

Self-Report Form for Mood Episodes (SRF-ME) - Overview

- The SRF-ME form is a tool through which the patient can become an active partner in their disease management by actively monitoring and recording changes in symptoms and mood.¹
- The SRF-ME form is designed to be completed in the waiting room, prior to the office visit.
- The SRF-ME includes self-reported frequency of DSM-IV symptoms of mood elevation and depression.
- Collecting information at each visit allows for better tracking of symptoms and response to treatment.
- Answering standard questions before the MD visit allows for more productive office visit time with the clinician.

Validation

The SRF-ME demonstrates excellent sensitivity and specificity for hypomania, mania and for depression as compared with the treating clinician diagnosis derived from the Clinical Monitoring Form.²

	Sensitivity	Specificity	PPV*	NPV**
Mania/hypomania	0.83	0.97	0.80	0.98
Mixed	0.77	1.0	1.00	0.97
Depressed	0.71	0.92	0.77	0.91
Recovered	1.00	0.75	1.00	0.53
Subsyndromal	0.55	0.94	0.80	0.82

*PPV-Positive Predictive Value, **NPV-Negative Predictive Value

Use of the SRF-ME

The SRF-ME is intended to aid the clinician in comparing and monitoring changes from one office visit to the next.

1. Information regarding the SRF-ME form can be obtained through the Massachusetts General Hospital Bipolar Clinic & Research Program at : <http://www.manicdepressive.org/selfreport>
2. Farrelly N, Tran TB, Borrelli DJ, et al. The self report form for mood episodes in bipolar disorder. Program and abstracts of the American Psychiatric Association 2006 Annual Meeting; May 20-25, 2006: Toronto, Ontario, Canada. Poster NR 212.

Clinical Self-Report Form

Name: _____ ID# _____ Clinician: _____ Date / / _____

Since your last appointment:

Circle

Has there been a period of time when you were feeling down or depressed most of the day nearly everyday? Yes No
If Yes: Did it last as long as two weeks? Yes No

What about being a lot less interested in most things or unable to enjoy things you usually enjoy? Yes No
If Yes: Did it last as long as 2 weeks? Yes No

Has there been a period of time when you were feeling so good or so hyper people thought you were not your normal self or you were so hyper you got in trouble? Yes No
If Yes: Was it more than just feeling good? Yes No
Did anyone say you were manic? Yes No

What about a period of time when you were so irritable that you would shout at people or start fights or arguments? Yes No

Have you experienced a major stress that you feel has caused your mood to change? Yes No
If Yes, (describe) _____

Have you experienced other medical problems? Yes No
If Yes, (describe) _____

Used additional psychiatric care/treatment Yes No Other medical treatment Yes No Onset of last menses ___ / ___ / ___

Over the past 10 days how many days have you been/had...

...depressed **most** of the day _____ /10 days ...unable to experience pleasure **most** of the day _____ /10 days
 ...**any** period of abnormal mood elevation _____ /10 days ...**any** period of abnormal irritability _____ /10 days
 ...**any** period of abnormal anxiety _____ /10 days

During the past week . . .

What is the **least** you have slept in any one day? _____ hrs What is the **most** you have slept any one day? _____ hrs
 Have you had: Panic Attacks ___ Binge/Purge ___ Headaches ___ **Your Weight?** _____
 Indicate your use of: Caffeine ___ cups/day Nicotine ___ packs/day Alcohol ___ drinks/week Drugs _____

For each item, rate this week compared to your usual (when well)	←-----Decreased-----→					Well ↓	Increased -----→				
	Constant and Severe	Nearly Every Day	Often	Rarely and/or mild			Rarely and/or mild	Often	Nearly Every Day	Constant and Severe	
Sleep						Normal					
Ability to enjoy pleasant things / usual interests						Normal					
Self confidence/Self Esteem						Normal					
Energy						Normal					
Ability to Concentrate						Normal					
Distractibility						None					
Appetite						Normal					
Physical restlessness/agitation						None					
Rate of speech or thoughts						None					
Feel life isn't worth living or suicidal thoughts						None					
Talking						Normal					
Racing thoughts						None					
Making plans or getting new projects started						Normal					
Behaviors others regard as excessive, foolish or risky						None					

Please complete for all medications used since your last visit

Medication	Total daily dose	Mg missed this week	Comments / adverse effects	<input type="checkbox"/> Check if no adverse effects
	Mg	Mg		
	Mg	Mg		
	Mg	Mg		
	Mg	Mg		
	Mg	Mg		
	Mg	Mg		
	Mg	Mg		
	Mg	Mg		

Clinical Self-Report Form - Directions

Should I complete the Clinical Self-Report Form?

YES

The Clinical Self-Report Form was designed to systematically collect information about the symptoms commonly experienced by patients with mood disorders. Collecting information at each visit allows your doctor to better track the course of your symptoms and your response to treatment. Answering standard questions before your visit allows for more productive time with your doctor. We strongly recommend filling one out at each visit.

