

Notes on Injection Clinical Encounter (NICE) Form

Patient Name:		Date:		
Long-Acting Injectable Med/Dose:		Refills:		
Injection Details	Injection site ____ Right/Left ____ Delt/Glut Previous site ____ Right/Left ____ Delt/Glut	Lot #: _____ Expiration: _____		
Weight: _____ lbs Last weight: _____ lbs Change: _____ lbs				
Individual Patient Symptoms: Observations & Brief Interview				
Appearance (Observe)	Affect (Observe)	Interaction (Observe)	Sleep & Appetite (Interview)	
<input type="checkbox"/> Appropriately dressed <input type="checkbox"/> Disheveled <input type="checkbox"/> Good hygiene <input type="checkbox"/> Poor hygiene <input type="checkbox"/> Relaxed posture <input type="checkbox"/> Agitated	<input type="checkbox"/> Anxious <input type="checkbox"/> Pre-occupied <input type="checkbox"/> Restless <input type="checkbox"/> Suspicious <input type="checkbox"/> Normal (euthymic) <input type="checkbox"/> Ambivalent	<input type="checkbox"/> Makes eye contact <input type="checkbox"/> Avoids eye contact <input type="checkbox"/> Initiates conversation <input type="checkbox"/> Socially withdrawn <input type="checkbox"/> Engaging conversation	<input type="checkbox"/> Sleeping well <input type="checkbox"/> Not sleeping well <input type="checkbox"/> Good appetite <input type="checkbox"/> Poor appetite	
Appointment	Mood	Auditory Hallucinations (compared to last appointment)	Speech	Other Symptoms
<input type="checkbox"/> Arrived on time <input type="checkbox"/> Arrived early <input type="checkbox"/> Arrived late <input type="checkbox"/> No show	<input type="checkbox"/> Balanced <input type="checkbox"/> Depressed <input type="checkbox"/> Upset <input type="checkbox"/> Excitable	<input type="checkbox"/> Same <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> None <input type="checkbox"/> Talking to self	<input type="checkbox"/> Normal volume <input type="checkbox"/> Soft <input type="checkbox"/> Loud <input type="checkbox"/> One-word/short responses <input type="checkbox"/> Excessive/fast <input type="checkbox"/> Clear/thoughtful speech <input type="checkbox"/> Disorganized/hard to follow	<input type="checkbox"/> Paranoia <input type="checkbox"/> Delusions
Social History:				
<input type="checkbox"/> Using drugs (including cannabis)?-if yes, what type: <input type="checkbox"/> Drinking alcohol? - if yes, what type and how often: <input type="checkbox"/> Vaping <input type="checkbox"/> Smoking				
Any thoughts of suicide? <input type="checkbox"/> Yes* <input type="checkbox"/> No <small>*If yes, contact prescriber and ask patient to contact Suicide and Crisis Lifeline (988). Offer to call with patient. If not viable or patient unwilling and at imminent risk of suicide, call 911.</small>				
Side effects: <input type="checkbox"/> Patient reports new side effect(s) <input type="checkbox"/> Patient denies any new side effects If yes, list effect(s) with duration:				
Other Notes/comments:				
Administered by: ____ Nurse ____ Pharmacist		Today's injection tolerated? ____ Yes/No		
Overall assessment:		Last Injection:		
<input type="checkbox"/> No health concerns <input type="checkbox"/> See other comments for any health concerns		<input type="checkbox"/> No injection pain <input type="checkbox"/> Injection pain for more than 3 days		
Needs New Rx? ____ Y/N	Next appt: _____	Next injection needed by: _____	Faxed <input type="checkbox"/>	
Nurse or Pharmacist Signature:				

NICE Form should be saved in patient's records and faxed to prescriber's office