I. BIOPHYSICAL ASSESSMENT

A. VITAL DATA

Height __________ Weight __________ Blood Pressure __________ Temperature __________
Pulse __________ Respiration __________ Pulse Ox __________ % Room Air

Allergies and/or type of adverse reaction:

Date of last PPD skin test or Quantiferon TB-ELISA (blood test) __________ Results: __________

B. EXISTING HEALTH PROBLEMS Check all current health problems

[ ] Arthritis [ ] Hepatitis
[ ] Asthma [ ] A
[ ] Cancer [ ] B
[ ] Cardiac Disease [ ] C
[ ] Constipation [ ] History of Seizures
[ ] COPD [ ] HIV/AIDS
[ ] CVA [ ] Hypertension
[ ] Diabetes [ ] Liver
[ ] GERD [ ] Renal
[ ] Head Trauma [ ] Thyroid
[ ] Other:

Comments: __________

C. Assessment of Pain: [ ] No report of pain at this time

If the patient reports pain, complete as indicated.

Current or History of Pain (Please Specify): __________

FLACC Pain Scale: If the patient is non-verbal and unable to provide information about pain, Please complete the FLACC Scale (Face, Legs, Activity, Cry and Consolability to assess pain.

Severity: [ ] (1-10): __________ OR

Location: __________ FLACC Score: __________ Onset: __________

Duration: [ ] Acute Pain (Few seconds to less than 6 months) [ ] Chronic Pain (Greater than 6 months)

Type of Pain (Circle all that apply):
- Cutaneous (Sensation)
- Somatic (Tendons, Ligaments, Bones, Blood Vessels, Nerves)
- Visceral (Organs)
- Referred
- Neuropathic (Functional pain)

Quality of Pain: (Circle all that apply):
- Sharp
- Dull
- Diffuse
- Shifting
- Burning

Aggravating Factors (Circumstances which cause pain to return or escalate):

Neutrophils

Alleviating Factors (Techniques or circumstances that reduce or relieve the pain):

Effect on Level of Functioning (Sleep, Changes in Mood, Appetite, Work, Exercise, ADL’s, Relations):

Current Treatments

- Drug Therapy (please specify):
- Acupuncture
- Relaxation/Meditation/Imagery
- Other:

Effectiveness (Relief, Some Benefit, Not Effective):

Biofeedback
Heat/Cold
Does pain appear to be associated with substance withdrawal?: [ ] Yes [ ] No [ ] N/A
Does pain appear to be associated with a co-occurring medical issue?: [ ] Yes [ ] No [ ] N/A
If yes, please specify: ____________________________

Please ensure that any identified pain issues are in the Plan of Care with Nursing interventions that include patient education.
Refer patient to the ACS Clinician for treatment of pain.

D. OBSERVATIONS – Identifying Marks/Injuries
Check all applicable observations and indicate on figure location

[ ] None Observed
[ ] Bruises
[ ] Cuts
[ ] Decubiti
[ ] Discolorations
[ ] Open Wounds
[ ] Piercings (note object & location)
[ ] Rashes
[ ] Scars

FRONT

BACK

Comments:

E. Nutritional/Metabolic (within the last year)
[ ] No impairments noted
[ ] Weight loss (last year)
  approx. amount: ________________
[ ] Weight gain (last year)
  approx. amount: ________________
[ ] Appearance:
  [ ] underweight
  [ ] over weight
  [ ] malnourished
[ ] Eating habits:
  [ ] loss of appetite
  [ ] slow eater
  [ ] fast eater
  [ ] refusal to eat
[ ] Cultural food preferences: ____________________________
[ ] Other: ____________________________

F. Prosthetic Devices
[ ] Artificial limb(s)
[ ] Contact lenses
[ ] Dentures [ ] full [ ] partial
[ ] Glasses
[ ] Hearing aid
[ ] None
[ ] Ostomy devices
[ ] Pacemaker
[ ] Other: ____________________________

Comments

G. Activities of Daily Living
1. Grooming/Personal Indicate
   I = Independent  or  A = Assisted
   • Bathing __________
   • Dressing ________
   • Eating _________
   • Hair Care ________
   • Hygiene ________
   • Shaving _________
   • Showering ________
   • Toileting ________
   • Other __________

