



# Perinatal Psychiatry Services

National Institute of Mental Health & Neuro Sciences, Bangalore 29



## MBU Clinical Assessment Form

MBU No:

Date of filling the form:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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dd / mm/ yr

UHID No:

P.No:

Patient Name:

Unit:

Age:

DOA:        
dd / mm / yr  
yr

DOD:        
dd / mm / yr

Spouse's Name:

Name of the Doctor:

Signature:



<b>Risk to others and other risks</b>								
Has the mother been violent towards other relatives or hospital staff?								
Does the mother have any medical illness? (Hypertension, Diabetes, Thyroid disorders, Anemia)								
Has the mother been having any infection? (HIV, Breast abscess, TB, MRSA, vaginal infection)								
Has the mother faced any form of violence from others in this episode? (e.g assault, evidence of injuries)								
<b>INFANT HEALTH</b>								
Does the baby have any health problem that requires care within 24 hours? (Diarrhea, Respiratory difficulties, High grade fever)								
Are there any immediate concerns related to infant feeding( does the baby need top feeds?)								

**Guidance Note-** Explain to the caregiver the purpose of this assessment and need for correct information to help us give the best possible care.

- Risk Assessment should be done in privacy
- The risk assessment should be subsequently done every day for the first one week of inpatient stay and for longer if needed
- The assessments done during the inpatient stay should include the last 24 hours as the time frame.

*If any of the above questions are answered as YES please inform the Post-doctoral Fellow in Women's Mental Health / Unit Senior Resident and Dr. Sundarnag G or Dr. Harish T or Dr. Geetha Desai or Dr. Prabha Chandra, MBU Consultants. This will help us in taking appropriate remedial and safety measures.*

**Consider referring the patient if any of the complications, mentioned below, is present.**

		Yes	No
1	Intense Headache.	<input type="checkbox"/>	<input type="checkbox"/>
2	Focal neurological deficits.	<input type="checkbox"/>	<input type="checkbox"/>
3	Seizures.	<input type="checkbox"/>	<input type="checkbox"/>
4	Papilledema.	<input type="checkbox"/>	<input type="checkbox"/>
5	Alteration of consciousness.	<input type="checkbox"/>	<input type="checkbox"/>
6	Cranial nerve palsy, especially 6 <sup>th</sup> CN	<input type="checkbox"/>	<input type="checkbox"/>
7	Sudden onset of pain, tenderness, redness and an increase in skin temp of the calf.	<input type="checkbox"/>	<input type="checkbox"/>
8	Chest pain.	<input type="checkbox"/>	<input type="checkbox"/>
9	Sudden shortness of breath.	<input type="checkbox"/>	<input type="checkbox"/>
10	Rapid respirations.	<input type="checkbox"/>	<input type="checkbox"/>
11	Air hunger/anxiety.	<input type="checkbox"/>	<input type="checkbox"/>
12	Circulatory collapse--weak, rapid pulse and hypotension.	<input type="checkbox"/>	<input type="checkbox"/>
13	Cyanosis.	<input type="checkbox"/>	<input type="checkbox"/>
14	Presence of post-partum hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>
15	Fever.	<input type="checkbox"/>	<input type="checkbox"/>
16	Profuse, foul smelling vaginal discharge, sometimes frothy.	<input type="checkbox"/>	<input type="checkbox"/>
17	Malaise, anorexia, chills, tachycardia.	<input type="checkbox"/>	<input type="checkbox"/>
18	Pelvic pain.	<input type="checkbox"/>	<input type="checkbox"/>
19	Elevated blood pressure	<input type="checkbox"/>	<input type="checkbox"/>

<b>Also Monitor for:</b>		Yes	No
	LSCS incision site for bleeding or infection	<input type="checkbox"/>	<input type="checkbox"/>
	Perineal pain due to episiotomy scar	<input type="checkbox"/>	<input type="checkbox"/>
	Haemorrhoids and constipation	<input type="checkbox"/>	<input type="checkbox"/>
	Marked engorgement and pain in breast	<input type="checkbox"/>	<input type="checkbox"/>
	Chills, Fever, tachycardia, hardness and reddening of breasts.	<input type="checkbox"/>	<input type="checkbox"/>

UHID NO:

**A1** **SOCIO - DEMOGRAPHIC PROFILE**

<b>PATIENT DETAILS</b>	<b>Name of the Patient</b>
	<b>Spouse's Name</b>
	<b>Age in Years</b>
	<b>Address:</b>
	<b>Mobile No. of the Patient :</b>
	<b>Mobile No. of the Husband:</b>
	<b>Mobile No. of the Caregiver:</b>
	<b>Years of Education (Patient)</b>
	<b>Marital Status:</b> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/>
	<b>Duration of Marriage:</b> Years <input type="text"/> <input type="text"/> Months <input type="text"/> <input type="text"/>
	<b>Religion:</b> Hindu <input type="checkbox"/> Christian <input type="checkbox"/> Muslim <input type="checkbox"/> Others <input type="checkbox"/>
	<b>Socioeconomic Status:</b> BPL <input type="checkbox"/> APL <input type="checkbox"/>
	<b>Family Income:</b> (as declared in hospital record) _____ (per month)
	<b>Domicile:</b> Urban <input type="checkbox"/> Semi urban <input type="checkbox"/> Rural <input type="checkbox"/>

**Occupation:**

Home maker	<input type="checkbox"/>
Manual Labour	<input type="checkbox"/>
Govt . Employee	<input type="checkbox"/>
Private Professional	<input type="checkbox"/>
Others(Specify)	<input type="checkbox"/>
_____	

**B****Spouse & Family**

<b>SPOUSE DETAILS</b>	<b>Age of the Spouse:</b> _____
	<b>Education of the Spouse( in Years)</b> _____
	<b>Occupation of the Spouse</b>
	Unemployed <input type="checkbox"/>
	Unskilled <input type="checkbox"/>
	Skilled <input type="checkbox"/>
	Private <input type="checkbox"/>
	Government <input type="checkbox"/>
Professional <input type="checkbox"/>	
Others <input type="checkbox"/>	
Income of the Spouse (per month) _____	
Spouse's mental health problems? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Spouse's ADS or other substance abuse? Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>FAMILY DETAILS</b>	<b>Type of family:</b>
	Nuclear family <input type="checkbox"/> Joint family <input type="checkbox"/> Extended family <input type="checkbox"/>
	<b>Family history of mental illness:</b>
	Present <input type="checkbox"/> Absent <input type="checkbox"/>
	If Present who is affected: 1 <sup>o</sup> <input type="checkbox"/> 2 <sup>o</sup> <input type="checkbox"/> 3 <sup>o</sup> <input type="checkbox"/>
	<b>If yes, nature of illness:</b> _____
	<b>History of consanguinity:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>
	<b>If yes degree of consanguinity</b> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/>
	<b>Family history of pregnancy related postpartum</b>
	Mental illness Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>If yes, in whom?</b> Mother <input type="checkbox"/> Grand Mother <input type="checkbox"/> Sister <input type="checkbox"/> Others <input type="checkbox"/>	
<b>Diagnosis of Postpartum mental Illness or pregnancy related illness:</b> _____	

## C

## Support Scale

<b>Employment during the pregnancy (If mother was employed)</b>	
No change (or improvement) in the employment noted	0
Mother gave up her work by choice	1
Mother experienced adversity at work due to the pregnancy	2
Mother lost her employment because of pregnancy	3
Mother was unemployed at the start of the pregnancy	8
<b>Hardship during pregnancy (This covers housing and financial problems)</b>	
No hardship	0
Some financial stringency	1
Destitution, homelessness or abject poverty	2
<b>Relationship with baby's father before the pregnancy</b>	
The couple are much in love and the best of friends	0
The relationship has its ups and downs, but is harmonious	1
There are frequent quarrels	2
There was major friction, with threats to leave	3
Periods of separation or intimate partner violence have already occurred	4
<b>Relationship with baby's father during the pregnancy</b>	
The pregnancy has improved the relationship	0
No change	1
The relationship has deteriorated	2
The relationship has severely deteriorated, resulting in violence, or threats to leave	3
The relationship has come to an end since the beginning of the pregnancy	4
<b>Support provided by baby's father during the pregnancy</b>	
More support than usual	0
No change	1
Less or insufficient support	2
No support	3
<b>Relationship with family of origin</b>	
The pregnancy has improved the relationship	0
No change, and no major problem	1
No change, but poor	2
The relationship has deteriorated	3
The relationship has severely deteriorated	4

<b>Relationship with family by marriage</b>	
The pregnancy has improved the relationship	0
No change, and no major problem	1
No change, but poor	2
The relationship has deteriorated	3
The relationship has severely deteriorated	4
<b>Family and network emotional and practical support during pregnancy This is an overview of the total support, in addition to that supplied by child's father</b>	
Plenty of support	0
Some support, but insufficient	1
No support	2
<b>Intimate partner psychological, physical or sexual violence during the pregnancy</b>	
None	0
There is an atmosphere of criticism, humiliation, over control or belittling, with hurtful remarks	1
Threats of violence	2
At least one incident of physical abuse	3
Severe or recurrent abuse ( <u>or</u> physical abuse directed at the abdomen)	4



# GENOGRAM

**D. Obstetric History**

**C1. Past Pregnancies & Postpartum**

	History of PMDD, PMS	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>
	Parity:	Primi	Multi	<input type="checkbox"/>	<input type="checkbox"/>
	<b>If Primi, go to D.1 current pregnancy section</b>				
<b>GPLA</b>	Any h/o abortion?	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>
	If yes, was it,	Spontaneous	Induced	<input type="checkbox"/>	<input type="checkbox"/>
	Any h/o still-birth?		Yes	No	<input type="checkbox"/>
	Any h/o neonatal complications/ NICU care in previous pregnancy?	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>
	If yes details:				
	H/o treatment for infertility?	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>
	If yes, Details:				
	Any preference about the gender of baby during previous pregnancy?	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>

