The Day 1 Psychiatry Survival Kit

Indication: Medical students entering the psychiatry clinical rotation.

Mechanism: Transforms abstract DSM-5-TR criteria into actionable clinical workflows.

Contents: Structural intake methods, threshold-based diagnostic mnemonics, and 16 critical threat detection protocols.

Adapted from PsychoPharmRef | Data current as of May 2026.

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The Rotation Playbook

Phase 1

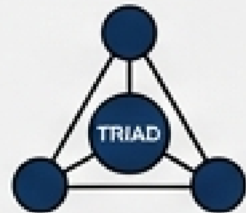
Preparation

Build the ward arsenal. Print the structural scales and 4-quadrant intake forms forms before day one.

Phase 2

Execution

Master the Diagnostic Triad. Map SIGECAPS, DIGFAST, and SAD PERSONS directly to DSM-5-TR thresholds.



Phase 3

Threat Detection

Flag the masqueraders. Memorize the 16 psychiatric red flags that require immediate senior escalation.

Phase 4

Consolidation

Close the learning loop. See the patient, formulate the one-liner, and align night-of reading with day-of presentations.

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Phase 1: The Ward Arsenal

Rounding Forms

- [ ] One-page Psychiatric History & MSE (4-quadrant layout)
- [ ] One-page Psychiatric SOAP Follow-up

Diagnostic Scales

- [ ] PHQ-9 (Depression) & GAD-7 (Anxiety)
- [ ] CIWA-Ar (Alcohol) & COWS (Opiate)
- [ ] AIMS (Dyskinesia) & BFCRS (Catatonia)

Cognitive & Safety

- [ ] MoCA / SLUMS (Cognition)
- [ ] C-SSRS (Suicide Risk Assessment)

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The 4-Quadrant Intake Method

Built specifically for medicine clerkship-style rounding. Captures a clean intake in ten minutes.

Chief Complaint, HPI, Review of Systems	Mental Status Exam (MSE), Vitals, Labs
Psychosocial history, SUD/AUD, Allergies, Medical/Surgical history, Family history, Psychiatric history	**Diagnosis, Assessment, and Plan**

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Phase 2: The Diagnostic Triad

Depression (SIG E CAPS)	**Mania (DIG FAST)**	**Suicide Risk (SAD PERSONS)**
Diagnostic Threshold Depressed mood/anhedonia + ≥5 symptoms for ≥2 weeks.	**Diagnostic Threshold** Elevated/irritable mood + ≥3 symptoms (4 if only irritable) for ≥7 days.	**Diagnostic Threshold** 10 clinical risk factors (Not a numerical score).
Next Step Quantify severity with PHQ-9.	**Next Step** Differentiate hypomania (≥4 days, no severe impairment/psychosis).	**Next Step** Mandatory quantification using C-SSRS.

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Decoding Depression

Sleep
(Insomnia/Hypersomnia)

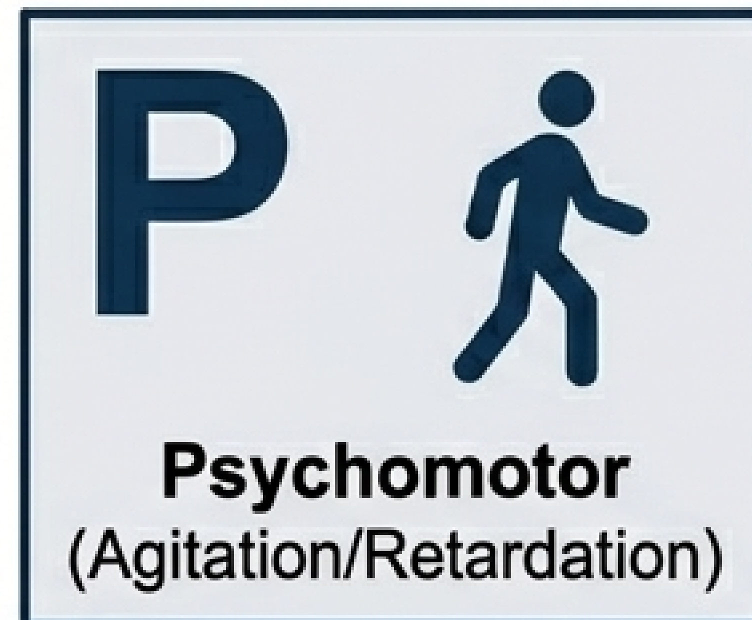
Interest
(Anhedonia loss)

Guilt
(Worthlessness)

