MARVIX AI

GERIATRIC PSYCHIATRY SOAP NOTE TEMPLATE

Questions? Visit us at www.marvix.ai

1 PATIENT INFORMATION

NAME

DATE OF SERVICE

DOB

PROVIDER

AGE / SEX

CREDENTIALS

MRN / PATIENT ID

VISIT TYPE: GERIATRIC PSYCHIATRY CONSULTATION / FOLLOW-UP / MEDICATION MANAGEMENT

CARE SETTING: OUTPATIENT / INPATIENT / ASSISTED LIVING / SKILLED NURSING FACILITY / TELEHEALTH

REFERRAL SOURCE

PRIMARY CARE PROVIDER, IF APPLICABLE

CAREGIVER / FAMILY MEMBER PRESENT

INFORMANT / COLLATERAL SOURCE

RESIDENCE / LIVING SITUATION

CC CHIEF COMPLAINT

Primary geriatric psychiatry-related reason for the visit in the patient's or caregiver's own words when possible — depression, anxiety, agitation, cognitive changes, sleep disturbance, psychosis, behavioral disturbance, medication review, safety concern, caregiver concern, or psychiatric follow-up in the setting of aging or neurocognitive disorder...

S SUBJECTIVE

3a REASON FOR GERIATRIC PSYCHIATRY EVALUATION

Initial evaluation, medication management, behavioral symptoms, mood/anxiety symptoms, cognitive decline, dementia-related behaviors, psychosis, insomnia, grief, adjustment to illness, hospital follow-up, nursing facility evaluation, capacity-related concern, or safety assessment:

3b MOOD SYMPTOMS

Depressed mood, anhedonia, tearfulness, hopelessness, guilt, loneliness, apathy, irritability, low motivation, social withdrawal, grief symptoms, mood reactivity:

3c ANXIETY SYMPTOMS

Excessive worry, panic symptoms, restlessness, somatic anxiety, fear of falling, health-related anxiety, separation from caregiver, avoidance, anxiety-related functional impairment:

3d COGNITIVE SYMPTOMS

Memory loss, repetitive questioning, confusion, disorientation, word-finding difficulty, executive dysfunction, poor judgment, attention problems, visuospatial difficulty, fluctuations, progression of cognitive symptoms:

3e BEHAVIORAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA, IF APPLICABLE

Agitation, aggression, wandering, sundowning, paranoia, hallucinations, delusions, resistance to care, sleep-wake reversal, disinhibition, hoarding, repetitive behaviors, caregiver distress:

3f PSYCHOTIC SYMPTOMS

Hallucinations, delusions, paranoia, misidentification, suspiciousness, disorganized thinking, impaired reality testing:

3g SLEEP AND APPETITE

Insomnia, sleep maintenance difficulty, early awakening, hypersomnia, nightmares, REM behavior symptoms, sleep-wake reversal, daytime naps, appetite changes, weight loss, weight gain, hydration/nutrition concerns:

3h FUNCTIONAL STATUS

ADLs and IADLs — bathing, dressing, toileting, transfers, feeding, medication management, finances, cooking, shopping, driving, phone use, housework, ability to live independently:

3i MEDICAL AND NEUROLOGIC CONTEXT

Dementia, mild cognitive impairment, Parkinson disease, stroke, seizure disorder, chronic pain, sleep apnea, frailty, sensory impairment, falls, delirium history, cardiovascular disease, diabetes, renal disease, other conditions affecting psychiatric presentation:

3j MEDICATION HISTORY AND TREATMENT RESPONSE

Current psychiatric and non-psychiatric medications, adherence, missed doses, side effects, prior medication trials, sedating medications, anticholinergic burden, benzodiazepine use, opioids, polypharmacy concerns, medication changes, refill needs:

3k SUBSTANCE USE

Alcohol, tobacco, cannabis, sedative use, opioid use, prescription misuse, or other substance use — frequency, quantity, last use, withdrawal symptoms, impact on mood, cognition, falls, or sleep:

3l SAFETY CONCERNS

Suicidal ideation, self-harm, homicidal ideation, aggression, wandering, falls, driving risk, medication errors, stove safety, financial exploitation, neglect, abuse, access to weapons, need for higher level of care:

3m CAREGIVER / FACILITY INPUT

Caregiver or facility-reported behavior changes, medication adherence, sleep pattern, agitation triggers, safety concerns, functional decline, care burden, response to interventions, support needs:

3n PERTINENT NEGATIVES

Denial of suicidal ideation, homicidal ideation, hallucinations, delusions, acute confusion, recent falls, wandering, medication misuse, abuse/neglect concerns, or acute safety concerns when clinically relevant...

ROS GERIATRIC PSYCHIATRIC REVIEW OF SYSTEMS

DEPRESSION, APATHY, ANHEDONIA, HOPELESSNESS, LONELINESS, OR GRIEF SYMPTOMS

ANXIETY, PANIC SYMPTOMS, RESTLESSNESS, FEAR OF FALLING, OR HEALTH-RELATED WORRY

MEMORY LOSS, CONFUSION, DISORIENTATION, ATTENTION PROBLEMS, OR EXECUTIVE DYSFUNCTION

HALLUCINATIONS, PARANOIA, DELUSIONS, OR MISIDENTIFICATION

AGITATION, AGGRESSION, WANDERING, SUNDOWNING, OR RESISTANCE TO CARE

SLEEP DISTURBANCE, NIGHTMARES, REM BEHAVIOR SYMPTOMS, OR SLEEP-WAKE REVERSAL

APPETITE CHANGE, WEIGHT CHANGE, DEHYDRATION, FATIGUE, OR FRAILTY SYMPTOMS

FALLS, DIZZINESS, GAIT INSTABILITY, TREMOR, WEAKNESS, OR NEUROLOGIC SYMPTOMS

MEDICATION SIDE EFFECTS, SEDATION, ANTICHOLINERGIC EFFECTS, OR POLYPHARMACY CONCERNS

SUICIDAL IDEATION, SELF-HARM, HOMICIDAL IDEATION, ABUSE, NEGLECT, OR EXPLOITATION CONCERNS

O OBJECTIVE / MENTAL STATUS EXAMINATION

5a VITALS, IF OBTAINED

TEMPERATURE

OXYGEN SATURATION

BLOOD PRESSURE

WEIGHT / BMI IF RELEVANT

HEART RATE

ORTHOSTATIC VITALS, IF OBTAINED

RESPIRATORY RATE

5b MENTAL STATUS EXAMINATION

GENERAL APPEARANCE (GROOMING, HYGIENE, DRESS, APPARENT AGE, NUTRITIONAL APPEARANCE, FRAILTY, DISTRESS LEVEL)

BEHAVIOR (COOPERATION, EYE CONTACT, PSYCHOMOTOR ACTIVITY, AGITATION, RETARDATION, RESTLESSNESS, GUARDEDNESS, IMPULSIVITY, TREMOR, ABNORMAL MOVEMENTS, INTERACTION WITH CAREGIVER)

SPEECH (RATE, VOLUME, FLUENCY, ARTICULATION, COHERENCE, SPONTANEITY, LATENCY, WORD-FINDING DIFFICULTY, POVERTY OF SPEECH, PRESSURED SPEECH)

MOOD (PATIENT-REPORTED EMOTIONAL STATE; CAREGIVER-REPORTED MOOD PATTERN WHEN RELEVANT)

AFFECT (RANGE, CONGRUENCE, INTENSITY, REACTIVITY, LABILITY, RESTRICTION, APPROPRIATENESS)

THOUGHT PROCESS (LINEARITY, GOAL DIRECTION, CIRCUMSTANTIALITY, TANGENTIALITY, DISORGANIZATION, PERSEVERATION, THOUGHT BLOCKING, SLOWED THOUGHT PROCESS)

THOUGHT CONTENT (SI, HI, DELUSIONS, PARANOIA, GUILT, HOPELESSNESS, PREOCCUPATIONS, SOMATIC CONCERNS, CAREGIVER-RELATED CONCERNS)