<b>Antenatal Details of previous pregnancies</b>	<b>Antenatal visits</b> Regular Irregular <input type="checkbox"/> <input type="checkbox"/>
	<b>IFA supplementation</b> Regular Irregular <input type="checkbox"/> <input type="checkbox"/>
	<b>USG abdomen/pelvis</b> Done Not Done <input type="checkbox"/> <input type="checkbox"/>
	<b>Other Medication Use in pregnancy including psychotropics</b> Yes No <input type="checkbox"/> <input type="checkbox"/>
	<b>Anemia</b> Yes No <input type="checkbox"/> <input type="checkbox"/>
	<b>Hyperemesis gravidarum</b> Yes No <input type="checkbox"/> <input type="checkbox"/>
	<b>Antepartum hemorrhage</b> Yes No <input type="checkbox"/> <input type="checkbox"/>
	<b>Labour complications</b> Yes No <input type="checkbox"/> <input type="checkbox"/>
	<b>Preeclampsia/Eclampsia</b> Yes No <input type="checkbox"/> <input type="checkbox"/>
	<b>Gestational diabetes mellitus</b> Yes No <input type="checkbox"/> <input type="checkbox"/>
	<b>Any Surgical wound complications</b> Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>Delivery details of previous pregnancies</b>	Duration of Gestation Term <input type="checkbox"/> Pre-term <input type="checkbox"/> st-term <input type="checkbox"/>
	Mode of Delivery Normal <input type="checkbox"/> LSCS <input type="checkbox"/> Forceps <input type="checkbox"/>
	Place of Delivery Home <input type="checkbox"/> Hospital <input type="checkbox"/>
<b>Pregnancy Outcome of previous pregnancies</b>	Healthy Baby <input type="checkbox"/> Baby had neonatal problems <input type="checkbox"/> Still birth <input type="checkbox"/>
	IVGR <input type="checkbox"/> Congenital anomalies <input type="checkbox"/> Early neonatal death <input type="checkbox"/>
	Developmental delay <input type="checkbox"/> Other health problems <input type="checkbox"/>
	<b>Breast Feeding</b> Yes <input type="checkbox"/> No <input type="checkbox"/>

**D1****Current Pregnancy & Postpartum Period**

<b>Antenatal</b>	Is the current pregnancy planned? Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
	If unplanned, was termination considered? Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
	If yes provide details.....	
	What was the regularity of Visits Antenatal	
	Care during recent Pregnancy	<3 <input type="checkbox"/>
	(Minimum 3 ANC visits) No. of visits	>3 <input type="checkbox"/>
	What was the attitude of the mother towards current pregnancy	Positive <input type="checkbox"/> Negative/Indifference <input type="checkbox"/> Hostile <input type="checkbox"/>
	Quality of Maternal fetal bonding	Positive <input type="checkbox"/> Neutral <input type="checkbox"/> Negative <input type="checkbox"/>
Where there any attempts at fetal harm/ risk posed to foetus because of mental health? If yes,	Yes <input type="checkbox"/> No <input type="checkbox"/> Deliberate <input type="checkbox"/> Non-deliberate <input type="checkbox"/>	

(tick $\checkmark$ if present, X if absent)	1 <sup>st</sup> Trimester	2 <sup>nd</sup> Trimester	3 <sup>rd</sup> Trimester	During labour & Immediate Postpartum
Antenatal visits				
IFA supplementation				
USG abdomen/pelvis				
Other Medication Use in pregnancy including psychotropics				
Obesity				
Hyperemesis gravidarum				
Antepartum hemorrhage				
Labour complications				
Preeclampsia/Eclampsia				
Gestational diabetes mellitus				
Anemia				
Any Surgical wound complications				
Thyroid dysfunction				
Hypertension				

<b>Delivery details of current pregnancy</b>	Duration of Gestation   Term <input type="checkbox"/> Pre-term <input type="checkbox"/> Post-term <input type="checkbox"/>
	Mode of Delivery   Normal <input type="checkbox"/> LSCS <input type="checkbox"/> Forceps <input type="checkbox"/>
	Place of Delivery   Home <input type="checkbox"/> Hospital <input type="checkbox"/>
<b>Pregnancy Outcome of current pregnancy</b>	Healthy Baby <input type="checkbox"/> Baby had neonatal problems <input type="checkbox"/> Still birth <input type="checkbox"/>
	IVGR <input type="checkbox"/> Congenital anomalies <input type="checkbox"/> Early neonatal death <input type="checkbox"/>
	Developmental delay <input type="checkbox"/> Other health problems <input type="checkbox"/>

<b>Painful or distressing experience of parturition</b>	Easy delivery <input type="checkbox"/>
	Delivery was painful but mother felt in control and was not greatly distressed <input type="checkbox"/>
	Pain was severe and prolonged, and delivery a distressing experience <input type="checkbox"/>
	Extreme pain and distress, eg. Fear of her own death <input type="checkbox"/>
	Any h/o neonatal complications/NICU care? Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, details:
<b>Medical Complications during postpartum</b>	PPH <input type="checkbox"/>
	CVT <input type="checkbox"/>
	Anemia <input type="checkbox"/>
	HT <input type="checkbox"/>
	Infections <input type="checkbox"/>
	Thyroid disorders <input type="checkbox"/>
	Breast abscess/mastitis <input type="checkbox"/>

**D2****MENTAL HEALTH HISTORY****Antenatal Mental Health History**

<b>Anxiety symptoms</b>		
<b>Anxiety During pregnancy</b>	No anxiety or undue worrying	<b>0</b>
	Mild Anxiety/Worrying – mother was able to control her symptoms	<b>1</b>
	Moderate anxiety/worrying – Symptoms impair functioning or sleep	<b>2</b>
	Severe anxiety/worrying – incapacitating for everyday activities	<b>3</b>

<b>Depressive symptoms</b>		
<b>Prenatal Depression</b>	No depression	<b>0</b>
	Mild Depression – mother was able to control her symptoms	<b>1</b>
	Moderate depression – symptoms impair functioning	<b>2</b>
	Severe depression – incapacitating for everyday activities	<b>3</b>

<b>Obsessive Compulsive symptoms during pregnancy</b>		
No evidence of obsessional disorder		<b>0</b>
Pre-existing obsessional ideas or rituals during pregnancy		<b>1</b>
New onset of obsessional compulsive disorder during pregnancy		<b>2</b>
Obsessional aggressive or sexual thoughts or impulses about the foetus or other children combinations can be coded by the addition of two ratings, for example, 5= a new onset of compulsive rituals and obsessions of infanticide.		<b>3</b>

<b>Severity of prepartum obsessive/compulsive disorder</b>		
No obsessive/compulsive disorder		<b>0</b>
Mild obsessive/compulsive disorder – mother was above to control her symptoms		<b>1</b>
Moderate obsessive/compulsive disorder – symptoms impaired functioning		<b>2</b>
Severe obsessive/compulsive disorder – incapacitating for everyday activities		<b>3</b>

<b>Irritability</b>		
Never		<b>0</b>
Seldom, and not more than usual		<b>1</b>
More frequently than before the pregnancy		<b>2</b>
Often		<b>3</b>

<b>Sleep</b>		
No insomnia		<b>0</b>
Sleeplessness a problem		<b>1</b>
Insomnia one of her main complaints		<b>2</b>
Hypersomnolism		<b>7</b>

**Excessive worries about the outcome/fetal health of pregnancy**

Yes  No

**If yes,**

- Fear of Parturition
- Fear of foetal death
- Fear of foetal abnormality or other fears about health of unborn child
- Fear of inadequacy as a mother
- Fear of occurrence or recurrence of mental illness
- Fear that there will be too little support
- Financial worries

**Fear of labour (Pain, distress, bleeding)**

Yes  No

**Fear of injections and surgeries**

Yes  No

**Any other**

Yes  No

**If yes for any of the above, please provide details on the onset, severity, impact and coping**

Any history of self harm during pregnancy?

Yes  No

If yes details:



**D3****Medical & Psychiatric Past History**

<b>Past History</b>	Any chronic/major medical illness	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
	If yes, nature/ Medical Illness Details						
	Past history of any psychiatric illness?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
	If Yes,	In patient	<input type="checkbox"/>	Out patient	<input type="checkbox"/>	No Medical Treatment	<input type="checkbox"/>
	Diagnosis of past episodes _____						
	Age at onset of the illness _____						
	Duration of Illness _____ (in months)						
	Number of hospitalizations: _____						
	Number of relapses: _____						
	Who is supervising patient medication: _____ (relationship to the patient)						



**Any history of impaired intellectual development ?**

Yes

No

**If yes, details**

**Pre morbid Personality traits**

Anxious

Dependent

Emotionally unstable

Paranoid

Schizoid

Schizotypal

Anankastic

Histrionic

Narcistic

Anti-social

Other Neurotic traits

Somatization

**E1**

**Current Clinical Profile Of The Patient**

When did the first symptom appear? Pregnancy (weeks)  Postpartum (Days)

What was the first symptom to appear? \_\_\_\_\_

After how many days of onset of symptoms, did they seek help from a mental health professional?  Days

First help sought – General practitioner

Faith healer

Complementary and alternative medicine systems

Psychiatrist

Duration of current episode or exacerbation in days

Current ICD 10 Diagnosis \_\_\_\_\_

<b>PSYCHOPATHOLOGY</b>	Infant related delusions	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Infant related hallucinations	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Catatonia	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
<b>PSYCHOTIC/overvalued IDEAS ABOUT THE BABY</b>	Someone will take the baby away		<input type="text" value="1"/>		
	Someone will kill or harm the baby		<input type="text" value="2"/>		
	The baby is a devil/ill fated		<input type="text" value="3"/>		
	The baby is god/ has special powers		<input type="text" value="4"/>		
	It is someone else's baby		<input type="text" value="5"/>		
	Baby has an illness/problem		<input type="text" value="6"/>		
	Any other, describe:				

**E2****Relevant Rating Scales to be filled**

Admission

1<sup>st</sup> Week2<sup>nd</sup> Week

at Discharge

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

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

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

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

1. EPDS 2. EPDS 3. EPDS 4. EPDS 1. YMRS 2. YMRS 3. YMRS 4. YMRS 1. BPRS 2. BPRS 3. BPRS 4. BPRS 1. BFCRS 2. BFCRS 3. BFCRS 4. BFCRS 1. YBOCS 2. YBOCS 3. YBOCS 4. YBOCS 1. CGI 2. CGI 3. CGI 4. CGI

## **RATING SCALES**

1. Catatonia
2. Brief Psychiatric Rating Scale
3. Edinburgh Postnatal Depression Scale
4. YMRS
5. CGI

## CATATONIA RATING SCALE

Use the presence or absence of items 1 - 14 for screening & 0 - 3 scale for items 1 -23 to rate severity.

