





9.	Liason services	<input type="checkbox"/>
10.	Others please specify	
	a.	
	b.	
	c.	
	d.	

**2.2: FACILITIES AVAILABLE (Tick whichever is available and state capacity indicators)**

Name of Facility		Capacity indicators:	
1.	Dedicated psychiatric in patient wards	<input type="checkbox"/>	Patients / year Number of beds
2.	Psychiatric beds in Medical or other wards	<input type="checkbox"/>	Patients / year Number of beds
3.	Outpatient clinics	<input type="checkbox"/>	Patients/year
4.	Day care clinics	<input type="checkbox"/>	Patients / year
5.	Child Psychiatric Clinic (either in Psychiatry department or in Paediatric Department)	<input type="checkbox"/>	Patients/ year
6.	Geriatric Psychiatric Clinic (either in Geriatric department or in Psychiatry Department)	<input type="checkbox"/>	Patients/ year
7.	Addiction Clinic s	<input type="checkbox"/>	Patients/ year
8.	Methadone Clinic	<input type="checkbox"/>	Patients / year
9.	Sleep Laboratory	<input type="checkbox"/>	Patients / year
10.	Psychometric Testing Clinic	<input type="checkbox"/>	Patients / year
11.	Others please specify		
	a.		
	b.		
	c.		

**2.3: MEDICAL TECHNOLOGY / DEVICES AVAILABLE (Please only quantify devices that are situated in the Department)**

\* Functioning = Devices that are currently in working order AND being used by the department

\*\* Non functioning = Devices that are either non operational OR operational but NOT used in the department due to lack of staff or any other reasons.

Name of device: (Tick whichever is available)		Quantity on site	
		*Functioning	* Non functioning
1.	Electroconvulsive Therapy Machine	<input type="checkbox"/>	
2.	Polysomnograph system	<input type="checkbox"/>	
	a. Full system	<input type="checkbox"/>	
	b. Portable	<input type="checkbox"/>	
3.	Biofeedback system	<input type="checkbox"/>	
4.	Others please specify	<input type="checkbox"/>	
	a.	<input type="checkbox"/>	
	b.	<input type="checkbox"/>	
	c.	<input type="checkbox"/>	
	d.	<input type="checkbox"/>	

## 2.4: HUMAN RESOURCE

Designation		Visiting (Number of)	Resident (Number of)
Consultants ( <i>Defined as 5 years post-gazettment or post-fellowship in Psychiatry</i> )	<input type="checkbox"/>		
Number of clinical specialists ( <i>Defined as Medical Officers with many years of experience in the specialty but with NO formal Masters' or Postgraduate training</i> )	<input type="checkbox"/>		
Family Medicine specialists ( <i>with training in Psychiatry</i> )	<input type="checkbox"/>		
Medical officers including Master's trainees in Psychiatry	<input type="checkbox"/>	N/A	
Number of nurse s with post basic training in psychiatry	<input type="checkbox"/>	N/A	
Number of nurses without post basic training in psychiatry	<input type="checkbox"/>	N/A	
Number of Assistant Medical Officer with post basic training in psychiatry	<input type="checkbox"/>	N/A	
Number of Assistant Medical Officer without post basic training in psychiatry	<input type="checkbox"/>	N/A	
Clinical Psychologists -	<input type="checkbox"/>	N/A	
Counsellors	<input type="checkbox"/>		
Occupational Therapists	<input type="checkbox"/>	N/A	
Social Workers	<input type="checkbox"/>	N/A	
Physiotherapist	<input type="checkbox"/>		

## SECTION 3: PATIENT CARE

### 3.1: PATIENT CENSUS

#### 3.1.1 OUTPATIENT CENSUS

Number of new cases seen:	
Number of follow up cases seen:	

#### 3.1.2 INPATIENT CENSUS

Total admissions:	
Number of voluntary admissions:	
Number of certified admissions:	
Number of court sent (forensic) admissions:	
Number of new cases admitted:	
Number of follow up cases admitted:	

#### 3.1.3 DAY CARE SERVICES / COMMUNITY SERVICES/ AMBULATORY SERVICES (*if available*)

Number of cases:	
Home visits by Community services	
Number of visits per year	

### 3.2: PROCEDURES PERFORMED

DIAGNOSTIC PROCEDURES *(tick whichever is available and indicate quantity done per year)*

Name of procedure		Number done
1) Psychometric testing	<input type="checkbox"/>	
2) Sleep sonography	<input type="checkbox"/>	
3) Others please specify	<input type="checkbox"/>	
a)	<input type="checkbox"/>	
b)	<input type="checkbox"/>	
c)	<input type="checkbox"/>	

### THERAPEUTIC PROCEDURES

Name of procedure		Number done
1) Electroconvulsive Therapy (ECT)	<input type="checkbox"/>	
2) Others please specify	<input type="checkbox"/>	
a.	<input type="checkbox"/>	
b.		
c.		
d.		

### 3.3 : CLINICAL PRACTICES *(Tick whichever is available)*- USE OF :

MEDICATION		Number of new cases / year
1. Atypical antipsychotics	<input type="checkbox"/>	
a. Risperidone	<input type="checkbox"/>	
b. Quetiapine	<input type="checkbox"/>	
c. Ziprasidone	<input type="checkbox"/>	
d. Clozapine	<input type="checkbox"/>	
e. Aripiprazole	<input type="checkbox"/>	
f. Paliperidone	<input type="checkbox"/>	
g. Risperdal Consta	<input type="checkbox"/>	
2. Antidepressants	<input type="checkbox"/>	
a. Fluvoxamine	<input type="checkbox"/>	
b. Fluoxetine	<input type="checkbox"/>	
c. Setraline	<input type="checkbox"/>	
d. Duloxetine	<input type="checkbox"/>	

e. Escitalopram	<input type="checkbox"/>	
3. Mood Stabilizers	<input type="checkbox"/>	
a. Carbamazepine	<input type="checkbox"/>	
b. Lamotrigine	<input type="checkbox"/>	
c. Lithium	<input type="checkbox"/>	
d. Sodium Valproate / Valporic Acid	<input type="checkbox"/>	
4. Addiction Medication	<input type="checkbox"/>	
a. Buprenorphine	<input type="checkbox"/>	
b. Methadone	<input type="checkbox"/>	
c. Naltrexone	<input type="checkbox"/>	
5. Anti Alzheimer's	<input type="checkbox"/>	
a. Galantamine	<input type="checkbox"/>	
b. Rivastigmine	<input type="checkbox"/>	
c. Memantine	<input type="checkbox"/>	
d. Donepezil	<input type="checkbox"/>	
6. Attention Deficit Hyperactivity Disorder (ADHD)	<input type="checkbox"/>	
a. Methylphenidate	<input type="checkbox"/>	
b. Atomoxetine	<input type="checkbox"/>	
c. Dextroamphetamine	<input type="checkbox"/>	
d. Methylphenidate	<input type="checkbox"/>	