## **DEPRESSION DISCLOSURE**

Complete upon admissi	form must be reviewed wi on, quarterly, with a sign sentative/guardian/facility.				
	is	committed in prov	ding Quality	of Care to all resi	dents. For each
(Facility	Name)				
resident to receive and t	for(Facility	Name)	to provide	the necessary ca	re and services
comprehensive assess representative/guardiar	e highest practicable phys ment and plan of care, n, physicians and facility ment, interventions and a	t is necessary to staff. Resident/res	build a tean	n between the re entative/guardian	sident/resident participation in
hopelessness, worthles sadness. It affects the v become severe or prolo	ormal, serious mood di ssness, despair, morbid way one feels about the fu onged or interfere with a p an when symptoms are p	thoughts and aguture and can alte erson's interperson	itation. Depre basic attitud nal or occupa	ession is much es about the pers ational functioning	more than just son. Moods can
to as secondary deprenvironmental catastrobiological. It may be caendogenous depression. Risk factors for depress		omething outside us medical cond emical factors suc d difficult to treat.	the person tion. Endoge h as neurotra	such as loss or nous depression ansmitter function	f a loved one, is primary or ing. Of the two,
<ul> <li>Trauma</li> <li>Stress</li> <li>Personal or fa</li> <li>Serious illness</li> <li>Certain medic</li> </ul>	mily history of depressions – cancer, diabetes, hear ations (side effects)	rt disease, Parkins	on's disease,	CVA (stroke)	g situation
		CLINICAL SY		and amoranay.	
Depression  Self-s Diffic Preod Pess Irritat Depe Char Insor Trout Fatig Loss Incre	easant feelings about self- sacrificing, especially in re- sulty concentrating or inde- ccupation with trivial thing imistic outlook toward life- bility toward self for not live- endence on others for gra- nges in appetite or weight mail or hypersomnia ole sleeping, early-morning ue or decreased energy of interest or pleasure in lase in aches/pains, head e and/or no easing with the	sad, anxious, estation to giving in cisiveness is ring up to an ideal tification changes g awakening, over hobbies and activaches, cramps, di	mpty to others standard rsleeping ities	ems without a clea	ar physical
NAME-Last	First Middle	Attending Physicia	1	Record No.	Room/Bed

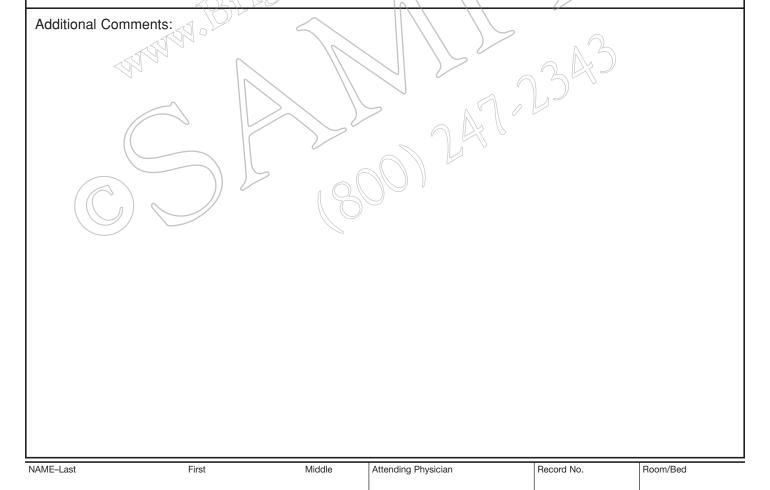
## **DEPRESSION DISCLOSURE**

Stage	CLINICAL SYMPTOMS
Severe Depression	<ul> <li>Despair</li> <li>Sense of emptiness</li> <li>Unrelieved feelings of guilt, worthlessness, helplessness</li> <li>Severe immobility or agitated behavior</li> <li>Catastrophic expectations and outlook</li> <li>Thoughts of death or suicide, suicide attempts</li> <li>Lack of interest in self and environment</li> <li>Slowed thought process</li> <li>Slowed bodily processes</li> <li>Excessive preoccupation with self</li> <li>Delusional thinking</li> <li>Loss of contact with reality</li> <li>Insomnia or hypersomnia</li> </ul>

Persons with Depression may develop complications that put them at risk for:

- Untreated mild depression may lead to recurrent major depression or a dysthymic disorder
- Use/abuse of alcohol or drugs to "feel better"
- Untreated depressive illness which can lead to suicide

(\*If not addressed in the plan of care: Specify resident condition, treatment options, expected outcomes, consequences of refusing treatment, resident's concerns, medications that may affect the disease process, and offer relevant alternatives if the resident has refused treatment.



## **ACKNOWLEDGEMENT OF RECEIPT OF DEPRESSION DISCLOSURE**

I,, acki	nowledge that I have received a copy of
(Resident/Resident Representative/Guardian)	
Depression D	Disclosure which summarizes the clinical
symptoms a resident diagnosed with Depression may exhibit. Residents from complications/adverse events and clinical symptoms that are a disease.	-
The Resident/Resident Representative/Guardian acknowledges that coas a result of the disease process.	omplications/adverse events may occur
This facility recognizes the relationship between the Resident and the critical element in identifying all of the resident's disease symptoms. The the Resident Representative/Guardian report all information regarding complications or changes in the resident's usual behavior or status to the	facility staff and physician requests that g changes listed as clinical symptoms,
I understand the facility will review this information with Resident/Reside	dent Representative/Guardian) when there
is a significant change of the resident's condition, quarterly and whe Representative/Guardian or Facility as a necessary part of the plan of c	
By signing, the Resident/Resident Representative/Guardian acknowledges risks associated with depression as well as the importance of and partic resident.	// \ \ ' ' / /
ACKNOWLEDGEMENT SIGNATU	
Resident/Resident Representative/Guardian	Date Signed
Resident/Resident Representative/Guardian	Date Signed
Resident/Resident Representative/Guardian  If signed by Resident Representative/Guardian, complete the following:  Print Name  Relations	Date Signed
Resident/Resident Representative/Guardian  If signed by Resident Representative/Guardian, complete the following:	Date Signed
Resident/Resident Representative/Guardian  If signed by Resident Representative/Guardian, complete the following:  Print Name  Relations  Person completing this form:	Date Signed
Resident/Resident Representative/Guardian  If signed by Resident Representative/Guardian, complete the following:  Print Name  Relations  Person completing this form:	Date Signed  Date Signed
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