<b>Excitement</b>	Extreme hyperactivity, constant motor unrest which is apparently non-purposeful. Not to be attributed to akathisia or goal-directed agitation.	<p>Absent <span style="float: right; border: 1px solid black; padding: 2px 5px;">0</span></p> <p>Excessive Motion, Intermittent <span style="float: right; border: 1px solid black; padding: 2px 5px;">1</span></p> <p>Constant motion, hyperkinetic without rest periods <span style="float: right; border: 1px solid black; padding: 2px 5px;">2</span></p> <p>Full-blown catatonic excitement, endless frenzied motor activity. <span style="float: right; border: 1px solid black; padding: 2px 5px;">3</span></p>
<b>Immobility/stupor</b>	Extreme hypoactivity, immobile, minimally responsive to stimuli.	<p>Absent. <span style="float: right; border: 1px solid black; padding: 2px 5px;">0</span></p> <p>Sits abnormally still, may interact briefly. <span style="float: right; border: 1px solid black; padding: 2px 5px;">1</span></p> <p>Virtually no interaction with external world. <span style="float: right; border: 1px solid black; padding: 2px 5px;">2</span></p> <p>Stuporous, non-reactive to painful stimuli. <span style="float: right; border: 1px solid black; padding: 2px 5px;">3</span></p>
<b>Mutism</b>	Verbally unresponsive or minimally responsive	<p>Absent. <span style="float: right; border: 1px solid black; padding: 2px 5px;">0</span></p> <p>Verbally unresponsive to majority of questions; incomprehensible whisper. <span style="float: right; border: 1px solid black; padding: 2px 5px;">1</span></p> <p>Speaks less than 20 words/5mins <span style="float: right; border: 1px solid black; padding: 2px 5px;">2</span></p> <p>No speech. <span style="float: right; border: 1px solid black; padding: 2px 5px;">3</span></p>
<b>Staring</b>	Fixed gaze, little or no visual scanning of environment, decreased blinking	<p>Absent <span style="float: right; border: 1px solid black; padding: 2px 5px;">0</span></p> <p>Poor eye contact, repeatedly gazes less than 20 s between shifting of attention; decreased blinking <span style="float: right; border: 1px solid black; padding: 2px 5px;">1</span></p> <p>Gaze held longer than 20 s, occasionally shifts attention <span style="float: right; border: 1px solid black; padding: 2px 5px;">2</span></p> <p>Fixed gaze, non-reactive <span style="float: right; border: 1px solid black; padding: 2px 5px;">3</span></p>

<b>Posturing/catalepsy</b>	Spontaneous maintenance of posture (s), including mundane (e.g. sitting or standing for long periods without reacting)	Absent.	0
		Less than 1 mm	1
		Greater than one minute, less than 15 mm.	2
		Bizarre posture, or mundane maintained more than 15 mm	3
<b>Grimacing</b>	Maintenance of odd facial expressions	Absent.	0
		Less than 10s	1
		Less than 1 mm	2
		Bizarre expression(s) or maintained more than 1 mm.	3
<b>Echopraxia/echolalia</b>	Mimicking of examiner's movements/speech	Absent	0
		Occasional	1
		Frequent	2
		Constant	3
<b>Stereotypy</b>	Repetitive, non-goal-directed motor activity (e.g. finger-play, repeatedly touching, patting or rubbing self); abnormality not inherent in act but in its frequency	Absent	0
		Occasional	1
		Frequent	2
		Constant	3
<b>Mannerisms</b>	Odd, purposeful movements (hopping or walking tiptoe, saluting passers-by or exaggerated caricatures of mundane movements); abnormality inherent in act itself.	Absent	0
		Occasional	1
		Frequent	2
		Constant	3
<b>Verbigeration</b>	Repetition of phrases or sentences (like a scratched records)	Absent	0
		Occasional	1
		Frequent	2
		Constant	3



<b>Rigidity</b>	Maintenance of a rigid position despite efforts to be moved, exclude if cog-wheeling or tremor present	Absent	0
		Mild resistance	1
		Moderate	2
		Severe, cannot be repositioned	3
<b>Negativism</b>	Apparently motiveless resistance to instructions or attempts to move/examine patients. Contrary behaviour, does exact opposite of instruction.	Absent	0
		Mild resistance and/or occasionally contrary	1
		Moderate resistance and/or frequently contrary	2
		Severe resistance and/or continually contrary	3
<b>Waxy flexibility</b>	During repositioning of patient, patient offers initial resistance before allowing himself to be repositioned, similar to that of a bending candle	Absent	0
		Present	3
<b>Withdrawal</b>	Refusal to eat, drink and/or make eye contact	0 = Absent.	0
		1 = Minimal PO intake/interaction for less than 1 day.	1
		2 = Minimal PO intake/interaction for more than 1 day.	2
		3 = No PO intake/interaction for 1 day or more	3
<b>Impulsivity</b>	Patient suddenly engages in inappropriate behaviour (e.g. runs down hallway, starts screaming or takes off clothes) without provocation. Afterwards can give no, or only a facile explanation.	Absent	0
		Occasional	1
		Frequent	2
		Constant or not redirectable	3

<b>Automatic obedience</b>	Exaggerated cooperation with examiner's request or spontaneous continuation of movement requested	Absent	0
		Occasional	1
		Frequent	2
		Constant	3
<b>Mitgehen</b>	"Anglepoise lamp" arm raising in response to light pressure of finger, despite instructions to the contrary	Absent	0
		Present	3
<b>Gegenhalten</b>	Resistance to passive movement which is proportion to strength of the stimulus, appears automatic rather than willful	Absent	0
		Present	3
<b>Ambitendency</b>	Patient appears "motorically stuck" in indecisive, hesitant movement	Absent	0
		Present	3
<b>Grasp reflex:</b>	Per neurological exam.	Absent	0
		Present	3
<b>Perseveration</b>	Repeatedly returns to same topic or persists with movement	Absent	0
		Present	3
<b>Combativeness</b>	Usually in an undirected manner, with no, or only a facile explanation afterwards	Absent	0
		Occasionally strikes out, low potential for injury	1
		Frequently strikes out, moderate potential for injury	2
		Serious danger to others	3

<b>Autonomic abnormality</b>	Circle: temperature, BP, pulse, respiratory rate, diaphoresis.	Absent	<input type="text" value="0"/>
		Abnormality of one parameter (exclude pre-existing hypertension).	<input type="text" value="1"/>
		Abnormality of two parameters	<input type="text" value="2"/>
		Abnormality of three or more parameters	<input type="text" value="3"/>

### **Appendix I Standardized examination for catatonia**

The method described here is used to complete the 23-item Bush-Francis Catatonia Rating Scale (CRS) and the 14-item Catatonia Screening Instrument (CSI). Item definitions on the two scales are the same. The CRS measures the severity of 23 signs on a 0- 3 scale, while the CSI measures only the presence or absence of the first 14 signs.

Ratings are to be made solely on the basis of observed behaviour during the examination with the exception of completion of the items for 'withdrawal' and autonomic abnormality', which may be based on directly observed behaviour and for chart documentation.

As a general rule, only rate items which are clearly present If uncertain as to the presence of an item, rate the item as '0'.

## Brief Psychiatric Rating Scale

From Ventura, Green, Shaner&Lieberman (1993) Training and quality assurance with the Brief Psychiatric Rating Scale. "The Drift buster" International Journal of Methods in Psychiatric Research.

### Instructions

This form consists of 24 symptom constructs, each to be rated in a 7-point scale of severity ranging from „not present" to „extremely severe" If a specific symptom is not rated, mark „NA" (No assessed). Circle the number headed by the term that best describes the patient's present condition.

