617  Office Phone : (817) 272-2776  Office Hours: By Appointment  Email : [clieser@uta.edu](mailto:clieser@uta.edu)  Faculty Profile: <https://www.uta.edu/mentis/profile/?2801> |
| **Linda Trowbridge, MSN, RN, PMHNP-BC**  ***Clinical Instructor***  Office Number: Pickard Hall, Rm. # 626  Office hours: By appointment  Email: [lstrowbridge@uta.edu](mailto:lstrowbridge@uta.edu)  Faculty profile: TBA |
| **Debra Lamont, MSN, RN, PMHNP-BC**  ***Clinical Instructor***  Office Number: Pickard Hall, Rm. #626  Office Hours: By appointment  Email:[drlamont@uta.edu](mailto:drlamont@uta.edu)  Faculty Profile: TBA  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Jason Smith, MSN, RN, PMHNP-BC**  ***Clinical Instructor***  Office Number: Pickard Hall, Rm. #626  Office Hours: By appointment  Email: [Jason.smith@uta.edu](mailto:Jason.smith@uta.edu)  Faculty Profile: <https://www.uta.edu/profiles/jason-smith-4151>  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Shari Scott, PhD, RN, PMHNP-BC, LMFT-S, LPC-S**  ***Assistant Clinical Professor***  Office Number: Pickard Hall, Rm. #626  Office Hours: By appointment  Email: shari.scott@uta.edu  Faculty Profile: TBA  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Linda Bett, DNP, RN, PMHNP-BC**  ***Assistant Clinical Professor***  Office Number: Pickard Hall, Rm. #626  Office Hours: By appointment  Email: [Linda.bett@uta.edu](mailto:Linda.bett@uta.edu)  Faculty Profile: TBA  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section Information:** NURS 5424 Sections 001-009

**Time and Place of Class Meetings:** Pickard Hall Room #223, Wednesdays 10am-4pm

Breakout rooms 549 A, 212, and 549 (except first class)

**Description of Course Content:** Advanced clinical management of individuals, families, and groups at risk for and experiencing acute and chronic psychiatric disorders.

**Student Learning Outcomes:** Upon completion of the course, the student will be able to:

1. Diagnose individuals with less complex acute and chronic psychiatric disorders, integrating neurobiological and psychosocial theories.
2. Use individual and group therapies to promote health and prevent illness for individuals and families.
3. Provide individual, group, and family therapies in the treatment of less complex acute and chronic psychiatric disorders.
4. Provide culturally, spiritually, ethnicity, age, gender, and sexual orientation sensitive mental health care in populations with less complex acute and chronic psychiatric disorders.
5. Use evidence based psychopharmacological and non-pharmacological interventions in the management of less complex acute and chronic psychiatric disorders.

**Required Textbooks and Other Course Materials:**

1. American Psychiatric Association, (2013). *Diagnostic and Statistical Manual of Mental*

*Disorders (DSM-5).* (5th ed.). Washington, DC: American Psychiatric Association **ISBN:**

**9780890425558**

1. Nichols, M. (2012) *Family Therapy: Concepts and Methods*. (10th ed.). Allyn & Bacon, Inc. **ISBN: 9780205827190**
2. Sadock, B. and Sadock, V. (2014). *Kaplan and Sadock's Synopsis of Psychiatry.* (11th ed.). Philadelphia: Lippincott Williams &Wilkins. **ISBN:**
3. Stahl, S. (2013). *Stahl’s Essential Psychopharmacology*: *Neuroscientific Basis and Practical Applications.* (4th ed.). Cambridge: Cambridge University Press **ISBN: 9781107686465**
4. Corey, G. (2012). *Theory and Practice of Counseling and Psychotherapy*. (9th ed.). Cengage Learning. **ISBN:** **9780840028549**
5. Wheeler, K. . *Psychotherapy for the Advanced Practice Psychiatric Nurse*.(2nd ed)Springer Publishing Company. **ISBN: 9780826110008**
6. Corey, MS, Corey, G and Corey, C. (2013). *Groups: Process and Practice*. (9th ed.). Cengage Learning. **ISBN: 9781133945468**
7. Stahl, S. *Prescriber’s Guide,* (5th ed.), Cambridge University Press. **ISBN: 9781107675025**
8. Stein, B.J, Lerer, B & Stahl, S.M. (2012) *Essential Evidence-Based Psychopharmacology.* (2nd ed.). Cambridge University Press. **ISBN: 9781107400108**

**Recommended:**

1. Zimmerman. *Interview Guide for Evaluating DSM-5 Psychiatric Disorders & the Mental Status.* Psych Products Press. **ISBN: 9780963382115**
2. Linehan, M. (1993). *Skills Training Manual for Treating Borderline Personality Disorder.* New York: The Guilford Press **IBSN: 9780898620344**
3. Hamkins, S. (2014) The Art of Narrative Psychiatry. New York: Oxford. ISBN : 9780199982042
4. Carlat. *Psychiatric Interview* (3rd ed.). Lippincott Williams & Wilkins. **ISBN: 9781451110197**
5. Burdick. *Mindfulness Skills Workbook for Clinicians & Clients.* CMI. **ISBN: 9781936128457**

**Descriptions of major assignments and examinations with due dates (Subject to change)**

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| **Description** | **Percentage/ P/F** | | **Due Date** | |
| 1. Preceptor Evaluations –med management | Pass/ Fail | | 12/2/15 | |
| 1. Preceptor Evaluation-therapy | Pass/ Fail | | 12/2/15 | |
| 1. Clinical Notebook | Pass/ Fail | | 10/28 and 12/2/15 | |
| 1. Final Clinical Practicum (includes SOAP note due in 48 hr) | 10% | | TBD | |
| 1. SOAP Notes (1) | 5% | | 10/21/15 | |
| 1. CDM (2) | 20% | | 9/18 and 11/18 | |
| 1. Test #1 | 12.5% | | 9/23/15 | |
| 1. Test #2 | 12.5% | | 10/21/15 | |
| 1. Therapy Presentations & discussion | 10% | | 9/16, 9/30, 10/14,11/4,11/18\* | |
| 1. Final Exam (comprehensive) | 15% | | 12/14/15 | |
| 1. Moment therapy map 2. Caltura video presentation | 2.5%  2.5% | | 11/9  10/5 | |
| 1. Family case study | 5% | | 11/25 | |
| 1. Participation class & Blackboard 2. Diff. diagnosis, medication quizzes | Pass/ Fail  5% | | (online the weekend before class or in class-see calendar) Open book, but individual work 9/16, 9/30, 10/14, 11/4, 11/18 \* | |
| \*one of the 5 grades may be dropped if student so chooses | **100%** | |  | |

**Attendance Policy: Attendance:** At the University of Texas at Arlington, taking attendance is not required. Rather, each faculty member is free to develop his or her own methods of evaluating students’ academic performance, which includes establishing course-specific policies on attendance. As the instructor of this course, **a graded activity will occur at each class, and attendance is expected.** *See grading criteria for details.*

**Other Requirements:** Prerequisite: NURS 5303; NURS 5305 or concurrent enrollment, or Certificate Program Standing. You will meet before or after class 2-3 times for “clinical supervision” related to your therapy experiences, which counts as clinical time, with your clinical advisor; some classes may be scheduled to end ½ to 1 hour past 4pm; 3 online tests on non-class days; most assignments are due on non-class days; online discussion on blackboard for several assignments with your clinical group; lectures posted before class day to be viewed/listened to before class.

**Respondus: Using LockDown Browser for Online Exams**

This course requires the use of LockDown Browser and an external webcam for online exams. Click on link on face page of Blackboard and watch the video and then install respondus to your computer desktop. You will need to use a webcam to scan your student id card and to scan your environment before taking the exam and so must purchase a webcam if your computer does not have an internal webcam.

To take an online test, start LockDown Browser and navigate to the exam. (You won’t be able to access the exam with a standard web browser.)

For additional details on using LockDown Browser, Contact Bb support or the HELP desk for any questions about this browser.

Finally, when taking an online exam, follow these guidelines:

* Ensure you’re in a location where you won’t be interrupted
* Turn off all mobile devices, phones, etc.
* Clear your desk of all external materials — books, papers, other computers, or devices
* Remain at your desk or workstation for the duration of the test
* LockDown Browser will prevent you from accessing other websites or applications; you will be unable to exit the test until all questions are completed and submitted
* Scan your student id card for identification purposes and scan the environment of the area where you are taking the exam.
* You will then be automatically sent to Bb and to the test. No password is required.

**Grading Policy:** Students are expected to keep track of their performance throughout the semester and seek guidance from available sources (including the instructor) if their performance drops below satisfactory levels.

Course Grading Scale

A = 92 to 100

B = 83 to 91

C = 74 to 82

D = 68 to 73 – cannot progress

F = below 68 – cannot progress

**Grade Grievances**: Any appeal of a grade in this course must follow the procedures and deadlines for grade-related grievances as published in the current University Catalog at <http://catalog.uta.edu/academicregulations/grades/#graduatetext>.

**Make-up Exams:** Contact your instructor for details.

**Test Reviews:** Contact faculty for instructions.

**Expectations of Out-of-Class Study:** Beyond the time required to attend each class meeting, students enrolled in this course should expect to spend at least an additional 9 hours per week on their own time in course-related activities, including reading required materials, completing assignments, preparing for exams, etc.

**CONHI - language**

**Drop Policy:** Graduate students who wish to change a schedule by either dropping or adding a course must first consult with their Graduate Advisor. Regulations pertaining to adding or dropping courses are described below. Adds and drops may be made through late registration either on the Web at MyMav or in person through the student’s academic department. Drops can continue through a point two-thirds of the way through the term or session. It is the student's responsibility to officially withdraw if they do not plan to attend after registering. **Students will not be automatically dropped for non-attendance**. Repayment of certain types of financial aid administered through the University may be required as the result of dropping classes or withdrawing. Contact the Office of Financial Aid and Scholarships at <http://www.uta.edu/fao/>  .  The last day to drop a course is listed in the Academic Calendar available at <http://www.uta.edu/uta/acadcal.php?session=20146>

1.      A student may not add a course after the end of late registration.

2.      A student dropping a graduate course after the Census Date but on or before the last day to drop may, receive a grade of W. Students dropping a course must:

(a)  Contact your graduate advisor to obtain the drop form and further instructions before the last day to drop.

**Census Day: September 14, 2015**

**Last day to drop or withdraw November 4, 2015 by 4:00 p.m.**

**Americans with Disabilities Act:** The University of Texas at Arlington is on record as being committed to both the spirit and letter of all federal equal opportunity legislation, including the *Americans with Disabilities Act (ADA)*. All instructors at UT Arlington are required by law to provide "reasonable accommodations" to students with disabilities, so as not to discriminate on the basis of that disability. Any student requiring an accommodation for this course must provide the instructor with official documentation in the form of a letter certified by the staff in the Office for Students with Disabilities, University Hall 102. Only those students who have officially documented a need for an accommodation will have their request honored. Information regarding diagnostic criteria and policies for obtaining disability-based academic accommodations can be found at [www.uta.edu/disability](http://www.uta.edu/disability) or by calling the Office for Students with Disabilities at (817) 272-3364.