Comments

Page 2 of 9
Complete Fall Risk Screening CVH-574

II. INTERPERSONAL CONSIDERATIONS

A. Relations
1. Who are the important people in your life? _________________________________

2. Who do you want involved in your treatment plan meeting? ____________________

3. Describe how easy or difficult it is for you to get along with others: ____________________

B. Self Concept
1. Describe what you like about yourself: _________________________________

2. Describe what you would like to change about yourself or traits you’d like to work on: ____________________

3. Are there hobbies or interests which give you pleasure? ____________________

C. Sexuality
1. Within the last month have you been sexually active? [ ] No [ ] Yes

2. What is your sexual preference? _________________________________

3. Do you use precautions? [ ] No [ ] Yes Describe: ____________________

4. Have you ever gotten into trouble because of your sexual behavior? [ ] No [ ] Yes Describe: ____________________

D. Spiritual
1. Do you currently practice any religion? [ ] No [ ] Yes Describe: ____________________

2. How will your spiritual beliefs/practices be affected while in the hospital? ____________________

E. Cultural
1. Do you have any specific beliefs regarding the emotional/mental or physical distress you are experiencing?
   [ ] No [ ] Yes Describe: ____________________

2. Do you or your family have any remedies which you use to address your health problems?
   [ ] No [ ] Yes Describe: ____________________

3. Are there any cultural or family practices you would like us to know about while you are in the hospital?
   [ ] No [ ] Yes Describe: ____________________
III. MENTAL HEALTH ASSESSMENT (Check all that apply)

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Affect/Mood</th>
<th>Thought Content (Describe)</th>
<th>Thought Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Neat, clean, appropriate</td>
<td>[ ] Appropriate</td>
<td>[ ] No deficits noted</td>
<td>[ ] No deficits noted</td>
</tr>
<tr>
<td>[ ] Disheveled</td>
<td>[ ] Anxious</td>
<td>[ ] Delusional</td>
<td>[ ] Blocking</td>
</tr>
<tr>
<td>[ ] Dirty skin, hair, nails and clothing</td>
<td>[ ] Cheerful</td>
<td>[ ] Obsessive</td>
<td>[ ] Circumstantial</td>
</tr>
<tr>
<td>[ ] Other: __________</td>
<td>[ ] Dysphoric</td>
<td>[ ] Phobic</td>
<td>[ ] Looseness of associations</td>
</tr>
<tr>
<td></td>
<td>[ ] Euphoric</td>
<td></td>
<td>[ ] Racing</td>
</tr>
<tr>
<td></td>
<td>[ ] Flat</td>
<td></td>
<td>[ ] Tangential</td>
</tr>
<tr>
<td></td>
<td>[ ] Labile</td>
<td></td>
<td>[ ] Other: __________</td>
</tr>
<tr>
<td></td>
<td>[ ] Labile</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Other: __________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Orientation</th>
<th>Perceptions</th>
<th>Memory</th>
<th>Motor Behavior</th>
<th>Speech</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Oriented</td>
<td>[ ] Reality based</td>
<td>[ ] Recent memory in tact</td>
<td>[ ] No deficits noted</td>
<td>[ ] No impairments noted</td>
</tr>
<tr>
<td></td>
<td>[ ] Hallucinations</td>
<td></td>
<td></td>
<td>[ ] Monosyllabic</td>
</tr>
<tr>
<td></td>
<td>[ ] Illusions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Remote memory intact</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Deficits in recent memory</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] Disoriented (time, place, person)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] Confused</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] Confused</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IV. RISK ASSESSMENT

A. SELF-HARM AND SUICIDE RISK (Check the appropriate answer (Y/N) and comment on patients’ answers or record patients’ response to specific questions.)

**COMMENTS/PATIENT RESPONSE “Provide Quotes”**

1. How does the future look to you?

2. What things in your life make you want to go on living?

3. Whom do you rely on during difficult times?

4. Has treatment been effective for you in the past year?
   - [ ] Yes [ ] No [ ] N/A. If no, explain why:

5. Are there things that you’ve been feeling guilty about or blaming yourself for? [ ] Yes [ ] No

6. Do you ever wish you could go to sleep and just not wake up?  
   - [ ] Yes [ ] No

7. Do you feel that life is not worth living?  
   - [ ] Yes [ ] No

8. Do you consider yourself an impulsive person? [ ] Yes [ ] No
   - Why or Why Not?

9. **If no, proceed to # 12**  
   When people are feeling extremely upset, they sometimes have thoughts of wanting to harm themselves. Do you have any thoughts of wanting to harm/hurt yourself? [ ] Yes [ ] No