1	2	3	4	5	6	7
Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe

1	Somatic Concern	NA	1	2	3	4	5	6	7
2	Anxiety	NA	1	2	3	4	5	6	7
3	Depression	NA	1	2	3	4	5	6	7
4	Suicidality	NA	1	2	3	4	5	6	7
5	Guilt	NA	1	2	3	4	5	6	7
6	Hostility	NA	1	2	3	4	5	6	7
7	Elated Mood	NA	1	2	3	4	5	6	7
8	Grandiosity	NA	1	2	3	4	5	6	7
9	Suspiciousness	NA	1	2	3	4	5	6	7
10	Hallucinations	NA	1	2	3	4	5	6	7
11	Unusual thought content	NA	1	2	3	4	5	6	7
12	Bizarre behaviour	NA	1	2	3	4	5	6	7
13	Self-neglect	NA	1	2	3	4	5	6	7
14	Disorientation	NA	1	2	3	4	5	6	7
15	Conceptual disorganization	NA	1	2	3	4	5	6	7
16	Blunted affect	NA	1	2	3	4	5	6	7
17	Emotional Withdrawal	NA	1	2	3	4	5	6	7
18	Motor retardation	NA	1	2	3	4	5	6	7
19	Tension	NA	1	2	3	4	5	6	7
20	Uncooperativeness	NA	1	2	3	4	5	6	7
21	Excitement	NA	1	2	3	4	5	6	7
22	Distractibility	NA	1	2	3	4	5	6	7
23	Motor hyperactivity	NA	1	2	3	4	5	6	7
24	Mannerisms and posturing	NA	1	2	3	4	5	6	7

# Edinburgh Postnatal Depression Scale<sup>1</sup> (EPDS)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Your Date of Birth: \_\_\_\_\_

Baby's Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time      This would mean: "I have felt happy most of the time" during the past week.
- No, not very often      Please complete the other questions in the same way.
- No, not at all
- 

In the past 7 days:

1. I have been able to laugh and see the funny side of things  
As much as I always could  
 Not quite so much now  
 Definitely not so much now  
 Not at all
2. I have looked forward with enjoyment to things  
As much as I ever did  
 Rather less than I used to  
 Definitely less than I used to  
 Hardly at all
- \*3. I have blamed myself unnecessarily when things went wrong  
Yes, most of the time  
 Yes, some of the time  
 Not very often  
 No, never
4. I have been anxious or worried for no good reason  
No, not at all  
Hardly ever  
Yes, sometimes  
Yes, very often
- \*5 I have felt scared or panicky for no very good reason  
Yes, quite a lot  
Yes, sometimes  
No, not much  
No, not at all
- \*6. Things have been getting on top of me  
Yes, most of the time I haven't been able to cope at all  
 Yes, sometimes I haven't been coping as well as usual  
 No, most of the time I have coped quite well  
 No, I have been coping as well as ever
- \*7 I have been so unhappy that I have had difficulty sleeping  
Yes, most of the time  
Yes, sometimes  
 Not very often  
 No, not at all
- \*8 I have felt sad or miserable  
Yes, most of the time  
 Yes, quite often  
 Not very often  
 No, not at all
- \*9 I have been so unhappy that I have been crying  
Yes, most of the time  
Yes, quite often  
Only occasionally  
No, never
- \*10 The thought of harming myself has occurred to me  
Yes, quite often  
Sometimes  
Hardly ever  
Never

Administered/Reviewed by \_\_\_\_\_

Date \_\_\_\_\_

# Edinburgh Postnatal Depression Scale<sup>1</sup> (EPDS)

Postpartum depression is the most common complication of childbearing.<sup>2</sup> The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for “perinatal” depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt **during the previous week**. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women’s Health Information Center <[www.4women.gov](http://www.4women.gov)> and from groups such as Postpartum Support International <[www.chss.iup.edu/postpartum](http://www.chss.iup.edu/postpartum)> and Depression after Delivery <[www.depressionafterdelivery.com](http://www.depressionafterdelivery.com)>.

## SCORING

### QUESTIONS 1, 2, & 4 (without an \*)

Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

### QUESTIONS 3, 5-10 (marked with an \*)

Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30

Possible Depression: 10 or greater

Always look at item 10 (suicidal thoughts)

Users may reproduce the scale without further permission, providing they respect copyright by quoting the names of the authors, the title, and the source of the paper in all reproduced copies.

### Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

<sup>1</sup> Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

<sup>2</sup> Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

## YMRS SCALE

SI No.		Admission	Discharge
1.	<b>Elevated Mood</b>		
	0 Absent		
	1 Mild or Possibly Increase on questioning		
	2 Definite subjective elevation; optimistic, self-confident, cheerful, appropriate to content		
	3 Elevated; inappropriate to content, humorous		
	4 Euphoric; inappropriate laughter; singing		
2.	<b>Increased Motor Activity-Energy</b>		
	0 Absent		
	1 Subjectively increased		
	2 Animated; gestures increased		
	3 Excessive energy; hyperactive at times; restless (can be calmed)		
	4 Motor excitement; continuous hyperactivity (cannot be calmed)		
3	<b>Sexual Interest</b>		
	0 Normal; not increased		
	1 Mildly or possibly increased		
	2 Definite subjective increase on questioning		
	3 Spontaneous sexual content; elaborates on sexual matters; hypersexual by self report		
	4 Overt sexual acts (toward patients, staff, or interviewer)		
4	<b>Sleep</b>		
	0 Reports on decrease in sleep		
	1 Sleeping less than normal amount by up to one hour		
	2 Sleeping less than normal by more than one hour		
	3 Reports decreased need for sleep		
	4 Denies need for sleep		
5	<b>Irritability</b>		
	0 Absent		
	2 Subjectively increased		
	4 Irritable at times during interview; recent episodes of anger or annoyance on ward		
	6 Frequently irritable during interview; short, curt throughout		
	8 Hostile, uncooperative; interview impossible		
6	<b>Speech (Rate and Amount)</b>		
	0 No increase		
	2 Feels talkative		
	4 Increased rate or amount at times, verbose at times		
	6 Push; consistently increased rate and amount; difficult to interrupt		
	8 Pressured; uninterruptible, continuous speech		
7	<b>Language-Thought Disorder</b>		
	0 Absent		
	1 Circumstantial; mild distractibility; quick thoughts		
	2 Distractible, loses goal of thought; changes topics frequently; racing thoughts		
	3 Flight of ideas; tangentiality; difficult to follow; rhyming, echolalia		
	4 Incoherent; communication impossible		
8	<b>Content</b>		
	0 Normal		
	2 Questionable plans, new interests		
	4 Special project(s); hyper-religious		
	6 Grandiose or paranoid ideas; ideas of reference		
	8 Delusions; hallucinations		

9	<b>Disruptive-Aggressive Behavior</b>			
	0	Absent, cooperative		
	2	Sarcastic; loud at times, guarded		
	4	Demanding; threats on ward		
	6	Threatens interviewer; shouting; interview difficult		
	8	Assaultive, destructive; interview impossible		
10	<b>Appearance</b>			
	0	Appropriate dress and grooming		
	1	Minimally unkempt		
	2	Poorly groomed; moderately disheveled; overdressed		
	3	Disheveled; partly clothed; garish make-up		
	4	Completely unkempt; decorated; bizarre garb		
11	<b>Insight</b>			
	0	Present; admits illness; agrees with need for treatment		
	1	Possibly ill		
	2	Admits behaviors change, but denies illness		
	3	Admits possible change in behavior, but denies illness		
	4	Denies only behavior change		



## Clinical Global Impression (CGI)

### 1. Severity of illness

Considering your clinical experience with this particular population, how severely ill is the patient at this time!

- 0 = Not assessed      4 = Moderately ill  
 1 = Normal, not at all ill      5 = Markedly ill  
 2 = Borderline mentally ill      6 = Severely ill  
 3 = Mildly ill      7 = Among the most extremely ill patients

### 2. Global improvement: Rate overall improvement whether or not, in your judgement, it is due entirely to drug treatment

Compared to his condition at admission to the project, how much has he changed!

- 0 = Not assessed      4 = No change  
 1 = Very much improved      5 = 'Slightly' worse  
 2 = Much improved      6 = Much worse  
 3 = 'Slightly' improved      7 = Very much worse

### 3. Efficacy index: Rate this item on the basis of drug effect only.

Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with patient's functioning'.

Therapeutic effect		Side effects			
		None	Do not significantly interfere with patient's functioning	Significantly interfere with patient's functioning	Outweighs the therapeutic effect
<b>Marked</b>	<b>Vast improvement</b> Complete or nearly complete remission of all symptoms	01	02	03	04
Moderate	Decided improvement Partial remission of	05	06	07	08
<b>Minimal</b>	Slight improvement which doesn't alter status of care of patient	09	10	11	12
Unchanged or worse		13	14	15	16
Not assessed = 00					

Reproduced from Guy W, editor. ECDEU Assessment Manual for Psychopharmacology. 1976. Rockville, MD, U.S. Department of Health, Education, and Welfare

# **INFANT ASSESSMENTS**

**F1****INFANT HISTORY**

<b>DOB of the baby</b>	<b>Date</b> <input type="text"/> <input type="text"/> <b>Month</b> <input type="text"/> <input type="text"/> <b>Year</b> <input type="text"/> <input type="text"/>
<b>Baby Age in weeks</b>	<input type="text"/>
<b>Birth weight of baby in kgs</b>	<input type="text"/>
<b>Gender of the baby</b>	Male <input type="checkbox"/> Female <input type="checkbox"/>
<b>If Twins</b>	Both Female <input type="checkbox"/> Both Male <input type="checkbox"/> One Male and one Female <input type="checkbox"/>
<b>Mother infant Joint Admission at intake</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Was the baby admitted at a later point of time after mother's admission?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>If yes mention the reasons</b>	
<b>Separation of infant following joint admissions at MBU</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>If not admitted initially mention the reasons</b>	
<b>INFANT HEALTH</b>	Congenital Anomalies: Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes Major <input type="checkbox"/> Minor <input type="checkbox"/>
	Details:
<b>Developmental milestones:</b>	Motor Adequate for age <input type="checkbox"/> Inadequate <input type="checkbox"/>
	Social Adequate for age <input type="checkbox"/> Inadequate <input type="checkbox"/>
	Language Adequate for age <input type="checkbox"/> Inadequate <input type="checkbox"/>
<b>Immunization</b>	BCG OPV <input type="checkbox"/> DPT <input type="checkbox"/>
<b>H/o NICU/Care</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Physical examination:</b>	<b>Weight</b> <input type="text"/>
	<b>Height</b> <input type="text"/>
	<b>Head Circumference</b> <input type="text"/>

