PSYCHIATRIC CLINIC
123 Main Street
Anywhere, US 12345
555-678-9100

Smith, Stacey

10/30/2013
3:39:54 PM

ID: 1000010651905 DOB: 9-5-1998

Admission Orders: Inpatient Eating Disorder Unit
Psychiatrist

INTERVAL HISTORY:

DIAGNOSES: The following Diagnoses are based on currently available information and may change as additional information becomes available.

Axis I: **Anorexia Nervosa Restricting Type, 307.1 (F50.01) (Active)**
Axis II: Deferred Diagnosis 799.99
Axis III: See Medical History
Axis IV: Primary Support Group
Social Environment
Axis V: 60

INSTRUCTIONS / RECOMMENDATIONS / PLAN:

Admission Orders

Admit: Adolescent Eating Disorder Unit.

Condition: Critical
Legal Status: Voluntary:
Routine Admission Lab Screen:
- CBC with differential/platelet count
- Comprehensive Metabolic Panel
- TSH
- Syphilis Serology (RPR)
- Routine Urninalysis

Chest X Ray
EKG

Activity Orders

Routine precautions include:

Smith, Stacey

ID: 1000010651905 DOB: 9-5-1998

10/30/2013
3:39 PM

Admission Orders: Inpatient Eating Disorder Unit
Psychiatrist

START 15 Minute Checks
Elopement Precautions:
PRIVILEGES:
On Unit
Use of Electronics:

Nursing Instructions

Notify M.D. if...
- Minor wound not healing or infected.
- Temperature >100
- Sore throat for > 24 hours
- Respiratory Distress
- Heart Rate > 100 or < 60

Constipation: Administer Miralax mixed with any appropriate liquid po 1-2 times per day. DO NOT exceed more than 2 doses per day.
Daily Weight
Dysmenorrhea or Muscle Strain: Apply heat pack to effected area prn
Gas: Administer Phazyme 1-2 tabs po qid prn
General Wound Care: Clean wound with sterile water, soap, or hydrogen peroxide. Apply dressing as needed until healed.
Lactose Intolerance: Administer Lactaid 1-2 tabs po qid prn
)Minor Cuts: Apply Neosporin Cream TID until healed then stop.
Minor Injury: Ice pack to injured area for 15-20 minutes every six hours. If swelling and bruising occurs call MD.
Nasal Irritation: Administer saline nasal spray 1-2 puffs q1h
Sore Throat / Canker Sore: Administer Oragel PO q2h to affected area up to five days.

Start Prozac 20 mg PO QAM (Depression)
Start Abilify 5 mg PO QAM (Antidepr Augm.)
Increased Ambien CR 12.5 mg PO QHS PRN (Insomnia)

NOTES & RISK FACTORS:
History of cutting wrists when profoundly depressed.
High nutritional risk

Smith, Stacey

ID: 1000010651905 DOB: 9-5-1998

Admission Orders: Inpatient Eating Disorder Unit
Psychiatrist

Elizabeth Lobao (MD)

Electronically Signed
By: Elizabeth Lobao (MD)
On: 10/30/2013 3:44:02 PM

Complete Evaluation / INPATIENT: Eating Disorder Center
Liz Lobao LCSW

Smith, Stacey

ID: 1000010651905 DOB: 9-5-1998

HISTORY: Stacey is a single, American 15 year old young woman. Her chief complaint is, "My parents are over involved in my eating habits."
The following information was received from:
Stacey.
Family: both parents
A professional source: gynecologist

Symptoms of anorexia, with a refusal to maintain a normal weight, are present. Stacey refuses to maintain a normal body weight. She expresses a fear of gaining weight. She denies the seriousness of her medical condition. Her self image is unduly influenced by her body size and shape. No purging, inappropriate use of laxatives, diuretics, enemas or pills are reported.
Stacey frequently checks her weight. This typically occurs three times a day. Stacey carefully scrutinizes her body for signs of what she considers excess weight.