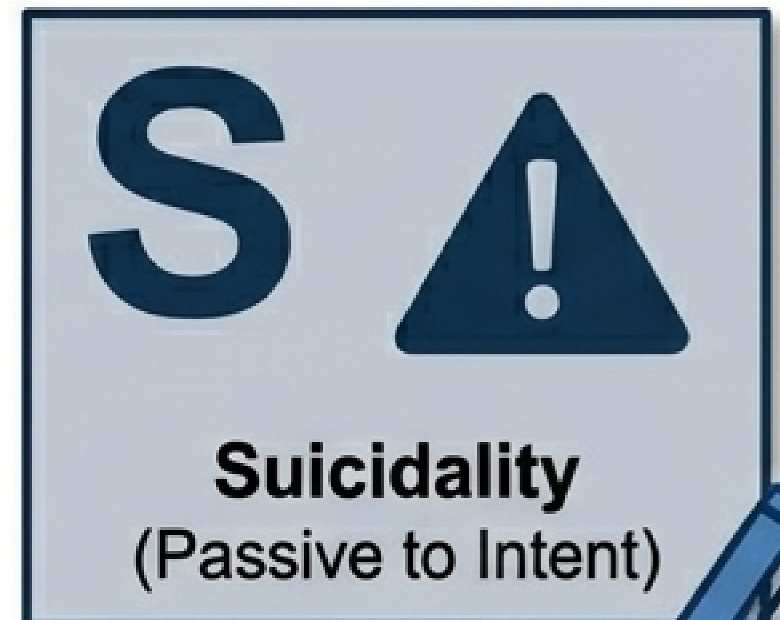
Energy
(Anergia/Fatigue)

Concentration
(Cognitive slowing)

Appetite
(Weight change)



Psychomotor
(Agitation/Retardation)



Suicidality
(Passive to Intent)

Must include depressed mood or anhedonia + ≥5 total symptoms most days for ≥2 weeks.

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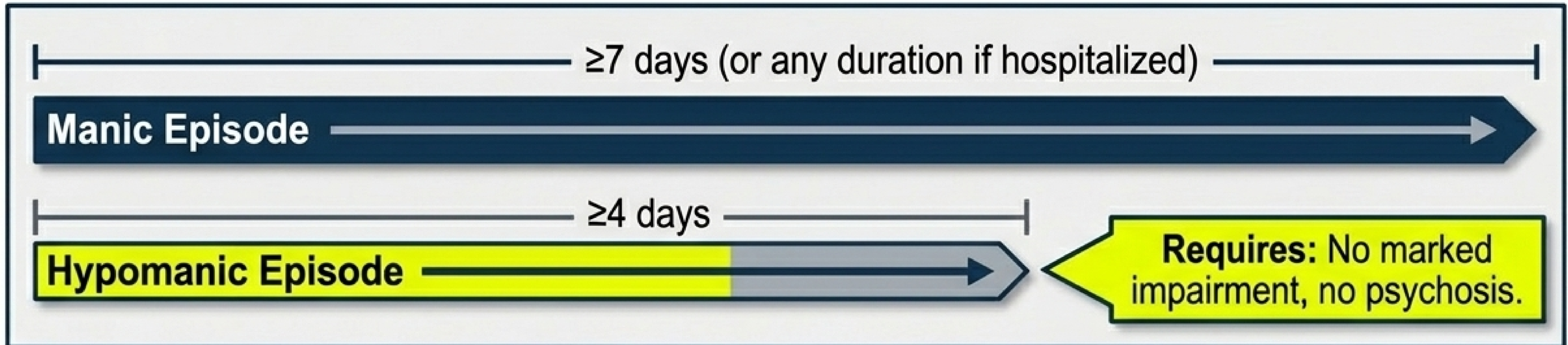
Mapping Mania



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Triage & Risk (SAD PERSONS)

WARNING: Teaching mnemonic only. Poor positive predictive value as a numeric score. Always follow with C-SSRS to document risk/protective factors.

- [ ] **S**ex (Male)
- [ ] **A**ge (<19 or >45/>60)
- [ ] **D**epression / Hopelessness
- [ ] **P**revious attempts / Psych care
- [ ] **E**xcessive substance use
- [ ] **R**ational thinking loss (Psychosis/Cognitive)
- [ ] **S**eparated / Widowed / Isolated
- [ ] **O**rganized plan / Lethal means
- [ ] **N**o social supports
- [ ] **S**ickness (Chronic illness/Pain)