<b>Baby's Health status (from birth till date)</b>	Normal	<input type="checkbox"/>
	Infections	<input type="checkbox"/>
	Congenital Anomalies	<input type="checkbox"/>
	LBW	<input type="checkbox"/>
	Nutritional Problems	<input type="checkbox"/>
	Serious Physical Illness	<input type="checkbox"/>
	Others	<input type="checkbox"/>
<b>Reaction of mother and family to gender of infant</b>	How happy are you with baby's gender?	Disappointed <input type="checkbox"/> Happy <input type="checkbox"/> Neither disappointed nor happy <input type="checkbox"/>
	How happy are your spouse/in-laws with the baby's gender?	Disappointed <input type="checkbox"/> Happy <input type="checkbox"/> Neither disappointed nor happy <input type="checkbox"/>
	Critical Comments from family, friends about gender of baby	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Reaction to Babies Appearance</b>	How happy are you with your baby's appearance?	Disappointed <input type="checkbox"/> Happy <input type="checkbox"/> Neither disappointed nor happy <input type="checkbox"/>
	How happy are your spouse/in-laws with baby's appearance?	Disappointed <input type="checkbox"/> Happy <input type="checkbox"/> Neither disappointed nor happy <input type="checkbox"/>
	Critical Comments from family, friends about appearance of the baby	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Referral to pediatrician after admission?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Reason for referral</b>	Infection <input type="checkbox"/> Feeding <input type="checkbox"/> Immunization <input type="checkbox"/> Others (specify) _____	
<b>How soon after birth did the mother have contact with her baby (rooming in)</b>		

## Infant Behavior Questionnaire

INSTRUCTIONS:  
(TO MOTHER OR MAIN CAREGIVER OF INFANT)  
Please read carefully before starting

As you read/I mention each description of the baby's behavior below, please indicate how often the baby did this during the LAST WEEK (the past seven days) by circling one of the numbers in the left column. These numbers indicate how often you observed the behavior described during the last week.

1. Never
2. Very Rarely
3. Less than half the time
4. About half the time
5. More than half the time
6. Almost always
7. Always
10. Does not Apply

The "Does Not Apply" (X) is used when you did not see the baby in the situation described during the last week. For example, if the situation mentions the baby having to wait for food or liquids and there was no time during the last week when the baby had to wait, circle the (X) column. "Does Not Apply" is different from "Never" (1). "Never" is used when you saw the baby in the situation but the baby never engaged in the behavior listed during the last week. For example, if the baby did have to wait for food or liquids at least once but never cried loudly while waiting, circle the (1) column.

Please be sure to circle a number for every item.

**Note: To be done if infant is 3 months or older. Not applicable for 0-3 months old baby**

1	2	3	4	5	6	7	X
Never	Very Rarely	Less than half the time	About half the time	More than half the time	Almost always	Always	Does not Apply

Sleeping	Before falling asleep at night during the last week, how often did the baby	Show no fussing or crying							
		1	2	3	4	5	6	7	X
	After sleeping How often did the baby	Fuss or cry immediately?							
		1	2	3	4	5	6	7	X
		Play quietly in the crib?							
		1	2	3	4	5	6	7	X
	How often did the baby:	Cry if someone doesn't come within a few minutes?							
		1	2	3	4	5	6	7	X
		Seem angry (crying, and fussing) when you left her/him in the crib?							
		1	2	3	4	5	6	7	X
Seem contented when left in the crib?									
	1	2	3	4	5	6	7	X	
Bathing and Dressing	When face was washed, how often did the baby:	Fuss or cry							
		1	2	3	4	5	6	7	X
	When hair was washed, how often did the baby:	Fuss or cry							
		1	2	3	4	5	6	7	X
Play	When something the baby was playing with had to be removed, how often did s/he:	Cry or show distress for a time?							
		1	2	3	4	5	6	7	X
		Seem not bothered?							
	1	2	3	4	5	6	7	X	
Daily Activities	How often during the last week did the baby:	Cry or show distress at a change in parents' appearance, (glasses off, shower cap on, etc.)?							
		1	2	3	4	5	6	7	X
	How often during the last week did the baby:	Protest being placed in a confining place (infant seat, play pen, car seat, etc.)?							
		1	2	3	4	5	6	7	X
		Startle at a sudden change in body position (for example, when moved suddenly)?							
		1	2	3	4	5	6	7	X
	When placed on his/her back, how often did the baby	Startle to a loud or sudden noise?							
		1	2	3	4	5	6	7	X
	When the baby wanted something, how often did s/he:	Fuss or protest?							
		1	2	3	4	5	6	7	X
Become upset when s/he could not get what s/he wanted?									
1		2	3	4	5	6	7	X	
When placed in an infant seat or car seat, how often did the baby:	Have tantrums (crying, screaming, face red, etc) when s/he did not get what s/he wanted?								
	1	2	3	4	5	6	7	X	
When placed in an infant seat or car seat, how often did the baby:	Show distress at first then quiet down?								
	1	2	3	4	5	6	7	X	

<b>Two Week Time Span</b>	When introduced to an unfamiliar adult, how often did the baby:	Cling to a parent?							
		1	2	3	4	5	6	7	X
		Refuse to go to the unfamiliar person?							
		1	2	3	4	5	6	7	X
		Hang back from the adult?							
		1	2	3	4	5	6	7	X
	When in the presence of several unfamiliar adults, how often did the baby:	Never "warm up" to the unfamiliar adult?							
		1	2	3	4	5	6	7	X
		Cling to a parent?							
		1	2	3	4	5	6	7	X
		Cry?							
		1	2	3	4	5	6	7	X
	When visiting a new place, how often did the baby:	Continue to be upset for 10 minutes or longer?							
		1	2	3	4	5	6	7	X
		Show distress for the first few minutes?							
		1	2	3	4	5	6	7	X
	When your baby was approached by an unfamiliar person when you and s/he were out (for example, shopping), how often did the baby:	Continue to be upset for 10 minutes or more?							
		1	2	3	4	5	6	7	X
		Show distress							
		1	2	3	4	5	6	7	X
When an unfamiliar adult came to your home or apartment, how often did your baby:	Cry?								
	1	2	3	4	5	6	7	X	
	Allow her/himself to be picked up without protest?								
	1	2	3	4	5	6	7	X	
		Cry when the visitor attempted to pick her/him up?							
		1	2	3	4	5	6	7	X

**F2****INFANT HEALTH AT ADMISSION**

<b>Skin</b>	<b>Jaundice</b> <input type="checkbox"/>
	<b>Dry</b> <input type="checkbox"/>
	<b>Rash</b> <input type="checkbox"/>
	<b>Ear Discharge</b> <input type="checkbox"/>
	<b>Eye Discharge</b> <input type="checkbox"/>
<b>CVS</b>	<b>Cyanosis</b> <input type="checkbox"/>
	<b>Murmur/added sound</b> <input type="checkbox"/>
	<b>Related Surgeries</b> <input type="checkbox"/>
<b>Respiratory System</b>	<b>Difficulty breathing</b> <input type="checkbox"/>
	<b>URTI</b> <input type="checkbox"/>
	<b>Umbilicus(Discharge)</b> <input type="checkbox"/>
<b>CNS</b>	<b>Microcephaly</b> <input type="checkbox"/>
	<b>Hypotonia/Hypotonia</b> <input type="checkbox"/>
	<b>Nystagmus</b> <input type="checkbox"/>
	<b>Paralysis</b> <input type="checkbox"/>
	<b>Seizures</b> <input type="checkbox"/>
	<b>Craniofacial anomalies</b> <input type="checkbox"/>
<b>Gastrointestinal abnormalities</b>	<b>Constipation</b> <input type="checkbox"/>
	<b>Diarrhoea</b> <input type="checkbox"/>
	<b>Dehydration</b> <input type="checkbox"/>
	<b>Vomiting</b> <input type="checkbox"/>





**G1****Breast feeding in the MBU**

(Some questions need to be asked at admission, during admission and at discharge)

Did the mother ever breast feed the infant after birth?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If No, cite the reasons	Inadequate lactation <input type="checkbox"/> Due to the symptoms of Mental illness <input type="checkbox"/> Physical illness(e.g infections, breast abscess) <input type="checkbox"/> Poor infant health <input type="checkbox"/> Admission of infant to hospital <input type="checkbox"/> Family chose to stop breast feeds <input type="checkbox"/> Any others <input type="checkbox"/>
If Yes, How soon after birth was breast-feeding initiated?	<input type="text"/> in days
Was the infant exclusively breast fed <b>till the onset of</b> mental illness?	Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
If No, cite the reasons	Inadequate lactation <input type="checkbox"/> Due to the symptoms of Mental illness <input type="checkbox"/> Physical illness(e.g infections, breast abscess) <input type="checkbox"/> Poor infant health <input type="checkbox"/> Admission of infant to hospital <input type="checkbox"/> Family chose to stop breast feeds <input type="checkbox"/> Any others <input type="checkbox"/>
Was the infant exclusively breast fed <b>after the onset of</b> illness till the current admission?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If No cite the reasons	Inadequate lactation <input type="checkbox"/> Due to the symptoms of Mental illness <input type="checkbox"/> Physical illness(e.g infections, breast abscess) <input type="checkbox"/> Poor infant health <input type="checkbox"/> Admission of infant to hospital <input type="checkbox"/> Family chose to stop breast feeds <input type="checkbox"/> Any others <input type="checkbox"/>