10. When you begin to have thoughts of harming yourself what do you do?

11. Patient has a history of acting on these thoughts.  
   - [ ] Yes [ ] No If yes, please describe:
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 Have there been times when voices told you to hurt or kill yourself?</td>
<td>[ ] Yes  [ ] No</td>
</tr>
<tr>
<td>13 Have you ever had thoughts of wanting to kill yourself in the past year?</td>
<td>[ ] Yes  [ ] No <strong>If no, proceed to # 27</strong></td>
</tr>
</tbody>
</table>
| 14 Can you tell me about the first time you ever thought about suicide? | [ ] Yes  [ ] No  
| a. What triggered your thinking about suicide? | [ ] Yes  [ ] No |
| b. Why did you think suicide was the best option at that time? | [ ] Yes  [ ] No  
| c. Did you want to die? | [ ] Yes  [ ] No  
| d. Please tell me exactly what you did. | [ ] Yes  [ ] No  
| e. Were you injured by the suicide attempt? | [ ] Yes  [ ] No  
| f. Did you receive medical care? | [ ] Yes  [ ] No  
| g. Did you take steps to prevent your discovery or rescue? | [ ] Yes  [ ] No  
| h. How do you feel about surviving? | [ ] Yes  [ ] No  
| i. Did you learn anything helpful about yourself or others? | [ ] Yes  [ ] No  
| 15 Have there been other times in your life when you tried to kill yourself? | [ ] Yes  [ ] No  
| 16 Have you thought about or tried to take your life in the past year? | [ ] Yes  [ ] No  
| 17 Have you thought about or tried to take your life in the past month? | [ ] Yes  [ ] No  
| 18 How often do you think about killing yourself? *(Check one)*  
| Frequency: [ ] Never  [ ] Rarely  [ ] Sometimes  [ ] Frequently  [ ] Daily  
| 19 When have these thoughts, how intense or severe are they? *(Circle one)*  
| Intensity: Mild  1  2  3  4  5  6  7  8  9  10  Severe  
| 20 Have you thought about when you would kill yourself? | [ ] Yes  [ ] No  
| 21 Have you thought about where you would kill yourself? | [ ] Yes  [ ] No  
| 22 Have you thought about how? | [ ] Yes  [ ] No  
| 23 Do you have access to the means to end your life? | [ ] Yes  [ ] No  
| 24 Have you made any particular preparations? | [ ] Yes  [ ] No  
| 25 Have you rehearsed your suicide in any way? | [ ] Yes  [ ] No  
| 26 Why do you want to die? | [ ] Yes  [ ] No  

COMMENTS/PATIENT RESPONSE “Provide Quotes”
<table>
<thead>
<tr>
<th>Question</th>
<th>EVER</th>
<th>Past 6 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indication of Self Harm</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Self Mutilating Behaviors</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Suicidal Ideation</td>
<td>[ ]</td>
<td>[ ] Unknown</td>
</tr>
<tr>
<td>Suicidal Intent</td>
<td>[ ]</td>
<td>[ ] Unknown</td>
</tr>
<tr>
<td>Suicide Plan</td>
<td>[ ]</td>
<td>[ ] Unknown</td>
</tr>
<tr>
<td>Single Attempt</td>
<td>[ ]</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Multiple Attempts</td>
<td>[ ]</td>
<td>[ ] No</td>
</tr>
</tbody>
</table>

27 Has anyone in your family attempted suicide?  [ ] No  [ ] Yes  If yes, date: __________ (month/year)
Please identify who, when and circumstances:

28 Self Harm and Suicide Risk History:

Immediately notify the MD if there are any YES responses or new information is obtained regarding the patient’s suicidal potential which was not elicited during the MD assessment.

