

EDINBURGH DEPRESSION SCALE *

SCORE	:110	CRIT.:
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Please PRINT clearly

Name (last, first, mi) _____ (Health Plan) ID# _____ Date of birth ___/___/___ Newborn's date of birth ___/___/___

Phone # (with area code) _____ Best time of Day to call: Morning Afternoon Evening

Mailing address (street) _____ city _____ state _____ zip code _____ Today's date ___/___/___

As you have recently had a baby, we would like to know how you are feeling. Below are ten statements about feelings. Please mark (X) the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today. Try to answer all 10 items.

EXAMPLE

I have felt happy.

___ Yes, all of the time

X Yes, most of the time

___ No, not very often

___ No, not at all

This answer means: "I have felt happy most of the time during the past week.

NOW, PLEASE PROCEED TO ITEM #1 and recall your feelings during the past 7 days.

1. I have been able to laugh and see the funny side of things

___ As much as I always could

___ Not quite so much now

___ Definitely not so much now

___ Not at all

2. I have looked forward with enjoyment to things.

___ As much as I ever did

___ Rather less than I used to

___ Definitely less than I used to

___ Hardly at all

3. I have blamed myself unnecessarily when things went wrong.

___ Yes, most of the time

___ Yes, some of the time

___ Not very often

___ No, never

4. I have been anxious and worried for no good reason.

___ No, not at all

___ Hardly ever

___ Yes, sometimes

___ Yes, very often

5. I have felt scared or panicky without good reason.

___ Yes, quite a lot

___ Yes, sometimes

___ No, not much

___ No, not at all

6. Things have been getting on top of me.

___ Yes, most of the time I haven't been able to cope at all

___ Yes, sometimes I haven't been coping as well as usual

___ No, most of the time I have coped quite well

___ No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping.

___ Yes, all of the time

___ Yes, most of the time

___ Not very often

___ No, not at all

8. I have felt sad or miserable.

___ Yes, most of the time

___ Yes, quite often

___ Not very often

___ No, not at all

9. I have been so unhappy that I have been crying

___ Yes, most of the time

___ Yes, quite often

___ Only occasionally

___ No, never

10. The thought of harming myself has occurred to me.

___ Yes, quite often

___ Sometimes

___ Hardly ever

___ Never

* Cox, JL, Holden, JM, Sagovsky, R "Detection of Postnatal Depression: Development of the 10-item Edinburgh Postnatal Depression Scale," *British Journal of Psychiatry*, 1987, 150, 182-186

Please turn over, complete your doctor's information on the back.

Authorization for Disclosure of Medical Information

It is important for your doctor to have all of your medical information to ensure that you and your baby received the best care possible.

Should your screening test show that you might have Post-Partum Depression, we would like to send your results to your doctor. Sending the test results is like having lab work sent to your doctor. The purpose of sending the results of your *Edinburgh Depression Scale* to your doctor is to assist in identifying any follow-up medical care that may be needed.

Please allow us to send your test results to your doctor by signing the release of information below. We will only send results that show a possibility of Post-Partum Depression and you provide the name of your doctor.

I, (print name) _____ would like (Health Plan)/ValueOptions to send the results of my *Edinburgh Depression Scale* to:

Dr. _____ [] Primary Care Doctor [] OB/GYN [] Therapist Address: _____ City: _____ State _____ Zip _____
Dr. _____ [] Primary Care Doctor [] OB/GYN [] Therapist Address: _____ City: _____ State _____ Zip _____

*You should complete this form if you wish to authorize ValueOptions to disclose the results of your **EDINBURGH DEPRESSION SCALE** to persons who may or may not directly be involved in making decisions regarding your health care. This authorization will remain in effect until the (a) date you specify; (b) one (1) year from date signed; or (c) the date you withdraw your permission.*

Complete your acknowledgement that You understand that:

- You have the right to review the information that is being used or disclosed;
- You do not have to complete this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine you benefits;
- The information used or disclosed by this authorization may be at risk for redisclosure by the recipient and no longer protected by federal privacy laws;
- You have a right to revoke this authorization at any time by completing and sending to
- ValueOptions a "Revocation of Authorization" Form, which may be obtained from ValueOptions; and
- You have a right to receive a copy of this signed authorization.

**Mail to: Attn: NESC QM Department
433 River Street, Suite 5000, Troy NY
12180**

Permission/authorization to release this information expires one year from the date below.

Patient Signature: _____ **Date:** ____/____/____