Type of Infant feeding before admission	Continued as before <input type="checkbox"/>	
	Disrupted but no complementary feed <input type="checkbox"/>	
	Breast feeds with complementary feed <input type="checkbox"/>	
	Only bottle fed- No breast feeding <input type="checkbox"/>	
	Bottle fed with expressed breast milk <input type="checkbox"/>	
If BF disrupted due to mental illness, what were the reasons (may be more than one reason)?	Mother refused to feed <input type="checkbox"/>	
	Mother was too disturbed <input type="checkbox"/>	
	Family felt it was not safe for infant to be with mother <input type="checkbox"/>	
	Family worried about effect of medications <input type="checkbox"/>	
	Family/Mother worried that milk was not enough <input type="checkbox"/>	
	Any other? <input type="checkbox"/>	
If BF retained (even partial) – how did family ensure that it continued despite the mental health problem?	Mother cooperated despite mental illness <input type="checkbox"/>	
	They cajoled and forced mother to feed child <input type="checkbox"/>	
	Expressed Breast Milk was given <input type="checkbox"/>	
Has Infant feeding changed after being ADMITTED TO THE HOSPITAL-( to be filled after one week of admission)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If Yes, what is the change?	Breast feeding restarted/started after coming to the MBU <input type="checkbox"/>	
	Expressed Breast Milk <input type="checkbox"/>	
	Feeding with Complementary feeds <input type="checkbox"/>	
	Only Complementary feeds <input type="checkbox"/>	
What have been the challenges to infant feeding after admission?( More than one option is possible)	Mother too drowsy <input type="checkbox"/>	
	Instructions about breast feeding related to medication too confusing <input type="checkbox"/>	
	Mother refuses/unable to feed because of social withdrawal, catatonia <input type="checkbox"/>	
	Mother unable to feed because of delusions/psychotic symptoms/irritability/restlessness <input type="checkbox"/>	
	Breast conditions ( engorgement, infection, nipple problems) <input type="checkbox"/>	
How is the infant feeding handled at night?	Non Human Milk <input type="checkbox"/>	
	Expressed Breast Milk <input type="checkbox"/>	
	A combination of the two <input type="checkbox"/>	

<p><b>Family's views on the Effects of Medication on the infant ( only if breast feeding)</b>  <b>Refers awareness about milk hygiene</b></p>	<p>Has the family felt that the infant has any side effects of drugs due to breast feeding?/ Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
	<p>If Yes, mention the side effects according to them</p>	
	<p>What information has been given about breast feeding by the nurses/doctors related to drugs or ECT? (in the family"s own words)</p>	<p>Give breast feed just before taking the drug <input type="checkbox"/></p> <p>Omit night feed <input type="checkbox"/></p> <p>Do not breast feed <input type="checkbox"/></p> <p>Give expressed milk when patient sleeping or disturbed or in ECT <input type="checkbox"/></p> <p>Give non human milk when patient sleeping or disturbed or in ECT <input type="checkbox"/></p> <p>No Information given <input type="checkbox"/></p> <p>Family not sure <input type="checkbox"/></p> <p>Give breast feeds after 4 hours of day <input type="checkbox"/></p> <p>Others <input type="checkbox"/></p>

**G2** **Satisfaction with Infant feeding support in MBU**

(for both mother and caregiver to be done after 1 week of admission)

18.	How supportive and helpful has the MBU staff been about infant feeding?
19.	How would you rate the facilities in the MBU for infant feeding ( Availability of breast pump, infant feeding equipment, sterilization facilities, availability of non human milk)
20.	Is there anything else that can be done in the MBU to help mothers with infant feeding?

**Details of Investigations for Current Episode**

<b>Investigations</b>	<b>Date</b>	<b>Values</b>
Hemoglobin		
Total Leucocyte Count		
Neutrophils		
<b>Lymphocytes</b>		
<b>Eosinophils</b>		
<b>Monocytes</b>		
<b>Peripheral smear</b>		
1		
2		N-N
3		N-Hypo
4		Micro-Hypo
5		Macro-NC
6		Macro-Hypo
		Others
<b>MCV</b>		
<b>MCH</b>		
<b>MCHC</b>		
<b>Platelets</b>		
<b>FBS</b>		
<b>PPBS</b>		
<b>RBS</b>		
<b>Na</b>		
<b>K</b>		
<b>Cl</b>		
<b>Urea</b>		
<b>Creatinine</b>		
<b>SGOT</b>		
<b>SGPT</b>		

<b>Bilirubin</b>		
<b>AlkPhos</b>		
<b>TSH</b>		
<b>T3</b>		
<b>T4</b>		
<b>HDL</b>		
<b>LDL</b>		
<b>VLDL</b>		
<b>TGs</b>		
<b>TChol</b>		
<b>Serum B12</b>		
<b>Serum Folate</b>		
<b>CT Scan</b>		
<b>MRI</b>		
<b>Other Investigations If any</b>		

# AT ADMISSION

11

## RATING OF MATERNAL BEHAVIOR FOR POSTPARTUM MOTHERS

Name:

P.No:

Date:

### 1. CARE FOR THE BABY'S BASIC NEEDS?

Is she able to dress, bathe, feed, make the baby sleep?

	Manages Most of the Child Care Herself with minimal help	Manages only some tasks but needs assistance or coaxing for most tasks	Is not able to manage any of the childcare tasks
Dress	1	2	3
Bathe	1	2	3
Feed	1	2	3
Make the baby sleep	1	2	3

**Total Score:**

### 2. AFFECTIONATE BEHAVIOR

	Normal affection like any other mother	Most of the time but occasionally does not	Minimal show of affectionate behavior	Hardly any affectionate behaviour
Holding	1	2	3	4
Comforting	1	2	3	4
Gazing	1	2	3	4
Talking	1	2	3	4
Cuddling and smiling with baby	1	2	3	4

**Total Score:**

### 3. SIGNIFICANT INCIDENTS

	1	2
Shouting at the baby	No	Yes
Hitting the baby	No	Yes
Trying to smother the baby	No	Yes
Trying to harm the baby in any other way	No	Yes
Neglecting the baby	No	Yes

**Total Score:**

### 4. OVERALL ASSESSMENT OF SAFETY

1	2	3
Completely Safe	Safe, but only under supervision	Unsafe

**Total Score 1-4**

### 5. HOW DOES THE MOTHER HANDLE SEPERATION FROM THE BABY?

E.g. if the baby is taken away for a while

1	2	3	4	5
Normal concern	Unconcerned	Gets anxious	Gets disturbed	Does not allow anyone to take the baby or let the baby out of sight

### 6. WAS THE MOTHER SEPERATED FROM THE BABY IN THE LAST FEW DAYS?

1	2
No	Yes

### REASONS

	0	1
Family's apprehension regarding safety	No	Yes
Mother is too disturbed	No	Yes
Side effect of medications	No	Yes
Inconvenient to keep baby in hospital	No	Yes
Caregiver in hospital is unwilling to take additional responsibility	No	Yes
Baby is unwell	No	Yes
Doctor has advised to keep baby away temporarily	No	Yes



## AT ADMISSION

12

### POST-PARTUM BONDING INSTRUMENT

Please indicate how often the following are true for you.

There are no 'right' or 'wrong' answers: Choose the answer which seems right in your recent experience.

		Always	Very often	Quite often	Some-times	Rarely	Never
F1	I feel close to my baby						
F1	I wish the old days when I had no baby would come back						
F2	I feel distant from my baby						
F2	I love to cuddle my baby						
F2	I regret having this baby						
F1	The baby does not seem to be mine						
F1	My baby makes me tense						
F1	I love my baby a lot						
F1	I feel happy when my baby smiles or laughs						
F1	My baby irritates me						
F2	I enjoy playing with my baby						
F1	My baby cries too much						
F1	I feel trapped as a mother						
F2	I feel angry with my baby						
F1	I resent my baby						
F1	My baby is the most beautiful baby in the world						
F1	I wish my baby would somehow go away						
F4	I have done harmful things to my baby						
F3	My baby makes me anxious						
F3	I am afraid of my baby						
F2	My baby annoys me						
F3	I feel confident when caring for my baby						
F2	I feel the only solution is for someone else to look after my baby						
F4	I feel like hurting my baby						
F3	My baby is easily comforted						

F1 =  F2 =   =

❖ Please add up the score using the scoring method overleaf

## **SCORE 1 - GENERAL FACTOR POSITIVE/NEGATIVE AFFECTIVE RESPONSE TO BABY**

My baby winds me up  
My baby irritates me  
I resent my baby  
I wish my baby would somehow go away  
My baby cries too much  
The baby does not seem to be mine  
I feel trapped as a mother  
I wish the old days when I had no baby would come back

Score:

Always = 5; very often = 4; quite often = 3; sometimes = 2; rarely = 1; never = 0

I feel close to my baby  
I feel happy when my baby smiles or laughs  
I love my baby to bits  
My baby is the most beautiful baby in the world

Score:

Always = 0; very often = 1; quite often = 2; sometimes = 3; rarely = 4; never = 5

**Cut-off points**      **11 = normal**  
                                 **12 = high**

## **SCORE 2 - ANGER AND REJECTION**

My baby annoys me  
I feel distant from my baby  
I feel the only solution is for someone else to look after my baby  
I regret having this baby  
I feel angry with my baby

Score:

Always = 5; very often = 4; quite often = 3; sometimes = 2; rarely = 1; never = 0

I love to cuddle my baby  
I enjoy playing with my baby

Score:

Always = 0; very often = 1; quite often = 2; sometimes = 3; rarely = 4; never = 5

**Cut-off points**      **16 = normal**  
                                 **17 = high**

### **SCORE 3 - CONFIDENCE AND ANXIETY**

My baby makes me anxious  
I am afraid of my baby

Score:

Always = 5; very often = 4; quite often = 3; sometimes = 2; rarely = 1; 0 = never

My baby is easily comforted  
I feel confident when changing my baby

Always = 0; very often = 1; quite often = 2; sometimes = 3; rarely = 4; never = 5

**Cut-off points**      **9 = normal**  
                                 **10 = high**

### **SCORE 4 - AGGRESSION TO BABY**

I feel like hurting my baby  
I have done harmful things to my baby

Score:

Always = 5; very often = 4; quite often = 3; sometimes = 2; rarely = 1; never = 0

**Cut-off points**      **2 = normal**  
                                 **3 = high**

**Interpersonal Trauma Interview****(to be filled by PSW/ CP)**

I will ask you a few questions about certain experiences you may have had in your life so far. Some of these questions may be sensitive and personal in nature and may make you feel awkward. You have the option of skipping a question if you wish to do so. The questions will span different critical periods of your life starting from your childhood to your adult life. Please feel free to stop me for clarifications at any point. Can we begin?