MD Contacted:  [ ] No  [ ] Yes: ___________________________ ___________________________ AM/PM
Contacted by: ___________________________ ___________________________

B. AWOL RISK (Check all that apply)

[ ] No evidence at this time
[ ] History of AWOL attempts
[ ] Expressed desire to go AWOL
[ ] Denies need for hospitalization

C. VIOLENCE RISK (Check all that apply)

[ ] No current evidence or history of violence risk
[ ] Fire Setting
  [ ] Ever
  [ ] Past 6 months (Dates) ______________
[ ] Abuse of Animals
  [ ] Ever
  [ ] Past 6 months (Dates) ______________
[ ] Violence (Property or Person)
  [ ] Ever
  [ ] Past 6 months (Dates) ______________
[ ] Homicidal Ideation
  [ ] Ever
  [ ] Past 6 months (Dates) ______________

Describe Contributing Factors – Consider precipitants to anger, substance use, delusions of persecution, cognitive impairment, history of seizure.

Describe Motive, Intent, Access To Weapons: ___________________________
D. **ASSESSMENT OF VICTIMIZATION - Introduction:** These days many people are exposed to violence in some form. Violence is a health risk and can result in physical and emotional problems. It is our routine procedure to ask patients about their exposure to violence. If you are a victim of violence, we can better help you if we know about it.

**Instructions:** If the individual answers yes to any of the questions below, ask for details, such as who, how, where and when.

1. In the past 12 months, has anyone slapped, pushed, grabbed or shoved you? □ Yes □ No

2. In the past 12 months, has anyone choked, kicked, bit or punched you? □ Yes □ No

*3. In the past 12 months, has anyone forced or coerced you to have sex? □ Yes □ No

*4. In the past 12 months, has anyone threatened you with or actually used a weapon to scare or hurt you? □ Yes □ No

*5. Do you feel you are currently in danger? □ Yes □ No

If yes, please explain:

6. **Victimization Risk Factors (Check all that apply):**
   - [ ] No risk factors identified
   - [ ] Developmental Disabilities
   - [ ] Impulse Control Deficits
   - [ ] Allegations of Abuse
   - [ ] Cognitive Deficits
   - [ ] Altercations with Peers/Staff
   - [ ] Past Trauma History
   - [ ] Psychosis
   - [ ] Personal Boundaries Impaired
   - [ ] Impaired Judgment
   - [ ] Elderly

7. Does the patient appear at risk of victimization while hospitalized? □ Yes □ No

* New information revealed as a result of this assessment, particularly when Items 3-5 are positively endorsed, indicates risk of victimization and requires immediate safety measures instituted and MD notification.


E. **PAST HISTORY OF SECLUSION & RESTRAINT**

1. What are some of the things that make you angry? ________________________________________________

2. How do you generally respond or behave when you get angry? ________________________________________________

3. Have you ever been physically restrained or placed in seclusion? [ ] No [ ] Yes – Date of last incident: __________

Describe when, where, what happened, and reaction to restraint:

4. The CVH Seclusion and Restraint policy was reviewed with the patient. [ ] Yes [ ] No Reason: __________________________

If restraint or seclusion becomes necessary, who would you like staff to notify?

Contact Name _______________________________________ Phone Number: __________________________

Patient has signed a Release of Information to notify person(s) designated [ ] Yes [ ] No - If no, inform Social Worker

Social Worker name: __________________________ Date and Time of Notification:

5. Is there a pre-existing medical condition or disability that places the patient at risk should seclusion/restraint be utilized? [ ] No [ ] Yes, If yes please describe: __________________________
6. Is there history of sexual abuse that places the patient at greater psychological risk during seclusion/restraint?

[ ] No  [ ] Yes, If yes please describe: __________________________

F. PERSONAL PREFERENCES

1. What helps when you are not feeling well? (Check all that apply)

[ ] Lying down with a cold face cloth  [ ] Wrapping up in a blanket  [ ] Deep breathing
[ ] Additional(extra) medication  [ ] A warm or cool drink  [ ] Eating something
[ ] Taking a shower or bath  [ ] Reading  [ ] Writing in a diary/journal/letter
[ ] Exercise  [ ] Drawing  [ ] Playing a game
[ ] Sitting by the nurses station  [ ] Watching TV  [ ] Talking to staff
[ ] Calling your therapist  [ ] Talking with another patient  [ ] Talking with chaplain
[ ] Calling a friend or family  [ ] Pacing the halls  [ ] Listening to music
[ ] Going for a walk  [ ] Other, specify below

Elaborate on above choices as needed: ____________________________________________