**Title IX:** The University of Texas at Arlington does not discriminate on the basis of race, color, national origin, religion, age, gender, sexual orientation, disabilities, genetic information, and/or veteran status in its educational programs or activities it operates. For more information, visit [*uta.edu/eos*](http://www.uta.edu/hr/eos/index.php). For information regarding Title IX, visit [*uta.edu/titleIX*](http://www.uta.edu/titleix/)

**Academic Integrity:**  All students enrolled in this course are expected to adhere to the UT Arlington Honor Code:

*I pledge, on my honor, to uphold UT Arlington’s tradition of academic integrity, a tradition that values hard work and honest effort in the pursuit of academic excellence.*

*I promise that I will submit only work that I personally create or contribute to group collaborations, and I will appropriately reference any work from other sources. I will follow the highest standards of integrity and uphold the spirit of the Honor Code.*

UT Arlington faculty members may employ the Honor Code as they see fit in their courses, including (but not limited to) having students acknowledge the honor code as part of an examination or requiring students to incorporate the honor code into any work submitted.

Per UT System Regents’ Rule 50101, §2.2, suspected violations of university’s standards for academic integrity (including the Honor Code) will be referred to the Office of Student Conduct. Violators will be disciplined in accordance with the University policy, which may result in the student’s suspension or expulsion from the University.

"Scholastic dishonesty includes but is not limited to cheating, plagiarism, collusion, the submission for credit of any work or materials that are attributable in whole or in part to another person, taking an examination for another person, any act designed to give unfair advantage to a student or the attempt to commit such acts."

As a licensed registered nurse, graduate students are expected to demonstrate professional conduct as set forth in the Texas Board of Nursing rule **§215.8. in the event that a graduate student holding an RN license is found to have engaged in academic dishonesty, the college may report the nurse to the Texas BON using rule §215.8 as a guide.**

**Plagiarism:** Copying another student’s paper or any portion of it is plagiarism. Copying a portion of published material (e.g., books or journals) without adequately documenting the source is plagiarism. Consistent with APA format, **if five or more words in sequence are taken from a source**, those words must be placed in quotes and the source referenced with author’s name, date of publication, and page number of publication. If the author’s ideas are rephrased, by transposing words or expressing the same idea using different words, the idea must be attributed to the author by proper referencing giving the author’s name and date of publication. If a single author’s ideas are discussed in more than one paragraph, the author must be referenced, according to APA format. Authors whose words or ideas have been used in the preparation of a paper must be listed in the references cited at the end of the paper. Students are expected to review the plagiarism module from the UT Arlington Central Library via <http://library.uta.edu/plagiarism/index.html>

**Student Support Services**: UT Arlington provides a variety of resources and programs designed to help students develop academic skills, deal with personal situations, and better understand concepts and information related to their courses. Resources include tutoring, major-based learning centers, developmental education, advising and mentoring, personal counseling, and federally funded programs. For individualized referrals, students may visit the reception desk at University College (Ransom Hall), call the Maverick Resource Hotline at 817-272-6107, send a message to [resources@uta.edu](mailto:resources@uta.edu), or view the information at [www.uta.edu/resources](http://www.uta.edu/resources).

**The English Writing Center (411LIBR)**: Hours are 9 am to 8 pm Mondays-Thursdays, 9 am to 3 pm Fridays and Noon to 5 pm Saturdays and Sundays. Walk In ***Quick Hits*** sessions during all open hours Mon-Thurs. Register and make appointments online at [http://uta.mywconline.com](http://uta.mywconline.com/). Classroom Visits, Workshops, and advanced services for graduate students and faculty are also available. Please see [www.uta.edu/owl](http://www.uta.edu/owl) for detailed information.

**Student Success Faculty:** In order to assist masters nursing students who are at academic risk or who need academic support, there are graduate faculty members available to you. The goal of the success faculty members is to support student achievement in masters-level coursework so students can reach their educational goals. Students may contact a success faculty member directly, or a course instructor may encourage you to contact a success faculty member.

The success faculty in the MSN Program:

Dr. Donelle Barnes is available as a writing coach to assist students in the MSN Core courses; theory, research, and evidence based practice. Since these courses are writing intensive, Dr. Barnes can help students improve the clarity and organization of their written papers. She can be reached via email: [donelle@uta.edu](mailto:donelle@uta.edu).

Dr. Mary Schira is available as a success faculty to assist with diverse resources that may include study skills, testing challenges/approaches, managing multiple responsibilities, and addressing personal issues impacting academic performance.   Course content challenges may also be addressed, with referral to additional resources as indicated.  Dr. Schira can be reached via email:  [schira@uta.edu](mailto:schira@uta.edu).

**Electronic Communication:** UT Arlington has adopted MavMail as its official means to communicate with students about important deadlines and events, as well as to transact university-related business regarding financial aid, tuition, grades, graduation, etc. **All students are assigned a MavMail account and are responsible for checking the inbox regularly.** There is no additional charge to students for using this account, which remains active even after graduation. Information about activating and using MavMail is available at <http://www.uta.edu/oit/cs/email/mavmail.php>.

If you are unable to resolve your issue contact the Helpdesk at [helpdesk@uta.edu](mailto:helpdesk@uta.edu).

**Student Feedback Survey:** At the end of each term, students enrolled in classes categorized as lecture, seminar, or laboratory shall be directed to complete a Student Feedback Survey (SFS). Instructions on how to access the SFS for this course will be sent directly to each student through MavMail approximately 10 days before the end of the term. Each student’s feedback enters the SFS database anonymously and is aggregated with that of other students enrolled in the course. UT Arlington’s effort to solicit, gather, tabulate, and publish student feedback is required by state law; students are strongly urged to participate. For more information, visit <http://www.uta.edu/sfs>.

**Final Review Week:** A period of five class days prior to the first day of final examinations in the long sessions shall be designated as Final Review Week. The purpose of this week is to allow students sufficient time to prepare for final examinations. During this week, there shall be no scheduled activities such as required field trips or performances; and no instructor shall assign any themes, research problems or exercises of similar scope that have a completion date during or following this week *unless specified in the class syllabus*. During Final Review Week, an instructor shall not give any examinations constituting 10% or more of the final grade, except makeup tests and laboratory examinations. In addition, no instructor shall give any portion of the final examination during Final Review Week. During this week, classes are held as scheduled. In addition, instructors are not required to limit content to topics that have been previously covered; they may introduce new concepts as appropriate.

**Emergency Exit Procedures:** Should we experience an emergency event that requires us to vacate the building, students should exit the room and move toward the nearest exit. When exiting the building during an emergency, one should never take an elevator but should use the stairwells. Faculty members and instructional staff will assist students in selecting the safest route for evacuation and will make arrangements to assist individuals with disabilities.

**Librarian to Contact:**

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| Peace Williamson – 817-272-6208  [peace@uta.edu](mailto:peace@uta.edu) | Lydia Pyburn – 817-272-7593  [llpyburn@uta.edu](mailto:llpyburn@uta.edu) | Heather Scalf - 817-272-7436 |

Research Information on Nursing:

[**http://libguides.uta.edu/nursing**](http://libguides.uta.edu/nursing)

Library Home Page <http://www.uta.edu/library>

Subject Guides <http://libguides.uta.edu>

Subject Librarians <http://www.uta.edu/library/help/subject-librarians.php>

Database List <http://www.uta.edu/library/databases/index.php>

Course Reserves <http://pulse.uta.edu/vwebv/enterCourseReserve.do>

Library Catalog <http://uta.summon.serialssolutions.com/#!/>

E-Journals <http://pulse.uta.edu/vwebv/searchSubject>

Library Tutorials <http://www.uta.edu/library/help/tutorials.php>

Connecting from Off- Campus <http://libguides.uta.edu/offcampus>

Ask A Librarian [http://ask.uta.edu](http://ask.uta.edu/)

The following URL houses a page where we have gathered many commonly used resources needed by students in online courses: <http://www.uta.edu/library/services/distance.php>.

The subject librarian for your area can work with you to build a customized course page to support your class if you wish. For examples, visit <http://libguides.uta.edu/os> and <http://libguides.uta.edu/pols2311fm> .

**UTA College of Nursing and Health Innovation - Additional Information:**

**Clinical Evaluations:** Students must pass both the didactic and clinical portions of a clinical course in order to pass the course. In order to pass the clinical portion, the student must receive a passing grade (minimum of 83%) on the faculty evaluation of the student’s clinical performance (Nurse Practitioner Clinical Evaluation). Students who fail a faculty evaluation have a one-time option to retake the practicum. A second faculty member will be present during the clinical performance retake. If the student passes the clinical performance retake (minimum of 83%), the **maximum** grade the student can receive for the exam for purposes of grade calculation is 83%. If the student fails the retake, the student will receive a grade of “F” for the course.

**Clinical Clearance**: All students must have current clinical clearance to legally perform clinical hours each semester. If your clinical clearance is not current, you will be unable to do clinical hours that are required for this course and this would result in course failure.

For Students with the last name beginning A-M, your clinical coordinator is Janyth Mauricio. She can be reached at [janyth.mauricio@uta.edu](mailto:janyth.mauricio@uta.edu).

For Students with the last name beginning N-Z, your clinical coordinator is Angel Korenek. She can be reached at [Angel.Korenek@uta.edu](mailto:Angel.Korenek@uta.edu).

**Student Requirement for Preceptor Agreements/Packets:**

1. Clinical verification forms are to be sent to your clinical coordinator **PRIOR** to doing any clinical hours for approval of your preceptor and your clinical site.
2. Preceptor agreements must be signed and dated by the student and the preceptor either prior **OR** on your first clinical day but absolutely **no later** than three weeks after the start of the course. (If you are starting your hours later in the semester make arrangements to have the agreement signed/dated within the specified timeframe). They must contain your 1000 number and your course number. Incomplete forms will be returned to the student. Please submit these to your clinical coordinator ([janyth.mauricio@uta.edu](mailto:janyth.mauricio@uta.edu) for letters A-M or [Angel.korenek@uta.edu](mailto:Angel.korenek@uta.edu) for letters N-Z) for approval. You may also send the forms to [npclinicalclearance@uta.edu](mailto:npclinicalclearance@uta.edu).
3. Due to the implementation of the Typhon system, all preceptors who are precepting graduate nursing students for The University of Texas at Arlington will need to complete a current Preceptor Biographical Data Sheet as well as a preceptor agreement.
4. The signed/completed agreement is part of the clinical clearance process. Failure to submit in a timely fashion will result in inability to do your clinical hours and denied access to the E-Logs and Typhon system.