Sl No.	0-5 years:	
	Who looked after you during the first five years of your life?	Parents <input type="checkbox"/> Grandparents <input type="checkbox"/> Uncle/Aunt <input type="checkbox"/> Others <input type="text"/>
	During this time, did you experience any separation from your parents?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, Who did you have to stay away from?	Mother <input type="checkbox"/> Father <input type="checkbox"/> Both <input type="checkbox"/>
	For how long?	<input type="text"/> Days
	What was the reason for separation from your Mother or Father?	Death of Mother <input type="checkbox"/> Death of Father <input type="checkbox"/> Illness in Mother <input type="checkbox"/> Illness in Father <input type="checkbox"/> Job related transfer <input type="checkbox"/> Others <input type="text"/>
	How did you feel about it?	Positive(I was fine with it) <input type="checkbox"/> Neutral(I didn't react positively or negatively) <input type="checkbox"/> Negative(I was sad, anxious, confused, angry etc) <input type="checkbox"/> Dont know( I don't recall) <input type="checkbox"/>

<p>During this period, do you recall any incident at home, school or any other place that made you feel very upset?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>If yes, can you tell me what happened that made you feel so upset?</p>	
<p>On a scale of 1-10, where 1 is not at all upset and 10 is extremely upset, can you please rate how upset you were by this incident/s?</p> <p>1.....2.....3.....4.....5.....6.....8.....9.....10</p> <p>Not at all upset <span style="float: right;">Extremely upset</span></p>	
<p>6-18 years</p>	
<p style="text-align: center;"><b>Bullying</b></p>	
<p>During this period, do you recall any incident at home, school or any other place where you were...</p>	
<p>Were you teased excessively by your peers, seniors or others at your home, school or neighbourhood about something?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>If Yes, When did it happen/at what ages? ..... (Record age when it first happened, and subsequent ages when it happened)</p>	
<p>How often did it happen? (Rate whether Never-Occasionally-Sometimes-Often-Almost Always)</p>	
<p>For how long did it continue? .....(Record number of days or duration until which it continued)</p>	
<p>How many different people did so?..... (Number of people who subjected him/her to this experience)</p>	
<p>What has been your relationship with the person who did this to you? (check all that apply)</p>	<p>Mother <input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Aunt <input type="checkbox"/></p> <p>Sister <input type="checkbox"/> Brother <input type="checkbox"/> Friend <input type="checkbox"/> Cousin <input type="checkbox"/></p> <p>Relative <input type="checkbox"/> Teacher <input type="checkbox"/> Neighbour <input type="checkbox"/></p> <p>Stranger <input type="checkbox"/> Other <input type="checkbox"/> Don't wish to disclose <input type="checkbox"/></p>

**Emotional abuse**

During this period, do you recall any incident at home, school or any other place where you were...

	Shouted at using bad language, insulted/humiliated, neglected or hurt you emotionally in any other way) for something you did?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	How often did it happen?	Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Almost Always <input type="checkbox"/>
	For how long did it continue? .....(Record number of days or duration until which it continued)	
	How many different people did so?..... (Number of people who subjected him/her to this experience)	
	What has been your relationship with the person who did this to you? (check all that apply)	Mother <input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Aunt <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Friend <input type="checkbox"/> Cousin <input type="checkbox"/> Relative <input type="checkbox"/> Teacher <input type="checkbox"/> Neighbour <input type="checkbox"/> Stranger <input type="checkbox"/> Other <input type="checkbox"/> Don't wish to disclose <input type="checkbox"/>
	On a scale of 1-10, where 1 is not at all upset and 10 is extremely upset, can you please rate how upset you were by this incident/s?  1.....2.....3.....4.....5.....6.....8.....9.....10 Not at all upset <span style="float:right">Extremely upset</span>	

**Physical Abuse:**

During this period, do you recall any incident at home, school or any other place where you were...

	Physically punished (hit, kicked, slapped, thrown things at you, pushed, grabbed you or hurt you physically in any other way) for something you did?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	How often did it happen?	Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Almost Always <input type="checkbox"/>
	For how long did it continue? .....(Record number of days or duration until which it continued)	
	How many different people did so? .....(Number of people who subjected him/her to this experience)	
	What has been your relationship with the person who did this to you? (check all that apply)	Mother <input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Aunt <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Friend <input type="checkbox"/> Cousin <input type="checkbox"/> Relative <input type="checkbox"/> Teacher <input type="checkbox"/> Neighbour <input type="checkbox"/> Stranger <input type="checkbox"/> Other <input type="checkbox"/> Don't wish to disclose <input type="checkbox"/>
	On a scale of 1-10, where 1 is not at all upset and 10 is extremely upset, can you please rate how upset you were by this incident/s?  1.....2.....3.....4.....5.....6.....8.....9.....10 Not at all upset <span style="float:right">Extremely upset</span>	

### Sexual Abuse

During this period, do you recall any incident at home, school or any other place where you were...

	Touched in a way that made you uncomfortable or made you touch someone in a way that made you uncomfortable?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	How often did it happen?	Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Almost Always <input type="checkbox"/>
	For how long did it continue? .....(Record number of days or duration until which it continued)	
	How many different people did so? .....(Number of people who subjected him/her to this experience)	
	What has been your relationship with the person who did this to you? (check all that apply)	Mother <input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Aunt <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Friend <input type="checkbox"/> Cousin <input type="checkbox"/> Relative <input type="checkbox"/> Teacher <input type="checkbox"/> Neighbour <input type="checkbox"/> Stranger <input type="checkbox"/> Other <input type="checkbox"/> Don't wish to disclose <input type="checkbox"/>
	On a scale of 1-10, where 1 is not at all upset and 10 is extremely upset, can you please rate how upset you were by this incident/s?	
	1.....2.....3.....4.....5.....6.....8.....9.....10 Not at all upset <span style="float: right;">Extremely upset</span>	



**Gender Disadvantage**

	Made to feel inferior because you were a girl and not a boy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, When did this happen/at what ages? ..... (Record age when it first happened, and subsequent ages when it happened)	
	Who made you feel so? (check all that apply)	Mother <input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Aunt <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Friend <input type="checkbox"/> Cousin <input type="checkbox"/> Relative <input type="checkbox"/> Teacher <input type="checkbox"/> Neighbour <input type="checkbox"/> Stranger <input type="checkbox"/> Other <input type="checkbox"/> Don't wish to disclose <input type="checkbox"/>
	Treated differently only because you were a girl and not a boy in a way that upset you?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, were you (check all that apply)	Given less food to eat or less nutritious food Occasionally <input type="checkbox"/> Given fewer opportunities for education Often <input type="checkbox"/> Given fewer opportunities for play, including outdoor games <input type="checkbox"/> Anything else ..... Please Specify
	On a scale of 1-10, where 1 is not at all upset and 10 is extremely upset, can you please rate how upset you were by this incident/s? 1.....2.....3.....4.....5.....6.....8.....9.....10 Not at all upset <span style="float:right">Extremely upset</span>	

**Physical Appearance**

	Treated differently because of your physical appearance in a way that upset you?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, were you treated differently because of your (check all that apply)	Skin colour <input type="checkbox"/> Body size <input type="checkbox"/> Body weight <input type="checkbox"/> Skin or hair problems <input type="checkbox"/> Anything else ..... Please Specify
	On a scale of 1-10, where 1 is not at all upset and 10 is extremely upset, can you please rate how upset you were by this incident/s?  1-----2-----3-----4-----5-----6-----8-----9-----10 Not at all upset <span style="float:right">Extremely upset</span>	

**Medical Illnesses**

	During this period, have you had any physical/medical illnesses which caused you a lot of pain and/or suffering?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, what was the illness you had? .....please specify (record if acute or chronic)	Acute <input type="checkbox"/> Chronic <input type="checkbox"/>
	How did the illness come in the way of what you were doing or what you wished to do? (record the incident/s verbatim and code as traumatic versus not traumatic)	
	On a scale of 1-10, where 1 is not at all upset and 10 is extremely upset, can you please rate how upset you were by this incident/s?  1-----2-----3-----4-----5-----6-----8-----9-----10 Not at all upset <span style="float:right">Extremely upset</span>	

### Relationships

It is common among boys and girls to develop an interest in the opposite sex. Have you been in any romantic relationships during this period where

Were you in any relationship where you partner and you got sexually intimate and it resulted in a pregnancy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes, did you have any abortions prior to marriage?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
On a scale of 1-10, where 1 is not at all upset and 10 is extremely upset, can you please rate how upset you were by this incident/s? 1-----2-----3-----4-----5-----6-----8-----9-----10 Not at all upset <span style="float: right;">Extremely upset</span>		

### 18+ Years

#### Rejection by suitors

Did you experience multiple rejection by suitors/prospective grooms prior to your marriage?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
On a scale of 1-10, where 1 is not at all upset and 10 is extremely upset, can you please rate how upset you were by this incident/s? 1-----2-----3-----4-----5-----6-----8-----9-----10 Not at all upset <span style="float: right;">Extremely upset</span>		

#### Workplace Harassment

Did you feel emotionally harassed at your workplace?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Did you feel physically harassed at your workplace?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Did you feel sexually harassed at your workplace?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
On a scale of 1-10, where 1 is not at all upset and 10 is extremely upset, can you please rate how upset you were by this incident/s? 1-----2-----3-----4-----5-----6-----8-----9-----10 Not at all upset <span style="float: right;">Extremely upset</span>		

