

J-SPEED 精神版 英語表記例

Disaster Medical Record (Mental Health Edition) J-		Date of consultation
Please check all that apply		XXXXXX year XXXX month XXXX day
Age	<input type="checkbox"/> 0 years old <input type="checkbox"/> 1-14 years old <input type="checkbox"/> 15-64	Name of Consultant
Gender	1 <input type="checkbox"/> Male	
	2 <input type="checkbox"/> Female	
Attribu	3 <input type="checkbox"/> Supporter	Date of birth
Responded to Location	4 <input type="checkbox"/> Shelter	Address
	5 <input type="checkbox"/> Hospitals and first aid centers	
	6 <input type="checkbox"/> Home	
	7 <input type="checkbox"/> Other locations	Name of shelter/rescue center
Mental health		Telephone number
Complaint of the person	8 <input type="checkbox"/> Cannot sleep	Pre-existing mental illness
	9 <input type="checkbox"/> I am anxious	<input type="checkbox"/> Yes
	10 <input type="checkbox"/> Disasters come to mind.	Name of medication
	11 <input type="checkbox"/> I'm depressed.	
	12 <input type="checkbox"/> I feel sick.	Life History
	13 <input type="checkbox"/> I feel like dying	
	14 <input type="checkbox"/> I am being victimized by people	
	15 <input type="checkbox"/> I have memory loss	
	16 <input type="checkbox"/> Other	
Behavioral problems	17 <input type="checkbox"/> Difficulty in understanding what you are saying	
	18 <input type="checkbox"/> Angry person	
	19 <input type="checkbox"/> Excited	
	20 <input type="checkbox"/>	
	21 <input type="checkbox"/> Unresponsive	
	22 <input type="checkbox"/> Wandering	
	23 <input type="checkbox"/> Self-harming	
	24 <input type="checkbox"/> Attempting suicide	
	25 <input type="checkbox"/> Is verbally abusive or violent	
	26 <input type="checkbox"/> Cannot quit drinking alcohol	
	27 <input type="checkbox"/> Other	
ICD Classification	28 <input type="checkbox"/>	<input type="checkbox"/> Death or missing family/friends
	29 <input type="checkbox"/>	<input type="checkbox"/> Injuries
	30 <input type="checkbox"/>	<input type="checkbox"/> Damage to or flooding of house
	31 <input type="checkbox"/>	Family members <input type="checkbox"/> Yes <input type="checkbox"/> None
	32 <input type="checkbox"/>	Current medical history
	33 <input type="checkbox"/>	
	34 <input type="checkbox"/>	
	35 <input type="checkbox"/>	
	36 <input type="checkbox"/>	
	37 <input type="checkbox"/>	
	38 <input type="checkbox"/>	
	39 <input type="checkbox"/>	present illness
Support needed	40 <input type="checkbox"/> Psychiatric treatment	
	41 <input type="checkbox"/> Physical Medicine	
	42 <input type="checkbox"/> Health and welfare care	
	43 <input type="checkbox"/> Community, workplace, home, etc.	
Response	44 <input type="checkbox"/> Prescription	Response, Psychiatric urgency Yes/No
	45 <input type="checkbox"/> Hospitalization/residential care	
	46 <input type="checkbox"/> Referral to local health care facilities	
	47 <input type="checkbox"/> Listening, advice, etc.	
Outcome	48 <input type="checkbox"/> Continuation of support	
	49 <input type="checkbox"/> Termination of support	
	50 <input type="checkbox"/> Directly related	
	51 <input type="checkbox"/> Indirectly related	
	52 <input type="checkbox"/> No relation	