**Clinical Electronic Logs**:

Students are required to enter all patient encounters into the Typhon Group Healthcare Solutions (“Typhon”) electronic log system.  Typhon is both a student learning opportunity and an evaluation method for clinical courses.  Patient encounters include patients the student assesses, diagnoses, and manages as part of their clinical coursework.  Individual clinical courses may have additional guidelines/requirements related to their specific course and will be noted in the course syllabus (e.g. types of encounter required, number of patients required during course).

Students can access their Typhon account by entering their own unique username and password which will be accessible their first clinical semester. During the student’s first clinical semester they will be emailed a link to Typhon along with a unique login username and password once a Clinical Verification Form has been submitted by the student and the preceptor and site are approved.

The student’s electronic log data provides a description of the patients managed during the student’s clinical experience, including the number of patients, diagnoses of patients, and the type of interventions initiated.  As a result, the data is an essential requirement of the student’s clinical experience and is used to evaluate student clinical performance.  The data is also used to meet course requirements and to evaluate student clinical performance.  Upon completion of the Program, students will have access to an executive summary of their log entries through Typhon for their professional portfolio.

**Students are expected to enter information accurately so that (if needed) faculty may verify/validate the information provided.  Falsifying and/or misrepresenting patient encounter data is considered academic dishonesty.**

**Typhon requires students to enter their clinical patient data within 7 days of their actual clinical day.**

**Status of RN Licensure:** All graduate nursing students must have an unencumbered license as designated by the Texas Board of Nursing (BON) to participate in graduate clinical nursing courses. It is also imperative that any student whose license becomes encumbered by the BON must immediately notify the Associate Dean, Department of Graduate Nursing. The complete policy about encumbered licenses is available online at: [www.bon.state.tx.us](http://www.bon.state.tx.us)

**MSN Graduate Student Dress Code:** The University of Texas at Arlington College of Nursing and Health Innovation expects students to reflect professionalism and maintain high standards of appearance and grooming in the clinical setting. **Clinical faculty has final judgment on the appropriateness of student attire and corrective action for dress code infractions. Students not complying with this policy will not be allowed to participate in clinical.**

Please View the College of Nursing and Health Innovation Student Dress Code on the nursing website:<http://www.uta.edu/nursing/msn/msn-students> **.**

**UTA Student Identification: MSN Students MUST be clearly identified as UTA Graduate Students and wear a UTA College of Nursing and Health Innovation ID in the clinical environment.**

**Unsafe Clinical Behaviors:** Students deemed unsafe or incompetent will fail the course and receive a course grade of “F”. **Any of the following behaviors constitute a clinical failure**:

1. Fails to follow standards of professional practice as detailed by the Texas Nursing Practice Act \* (available at [www.bon.state.tx.us](http://www.bon.state.tx.us))

2. Unable to accept and/or act on constructive feedback.

3. Needs continuous, specific, and detailed supervision for the expected course performance.

4. Unable to implement advanced clinical behaviors required by the course.

5. Fails to complete required clinical assignments.

6. Falsifies clinical hours.

7. Violates student confidentiality agreement.

\*Students should also be aware that violation of the Nursing Practice Act is a “reportable offense” to the Texas Board of Nurse Examiners.

**Blood and Body Fluids Exposure:** A Health Verification form was signed by all MSN students at start of the program documenting personal health insurance coverage. All MSN students have mandatory health insurance and will need to manage exposure to blood and fluids. Current CDC guidelines can be found at:<http://www.cdc.gov/>

**Ebola exposure**: Please inform your faculty if you have been in contact with anyone who has Ebola/have traveled to a country that has Ebola virus.

**Confidentiality Agreement:** You signed a Confidentiality Form in orientation and were provided a copy of the form. Please take your copy of this Confidentiality Form with you to your clinical sites. **Please do not sign** other agency confidentiality forms. Contact your faculty if the agency requires you to sign their confidentiality form.

**Graduate Student Handbook:** Students are responsible for knowing and complying with all policies and information contained in the Graduate Student handbook online at: <http://www.uta.edu/nursing/msn/msn-students>

**Student Code of Ethics:** The University of Texas at Arlington College of Nursing and Health Innovation supports the Student Code of Ethics Policy. Students are responsible for knowing and complying with the Code. The Code can be found in the student handbook online: <http://www.uta.edu/nursing/msn/msn-students>

**No Gift Policy:** In accordance with Regent Rules and Regulations and the UTA Standards of Conduct, the College of Nursing and Health Innovation has a “no gift” policy. A donation to one of the UTA College of Nursing and Health Innovation Scholarship Funds, found at the following link: is <http://www.uta.edu/nursing/student-resources/scholarship> would be an appropriate way to recognize a faculty member’s contribution to your learning.  For information regarding Scholarship Funds, please contact the Dean’s office.

**Online Conduct:** The discussion board should be viewed as a public and professional forum for course-related discussions. Students are free to discuss academic matters and consult one another regarding academic resources. The tone of postings should be professional in nature.

It is not appropriate to post statements of a personal or political nature, or statements criticizing classmates or faculty. Inappropriate statements/language will be deleted by the course faculty and may result in denied access to the Discussion boards. Refer to UTA CONHI Student Handbook for more information.

***For this course Blackboard communication tools, discussion boards, and UTA MAV email will be used extensively and should be checked often.***

**Graduate Nursing Support Staff**

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| --- | --- |
| **Judy LeFlore, PhD, RN, NNP-BC, CPNP-PC & AC, ANEF, FAAN**  Interim Associate Dean  Graduate Nursing Programs  Director, PNP, ACPNP, NNP Programs  Pickard Hall Office #518  Email address:  [jleflore@uta.edu](mailto:jleflore@uta.edu) | **Kathy Daniel, PhD, RN, ANP/GNP-BC, AGSF**  Associate Chair, Graduate Nurse Practitioner Programs  Pickard Hall Office #615  817-272-0175  Email address: [kdaniel@uta.edu](mailto:kdaniel@uta.edu) |
| **Rose Olivier** , Administrative Assistant I  Pickard Hall Office # 605  (817) 272-9517  Email address: [olivier@uta.edu](mailto:olivier@uta.edu) | **Kim Doubrava (Hodges),** Support Specialist II  Pickard Hall Office #612  (817) 272-9373  Email address: [khodges@uta.edu](mailto:khodges@uta.edu) or [npclinicalclearance@uta.edu](mailto:npclinicalclearance@uta.edu) |
| **Janyth Mauricio (Arbeau),** Clinical Coordinator  Pickard Hall Office # 610  (817) 272-0788  Email address: [janyth.mauricio@uta.edu](mailto:janyth.mauricio@uta.edu) or  [npclinicalclearance@uta.edu](mailto:npclinicalclearance@uta.edu) | **Angel Trevino-Korenek,** Clinical Coordinator  Pickard Hall Office # 610  (817) 272-6344  Email address: [angel.korenek@uta.edu](mailto:angel.korenek@uta.edu) |

|  |  |
| --- | --- |
| **Graduate Advisors:** | |
| **Campus-based Programs:**  **NP Students with last Name A-L and Post MSN Certificate NP Program Students:**  Sheri Decker  Graduate Advisor III  Pickard Hall Office # 611  (817) 272-0829  Email: [s.decker@uta.edu](mailto:s.decker@uta.edu) | **Campus-based Programs:**  **NP Students with Last Name M-Z and ALL NNP Program Students:**  Luena Wilson  Graduate Advisor I  Pickard Hall Office # 613  (817) 272- 4798  Email: [lvwilson@uta.edu](mailto:lvwilson@uta.edu) |

**Course Schedule.** *As the instructor for this course, I reserve the right to adjust this schedule in any way that serves the educational needs of the students enrolled in this course. –Diane Snow.*