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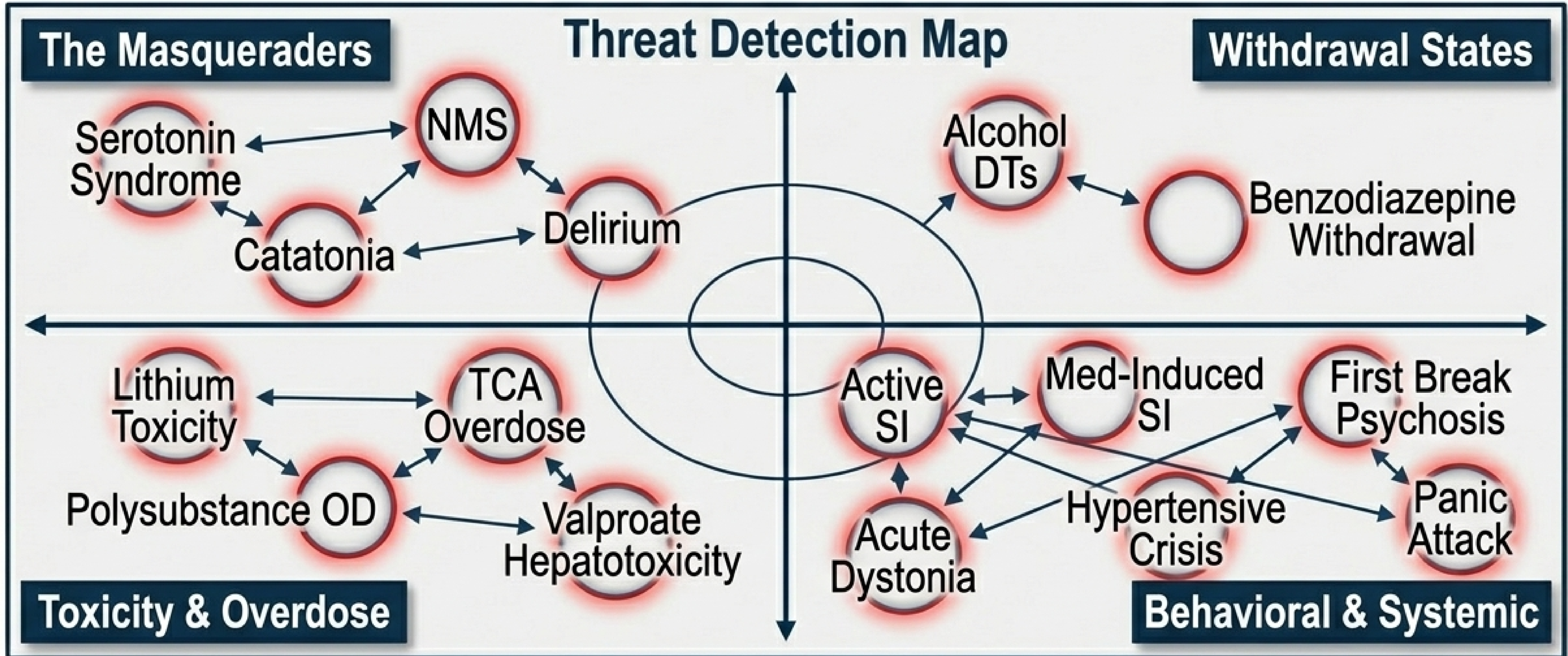
Phase 3: Psychiatric Red Flags

The 16 situations where the right response is to stop interviewing and call your senior.



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The Great Masqueraders: Hypermetabolic Confusers

	Serotonin Syndrome	Neuroleptic Malignant Syndrome (NMS)	Catatonia (Malignant)
Onset Speed	Hours (follows new serotonergic agent)	Days (follows D2 blocker escalation)	Variable (progression from baseline catatonia)
Key Neuromuscular Sign	Clonus/Hyperreflexia (Lower-extremity predominant)	"Lead-pipe" rigidity	Waxy flexibility / Posturing
Vital Sign Threat	Hyperthermia >41°C	Autonomic instability + Marked CK elevation	Thermoregulatory collapse (Indistinguishable from NMS)
Required Action	Cyproheptadine / Supportive	Hold AP, Bromocriptine/Dantrolene	Lorazepam challenge / ECT

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Withdrawal & Toxicity Alerts

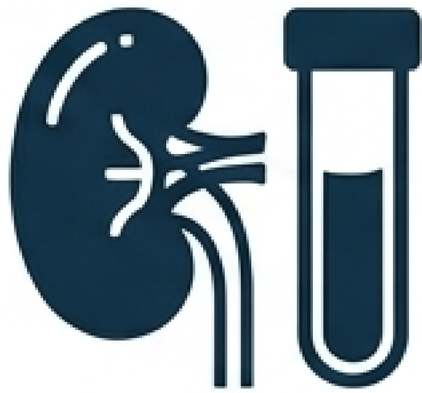
Alcohol Delirium Tremens (DTs)

Trigger: 48-96 hours post-last drink.
Signs: Autonomic instability, hallucinations, seizures.
Threat: 15% mortality untreated.
Action: CIWA-Ar, Thiamine before glucose, aggressive Benzos.