<b>Grief</b>	
Have you experienced the death of someone you were very close to during your lifetime?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, Who was the person who died? (Record close Vs. not)	Close <input type="checkbox"/> Not close <input type="checkbox"/>
How did the person die?	Illness <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Others .....
On a scale of 1-10, where 1 is not at all upset and 10 is extremely upset, can you please rate how upset you were by this incident/s?  1-----2-----3-----4-----5-----6-----8-----9-----10 Not at all upset <span style="float: right;">Extremely upset</span>	
<b>Marriage</b>	
Did you feel emotionally harassed prior to, during or after your wedding by your spouse?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you feel emotionally harassed prior to, during or after your wedding by your in laws?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you feel emotionally harassed prior to, during or after your wedding by your parents?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you feel physically harassed prior to, during or after your wedding by your spouse?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you feel physically harassed prior to, during or after your wedding by your in laws?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you feel physically harassed prior to, during or after your wedding by your parents?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you feel sexually harassed prior to, during or after your wedding by your spouse?	Yes <input type="checkbox"/> No <input type="checkbox"/>
On a scale of 1-10, where 1 is not at all upset and 10 is extremely upset, can you please rate how upset you were by this incident/s?  1-----2-----3-----4-----5-----6-----8-----9-----10 Not at all upset <span style="float: right;">Extremely upset</span>	

**Pregnancy and childbirth**

	Were you under a lot of pressure to conceive following your marriage?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Were you preoccupied or worried about the relationship between your spouse and you during your pregnancy?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Has your spouse ever threatened to leave you or do you fear that he will leave you during your pregnancy?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Have you experienced any emotional/physical or sexual harassment during your pregnancy?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Yes/ No; If Yes, what kind of harassment?. .....(Record type)				
	Have you experienced the death of someone you were very close to during your pregnancy?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Yes/ No; If Yes, who... .....(Record close Vs. not)				
	Were you under a pressure to have a male child?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Did you have difficulty conceiving naturally?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Did you have unplanned pregnancies?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	If Yes, did you have any miscarriages?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	If Yes, did you have any abortions?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Would you say you had a difficult pregnancy previously?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Would you say you had a difficult labour/delivery previously?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	<p>On a scale of 1-10, where 1 is not at all upset and 10 is extremely upset, can you please rate how upset you were by this incident/s?</p> <p>1.....2.....3.....4.....5.....6.....8.....9.....10</p> <p>Not at all upset <span style="float:right">Extremely upset</span></p>				
	<p>Are there any other difficult experiences that you may have had in your lifetime that you would like to share with me? Please specify.....</p>				
	<p>On a scale of 1-10, where 1 is not at all upset and 10 is extremely upset, can you please rate how upset you were by this incident/s?</p> <p>1.....2.....3.....4.....5.....6.....8.....9.....10</p> <p>Not at all upset <span style="float:right">Extremely upset</span></p>				

**K**

**INTERVENTIONS**

Current treatment

Name of the drug	Dose in mg/day	Duration	Side Effects
<b>Antipsychotics</b>			
1.			
2.			
3.			
<b>Mood stabilizers</b>			
1.			
2.			
3.			
<b>Antidepressants</b>			
1.			
2.			
3.			
<b>Benzodiazepines</b>			
1.			
2.			
3.			
<b>Anticholinergics</b>			
<b>Electroconvulsive therapy</b>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	
<b>Number of sessions:</b>			
<b>Total number of injectible sedatives required during this admission</b>			
<b>Indication</b>			
<b>Complications</b>			
<b>Any other stimulative therapies</b>			



## Psychosocial & Psychological Interventions Done

<b>1</b>	<b>Psychoeducation (Tick whichever is applicable)</b>	<b>Patient</b> <b>Husband</b> <b>Other family members</b>
<b>2</b>	<b>Bonding (Mention type of intervention)</b>	
<b>3</b>	<b>Individual Psychological therapies (specify goals and strategies)</b>	
<b>4</b>	<b>Relapse prevention strategies</b>	
<b>5</b>	<b>Lactation/ feeding Intervention</b>	
<b>6</b>	<b>Birth spacing (specific plan)</b>	
<b>7</b>	<b>Individual intervention for spouse (specify goals and strategies)</b>	
<b>8</b>	<b>Marital counseling/therapy (specify goals and strategies)</b>	
<b>9</b>	<b>Family counseling / therapy (specify goals and strategies)</b>	

<b>10</b>	<b>Interventions for child (Tick whichever is applicable)</b>	<b>Child protection services</b> <input type="checkbox"/> <b>Development assessment</b> <input type="checkbox"/> <b>Early development interventions</b> <input type="checkbox"/> <b>Others</b> <input type="checkbox"/>
<b>11</b>	<b>Group Interventions (Tick whichever is applicable)</b>	<b>Patient</b> <b>Care givers</b> <b>Spouse</b>
<b>12</b>	<b>Legal aid services</b>	
<b>13</b>	<b>Other psychosocial / psychological interventions (specify)</b>	

**Name of Clinical Psychology Trainee**

**Signature:**

**Name of Psychiatric Social Work Trainee**

**Signature:**





**MOTHER BABY PSYCHIATRY WARD**

**OUTCOME AT DISCHARGE**

1. Name	2. P Number
3. Unit	4. Date of Admission
5. Date at Discharge	6. Duration of Admission: _____(in days)
6. Planned Discharge          or    Discharge AMA          or Premature Discharge on Request	
7. Diagnosis at discharge  Multiaxial Perinatal Psychiatry diagnosis  Axis I- Psychiatric diagnosis Axis II- Personality disorders/ traits and Intellectual Impairment Axis III- Co morbid Medical Diagnosis Axis IV- Mother Infant Bonding/Interaction Disorders Axis V- Psychosocial factors	
8. Mobile No of pt/parent/husband	

**RISKS AT DISCHARGE**

BFCRS	<input type="checkbox"/>		
CATATONIA	<input type="checkbox"/>		
BPRS	<input type="checkbox"/>		
EPDS	<input type="checkbox"/>		
YMRS	<input type="checkbox"/>		
CGI	<input type="checkbox"/>		
<b>Risk to self</b> – Present	<input type="checkbox"/>	Absent	<input type="checkbox"/>
Risk to infant – Present	<input type="checkbox"/>	Absent	<input type="checkbox"/>
Medical conditions that need intervention- – present	<input type="checkbox"/>	absent	<input type="checkbox"/>

Details:

**INFANT CARE (Tick one of the below)**

Can manage independently

Needs some supervision but mostly independent

Needs a great deal of supervision

Mother is unable to care for the infant and most needs are met by surrogate

**INFANT FEEDING**

Yes

No

Exclusive Breast Feeding

**Supplementary feeding**

Due to Medical advice

Inadequate lactation

Mental health issues in mother

Mother reluctant to feed

**Only artificial feeds**

Contraindicated related to medication

Refuses to feed

Inadequate lactation

Breast pathology/infant feeding issues

❖ Note : Please rate EPDS, CGI, BPRS, Bonding at discharge and YMRS when applicable

<b>Infant Health and Behaviour</b>	Infections	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
	Feeding difficulties	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
	Need for Pediatrician review	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
	Developmental concerns	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
	Any concerns related to infant's responsiveness to adult figures					
		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Any evidence of behavioral difficulties						
	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		

**PSYCHOSOCIAL OUTCOMES AND CONCERNS** (Need to be rated by PSW M. Phil. Trainee)

**Knowledge about (in patient):**

- |                          |          |                          |            |                          |
|--------------------------|----------|--------------------------|------------|--------------------------|
| a) Psychiatric Disorder: | Adequate | <input type="checkbox"/> | Inadequate | <input type="checkbox"/> |
| b) Follow up:            | Adequate | <input type="checkbox"/> | Inadequate | <input type="checkbox"/> |
| c) Medication:           | Adequate | <input type="checkbox"/> | Inadequate | <input type="checkbox"/> |
| d) Hygiene:              | Adequate | <input type="checkbox"/> | Inadequate | <input type="checkbox"/> |
| e) Breast feeding:       | Adequate | <input type="checkbox"/> | Inadequate | <input type="checkbox"/> |

**Knowledge about (in care giver):**

- |                          |          |                          |            |                          |
|--------------------------|----------|--------------------------|------------|--------------------------|
| a) Psychiatric Disorder: | Adequate | <input type="checkbox"/> | Inadequate | <input type="checkbox"/> |
| b) Follow up:            | Adequate | <input type="checkbox"/> | Inadequate | <input type="checkbox"/> |
| c) Medication:           | Adequate | <input type="checkbox"/> | Inadequate | <input type="checkbox"/> |
| d) Hygiene:              | Adequate | <input type="checkbox"/> | Inadequate | <input type="checkbox"/> |
| e) Breast feeding:       | Adequate | <input type="checkbox"/> | Inadequate | <input type="checkbox"/> |

**Mother Infant Bonding**

**Factors Scores of PBI** - F1=  F2=  F3=  F4=

**Maternal Behaviour Ratings:**

- |                   |                          |
|-------------------|--------------------------|
| a. Care           | <input type="checkbox"/> |
| b. Affection      | <input type="checkbox"/> |
| c. Significant    | <input type="checkbox"/> |
| d. Overall Safety | <input type="checkbox"/> |
| e. Separation     | <input type="checkbox"/> |

**Contraception Planning:**

- a) Done with Mother
- Done with couple

**b) Specific Plans-**

- Barriers
- IUD
- Tubectomy
- No specific plans

**c) Planning for the future pregnancies**

- Done with mother
- Done with spouse
- Done with family

**Caregiver burden:**

High  Low

**Support**

- a) Partner Support: Adequate  Inadequate
- b) Support from maternal family : Adequate  Inadequate
- c) Support from In Laws : Adequate  Inadequate
- d) Presence of Neglect and Violence Yes  No

(Based on ward observation)

**Concerns about treatment**

- Poverty
- Distance from hospital
- Poor knowledge of illness
- Family issues
- Personality issues/poor insight

Any other important concerns at discharge which should be addressed

MBU Card given

Follow up date:

 /  / 

Information booklet given

MBU Mobile phone contact number

**Name and Signature of JR :**

**Name and Signature of SR :**

**Name and Signature of the PSW trainee:**

**Name and Signature of the PSW JC:**

**Name and Signature of Consultant :**

**Date:**