**The University of Texas at Arlington College of Nursing**

**N5424 Psychiatric Mental Health Nursing I**

**Fall 2015**

**Room 223**

**This calendar is subject to change. Diane Snow**

| **Date/Time** | **Topic** | **Readings Assignments\*** | | | **Speaker** |
| --- | --- | --- | --- | --- | --- |
| **Monday**  **8/31/2015** | **Lectures posted: Overview of individual therapies; intro to Group therapy. Making accurate DSM 5 diagnosis**  **Role of PMHNP** | Corey and Corey  Corey : Group chap 1-3 | | |  |
| **Wednesday**  **9/2/2015**  **Class 1**  **10am-4pm** | **Course Overview and introductions** |  | | |  |
| **10-11 am** | **Syllabus and Introductions** |  | | |  |
| **11-11: 40** | **Boundaries/transference/ counter transference issues/self-disclosure/self-awareness/role of therapy in PMHNP practice; ethics of therapy.** | Blackboard. Articles  Scope and Standards of Psychiatric Nursing (see ANA/APNA to order)  Powerpoint on Blackboard  Wheeler, Chapter 1  Sadock: relevant chapters | | | Diane, Linda T, Carol, Debra, Jason, Linda B, Shari |
| **11: 40- 12:30pm** | Make an accurate DSM 5 diagnosis workshop | DSM-5 –specifiers, rules of precedence, multiple diagnoses, V codes  Bring DSM-5  Read DSM 5 for rules of precedence, specifiers, V codes, etc. anxiety, mood, psychosis, addiction, dementia specifiers and course of illness, etc  (small group work ) | | |  |
| **12:30 – 1pm** | lunch | Faculty provides | | |  |
| **1:00-2:15pm** | Solution Focused Therapy | Corey, p. 433-35  Sadock & Sadock, relevant chapters  Nichols Chapter 6,7  Readings on Blackboard. | | | Jeanneane Keene, MSN, RN |
| **2:30-4pm** | **Group therapy- principles, ice breakers, starting and ending a session; types of groups, curative factors; confidentiality; multifamily groups**  **(in CLINICAL GROUPS)**  **Assign topics for therapy presentations** | Corey and Corey (Group Therapy): Chapter 1-3  Corey on group therapy  Sadock and Sadock on group therapy  You Tube  <https://www.youtube.com/watch?v=PwnfWMNbg48>  Irving Yalom and group therapy  <https://www.youtube.com/watch?v=XYc_APlH7VY>  This covers using REBT in a group  <https://www.youtube.com/watch?v=cV3IzZDDuAQ>  This covers Reality Therapy (see Cory)  <https://www.youtube.com/watch?v=Le8tEIHD_hk>  This talks about common mistakes in conducting group therapy  <https://www.youtube.com/watch?v=EYHthbg1nmY>  This gives an example of doing a go around and working with one person in group  <https://www.youtube.com/watch?v=ziPuilrd4Xs>  This talks about the gestalt concept of unfinished business    **Powerpoint on course materials** | | | Diane, Linda. Carol, Debra, Jason, Linda B and Shari  (in small groups) |
| **Friday 9/4/2015** | **CDM I open: (under tests in blackboard)**  **Due 9/18** |  | | |  |
| **Monday**  **9/14/2015** | **Lectures posted: intro to family therapy; strategies of group therapy; CBT: case conceptualization, setting agenda, making homework assignments; REBT, antidepressants** |  | | |  |
| **Wednesday**  **9/ 16/ 2014**  **Class 2**  **10- 10:45** | **Depression Case Study / Differential Diagnosis and Pharmacology Decision Making**  **Quiz #1**  **(you are asked to write differential diagnosis on each quiz and determine medication to start and then next step to add or change)** | **Review depression DSM5 diagnoses, antidepressants (side effects, drug/ drug interactions, starting doses, pharmacokinetics, neurotransmitters and decision making**  **Stahl: Evidence based psychopharm**  **Stahl: Prescribers Guide**  **Stahl: Essential Psychopharmacology**  **Power point lecture posted on antidepressants** | | | If online will be posted on blackboard Friday, Sat and Sunday before class.9/ 11. You have 1 to 1::30 miinutes |
| **11am-12:30pm** | **Psychodynamic Experiential Group Therapy** | **Review Corey: CBT, Sadock: CBT, readings on course materials, you tube** | | | Barbara Warren, LPC  TBC |
| **12:30-1pm** | **lunch** | **Students provide: ( 10 students) –optional** | | |  |
| **1:00-4pm** | **Depression Therapy & Graded Discussion of Evidence Based Non-pharmacological Treatment (therapy, etc)** | Be prepared to discuss and demonstrate which therapies would be appropriate for Depression Case Study.  Strategies will focus on their use in depression (be prepared)  1. Light therapy/ exercise and mood  2. Mood diaries and journaling  3. Interpersonal therapy  4. Behavioral activation  5. Psychoeducational manualized treatment  6. Mindfulness therapy for depression  7. CBT  8. REBT  Presented in groups up to 12 studnets | | |  |
| **Friday**  **9/18/2015** | **CDM #1 Due on blackboard.** |  | | |  |
| **Wednesday 9/23/2015** | **Test 1-Online quiz on blackboard**  **Test is open 7am to 11:59 pm** | Test blueprint –See blackboard | | |  |
| **Monday 9/28/2015** | **Lecture posted ahead: DBT ; Family Therapy structural and strategic; group therapy strategies; Anxiety Therapies** |  | | |  |
| **Wednesday 9/30/2015** | **Class 3** |  | | |  |
| **10-11:30am** | **Personality Disorders** | Sadock and Sadock  DSM 5: 10 Personality Disorders | | | Howard Cohen, MD  TBC |
| **11:30- 12** | **Lunch** | (may move to online weekend before : TBA) | | |  |
| **12-1 pm** | **Anxiety Case Study : Differential Diagnosis and Pharmacology Decision Making**  **Quiz #2** | Power point on course materials.  Review: SSRIs/ SNRIs, benzodiazepines, anticonvulsants used for anxiety  Review in Sadock, and pharm books,etc  Study DSM 5 differential diagnosis for anxiety/ trauma/ OC disorders | | | May move to online open book test weekend before =TBA |
| **1:00- 2 pm** | **Family Therapy (narrative family therapy )** | Review Nichols, Family Therapy, Corey, powerpoints and lectures on blackboard | | | Shari Scott, APRN, PMHNP, PhD |
| **2-4pm** | **Anxiety/OC/Trauma Therapy & Graded Discussion of Evidence Based Non-pharmacological Treatment (therapy, etc)**  **Clinical Groups** | Be prepared to discuss and demonstrate which therapies would be appropriate for Anxiety/OC/Trauma Case Study.  Strategies will focus on their use in anxiety/trauma/OC (be prepared)   1. Exposure response prevention 2. CBT 3. DBT   4. Psychoeducational manualized treatment  5. Mindfulness therapy for anxiety  6.Relaxation & imagery  7. Habit reversal training  8. EMDR | | |  |
|  |  | |  |
| **Monday**  **10/05/15** | **Kaltura video due, post on blackboard** |  | | |  |
|  |  |  | | |  |
| **Monday 10/12/15** | **Lecture posted: Social Rhythm therapy for Bipolar Disorder, Family focused therapy for bipolar disorder, Therapies for patients with schizophrenia** |  | | |  |
| **Wednesday**  **10/14/15**  **Class 4**  **Bipolar and Schizophrenia** | **Clinical notebooks-can send electronically by 7am, or bring to class.** |  | | |  |
| **9:00-11am** | **EMDR- Psychodrama**  **Note time!** | Wheeler, EMDR | | | Janice Imming Rogers  Confirmed |
| **11-12:30** | **Personality Disorders** | Sadock chapter and DSM 5 | | | Dr. Howard Cohen, MD |
|  | **Bipolar/Psychosis Case Study Differential Diagnosis and Pharmacology Decision Making**  **Quiz #3** | DSM 5 diagnoses for bipolar disorders, schizoaffective and schizophrenia  Evidence based medications to treat  (See power point on medications on course materials) Review antipsychotics, lithium, anticonvulsants. | | | ONLINE 10/ 9-10-11 |
| **12:30-1:30pm** | **DBT** | Linehan, Corey, Sadock, power point and  YouTube | | | Marcus Greenwood,,  confirmed |
| **1:45-4pm** | **Bipolar/Schizoaffective/Schizophrenia Therapy & Graded Discussion of Evidence Based Non-pharmacological Treatment (therapy, etc)**  **Clinical Groups** | Voice Over Power Point  Sadock and Sadock  Articles  SP demonstration of bipolar disorder (TBD) | | |  |
| **Wednesday**  **10/28/15**  **No class** | **SOAP #1 due**  **Post on blackboard** |  | | |  |
| **Wednesday**  **10/21/2015** | **Test 2 on Blackboard, no class**  **Open 7a to 11:59** | Test Blueprint on Blackboard discussion board | | |  |
|  |  |  | | |  |
| **Wednesday**  **11/04/2015** | **CDM 2 posted-Due 11/18/15** |  | | |  |
| **Monday**  **11/9/2015** | **TMM due on blackboard discussion board by group. Lead discussion x 1 week.**  **11/9-11/15** |  | | |  |
| **Monday 11/2/2015** | **Lectures posted on Addiction therapies: transgenerational Family Therapy; addicted family; Motivational Interviewing, Eating disorder- therapies** |  | | |  |
| **Wednesday11/4/2015**  **Class 5** | **Addiction and Eating Disorder**  **Therapies** |  | | |  |
| **10- 11:30** | **Trauma /Addiction and EMDR** | EMDR readings and youtubes | | | Debbie Dunbar, LMSW, |
| **11:30-12:30** | **Theory of Stress and Mindfulness** | Readings on blackboard | | | Lynn Kutler, RN, PhD student UTA CONHI  confirmed |
|  | **Addiction and Eating Disorder Case Study Differential Diagnosis and Pharmacology Decision Making**  **“ Quiz #3”** | DSM 5 diagnoses for substance use disorders and eating disorders  Evidence based medications to treat  (See power point on medications on course materials) Review Chantix, Suboxone, Naltrexone/Vivitrol, Antabuse, Campral, topiramate, SSRIs | | | Online will be available 11/ 6- 11/8  7 am to 11: 59pm  Open book test |
| **12:30-1:30 pm** | **Therapy with Eating Disorders** | Wheeler  Sadock  Corey | | | Shari Scott,, PhD, RN, PMHNP- BC, LPC, LMFT |
| **1:30 - 4pm** | **Addiction/Eating Disorder Therapy & Graded Discussion of Evidence Based Non-pharmacological Treatment (therapy, etc)**  **Clinical Groups**  **Addicted Family Demonstration** | Be prepared to discuss and demonstrate which therapies would be appropriate for Addiction and Eating Disorder Case Studies.  Strategies will focus on their use in substance use disorders and eating disorders (be prepared)   1. 12 step 2. Family therapy 3. Motivational interviewing/ SBIRT 4. Nutritional therapy   5.DBT  6. CBT | | |  |
| **Monday**  **11/16/2015** | **Lectures posted ahead: Bereavement therapy; ADHD therapies, Group therapy with children; Collaborative Parenting/Problem Solving** |  | | |  |
| **Wednesday**  **11/18/2015**  **Class 6** | **Age related therapies**  **Child and Geri Case Studies Differential Diagnosis and Pharmacology Decision Making**  **“ Quiz #5”** |  | | | online 11/13-11/15 . Open book test.. Must be your individual work. |
| **10-11** | **Collaborative Problem Solving/Collaborative Parenting** | **Materials on blackboard**  **Online Resources**  **Power point** | | | **Jesse Tucker, MSN, RN, PMHNP-BC**  **Confirmed** |
| **11:00-12:30pm** | **Child CBT and Play Therapy/Sand Therapy** | **Relevant chapters in Sadock, Corey**  **Online references** | | | Shari Scott, PhD,RN, PMHNP, LMFT-S |
| **1-4pm** | **Child and Geri Therapy and Graded Discussion of Evidence Based Non-pharmacological Treatment (therapy, etc)** | Be prepared to discuss and demonstrate which therapies would be appropriate for Child and Geri Case Studies.  Strategies will focus on their use in childhood disorders and geriatric disorders (be prepared) | | |  |
| **Wednesday**  **11/18/15** | **CDM II Due** |  | | |  |
| **Wednesday**  **11/25/15** | **Family Case Study due** | Post on assignment page and in clinical group page | | |  |
| **Wed**  **12/2/2015** | **Clinical notebooks due –send electronically. Typhon reports will be viewed by faculty online on this date** |  | | |  |
| **Monday**  **12/14/2015** | **Comprehensive Final Exam. Blackboard/online**  7am to 11:59pm |  | | |  |

**The University of Texas at Arlington College of Nursing**

**N5424 Psychiatric Mental Health Nursing I**

**Fall 2015**

**Therapy & Graded Discussion of Evidence Based Non-pharmacological Treatment (therapy, etc)**

**Classroom**

The purpose of this assignment is to determine and demonstrate the appropriate evidence based non pharmacological treatments (therapies, etc) for a case study “patient”. There are 5 main topics: depression, anxiety/OC/trauma, bipolar and schizophrenia, addiction and eating disorders, and age related (child and geri).

**Students Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Case Study Focus\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Intervention Strategy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Maximum Points Actual points**

1)The student  describes the therapeutic intervention/ therapy 5 \_\_\_\_\_\_\_  
         a) concepts of the therapy   
         b) neurobiological basis of the therapy (if relevant)  
         c) how change occurs using this therapy  
  
2)The student summarizes research of this therapy 10 \_\_\_\_\_\_\_

in treating \_\_\_\_\_\_\_\_\_   
         a) summarizes the application of the therapy to \_\_\_\_\_\_\_\_

         b) describes how the research supports its use

(e.g. metanalysis or Cochrane review or NIMH summary)  
         d) summarizes the studies comparing medication alone versus this therapy or combination (if relevant)

3) The student posts a tip sheet that covers ways 10 \_\_\_\_\_\_\_

to use the therapy with patients with \_\_\_\_\_

4) The student posts article related to use of the intervention 5 \_\_\_\_\_\_\_   
  
5) The student role plays an application of the 60 \_\_\_\_\_\_\_

therapy to the case study "patient"   
        a) Instruct the patient on the purpose of the intervention, if applicable.  
        b) Teach the patient about the proposed value and outcome of the intervention, if applicable  
        c) Use appropriate worksheets with the patient, if applicable   
        d)  Interact with the patient in therapeutic manner/building rapport/ using skills that demonstrate knowledge

of the therapy.  
        e.) Seek feedback from the patient regarding the outcome of the therapy strategy, if applicable

6) The student stimulates discussion and gives relevant feedback to peers about their presentations.

