

## PATIENT STRESS QUESTIONNAIRE SCORING

### PHQ-9 and PHQ Modified for Teens

- Annual Depression Screening given at all physicals for patients 12 and older- Bill G0444
- Depression assessment and follow up (outside of annual physical) - Bill 96127
  - To assess major depression a 2 or a 3 must be score on one of the first 2 questions-
    - If a 2 or 3 is not indicated the patient may still be depressed (depression NOS or another depressive disorder), but it is not major depression.

PHQ-9 Score	Severity: Provisional Diagnoses*	<u>ORDERS NEEDED WHEN PT SCORES</u> <u>DEPRESSED- One of the following orders must be completed</u>	Proposed Actions/ Evidence-Based Treatment Considerations
0-4	None: Minimal	✓ None	None
5 - 9	Mild: Minimal Depressive Symptoms Depression diagnosis may not be appropriate.	✓ <u>Referral Order</u> -Ref to psychiatry, psychology or behavior therapist ○ <u>OR</u> ✓ Referral Order - <u>Follow Up Adult Depression</u> to see you ○ <u>OR</u> ✓ <u>Prescribe</u> a Depression Medication	✓ Watchful waiting - provide support (e.g., educate patient to call if symptoms worsen; Offer self-management (books, websites) ✓ Have patient return in 1 month to repeat screening and reassess
10-14	Moderate: Minor Depression, or Dysthymia	✓ <u>Referral Order</u> -Ref to psychiatry, psychology or behavior therapist ○ <u>OR</u> ✓ Referral Order - <u>Follow Up Adult Depression</u> to see you ○ <u>OR</u> ✓ <u>Prescribe</u> a Depression Medication	✓ Develop treatment plan with consideration of counseling/psychotherapy, antidepressant medication and follow-up. ✓ Monitor with continued screenings over time
15-19	Moderately Severe: Depression	✓ <u>Referral Order</u> -Ref to psychiatry, psychology or behavior therapist ○ <u>OR</u> ✓ Referral Order - <u>Follow Up Adult Depression</u> to see you ○ <u>OR</u> ✓ <u>Prescribe</u> a Depression Medication	✓ Consider initiating anti-depressant medication and/or refer for psychotherapy and/or antidepressant medication ✓ Monitor with continued screenings over time
20 or greater	Severe: Major Depression	✓ <u>Referral Order</u> -Ref to psychiatry, psychology or behavior therapist ○ <u>OR</u> ✓ Referral Order - <u>Follow Up Adult Depression</u> to see you ○ <u>OR</u> ✓ <u>Prescribe</u> a Depression Medication	✓ Expedited referral to a mental health specialist for psychotherapy and/or antidepressant medication and collaborative management ✓ Consider Immediate initiation of anti-depressant medication ✓ Monitor with continued screenings over time

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### GAD-7- Adult and bill 96127

Total Score: anxiety severity

A Score of **8** or greater indicates probable GAD or Panic disorder

A Score of **10** or greater warrants further evaluation

### PC-PTSD- bill 96127

Yes to any **3** questions- Positive screen

Score	Risk	Provisional Dx	Follow up	Tx
Yes < 3 items	Negative	None	None	None
Yes > 3 items	Positive	Possible PTSD	Structural	Rx medication
Score	Risk	Provisional Dx	E/u Interview	Refer to BH/MH
0-5	Low	None or mild		Refer to Psychiatry
6-10	Moderate	Moderate Anxiety		
11-15	Moderate	Moderately Severe Anxiety	Further evaluation	Rx BH/MH Psych
16-21	high	Severe Anxiety	Further evaluation	Rx BH/MH Psych

### AUDIT- bill 96217 or SBIRT codes if intervention/discussion was over 15 minutes

Score	Risk	Treatment
0-7	Low risk	<ul style="list-style-type: none"> <li>None or information about non-risky use</li> </ul>
8-15	Risky or hazardous	<ul style="list-style-type: none"> <li>Brief intervention (BI)</li> <li>Possible BH referral or counseling</li> </ul>
16-19	High risk or harmful Assess for dependence	<ul style="list-style-type: none"> <li>BI</li> <li>Counseling</li> </ul>

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		<ul style="list-style-type: none"> <li>• Possible referral to treatment</li> </ul>
> 20	High risk Almost certainly dependent	<ul style="list-style-type: none"> <li>• Further assessment with family and significant others</li> <li>• Substance use referral (medical specialist or substance use treatment)</li> <li>• Pharmacotherapy</li> <li>• Relapse prevention and support</li> </ul>

### Suicide Behaviors Questionnaire-Revised (SBQ-R)

Description	
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#### Item 1: Taps into lifetime suicide ideation and/or suicide attempts

Selected Response 1	Non-Suicidal subgroup	1 point
Selected Response 2	Suicide Risk Ideation subgroup	2 points

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Selected Response 3a or 3b	Suicide Plan Subgroup	3 points	
Selected Response 4a or 4b	Suicide Attempt Subgroup	4 points	<b>TOTAL POINTS=</b> _____

**Item 2: assesses the *frequency* of suicidal ideation over the past 12 months. Selected response:**

Never	1 Point	
Rarely (1 time)	2 Points	
Sometimes (2 times)	3 Points	
Often (3-4 times)	4 Points	
Very often (5 or more times)	5 points	<b>TOTAL POINTS =</b> _____

**Item 3: taps into the threat of suicide attempt**

Selected Response 1	1 Point	
Selected Response 2a or 2b	2 Point	
Selected Response 3a or 3B	3 Points	<b>TOTAL POINTS =</b> _____

**Item 4: evaluates self-reported likelihood of suicidal behavior in the future. Selected Response:**

Never	0 points	
No Chance at all	1 Point	
Rather unlikely	2 points	
Unlikely	3 points	
Likely	4 points	
Rather Likely	5 Points	
Very Likely	6 Points	<b>TOTAL POINTS=</b> _____

**TOTAL SCORE =** \_\_\_\_\_

Sum all of the scores circled / checked by the respondents. The total score should range from 3-18.

**Interpretation for General Population:**

Score	Risk	Provisional Dx	Follow up	Tx
Score < 7	Low			
Score >7	High			

**Interpretation for Psychiatric Inpatients:**

Score	Risk	Provisional Dx	Follow up	Tx
Score < 8	Low			
Score >8	High			