2. What are some things that make it more difficult for you when you are already upset? (Check all that apply)

[ ] Being touched  [ ] Bedroom door being opened  [ ] People staring at me
[ ] Not having input/choices  [ ] Not being able to express my opinion  [ ] Being criticized
[ ] Being isolated/alone  [ ] Lack of staff availability/attention  [ ] Boredom/lack of activities
[ ] Seeing people in uniform  [ ] Loud noise  [ ] Yelling
[ ] Noise in general  [ ] Particular time of day  [ ] Time of year

Elaborate on above choices as needed: ____________________________________________

V. HEALTH TEACHING NEEDS (Check all that apply)

A. Patient’s Preferred Method of Learning

[ ] One on One Teaching  [ ] Written Information
[ ] Group Discussion  [ ] Other: __________________________

B. Barriers to Learning

[ ] None  [ ] Speech  [ ] Hearing
[ ] Developmental Disabilities  [ ] Other: __________________________

C. Nursing Educational Needs

[ ] Symptom Recognition  [ ] Medication  [ ] Symptom Management  [ ] Self Care
[ ] Psychiatric Illness/Treatment  [ ] Interpersonal Relations  [ ] Medical Condition  [ ] Other: __________________________
Patient Name: ___________________________ MPI# ________________________

VI PATIENT STRENGTHS (Check all that apply)

[ ] Ability to verbalize needs [ ] Goal Directed [ ] Has Hobbies - Describe: ___________________________
[ ] Ability to articulate clearly [ ] Values Health and Wellness
[ ] Motivated for treatment [ ] Knowledge regarding own self-care issues
[ ] Ability to collaborate [ ] Identifies Interests – Describe: ___________________________
[ ] Assertive [ ] Uses support system
[ ] Positive Attitude [ ] Ability to make relationships

[ ] Goal Directed
[ ] Values Health and Wellness
[ ] Knowledge regarding own self-care issues
[ ] Identifies Interests – Describe: ___________________________
[ ] Vocational Interests, Describe: ___________________________
[ ] Other: ___________________________

A. Coping Style/Preferences to decrease stress and avoid conflict: ______________________________________

B.  A. Patient expectations of future/continued treatment (in the patient’s own words): __________________________

B. Nursing Concerns (Include risk issues and problems that prevent the patient from being discharged): __________________________

C. Chronic Pain (include type and interventions to manage): ______________________________________

D. Health education needs identified through the Nursing Re-assessment, including specific teaching for Pain Management: __________________________

E. Services that will be needed post discharge: ______________________________________

Registered Nurse Signature:
____________________________________________________________ AM/PM
Signature of Assessing Registered Nurse             Date             Time
Print Name: ___________________________________________________
FALL RISK SCREENING

Patient Name: ____________________________

MPI #: ____________________________ Print or Addressograph Imprint

Type of Screening: ____________________________

- Admission (Date: ________)
- Annual
- Change in Patient Condition (without fall)

Completed by: RN Signature: ____________________________ Print Name: __________ Date: __________

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse History</td>
<td>None</td>
<td>Use more than one year ago</td>
<td>Use in the past year</td>
<td>Use at time of admission</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>18 - 49</td>
<td>50 - 59</td>
<td>60 – 70 years</td>
<td>Over 70 years</td>
<td></td>
</tr>
<tr>
<td>Fall History</td>
<td>No falls in last year</td>
<td>Fall in last 12 months</td>
<td>Fall in last 3 months</td>
<td>Fall in last month</td>
<td></td>
</tr>
<tr>
<td>Balance</td>
<td>Independently ambulatory</td>
<td>Non-ambulatory</td>
<td>Independently ambulatory with assistive devices</td>
<td>Ambulatory with assistive devices and staff supervision / assistance</td>
<td></td>
</tr>
<tr>
<td>Mental State</td>
<td>Oriented x 3</td>
<td>Oriented x 2</td>
<td>Oriented x 1</td>
<td>Any of the following: Disoriented, Delirious, Impaired Judgment, Impulsivity</td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>Normal</td>
<td>Wears glasses</td>
<td>Blurred vision, cataract, glaucoma</td>
<td>Severe visual disturbance or blindness</td>
<td></td>
</tr>
<tr>
<td>Medications known to increase fall risk - number of taken by patient</td>
<td>0</td>
<td>1-2</td>
<td>3-4</td>
<td>More than 4</td>
<td>List on back side</td>
</tr>
<tr>
<td>Incontinence</td>
<td>Not incontinent</td>
<td>Commode or urinal at bedside</td>
<td>Incontinent with toilet less than 30 feet from bedroom</td>
<td>Incontinent with toilet more than 30 feet from bedroom</td>
<td></td>
</tr>
</tbody>
</table>

0 – 10 = Low Risk 11 – 17 Medium Risk 18 – 24 = High Risk

TOTAL SCORE

Scoring of 0 – 10: No immediate action necessary.