5 \_\_\_\_\_\_\_

7).The student keeps to time limits (20 minutes total) 5 \_\_\_\_\_\_\_

Total graded\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 100 \_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The University of Texas at Arlington College of Nursing**

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Student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Advisor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSIGNMENTS/GRADE SUMMARY**

**ASSIGNMENTS DUE DATE GRADE**

1. SOAP Notes (1 total) 10/21 5% \_\_\_\_\_
2. Clinical Decision Making (1) 9/18 10% \_\_\_\_\_
3. Clinical Decision Making (2) 11/18 10% \_\_\_\_\_\_
4. Preceptor Evaluations 12/02 Pass/Fail\_\_\_\_\_\_

Sites where spend 12 hrs or more are required (med man, psychotherapy)

1. Practicum Evaluation TBA 10%\_\_\_
2. Family Case Study online 11/25 5%\_\_\_\_\_\_
3. Clinical Notebook 10/28 / 12/2 Pass/Fail\_\_\_\_\_\_\_

(Objectives summarized, Typhon ready for review, Tally-signed by preceptors and updated grid-can be sent electronically; reflective journaling of therapy experience, preceptor agreements)

1. Evaluation of Preceptors/Faculty 12/2 Credit \_\_\_\_\_
2. Test 1 9/23 12.5% \_\_\_\_\_\_
3. Test 2 10/21 12.5% \_\_\_\_\_\_
4. Therapy & Graded Discussion (**2**) 9/16, 9/30, 10/14, 11/4, 11/18 10%\_\_\_\_\_\_

1. Diff. Diagnosis /medication quizzes**(5**) 9/16, 9/30, 10/14, 11/4, 11/18\* 5%\_\_\_\_\_\_
2. Comprehensive Final Exam 12/14 15% \_\_\_\_\_\_
3. Therapy Moment Mapping 11/9 2.5% \_\_\_\_\_

(lead discussion x 1 week)

1. Caltura Video Taping 10/5 2.5% \_\_\_\_\_

15. Blackboard, participation, classroom participation Pass/Fail \_\_\_\_\_

Respond to discussion of therapy moment mapping

Submitted by peers;

Classroom participation –come prepared for workshops

Respond to family case study by clinical group x1 post minimum

**FINAL COURSE GRADE:** 100% \_\_\_\_\_\_

\*one quiz grade can be dropped at student’s discretion **The University of Texas at Arlington College of Nursing**

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**Clinical Decision Making I and II Tip Sheet**

This assignment will be given on Blackboard under “quizzes” and questions and point values will be provided. General info on CDM will be found on facepage under Quizzes then find CDM I. Click on CDM I and there will be questions that appear. This is in a "quiz" format with several sections. Each section has information followed by questions to be answered. Read carefully, and respond to the specifics asked. You will see how much each question is worth. (written after the word Question)

APA and referencing: You will be asked to have at least one peer-reviewed article, and there may be other requested references besides your texts. Please reference using correct APA format. Also the DSM 5 should be referenced (author is American Psychiatric Association), and Zimmerman, etc. Please use articles and texts rather than class notes. Please remember as you make your responses that this CDM is a formal paper so use complete sentences unless otherwise specified.

Answering questions: Once you have answered a question, you must submit the answer prior to getting access to the next. You will not be able to go back to your questions once you click submit---**do not skip a question**, as you will not be able to go back to that question either.

Try and do several sections at the same time. If you click “save” you will be able to stop and start where you left off. As long as you do not move to the next question, you will be able to access the question you are working on. You CAN save your answer and go back to the question if you want to revise or add to before moving to next question. Just don't move on until you are certain you are finished with that question. You can cut and paste from a word file to the quiz, but can’t cut and paste from the quiz to word file. Another method of cut and pasting: highlight your section on Word file then you do Control ‘C’. Then go into your blackboard box, and click Control ‘V’. It should paste the answer in the box. Recommended server: Firefox

You will be able to see the feedback from your clinical faculty for a short while after the assignment is returned. A box is provided for feedback for each section and points earned.

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**SOAP Note Grading Sheet**

**Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Faculty/advisor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Possible Actual**

**Points Points**

20 pts \_\_\_\_\_ A. Subjective data appropriately documented (if all areas not assessed, indicate which you would add in italics)

15 pts \_\_\_\_\_ B. Objective data appropriately documented. (if all areas not assessed indicate which you would add in italics)

15 pts \_\_\_\_\_ C. Assessment- Complete list of diagnoses formulated (psychiatric, medical and V factors/ stress and contextual factors) At least 2 differential diagnosis and 2 rule outs. Provide rationale for psychiatric diagnoses using DSM-5 criteria. Discuss decision making regarding differential and rule outs (e.g. what criteria are not met; what information will need to find out)

10 pts \_\_\_\_\_ D. Neurobiology of disorder(s). Include genetics/family history, neurotransmitters, neuroanatomy, current theories of causation, cultural factors specific for this patient of primary and secondary diagnoses (if there is more than 1); Include and cite references.

20 pts \_\_\_\_\_ E. Medication management plan, labs to order, screening tools & rationale. Plan should be cost-effective and evidence based. Include labs to order and rationale , meds and dosage (meds: why this med, what is neurochemistry action of med, side effects to monitor, expected benefits, contraindications, black box warnings). Use references when appropriate. Brief discussion of rationale for this medication versus other medications.

15 pts \_\_\_\_\_ F. Therapy and teaching plan & rationale. Type(s) of therapy, referrals and consultations, teaching plan, counseling-goals and follow up (rationale for this type of therapy, expected benefits, teaching, referrals, follow-up). Use references when appropriate.

5 points \_\_\_\_\_ G. Include references from at least 3 sources including one article from refereed journal. Use APA format

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**100 \_\_\_\_\_**

**Comments:**

**The University of Texas at Arlington College of Nursing**

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**Format for SOAP Note**

**A. SUBJECTIVE**

**Client identifying information**

**Chief Complaint**

**History of Present Illness**

Exploration of the chief complaint/stressors/ what’s been going on/why came, etc. See template

Neurovegetative Symptoms:

Sleep

Appetite and weight

Energy

Concentration/ guilt/ self-esteem, etc

Anhedonia

Mood

Diurnal variation of mood

SI/HI

Anxiety-all disorders

Mania

Psychosis

Sexual interest/performance

Attention/focus

**Psychiatric History**

**Alcohol and Other Drug use History**

**See template**

**Current Health Status:**

Allergies

Medical Conditions

Current prescribed medications

Health maintenance behaviors

Last menstrual period

Last physical exam

**Past Health Status:**

Major Childhood Illnesses

Major Illnesses

Accidents

Menstrual & pregnancy hx

Hospitalizations

Surgeries

**Developmental History**

See Practicum Guide

**Family History**

**See Practicum Guide**

**Social History**

Current health habits/ADLs

Educational History

Hobbies, talents, interests

Legal History

Current Living Situation

Marital and Relationship History

Work History

Financial Status

Military History

Religion/Spirituality

Social network/support system

Sexual History

**Focused Review of Systems**

**See Practicum Guide**

**B. OBJECTIVE**

**Mental Status Exam**

Appearance

Behavior & psychomotor activity

Attitude toward examiner/reliability

Mood

Affect

Speech

Perceptual disturbance

Thought processes

Thought content

Alertness and level of consciousness

Orientation

Memory

Concentration and attention

Capacity to read and write

Visuospatial ability

Abstract thinking, proverbs, and similarities

Fund of information and intelligence

Judgment

Insight

Assets/strengths

Liabilities

**Other objective data**

Vital Signs

Height/Weight/BMI

Lab results

Screening tool results

**Pertinent physical exam**

**C. ASSESSMENT**

**Psychiatric disorders (prioritize)**

**Medical disorders,**

**Stressors/contextual factors:**

**Differential diagnoses:**

**Rule out diagnoses:**

**DSM-5 criteria and discussion of rationale**

**D. NEUROBIOLOGY**

**Genetics and family history**

**Neurotransmitters**

**Neuroanatomical changes**

**Current theories of causation**

**Cultural factors**

**E. PLAN & RATIONALE**

**Labs/ Diagnostic Tests/ Screening Tools**

**Medications**

Dosage & directions

Why this med?

Neurochemistry & MOA

Side effects

Expected benefits

Contraindications

Black Box Warnings

**Therapy prescription**

Type(s), duration, etc

Why this therapy?

Expected benefits

Therapy goals

**Teaching plan**

**Referrals and consultations**

**Follow up**

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**Tips for SOAP Note**

1. **SOAP note should be completed on a psychiatric evaluation patient.**
2. **Be sure to review and cover all SOAP note grading criteria.**
3. **Follow provided SOAP note format when completing assignment.**
4. **If there is any information that was not obtained during interview, be sure to review chart for that information.**
5. **If information not asked during interview and not obtained through chart, type in italics what you would have asked.**
6. **Review of systems and physical exam should be focused and pertinent**
7. **If there was an intervention completed that you would have done differently, please type in italics what you would have done and why.**
8. **Be sure to provide rationale for ALL of your interventions.**

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**Therapy Moment Map**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinical Advisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Select 5 –10 minute segment of a therapy session and present on blackboard in My Group under your clinical advisor discussion board. **Use Powerpoint.** Can be from individual, group or family therapy experience. The focus is on developing skills, self-reflection, application of theory, and developing as a therapist, and provides “peer supervision” as well as faculty supervision. Respond to each classmate’s TMM on blackboard x 1 week. Moderate the discussion.

Scenario and purpose

Points Actual

1. Client description 10 ­­\_\_\_\_\_\_

Describe appearance, mood, affect of client

Age, gender, cultural identity, other identifying factors

Therapy location and preceptor, type (individual, family/group)

Date and time of therapy moment.

2. Setting Description 5 \_\_\_\_\_\_

Describe the room and where everyone is placed.

Are there distractions?

3. Background description 10 \_\_\_\_\_\_

What was happening just before the session

What do you know, if anything about emergent situations

between sessions, where the patient was just before the

session, and what the transition was like. Discuss the

circumstances of the therapy session that led you to the

therapy moment

5. Purpose of the interaction. 10 \_\_\_\_\_\_

Identify the therapy goal for the session

using an identified theoretical framework and rationale for selecting

this theory to use in the intervention.

6. Image that depicts your visualized 2.5 \_\_\_\_\_\_

outcome of the therapy session for

the patient.

This should include an image from clip art or

photo or drawing, not just a verbal image.

7. Description of obstacles the patient may have 5 \_\_\_\_\_\_

toward meeting the imagined outcome

**Therapy Moment Map Dialogue**

8. Dialogue displays an example of an intervention 10 \_\_\_\_\_\_

that can be analyzed to demonstrate your

clinical reasoning process. Use dialogue of your intervention

not therapist’s intervention when at all possible. When possible, include at least 5-10 minutes

of dialogue to be analyzed. Dialogue should reflect the type of therapy identified in #5.

***Analysi*s**

9. Description of what *you are thinking and feeling* 10 \_\_\_\_\_\_

during the therapy moment. Share any anxiety, frustration, etc

demonstrating self -reflection and self -awareness.

Post an image that describes your feelings

.

10. Analysis of the intervention 10 \_\_\_\_\_\_

is accurate and organized according to the

theory of particular therapeutic approach and

the relationship (with references)

11. Image of a future moment that will attract the 2.5 \_\_\_\_\_\_

patient toward achieving the outcome

12. Analysis of the client’s perception of **you** 10 \_\_\_\_\_\_

What do you think she/he perceives of you during this

therapy moment?

What do you think about yourself as beginning therapist?

13. Discussion Questions and Moderator 10 \_\_\_\_\_\_

At least two relevant discussion questions to guide

discussion about the therapy moment.

1. Response to peers posts online 5 \_\_\_\_\_\_\_

References –At least 2

Total Credit 100 \_\_\_\_\_\_\_

**The University of Texas at Arlington College of Nursing**

**N5424 Psychiatric Mental Health Nursing I**

**Fall 2015**

**Cultura Video Recording**

**Rapport Building in a Trauma Patient**

You will video a demonstration of you interviewing a patient with trauma issues (may use a family member or friend, fellow student as your patient). You will record 10 minutes interviewing this patient following a developed scenario. The focus of this assignment will be to demonstrate appropriate boundaries setting, communication skills and empathy. This assignment will be posted under assignments in blackboard.

**Maximum Actual**

1. Boundary setting 30 pts \_\_\_\_\_\_\_\_\_\_

Provide appropriate physical space

Use body language to show interest and concern

Set boundaries for the interview (introduce self, confidentiality, purpose, time frame)

Environmental support (lighting etc)

Professional in approach

Focus on patient needs

1. Communication 30 pts \_\_\_\_\_\_\_\_\_\_

Nonverbal communication

Good eye contact

Facial expression demonstrates interest

Verbal

Use reflective listening skills

Use silence appropriately

Clarify what patient means

Open ended questions

Age appropriate language

Empathy 30 pts \_\_\_\_\_\_\_\_\_\_ Validate patient’s experience and feelings

Offer encouragement and hope

Show genuine caring and concern for patient

Listen without judging or giving advice

Appropriate personal disclosure (only if goal directed and time sensitive)

**The University of Texas at Arlington College of Nursing**

**N5424 Psychiatric Mental Health Nursing I/ Fall 2015**

**Family Case Presentations**

**Present In Blackboard on discussion board**

The purpose of this assignment is to practice, in a "grand rounds" format, the written and verbal ability to "present" a family client and overall plan of care to your peers.

Select one family that you are familiar with from your therapy or med management experience. Select one family therapy/theory and analyze the family from this perspective. E.gl, Minuchin, Bowen, Satir, Narrative Family Therapy, strategic FT, other. Present the following information. You may use 2 or more perspectives if you wish, being sure to point out which theory you are using at the time. Lead discussion with your peers (your clinical group) for 1 week. Each student should post at least 1x to each person’s case presentation, and with current reference.

(Faculty may opt to use Collaborate and discuss as a group in a single session)

**Maximum Actual**

**Structural Data** \_\_\_10\_\_\_ **\_\_**\_\_\_\_\_

Who is in the family?

What brought them for help?

What is their home like?

What is their environment like?

Occupation-work info?

Socio-economic data?

Religious information?

Previous experience with therapy?

Medical diagnoses of members?

(include psychiatric/addictive

disorders)

Lifestyle

Marital status

**Family History** \_\_\_25\_\_\_\_\_\_\_\_\_

Analyze using concepts and assumptions

from family system theory that you have selected.

**GENOGRAM with correct symbols & detailed key**

Strengths of family over time

**Family System Theory Analysis** \_\_\_30\_\_\_ \_\_\_\_\_\_

Describe theory used (concepts)

Analyze family dynamics using concepts and assumptions

from family system theory of choice

e.g. Structural therapy: boundaries, subsystems

**Family Therapy** \_\_\_25\_\_\_\_\_\_\_\_\_

# Sessions

Goals of session(s)

Who attended, etc.

Strategies used

Examples of dialogue

**References (at least** 3) \_\_\_CR\_\_ \_\_\_\_\_\_

**Presentation Skills** \_\_\_10\_\_\_ \_\_\_\_\_\_

Organized, systematic

Responded to peers

**The University of Texas at Arlington College of Nursing**

**N5424 Psychiatric Mental Health Nursing I**

**Fall 2015**

**Clinical Notebook Grading Sheet**

**Journal Check #1** **Journal Check #2**

**Clinical Notebook Grading Sheet \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_**

**Clinical Objectives/Evaluation (P/F)** \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Present to each preceptor specific clinical

objectives for the experience and discuss ways to achieve these

objectives. **Evaluate each objective and describe**

**your experiences towards these objectives.**

**Reflective journaling (P/F)**

Journal entry for each day you spend in therapy (not med

management) Describe your experiences and what you learned,

level of your involvement, therapies applied, and self-reflection

and personal growth through the process

Boyd and Fales (1983) state that "reflective learning is the process of

internally examining and exploring an area of concern triggered

by an experience which creates and clarifies learning in terms of self

which results in change of perspective."

**\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**Typhon –(P/F)** \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Record all patients seen within 7 days (required by Typon). Include therapy

patients. Should have close to one patient per hr at minimum of clinical time

**Include summary print out. Therapy-enter patients such as**

**2-3 from each group session, all family members from family therapy,**

**all individual therapy patients. Use correct billing codes for psychiatry**

**Clinical Hours Tally Sheet/ Grid (P/F)** \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

This is a record of your clinical time towards your overall experience,

recording in appropriate category. Carry forward hours from other courses

as indicated. **Must have Preceptor signatures each day. Can put on separate**

**Page. Turn in both updated grid and signature sheets**

**Preceptor evaluation of student (12 hours or more) \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

**Psychotherapy evaluation of student (12 hours or more) \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

**Student Evaluation of All Preceptors \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

[**http://www.uta.edu/nursing/msn/msn-forms/**](http://www.uta.edu/nursing/msn/msn-forms/)

**Overall neatness and organization (P/F)** \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Notebook is organized, assignments are easy to locate. Grading sheets

are included. Send assignments to instructor by blackboard.Include all preceptor

agreements copies.

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**OVERALL GRADE (Criteria Pass/Fail)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The University of Texas at Arlington College of Nursing**

**N5424 Psychiatric Mental Health Nursing I**

**Fall 2015**

**Tips for Follow up Medication Management - Visit and Documentation**

1. What has happened since the last visit-update on symptoms, list all medications, response to medication, worsening of symptoms or improvement, new symptoms, review of expected side effects and indication if present or not, new or continued stressors, hospitalizations, medical issues-new or continuing, always include suicide evaluation, include relevant quotes from patient . Include significant positives and negatives. Include duration and severity of symptoms/problems.
2. Objective data-focus on appearance, speech, eye contact, level of cooperation, agitation, thought processes, thought content, perception, mood, affect, judgment, insight, etc. (brief notation of each area-include significant positives and negatives-e.g. no reckless behavior (on judgment )
3. Any screenings done (e.g. AIMS), recording of lab and VS e.g. what is most recent lithium level, date of level, last date of thyroid testing, etc. BMI, waist circumference, weight if applicable
4. Focus your thinking on “is this the correct diagnosis?” is this the correct medication(s), do we decrease the med, increase a med, change a med, stop a med, or change the dosing schedule of the med.
5. Write DSM 5 diagnosis for this patient, updating for this visit.
6. Write plan for this patient including all areas. If continuing the same meds, write them down, with the doses and schedule for taking. “Continue Paxil 20 mg qHS.: If new med, write Start Wellbutrin 150mg. XL qam., etc. If giving samples, indicate how many, if given RX, indicate # of pills and # of refills

**TYPHON WORKSHEET**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client # (DOB): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_ Ethnicity \_\_\_\_\_\_\_\_\_

Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CPT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnostics: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Diagnosis (DSM 5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Diagnosis #2 (DSM 5): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical illnesses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stress/ V code/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacology :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interventions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client complexity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Level of function\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-

**UTA College of Nursing**

**PMHNP Program**

**Psychiatric Evaluation Guide**

**The following is a suggested format for Psychiatric Evaluation of Patient-Please note that this is only a template, not a cookbook approach. For child, adjust language to developmental level of child, and add developmentally specific questions on parenting, discipline, ADHD etc. For older adult or disabled, add functional assessment and additional questions on cognitive function, memory, executive function, MMSE or MOCA score. Remember to tailor questions to the patient if you use this template. If you have questions for sections you don’t see here then address those questions in the proper area.**

**Patient (age, marital status, gender; ethnicity; reliable?)**

**Source of Data:**

**SUBJECTIVE DATA**

**Chief Complaint:** What can I help you with today? (build rapport!) put answer in quotes

**History of Present Illness: (explore issues in depth-get details of patient’s story and validate patient’s feelings. Do symptom analysis of each area of concern)**

**Timing:**

When did symptoms begin?

How were you feeling before that time?

Does the feeling occur daily, or does it come and go?

Did this feeling happen suddenly, or was it a gradual onset that you were unaware of the change in your thinking and feeling?

Is there any time in the day that the feeling is better or worse?

How long has this been going on?

**Quality:**

Is the feeling debilitating or severe?

How would you rate the depression on a numeric scale from 1 to 10?

**Quantity or Severity:**

How does it impact your life?

Does it interfere with your work?

Does it interfere with her daily activities or relationships?

**Setting:**

What was going on in your life when this began?

Were you facing any changes or new challenges in your life?

Have you ever had this before?

**Aggravating/Alleviating Factors:**

Is there anything that makes you feel worse?

Is there anything that makes you feel better?

Any medications that seem to help?

**Associated Symptoms:**

Are there any other symptoms or feelings that you have at this time?

Have you noticed anything that has changed over this time period along with your mood?

**Neurovegetative Symptoms:**

**Sleep: (get full details of duration, etc if problems)**

How many hours do you sleep?

Do you wake up before the alarm?

Do you feel rested when you get up?

Do you have problems going to sleep or staying asleep? How many times do you get up at night? How long does it take to fall back to sleep?

Do you take any medications to help you go to sleep?

Have you changed your routine?

Do you drink caffeine before going to bed? Exercise before going to bed?

Does your mind race when you try to go to sleep?

Any nightmares?

What is your normal amount of sleep?