DIRECTIONS

Clinical Self-Report Form

Name: Odysseus O. Attica ID# _____ Clinician: Sachs Date 03, 17, 02

Since your last appointment:
 Has there been a period of time when you were feeling down or depressed most of the day, nearly everyday? Yes No
 If Yes: Did it last as long as two weeks? Yes No
 What about being a lot less interested in most things or unable to enjoy things you usually enjoy? Yes No
 If Yes: Did it last as long as 2 weeks? Yes No
 Has there been a period of time when you were feeling so good or so hyper people thought you were not your normal self or you were so hyper you got in trouble? Yes No
 If Yes: Was it more than just feeling good? Yes No
 Did anyone say you were manic? Yes No
 What about a period of time when you were so irritable that you would shout at people or start fights or arguments? Yes No
 Have you experienced a major stress which you feel has caused your mood to change? Yes No
 If yes (describe) My ship sank and my wife left to marry another sailor
 Have you experienced other medical problems? Yes No
 If yes (describe) Migraine headaches
 Used additional psychiatric care/treatment Yes No Other medical treatment Yes No Onset of last menses _____
Over the past 10 days how many days have you been/had...
 ...depressed most of the day 8 /10 Days ...any period of abnormal mood elevation 0 /10 Days
 ...any period of abnormal irritability 2 /10 Days ...any period of abnormal anxiety 0 /10 Days
During the past week...
 What is the least you have slept in any one day 0.4 hrs What is the most you have slept in any one day 1.6 hrs
 Have you had: Panic Attacks No Binge/Purge No Headaches Yes Weight 185
 Indicate your use of: Caffeine 2 cups/day Nicotine 0 packs/day Alcohol 0 drinks/week Drugs _____

For each question, circle "YES" or "NO".
READ CAREFULLY!
 Keep in mind the time frame of each question

These questions refer to the past 10 days only
 What is...?

- **Depressed Mood** - feeling sad, blue, down, being unable to enjoy most things you usually find pleasurable
- **Elevated Mood** - feeling high, up, more capable than usual, feeling invulnerable - out of proportion to circumstances
- **Abnormal irritability** - feeling more easily annoyed, angry, or hostile than normal for the circumstances
- **Abnormal anxiety** - feeling more nervous, anxious, worried than normal for the circumstances

All remaining questions refer to this past week only

For each item rate this week compared to your usual (when well)	Decreased				Well	Increased			
	Constant and Severe	Nearly Every Day	Often	Rarely And/or mid		Rarely and/or mid	Often	Nearly Every Day	Constant And Severe
Sleep		<input checked="" type="checkbox"/>			Normal	<input checked="" type="checkbox"/>			
Ability to enjoy pleasant things / usual interests			<input checked="" type="checkbox"/>		Normal				
Self confidence/Self Esteem			<input checked="" type="checkbox"/>		Normal				
Energy			<input checked="" type="checkbox"/>		Normal				
Ability to Concentrate				<input checked="" type="checkbox"/>	None				
Distractibility					None		<input checked="" type="checkbox"/>		
Appetite				<input checked="" type="checkbox"/>	Normal	<input checked="" type="checkbox"/>			
Physical restlessness/agitation					None	<input checked="" type="checkbox"/>			
Slowing of movement, speech or thoughts					<input checked="" type="checkbox"/> None				
Feel life isn't worth living or suicidal thoughts					None		<input checked="" type="checkbox"/>		
Talking					<input checked="" type="checkbox"/> Normal				
Racing thoughts					None			<input checked="" type="checkbox"/>	
Making plans or getting new projects started				<input checked="" type="checkbox"/>	Normal				
Behaviors others regard as excessive, foolish or risky					None	<input checked="" type="checkbox"/>			

- Rate each item referring to this past week only.
- Check "Normal" or "None" if symptom has not been present.
- Check appropriate box to rate each item.
- You may check more than one box.
- Ask your doctor if you are unsure of an item

Please complete for all medications used since your last visit

Medication	Total daily dose	Mg missed this week	Comments / adverse effects	<input type="checkbox"/> Check if no adverse effects
<u>Eskalith CR</u>	<u>120</u> Mg	<u>240</u> Mg	<u>Trem or. Thirsty all the time.</u>	<input checked="" type="checkbox"/>
<u>Depakote</u>	<u>150</u> Mg	<u>300</u> Mg		<input checked="" type="checkbox"/>
<u>Ativan</u>	<u>1</u> Mg	<u>2</u> Mg	<u>Sedation. Worsening of memory.</u>	<input checked="" type="checkbox"/>
<u>Wellbutrin</u>	<u>300</u> Mg	<u>0</u> Mg		<input checked="" type="checkbox"/>
<u>Risperdal</u>	<u>1.5</u> Mg	<u>0</u> Mg		<input checked="" type="checkbox"/>

Check here if you have not had any noticeable side effects from your medications.

- Please indicate all medications you have taken since your last visit.
- If you can't remember how many milligrams (mg) you take, consult your doctor about your dose.
- List any side effects or comments you have about your treatments.

PLEASE GIVE THIS FORM TO YOUR DOCTOR AT THE BEGINNING OF YOUR APPOINTMENT

After filling out the Self-report Form once or twice, you'll find that it's much easier than it first appears, and you will be able to make better use of your appointment time.