SCORING OF 11 OR GREATER:

RN 1. Identifies the patient “at risk” of fall; places “Fall Risk” sticker on the spine of the patient’s medical record binder
2. Notifies Attending Psychiatrist/ACS Clinician/On-Call Physician of the patient’s score on the Fall Risk Screening

Attending Psychiatrist/ACS Clinician/On-Call Physician Notified: ____________________________
by: ____________________________ AM/PM
RN Signature: ____________________________ Name Printed: ____________________________ Date: __________ Time: __________

Attending Psychiatrist/ACS Clinician/On-Call Physician:

- Evaluation: ____________________________
- Physical Therapy Evaluation ordered
- Occupational Therapy Evaluation ordered (if indicated)
- Other orders: ____________________________

Signatures:

Attending Psychiatrist Signature: ____________________________ Print Name: __________ Date: __________ Time: __________ AM/PM

Ambulatory Care Clinician Signature: ____________________________ Print Name: __________ Date: __________ Time: __________ AM/PM

OR

On-Call MD Signature: ____________________________ Print Name: __________ Date: __________ Time: __________ AM/PM

Filing: Admission Screening following Admission H&P
Annual Screening following Annual H&P
Changes in Patient Condition Screening (without fall) chronological order with Physical Health Progress Notes
MEDICATIONS KNOWN TO INCREASE FALL RISK

Some of the medications most commonly used at this facility are listed below. This is not a complete list. Please refer to Lexicomp or Micromedex for information on additional medications. Please review each patient’s specific case and co-morbidities when making comparisons with this list.

<table>
<thead>
<tr>
<th>Category</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analgesics</td>
<td>Acetaminophen with codeine, Fentanyl, Hydrocodone, Morphine sulfate, Oxycodone, Tramadol</td>
</tr>
<tr>
<td>Anticholinergics/Antihistamines</td>
<td>Benztropine, Diphenhydramine</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>Carbamazepine, Divalproex sodium, Gabapentin, Lamotrigine, Oxcarbazepine, Phenobarbital, Phenytoin, Topiramate</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>Amitriptyline, Trazodone</td>
</tr>
<tr>
<td>Antidiabetic Agents</td>
<td>Glyburide, Insulin, Metformin, Pioglitazone</td>
</tr>
<tr>
<td>Antihypertensives by category</td>
<td>ACE Inhibitors (i.e. enalopril, lisinopril), Angiotensin Beta Blockers (i.e. atenolol, metoprolol, propanolol), Calcium Channel Blockers (i.e. amlodipine, diltiazem, nifedipine, verapamil), Cardiac glycosides (i.e. digoxin), Receptor Blockers (i.e. losartan), Vasodilators (nitroglycerine), Misc. (clonidine)</td>
</tr>
<tr>
<td>Anxiolytics</td>
<td>Clonazepam, Diazepam, Lorazepam</td>
</tr>
<tr>
<td>Diuretics</td>
<td>Furosemide, Hydrochlorothiazide (HCTZ)</td>
</tr>
<tr>
<td>Opiate Agonists/Partial Agonists</td>
<td>Buprenorphine, Methadone</td>
</tr>
<tr>
<td>Overactive Bladder and BPH Agents</td>
<td>Oxybutynin, Tamsulosin, Terazosin, Tolterodine</td>
</tr>
<tr>
<td>Psychotropics</td>
<td>Aripiprazole, Chlorpromazine, Clozapine, Fluphenazine, Haloperidol, Olanzapine, Quetiapine, Risperdal, Ziprasidone</td>
</tr>
<tr>
<td>Sedatives/Hypnotics</td>
<td>Hydroxyzine, Zaleplon, Zolpidem</td>
</tr>
</tbody>
</table>