Do you take naps?

**Appetite and weight: (recent)**

How is your appetite? Increased? Decreased?

Have you lost or gained any weight? If yes, over what period of time?

Do you feel that you need to lose weight?

Do you ever binge or fast? (if yes, then get full details)

Use any laxatives or vomiting to lose weight? (if yes, then get details)

Do you use exercise to lose weight?

Are you afraid of gaining weight?

Are you afraid you won’t be able to stop eating if you start?

What do you think about the appearance of your body?

What is your usual food intake in a day?

**Psychomotor Agitation or Retardation**

Feel body is in constant motion, feel agitated?

Or sluggish / slow/ not wanting to get out of bed?

**Energy:**

How would you describe your energy level?

Is there a certain time of the day that you have more energy?

Do you have more energy lately? Or less energy recently? For how long?

**Anhedonia:** What do you enjoy doing?

Are activities that you use to enjoy still enjoyable?If not then, is there anything that you still enjoy and can feel pleasure from doing?

How long have you not been able to enjoy things you once enjoyed?

**Concentration:** Are you able to concentrate? (give examples: remember what you read, concentrate on movie, pay attention to conversations)

**Guilt/Worthlessness**

**Mood:** Rate mood on 1-10 scale with 10 as best (or 1-100 with 50 being “level or stable mood” if suspect bipolar disorder, and below 50 depressed and above 50 manic)

Have you been feeling sad? Irritable? Angry? Happy?

(get details… most days.. how long.. 2 weeks or more? Is this is a change for you?)

**Diurnal variation of mood:** Are there certain times of the day that you feel better or worse than others?

**Suicidal ideation;** (concern is recent/current thoughts, but also, history of suicideal thoughts and suicidal attempts

Have you ever thought it would be better if you were dead?

Have you ever wanted to hurt yourself or kill yourself? Are you having these thoughts now? Have you ever hurt yourself or made a suicide attempt?

How often do you these thoughts of wanting to hurt or kill yourself occur? (every day, twice a week, etc) When was the last time? What do you do when these thoughts occur?

Do you feel your life is worth living? Or do you feel hopeless

Do you have a plan? What would keep you from acting on this plan?

**Homicidal ideation :** Have you ever thought that things would be better if someone else was dead?

Current Plan? Intent?

**Anxiety/OC and related disorders/Trauma : ( Ask at least 3 key screening questions for each disorder; if yes to any of the screening questions, you will need to assess all the criteria for that disorder to arrive at diagnosis using DSM 5 criteria (not all criteria are listed here); if no’s then no further questions needed re that disorder.**

**Anxiety:**

**Separation anxiety disorder:** Do you feel distress thinking about being away from home or from family? Do you worry about harm happening to family members? Do you have fear of leaving home because of fear of separation?

**Selective mutism:** Do you have trouble speaking when spoken to?

**Specific phobia:** Do you have fear or anxiety about a particular situation or object, such as heights, animals, seeing blood or receiving an injection?

**GAD:** Do you worry a lot? Is it difficult for you to control the worry? Do you ever feel restless, fidgety, or on edge? Muscle tension, feel the worse thing will happen? Fatigue? Mind goes blank? Irritability? Sleep disturbance? Lasting 6 months or more?

**Panic disorder**: Ever have short burst (abrupt surge) of anxiety that comes on very fast (within 10 minutes) when you feel you can’t breathe, your heart is racing, you get sweaty and feel like you are going to die? How long do they last? (less than 1 hour?) Do these attacks ever happen out of the blue like in middle of night? (unexpected) Do you fear another one will happen? Avoid things that might bring on another panic attack? Go through the 13 symptoms,

**Agoraphobia:** Do you have fear or anxiety about situations where you might not be able to escape or that you won’t be able to get the help you need or if you have panic like symptoms? Do you have fear or anxiety about using public transportation, being in open spaces, being in enclosed spaces, standing in line or being in a crowd, being outside of the home alone?

**Social Anxiety Disorder (Social Phobia):** Do you feel uncomfortable around people in social situations (e.g. social interactions, being observed, and performing in front of others? ) and think that they are scrutinizing you? Do you avoid certain social situations? Feel you will say or do something embarrassing or lead to rejection or offend others? Has this lasted at least 6 months?

**OC and Related disorders**

**OCD:** Do you constantly go back and check things that you did to see if you did them or feel the need to wash your hands? Or any other kind of rituals that you feel compelled to do? Do you have thoughts that are intrusive, and unwanted and that you try to ignore, suppress or neutralize with a compulsion? Does this take up an hour or more of your day?

**Body Dysmorphic Disorder**; Are there parts of your body that you feel are defective? Do you stand in front of mirror for long periods of times or do excessive grooming, or compare yourself to others?

**Trichotillomania:** Do you frequently pull out your hair resulting in hair loss?

**Hoarding:** Do you have difficulty letting go of possessions, throwing things away? Is your house very cluttered by these items that you accumulate?

**Skin Picking:** Do you frequently pick on your skin and cause skin lesions?

**Trauma:**

**PTSD**: Were you exposed to actual or threatened death, serious injury, or sexual violence (witness, directly experiencing, learning a violent or accidental event occurred to close family member, repeated exposure to details of the event), If yes, then ask: Do you have nightmares, flashbacks of any traumatic events in your life? Startle easily, avoid talking about the trauma? Feel numb or detached from others, or hypervigilant? Inability to experience positive emotions? Sleep disturbance? Verbal or physical aggression? Reckless or self destructive behavior? Experience hearing voices or seeing things when falling asleep? Length of time 1 month or more/

**Manic Symptoms: (Ask at least 5 screening questions to rule out mania; if yes to any, need thorough details of duration of symptoms and severity to determine if meets criteria for hypomania or mania episodes (BPI or II) using DSM 5.**

Do you ever have periods of extreme happiness or elevated mood or irritability? How long do they last? Can ask how high do the ups go (scale of 1-100 with 50 as level mood) and how low do the lows go? Where you are today?

Can you go 4-7 days without sleeping or ever feel rested after little sleep? Is that happening now? When was the last time?

Are you extremely talkative or has someone told you that you were during these times? (or extreme texting)

Racing thoughts? Feel agitated?

Spending sprees? other reckless behavior? Increased sexual activity during these times? Sexual indiscretion? Drugs or alcohol?

Start lots of projects, don’t finish, and jump from one thing to another..

Get started with something and won’t stop even if it is hurting you or someone else?

Consequences of these episodes? (look for financial, legal, occupation, educational, and relational)

**Psychosis**: Hallucinations? See things that others don’t see? Hear things that others don’t’ hear? Hear your name called or strange sounds? Smell things? Feel something crawling on your skin? Taste strange things in your mouth,, Do they happen only when you are Summering asleep?

Delusions? Ever think people are planning to hurt you? Ever feel that you have special talents or gifts? Ever have the idea that you can read people’s minds or they can read yours? Ever feel you can put thoughts in someone’s head or they can put thoughts in yours? Feel the TV is talking just to you? (paranoia, grandiose ideas, delusions of control, ideas of reference)

**Focus and attention**: (screening for ADHD when appropriate) Problems with inattention/ listening and remembering what was said? Daydreaming as child? Trouble understanding what you read or finishing a book?? Trouble with procrastination. Easily distracted? Late for meetings, misplace things? (adjust questions to age of patient) hyperactive as child? Impulsive-blurting out answers? Finishing others sentences? Trouble getting started with challenging project? Trouble finishing details of project? Happen before the age of 7?

**Consequences of any of the + symptoms**: (e.g. what problems have these symptoms caused for you in your relationships, in your job, etc.

**Psychiatric History:** Have you ever been diagnosed with any psychiatric disorders such as ….

Have you ever been treated for a mental illness or stress problem? Get details; who treated; Ever have problem you think should have had treatment for?

What meds were tried and did they work? (get medication history)

Ever been hospitalized? (get details)

Ever attempted suicide**? (**get details)

Ever go to counseling? (get details)

**Alcohol and Other Drug use History:**

Tobacco, alcohol, illicit drugs? **(Make sure to ask about each specific drug in this section. This also includes prescription drugs as well (e.g. Soma, Vicodin, Xanax) ; if HPI includes drugs and alcohol, cover in HPI; can say see HPI.)**

What kind and how often? IV drug use?

Do you feel you may have a problem? (insight)

Ask if has used more than 3 drinks in one occasion (women) in past year (more than 4 drinks for men). See the guidelines or asking these questions in Clinicians Guide. More than 14 drinks a week for men, 7 drinks a week for women is considered problem use. (ask about size of drink :

CAGE questionnaire (not as useful as AUDIT (or CRAAFT with teen) or questions about # drinks)

For any use of drugs/alcohol, ask questions to identify symptoms of intoxication, withdrawal, abuse, and dependency

Have you ever had 3 or more drinks at one time? (female, males over 65) 4 or more drinks at one time ? (males) How many times in past month? # drinks per week? (most used, use standardized drink chart for size of drink, 12 oz beer, 1 ½ oz liquor, 5 oz wine =`1 drink

When did you have first drink/drug, last? (look for symptoms of withdrawal), Do you have blackouts, withdrawal symptoms (ask about specifics for drugs/alcohol has been using)? Ever been through detox? How many times? Seizure?

Financial burden? Drink when driving? Arrested for? Medical problems.

Go through each class of drugs (Current, past, first use, last use, consequences) illicit /street drugs

Marijuana, cocaine, methamphetamine, opiates (Vicodin, Lortab, Oxycodone), benzos, hallucinogens, inhalants, ecstasy? (ask the questions about abuse and dependency, withdrawal and intoxication of any drugs admitted to using)

What are consequences of using drugs or alcohol-give example.. e.g. losing relationships, losing job?

Any illegal activities? Steal to get drugs? Arrested for possession or sales?

Cannot go without drugs or alcohol? Tried to stop? Need more to get high or same effect? Withdrawal symptoms if try to stop? Use more than intended?

Ever took more prescription drugs than prescribed? Such as Lortab, Vicodin, Xanax? (get details –now, in past, etc)

Abuse OTC such as dextromethorphine, bath salts?

Ever treated? (get details) 12 step? Last meeting? Formal treatment?

Nicotine use? # packs per day, how long, cigars, smokeless tobacco, SNUS, plans to change smoking habits?

Caffeine use per day (Red Bull, coffee, etc)

**Current Health Status:**

**Allergies:** drugs, environmental, seasonal?

**Medical Conditions:** Head injuries, seizures, trauma

**Current prescribed medications:** OTC and herbal? ( doses)

**Health maintenance behaviors:** Do you exercise?

How much and how frequently?

When last physical exam?

Last pap and lab work? What were the results?

Immunizations (include Pneumovax, shingles, if over 60)

What is your diet like?

Birth control?

**LMP:**

**Last physical exam:** When?

Mammogram, Dental check up?

