DEPRESSION DISCLOSURE

INSTRUCTIONS: This form must be reviewed with and signed by the resident/resident representative/guardian. Complete upon admission, quarterly, with a significant change of resident condition and upon the request of the resident/resident representative/guardian/facility.

_____ is committed in providing Quality of Care to all residents. For each
(Facility Name)

resident to receive and for _____ to provide the necessary care and services
(Facility Name)

to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, it is necessary to build a team between the resident/resident representative/guardian, physicians and facility staff. Resident/resident representative/guardian participation in the management, treatment, interventions and approaches is an essential part of the overall care plan for the resident.

Depression is an abnormal, serious mood disorder in which a person characteristically has a sense of hopelessness, worthlessness, despair, morbid thoughts and agitation. Depression is much more than just sadness. It affects the way one feels about the future and can alter basic attitudes about the person. Moods can become severe or prolonged or interfere with a person's interpersonal or occupational functioning. Depression is diagnosed by a physician when symptoms are present for at least two (2) weeks.

Two subsets of clinical depression are exogenous or reactive and endogenous. Reactive depression, also referred to as secondary depression, is caused by something outside the person such as loss of a loved one, environmental catastrophe, divorce or a serious medical condition. Endogenous depression is primary or biological. It may be caused by genetic or biochemical factors such as neurotransmitter functioning. Of the two, endogenous depression is often more severe and difficult to treat.

Risk factors for depression include:

- Major life changes – death of spouse, parent, friend, loved one, divorce, change in living situation
- Trauma
- Stress
- Personal or family history of depression
- Serious illness – cancer, diabetes, heart disease, Parkinson's disease, CVA (stroke)
- Certain medications (side effects)

***Note:** The symptoms may vary in severity. Each resident may experience symptoms differently.

Stage	CLINICAL SYMPTOMS
Mild Depression	• Unpleasant feelings about self – sad, anxious, empty • Self-sacrificing, especially in relation to giving in to others • Difficulty concentrating or indecisiveness • Preoccupation with trivial things • Pessimistic outlook toward life • Irritability toward self for not living up to an ideal standard • Dependence on others for gratification • Changes in appetite or weight changes • Insomnia or hypersomnia • Trouble sleeping, early-morning awakening, oversleeping • Fatigue or decreased energy • Loss of interest or pleasure in hobbies and activities • Increase in aches/pains, headaches, cramps, digestive problems without a clear physical cause and/or no easing with treatment

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

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

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.

Additional Comments:

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

ACKNOWLEDGEMENT OF RECEIPT OF DEPRESSION DISCLOSURE

I, _____, acknowledge that I have received a copy of
(Resident/Resident Representative/Guardian)

_____ Depression Disclosure which summarizes the clinical
(Facility Name)

symptoms a resident diagnosed with Depression may exhibit. Residents diagnosed with Depression may suffer from complications/adverse events and clinical symptoms that are a result of the natural progression of the disease.

The Resident/Resident Representative/Guardian acknowledges that complications/adverse events may occur as a result of the disease process.

This facility recognizes the relationship between the Resident and the Resident Representative/Guardian is a critical element in identifying all of the resident's disease symptoms. The facility staff and physician requests that the Resident Representative/Guardian report all information regarding changes listed as clinical symptoms, complications or changes in the resident's usual behavior or status to the facility immediately.

I understand the facility will review this information with _____ when there
(Resident/Resident Representative/Guardian)

is a significant change of the resident's condition, quarterly and when requested by the Resident/Resident Representative/Guardian or Facility as a necessary part of the plan of care for the resident.

By signing, the Resident/Resident Representative/Guardian acknowledges the clinical symptoms and complications/risks associated with depression as well as the importance of and participation in the overall plan of care for this resident.

ACKNOWLEDGEMENT SIGNATURES

_____ _____
Resident/Resident Representative/Guardian Date Signed

If signed by Resident Representative/Guardian, complete the following:

Print Name_____ Relationship_____

Person completing this form:_____ _____
Signature and Title Date Signed

Witness signature:_____ _____
Date Signed

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed