49220

PEDS-C
Depression Management Tracking Form

Please Use Black Pen To Fill Out Form.

Week #	Date of Assessment	Patient ID	Patient Letter Code	
week	assessdt ___ / ___ / ____ (mm dd yyyy)	idn ___ - ___ - ___	letcode	corrfix ○ Correction

Instructions

Use this form for enrolled patients in all treatment groups when they score over 19 (raw score) on the Children's Depression Inventory (aged 5 - 17 years) or when they score over 15 on the CES-D (aged 18 years or more).

CRA Use Only

1.A. Depression screen used: CDI ○ CES-D ○ dmtscrn

B. Patient's raw score: ___ dmtscor

2. Date of the form: ___ / ___ / ____ (mm dd yyyy) dmtfdat

3. Date the patient or parent/guardian was interviewed: ___ / ___ / ____ (mm dd yyyy) dmtdt

4. Indicate depressive symptoms present nearly every day during the same two week period which represent a change from the patient's previous level of functioning (Answer each item below).

	Yes	No	
A. Depressed mood most of the day	○	○	dmtmood
B. Markedly diminished interest or pleasure in all or almost all activities.	○	○	dmtintrst
C. Clinically significant weight loss in the absence of dieting or weight gain (e.g., a change of more than 5% of body weight in a month) or a decrease in appetite, including failure to make expected growth-related weight gains.	○	○	dmtwtls
D. Insomnia or hypersomnia	○	○	dmtsom
E. Observable psychomotor agitation or retardation	○	○	dmtmotr
F. Fatigue or loss of energy	○	○	dmtfatig
G. Feelings of worthlessness or excessive or inappropriate guilt	○	○	dmtwthls
H. Diminished ability to think or concentrate or indecisiveness	○	○	dmtindcv
I. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide	○	○	dmtsuicd

5. Are **five** of the above symptoms of a major depressive episode present? ○ ○ dmt5symp

Signature: ______________________ **Certif. #:** staffid1 ___ - ___

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52909

Week #	Date of Assessment	Patient ID	Patient Letter Code	
week	assessdt ___ / ___ / ____ (mm dd yyyy)	idn ___ - ___ - ___	letcode	corrfix Correction

6. Does the patient have the following indications for mental health professional care? (Answer each item)

	Yes	No	
A. Initial episode of depression	○	○	dmtepsid
B. Recent onset of depression	○	○	dmtonset
C. Absence of coexisting conditions	○	○	dmtnocon
D. Ability to make a no-suicide contract	○	○	dmtnosui
E. A high level of family discord	○	○	dmtfamds
F. Chronic, recurrent depression	○	○	dmtchron

7. Did the patient show ANY of the above indications? ○ ○ dmtind7

If **No**, skip to item 9.
If **Yes**, continue drug therapy and refer the patient to a mental health professional.

8. A. Was the patient referred to a mental health professional? Yes ○ No ○ NA ○ dmtrefmhp

If **No**, skip to item 9.

B. Date referred: ___ / ___ / ____ (mm dd yyyy) dmtrefmhpdt

C. Name of professional: ______________________

D. Phone number: ______________________

9. Does the patient have the following indications for specialty physician care? (Answer each item)

	Yes	No	
A. Lack of response to initial course of treatment	○	○	dmtnores
B. Coexisting substance abuse	○	○	dmtsubab
C. Recent suicide attempt	○	○	dmtrcsui
D. Psychosis	○	○	dmtpsyco
E. Bipolar disorder	○	○	dmtbipol
F. Inability of the family to monitor patient's safety	○	○	dmtfammn

10. Did the patient show ANY of the above indications? ○ ○ dmtind10

If **No**, skip to item 12.
If **Yes**, refer the patient to a specialty physician.

CRA Use Only

Signature: ______________________ **Certif. #:** staffid2 ___ - ___

27824

PEDS-C
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Week # week | **Date of Assessment** assessdt ___ / ___ / ___ (mm dd yyyy) | **Patient ID** idn ___ - ___ - ___ | **Patient Letter Code** letcode | corrfix ○ **Correction**

CRA Use Only

11. A. Was the patient referred to a specialty physician? **Yes** ○ **No** ○ dmtrefsdoc

If **No**, skip to item 12.

B. Date of referral to a specialty physician: ___ / ___ / ___ (mm dd yyyy) dmtrefsdocdt

C. Name of specialty physician: ______________________

D. Phone number: ______________________

12. A. Was the patient started on psychiatric medications? **Yes** ○ **No** ○ dmtpsymed

If **No**, skip to item 13.

B. Date started: ___ / ___ / ___ (mm dd yyyy) dmtpsymeddt

C. Name of medication: dmtpsymednam

D. Medication type: **Brand** ○ **Generic** ○ **Other** ○ dmtpsymedtyp

13. Was the initial depression management successful within 8 weeks? **Yes** ○ **No** ○ dmtsuc8wk

If **Yes**, skip to item 16.

14. Is the patient currently on study drug therapy? **Yes** ○ **No** ○ dmtthrpy

If **No**, skip to item 16.
If **Yes**, stop study drug therapy and begin untreated follow-up at the next visit.

15. Date of the Therapy Stop/Restart form documenting the stopping of study drug therapy: ___ / ___ / ___ (mm dd yyyy) dmtthrpystpdt

16.A. Has the patient withdrawn from the study (no further visits)? **Yes** ○ **No** ○ dmtwd

B. If **Yes**, date of the Withdrawal/Closeout form: ___ / ___ / ___ (mm dd yyyy) dmtwddt

Signature: ______________________ **Certif. #:** staffid3 ___ - ___