Benzo Withdrawal

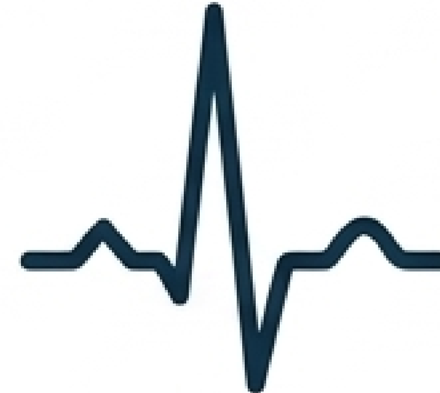
Trigger: Suddenly holding chronic clonazepam/alprazolam in hospital.
Signs: Protracted seizures, severe insomnia, autonomic hyperactivity.
Threat: Life-threatening status epilepticus.
Action: Always reconcile home doses.

Lithium Toxicity



Trigger: Dehydration, NSAIDs, ACE-I, AKI.
Signs: Coarse tremor, ataxia, confusion.
Threat: Narrow therapeutic index (0.6-1.2 mEq/L).
Action: Levels >2.5 mEq/L often require hemodialysis.

TCA Overdose



Trigger: Amitriptyline ingestion (1-week supply is lethal).
Signs: The 3 Cs (Cardiotoxicity, Convulsions, Coma).
Action: Check for wide QRS / terminal R in aVR; Sodium Bicarbonate is the antidote.

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Neuromuscular & Diet Alerts

Acute Dystonia

Trigger: Hours/days after escalating high-potency D2 blockers (especially young men).
Signs: Torticollis, oculogyric crisis, laryngospasm.
Action: IM diphenhydramine or benztropine. Laryngeal dystonia compromises airway.

Hypertensive Crisis (Tyramine Reaction)

Trigger: MAOI patient eating aged cheese, cured meat, or red wine.
Signs: Severe occipital headache, palpitations, sudden hypertension.
Action: Treat with phentolamine; avoid beta-blocker monotherapy.

Valproate-Induced Pancreatitis & Hepatotoxicity

Trigger: Divalproex/Valproic acid use (first 6 months), even with normal levels.
Signs: Abdominal pain, lethargy, hyperammonemia, transaminitis.
Action: Check LFTs and ammonia if symptomatic.

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Behavioral & Systemic Threats

Delirium

The medical masquerader.

Waxing/waning arousal, perceptual disturbance.

Not a primary psych diagnosis—it is a medical emergency (25-40% mortality) mislabeled as agitation.

Panic Attack Mimic

Peaks in ~10 mins.

Diagnosis of exclusion: Rule out PE, ACS, hypoglycemia, thyroid storm, pheochromocytoma before reassuring.

First-Break Psychosis

Paranoia/disorganization.

Shorter untreated duration = better function.

Risk of self-harm is highest during the first episode.

Medication-Induced SI

Emergent SI in first 1-4 weeks of starting antidepressants (<25 y/o), isotretinoin, or high-dose steroids.

FDA Boxed Warning requires close follow-up.

Drug Overdose.

Opioids are leading cause of accidental death under 50.

Pinpoint pupils/respiratory depression.

Action: Naloxone, always co-screen for acetaminophen/salicylates.

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Phase 4: The Consolidation Loop

Science of Learning Loop

1
See the Patient
Ask one question in every interview that you wouldn't have asked yesterday.

2
Formulate the One-Liner
Present every patient to your senior with a one-line clinical formulation rather than a chronological narrative.

3
Night-Of Reading
Read about the exact disorder you saw that day. Cements the link between the live patient and neurobiology/ pharmacology.

4
The Pocket Index Card
Keep a single physical index card with the core mnemonics in your white coat. Use spaced retrieval.

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The Student's Master Checklist

Print the 4-Quadrant H&P, SOAP sheet, and scales before Day 1.

Memorize SIGECAPS, DIGFAST, and SAD PERSONS.

Align nightly reading with daily patient encounters.

Commit the 16 psychiatric red flags to memory.

Ask before assuming. The question "Is this delirium, dementia, or depression?" is asked five times a week on inpatient medicine. The right answer is usually all three at once.

Access full clinical tools, digital workflows, and AI-assisted reviews at PsychoPharmRef.

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