PERCEPTION (AUDITORY OR VISUAL HALLUCINATIONS, ILLUSIONS, MISPERCEPTIONS, SUNDOWNING-RELATED PERCEPTUAL CHANGES, OR ABSENCE OF DISTURBANCE)

COGNITION (ORIENTATION, ATTENTION, CONCENTRATION, MEMORY, RECALL, EXECUTIVE FUNCTION, LANGUAGE, ABSTRACTION, VISUOSPATIAL ABILITY, COGNITIVE SCREENING FINDINGS)

INSIGHT (AWARENESS OF PSYCHIATRIC SYMPTOMS, COGNITIVE LIMITATIONS, SAFETY NEEDS, DIAGNOSIS, TREATMENT NEEDS, NEED FOR SUPPORT)

JUDGMENT (DECISION-MAKING, SAFETY AWARENESS, MEDICATION MANAGEMENT ABILITY, FINANCIAL JUDGMENT, DRIVING JUDGMENT, ABILITY TO USE CAREGIVER SUPPORT)

IMPULSE CONTROL (INTACT, LIMITED, IMPAIRED, OR FLUCTUATING)

SAFETY (ACUTE SAFETY CONCERNS, NEED FOR SUPERVISION, SAFETY PLAN, CAREGIVER MONITORING, FACILITY INTERVENTION, HIGHER LEVEL OF CARE)

AS COGNITIVE / FUNCTIONAL ASSESSMENT TOOLS

MOCA

MMSE

SLUMS

MINI-COG

PHQ-9 / GDS

GAD-7

C-SSRS

NEUROPSYCHIATRIC INVENTORY

AD8

FUNCTIONAL ACTIVITIES QUESTIONNAIRE

AIMS

FALLS RISK ASSESSMENT

SLEEP, BEHAVIOR, OR CAREGIVER BURDEN SCALES

Score, severity range, comparison to prior scores, informant source, clinical interpretation, and limitations such as sensory impairment, language, education, fatigue, delirium, or effort:

RA RISK ASSESSMENT

Suicidal ideation, plan, intent, means, prior attempts, and protective factors:

Self-harm thoughts, passive death wish, hopelessness, isolation, or access to lethal means:

Homicidal ideation, aggression, threats, target, means, and protective factors:

Psychosis-related safety concerns:

Dementia-related wandering, agitation, aggression, medication refusal, or unsafe behavior:

Fall risk, driving risk, medication mismanagement, stove/fire risk, financial exploitation, or self-neglect:

Abuse, neglect, exploitation, or domestic violence concerns:

Substance-related risk, intoxication, withdrawal, or sedative-related fall/cognitive risk:

OVERALL RISK LEVEL: LOW / MODERATE / HIGH

CLINICAL RATIONALE FOR RISK LEVEL

Safety plan, caregiver supervision plan, lethal means restriction, crisis resources, adult protective services involvement, emergency instructions, or higher level of care recommendation:

L LABORATORY AND DIAGNOSTIC RESULTS

Medication Monitoring Labs (CBC, CMP, LFTs, TSH, lipids, A1c, prolactin, lithium level, valproate level, renal function):

Cognitive / Reversible Cause Workup (B12, folate, vitamin D, TSH, infectious testing, RPR, HIV testing if indicated and consented, urinalysis, other delirium/cognitive workup):

Substance / Toxicology Testing (urine drug screen, alcohol testing, medication adherence testing, monitoring results):

Cardiac Monitoring (EKG/QTc when relevant to medication use, antipsychotic use, mood stabilizer use, or cardiac risk):

Neurologic / Medical Workup (brain imaging, EEG, sleep study, neuropsychological testing, fall evaluation, other studies relevant to psychiatric or cognitive symptoms):

Prior Records Reviewed (prior psychiatric records, primary care notes, neurology notes, neuropsychological testing, hospitalization records, emergency records, facility notes, medication administration records, therapy notes, collateral information):