**Past Health Status:**

**Major Childhood Illnesses:** measles, mumps. Rubella, whooping cough, chicken pox, rheumatic fever, polio

**Major Illnesses:** HTN, High Cholesterol, Heart Disease, Cancer, Seizures. Headaches, Asthma, Respiratory diseases, Arthritis, Hepatitis, Diabetes, Chronic Pain (dates, etc)

**Accidents:** broken bones, head injuries, seizures, lost consciousness?

**Menstrual hx/pregnancy hx,**

**Hospitalizations:**

**Surgeries:** What, where, when, any complications

**Past med history**: Any past prescription, OTC, herbal medications? What kind? What did you

take them for?

**Family History:**

Tell me about your family, who all is in your family?

How many siblings do you have?

What are the ages of your parents and your siblings?

Who all lived in your house when you were growing up?

What kind of relationships did you have growing up with your family members?

**Abuse:**

In your family, was anyone ever neglected or physically or emotionally abused? Did you witness any abuse?

Was there ever any sexual abuse to either you or your siblings?

**Medical and Psychiatric History:**

Has anyone in your family (parent, sibling, grandparent, aunt, uncle, cousin, children) ever had problems with alcohol or drug abuse?

Is there any history of psychiatric or mood disorder? (give example: depression, bipolar disorder, anxiety, ADHD, schizophrenia?) Ever treated? Response to treatment?

Has anyone in your family ever committed suicide or attempted to commit suicide? If so, who was it and when did the action occur?

What is the health status of all members of your family?

Is there a history of hypertension, cancer, high cholesterol, seizures, headaches, neurological disorders, diabetes?

Genogram of family (include parents, siblings, grandparents, aunts, uncles, cousins, offspring)

**Developmental History:**

Normal delivery? Complications? Was Mom using drugs or alcohol during pregnancy?

Milestones on time?

Birth through 3 years, childhood, adolescence: social relationships, cognitive, motor development;

Problems with learning? Peer relationships? Activities in school? Special classes? Diagnosed with learning disability? Odd behavior? Stereotypic behaviors (e.g. head banging,)

How many jobs? Relationship with co-workers?

Lost any family members or friends?

Abuse history (physical, psychological, sexual)

**Social History:**

**Current health habits/ADLs:** Functional assessment of geriatric pt ( ADL’s, IADLS)

What is your daily routine?

Are you able to take care of yourself?

Responsibilities?

Difficulty doing chores?

What do you do to stay healthy?

**Educational History:**

Highest degree/grade level?

School?

Grades?

Truancy?

**Hobbies, talents, interests:**

What kinds?

What did for fun past week?

**Legal History:**

Any charges past or present?

What was the outcome of those charges?

**Current Living Situation:**

Where?

How long?

With whom?

**Marital and Relationship History:**

Live together?

More arguments or disagreements?

Able to work out problems?

How many long term relationships have you had?

How did you handle the breakup of those relationships?

**Relationships:**

Friends? How many?

How often see?

Getting along?

Can you rely on them, turn to them for support?

**Work History:**

Where? How long?

How many hours?

Job- calling in sick or poor performance?

Able to concentrate?

How feel doing?

Is it what you want to be doing?

**Financial Status:**

Support self? Family?

Any stressors?

Any debt? How do you feel about that debt?

**Military History:**

Combat?

**Religion/Spirituality:**

Attend church? How often?

Religion?

Have spiritual beliefs?

What/Who do you turn to for spiritual support?

**Social network/support system:**

Who? How?

Who can you talk to/Are you comfortable talking to?

**Sexual History:**

How old when first sexually active?

How many partners in your life?

How do you feel about your sexuality?

**Review of Systems: (focus on systems relevant to history)**

**General Condition:** See HPI

Usual weight, recent weight changes, weakness, fatigue, fever, general statement of how feel

**Nutrition:** See HPI

**Skin/hair/nails:**

Rashes, itching, dermatitis, eczema, dryness, sweating, color change, changes in texture to hair/skin/nails

**HEENT:**

HEAD: headaches, dizziness, or loss of consciousness

EYES: blurry vision, wear eyeglasses or contacts, or have any blind spots or eye pain.

EARS: changes in her hearing, or any pain, dizziness or ringing in her ears

NOSE: drainage from her nose, or changes in sense of smell

MOUTH & THROAT: any change in taste or texture, sore throats, change in teeth

**Cardiovascular:**

Heart palpitations, arrhythmias, chest pain, dyspnea, or exercise intolerance?

**Peripheral vascular:**

Edema, varicosities, phlebitis

**Breasts:**

Tenderness, discharge, lumps, pain

**Respiratory:**

Shortness of breath, difficulty breathing, coughing, wheezing

**Gastrointestinal:**

Abdominal pain, constipation, diarrhea, difficulty swallowing, heart burn, gas, jaundice

**Urinary:**

Urgency, pain, frequency, nocturia, hematuria, change in force of stream

**Genitalia:**

Discharge, pain, sores, masses, regularity

**Musculoskeletal:**

Change in muscle mass, ability to exercise, muscle weakness, muscle pain, joint stiffness, limitation of motion

**Neurological:**

Seizures, fainting, weakness, change in sensation or coordination, tingling, tremors, or numbness, dizziness

**Endocrine:**

Change in the size of your thyroid gland, sensitivity or intolerance to heat or cold, problems maintaining body temperature, excessive thirst or hunger

**Lymphatic:**

Tenderness, enlargement of lymph nodes in groin, axilla, neck

**Hematological:**

Easy bruising or bleeding, anemia

**OBJECTIVE DATA**

**Do memory test. 3 objects – ball, car, dog. Repeat now, 1 minute and 5 minutes.**

**Mental Status Exam:**

Appearance:

Appears stated age

Body build:

Position:

Posture;

Eye contact:

Dress:

Grooming:

Manner/attitude:

Attentiveness:

Alertness:

Behavior and psychomotor activity: Mannerisms, ticks, gestures, twitches, hyperactivity, agitation, combativeness, etc.

Attitude toward examiner/reliability: cooperative, friendly, attentive, interested, frank, seductive, defensive, apathetic, hostile, evasive, etc.

Mood: Euthymic depressed sad tearful hopeless angry hostile suspicious sullen anxious belligerent; elated

Affect: normal, constricted, blunted, flat, labile (shifts rapidly); euphoric

Speech: quantity, rate, volume, and tone. Rapid, slow, pressured, hesitant, emotional, dramatic, monotonous, loud, whispered, slurred, mumbled; foul language; rhyming/punning

Perceptual disturbance: Hallucinations (auditory, visual, tactile, gustatory) illusions depersonalization

Thought processes: Clear coherent goal directed flight of ideas circumstantial loose associations word salad perseveration tangential thought blocking

Thought content:

Normal obsessions compulsions preoccupations phobias delusions paranoia religious somatic grandiose suicidal

Alertness and level of consciousness: alert, disoriented, lethargic, clouded, stuporous, comatose.

Orientation: person, place, time, and situation.

Memory: Recall objects at 1 min 3 min .

Can you name the last 3 presidents

Concentration and attention: Spell world forward backward serial 7’s

Ask patient to follow a three-stage command: "Take a paper in your right hand, fold it in half, and put it on the floor." (state all 3 commands and then hold paper out)

Capacity to read and write: Ask patient to write a sentence (say Write any sentence)

Visuospatial ability: correctly copy figure of intersecting pentagons

Abstract thinking, proverbs, and similarities: How are apples and oranges alike?

How are a chair and a table alike?

Abstract concrete impaired

Ask about proverb interpretation; e.g. Have you heard the expression: A bird in the hand is worth 2 in the bush?; (if no then try another: Have you heard The grass is always greener on the other side? What does that mean to you?

Fund of information and intelligence: level of education and intelligence; e.g. Ask to say who current President is; then ask to name president before him and keep going; or Ask to name 3 large states; Ask Who is Jonas Salk? Ask current events;

Judgment: what do we know so far, are they drinking and driving, etc. look at whole picture; Can ask: What would you do if found a stamped letter with address lying on street: or What would you do if you found a child who lost her parent in the mall: or What would you do if you heard fire alarm in the movies?

Good; fair; poor and give example

Insight: What kind of problem do you think that you are having?

Good intact fair limited

Assets/strengths: motivation? What are you good at?

Liabilities: What things do you think you need help with?

Other objective assessments:

T: P: R: BP: Wt. Ht: BMI

**Focused Physical Exam pertinent to patient’s presenting problems.**

**(always include heart and lungs; most always, need neuro exam)**

**ASSESSMENT**

**Diagnosis: (list all )**

Medical problems; include unexpected weight loss; hypersomnia; arthritis, DJD, Diabetes, etc

**Contexual factors**

R/O (Rule out are diagnoses that you are considering as possibilities; just need more information: e.g. MDD would be Rule out Bipolar Disorder;

Differential (medical, and more unlikely causes of symptoms) e.g. hypothyroidism; brain tumor; B12 deficiency; substance induced mood disorder; substance induced anxiety disorder; HIV;

**Plan:**

**Labs and diagnostic tests**

**Pharmacologic**

**Teaching plan**

**Counseling plan**

**Referrals and consultation**

**Follow up**

**The University of Texas at Arlington College of Nursing**

**Family PMHNP (post masters will be individualized) PROGRAM SUMMARY**

**(WEEKLY) CLINICAL HOUR TALLY SHEET – Fall 2015**

**NAME: TOTAL= 675 hr in program (585 psych clinical hours)**

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| **TYPE OF HOURS (Required)** | 9/2-9//5 | 9/6-9/12 | 9/13-9/19 | 9/20-26 | 9/27-10/3 | | 10/4-10/10 | | 1011-10/17 | 10/18-10/24 | 10/25-10/31 | 11/1-11/07 | 11/8-11/14 | 11/15-11/21 | 11/22-11/28 | 11/29-12/05 | 12/6-12/9 | **Hrs. From Previous Semesters** | **Hours this semester** | **TOTAL** |
| **ADULT PSYCH Management**  **180 Required** |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |  |
| **CHILD & ADOL PSYCH (up to age 18) Management.**  **175 Required** |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |  |
| **GERIATRIC PSYCH Management.**  **20 Required** |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |  |
| **ADULT MEDICAL MT.**  **45 Required**  **(N5305)­­** |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |  |
| **ADDICTION (med management or therapy)**  **45 Required** |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |  |
| **GROUP Therapy**  **50 Required** |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |  |
| **FAMILY Therapy**  **40 Required** |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |  |
| **INDIVIDUAL**  **Therapy**  **50 Required** |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |  |
| **SEMINARS**  **Practicum (5631)**  **25 + 4 CEU programs** |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |  |
| **Ped. Medical Management**  **45 Required**  **(Pedi management)** |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |  |
| **Total Hours** |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |  |

**N5424 Psych I**

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| Date, number of hours | Type of experience | Preceptor | Signature of preceptor |
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**Emergency Phone Numbers**: In case of an on-campus emergency, call the UT Arlington Police Department at 817-272-3003 (non-campus phone), 2-3003 (campus phone). You may also dial 911.