A ASSESSMENT

Primary psychiatric diagnosis or working diagnosis. Differential diagnoses considered. Cognitive diagnosis or neurocognitive disorder status when applicable. Current symptom severity and clinical status: improving, stable, worsening, or fluctuating. Relationship of psychiatric symptoms to aging, medical illness, dementia, delirium, neurologic disease, grief, pain, sleep, medications, or psychosocial stressors. Functional impairment across ADLs, IADLs, living situation, caregiving needs, and safety. Medication response, adherence, side effects, polypharmacy concerns, and anticholinergic/sedative burden. Substance use contribution. Caregiver burden, facility concerns, and support needs. Current safety risk and protective factors. Need for medication changes, therapy, behavioral interventions, cognitive workup, lab monitoring, caregiver education, higher level of care, or care coordination...

P PLAN

Medication plan (initiation, continuation, dose adjustment, taper, discontinuation, refill, side effect monitoring, fall/cognitive risk review, anticholinergic burden reduction, medication education):

Behavioral and non-pharmacologic plan (structured routine, sleep-wake regulation, agitation trigger identification, environmental modification, caregiver strategies, reassurance techniques, activity scheduling, behavioral activation):

Therapy plan (supportive psychotherapy, grief counseling, CBT, problem-solving therapy, caregiver-based intervention, family therapy, adjustment-focused therapy):

Cognitive and dementia care plan (cognitive monitoring, neuropsychological testing, neurology referral, dementia medication management, caregiver education, safety planning, advance care planning):

Safety plan (fall precautions, driving assessment, medication supervision, wandering precautions, home safety, financial safety, lethal means restriction, crisis resources, higher level of care):

Sleep and lifestyle plan (sleep hygiene, daytime activity, exercise, nutrition, hydration, sensory support, social engagement, routine-building):

Laboratory or monitoring plan (medication levels, metabolic labs, renal/hepatic monitoring, EKG/QTc, AIMS, cognitive screening, repeat assessments):

Caregiver and facility coordination plan (family, assisted living/SNF staff, primary care, neurology, therapy, case management, social work, home health, adult protective services when authorized or required):

Disposition or level-of-care plan (home support, assisted living, memory care, skilled nursing, inpatient psychiatry, medical admission, emergency evaluation):

Patient and caregiver education (diagnosis, medication risks/benefits, side effects, expected response, behavioral strategies, warning signs, safety concerns, when to seek urgent care):

F FOLLOW-UP

Follow-up timeframe and purpose — symptom reassessment, medication response, side effect monitoring, cognition review, safety review, caregiver concerns, facility updates, lab review, behavioral plan response, or higher level of care follow-through:

TD TIME DOCUMENTATION, IF APPLICABLE

TOTAL TIME SPENT

CARE COORDINATION TIME

MEDICATION MANAGEMENT TIME

SAFETY PLANNING TIME

PSYCHOTHERAPY / COUNSELING TIME

RECORDS REVIEW TIME, IF APPLICABLE

CAREGIVER COUNSELING TIME

FACILITY / COLLATERAL COMMUNICATION TIME, IF APPLICABLE

TB BILLING CONSIDERATIONS

E/M LEVEL: 99203 / 99204 / 99205 / 99213 / 99214 / 99215

PSYCHOTHERAPY CODE(S), IF APPLICABLE: 90832 / 90834 / 90837

FAMILY PSYCHOTHERAPY CODE(S), IF APPLICABLE: 90846 / 90847

PSYCHIATRIC DIAGNOSTIC EVALUATION CODE, IF APPLICABLE: 90791 / 90792

BASIS FOR BILLING: TIME-BASED / MDM / PSYCHOTHERAPY / FAMILY OR CAREGIVER CONFERENCE / DIAGNOSTIC EVALUATION

PRIMARY GERIATRIC PSYCHIATRIC DIAGNOSIS CODE + DESCRIPTION

SECONDARY NEUROCOGNITIVE / MEDICAL DIAGNOSIS CODE(S), IF APPLICABLE

SO **SIGNATURE**

PROVIDER NAME	CREDENTIALS	SPECIALTY: GERIATRIC PSYCHIATRY	DATE	TIME