Stacey follows the following dietary restrictions: She carefully counts calories. She consumes less than 1000 calories a day. Dietary fats are scrupulously avoided. Fluids intake is restricted. Stacey exercises excessively as a weight control technique. She exercises three or more hours a day

.
Nutritional History :
Measurements:
Height = 5' 5" (165 cm)
Weight = 100 lbs. (45.4 Kg)
BMI = 16.6, considered Underweight
Ideal Weight Range = 118-131
% Ideal Weight = 80

Current Dietary Orders / Meal Plan:

Gentle Diet
Add 200 300 400 kcal snack for total of kcal / day.
Add Benecal to 10 AM 3 PM 8 PM Scandishake snack for a total of kcal / day. Change 10 AM 3 PM 8 PM snack to 200 300 400 kcal snack for a total of kcal / day.

Nutritional History: There is no apparent precipitant for the onset of Stacey's eating disorder. The eating disorder, the age at which eating and weight took on a special significance, began around age 12. The course of this eating disorder has been basically chronic and unremitting. Stacey's adult weight has been in the following range:

High weight: 125-130
High weight occurred at age 13.
Low weight: 90-95
Low weight occurred at age 15
Current weight: 100 lbs.
Recent Weight Loss: Stacey has recently lost 1-3 pounds. This weight loss has occurred over the past month.

Current Height: 5'5"
Prior In Patient Treatment: Stacey has never received out patient treatment for her eating disorder.
Prior Out Patient Treatment: Stacey has never received out patient treatment for her eating disorder.
Prior Dietitian Experience: Stacey has been advised by a dietitian. Details are as follows: Stacey was noncompliant with scheduled appointments.
Current Self Perception: Stacey sees self as of normal weight.
Attitude/Experiences: She describes her family attitude towards her weight and eating habits as follows: "They monitor every single bite I put into my mouth, it is frustrating. "Stacey denies using food to avoid or suppress feelings. Stacey describes the following effect of her occupation or recreational activities on her eating habits: "Dance and exercise are my life, I have to be trim in order to perform."
Stacey's motivation for change is described as poor.

Measurements:

Height = 5' 5" (165 cm)
Weight = 100 lbs. (45.4 Kg)
BMI = 16.6, considered Underweight
Ideal Weight Range = 118-131
% Ideal Weight = 80

PAST PSYCHIATRIC HISTORY:

Prior Care Setting: Stacey is new to mental health treatment and does not have a prior care setting.

Prior Psychiatric Disorder: There is no prior history of a psychiatric disorder.

Psychiatric Hospitalization: Stacey has never been psychiatrically hospitalized.

Suicidal / Self Injurious: Stacey has no history of suicidal or self injurious behavior.

Addiction / Use History: Stacey denies any history of substance abuse.

Medication Compliance: There is no history of medication non compliance.

Psychotropic Medication History: Psychotropic medications have never been prescribed for Stacey.

Past psychiatric history is otherwise entirely negative.

SOCIAL/DEVELOPMENTAL HISTORY:

Developmental History: There were no post-partum complications. Birth weight was 8 pounds 4 ounces. Stacey passed the various developmental milestones at age appropriate times.

High Risk Psycho-Social Issues:

Family Negativity: Stacey's family is negative about or uncooperative with mental health services. It is felt that the risk of treatment non compliance by Stacey is increased because of her family's negative attitude toward mental health services.

Childhood History: Stacey was born in NYC. Stacey was raised by her parents, as part of an intact family.

She is the oldest child of four.

Family Stressors: Stresses on family life have included the following:

Financial Problems

Legal Problems

Current stress level on this family is considered high.

Childhood was dysfunctional and non supportive.

Indicators of emotional problems include the following;

Eating Disturbance;

Defiant or Oppositional Behavior

Violation of Rules

School History:

Stacey is currently in tenth grade. She was retained in third grade.

Current School Behavior: She Has a best friend. She takes responsibility for her behavior.

Stacey is interested in further education and a career. She has had few if any disciplinary problems. Stacey gets along well with adults and authority figures. Stacey gets along well with peers.

Abuse / Protective Services:

There is no known history of physical or sexual abuse or emotional abuse.

Financial Status: Stacey is financially comfortable.

Residence Status: She lives with her parents.

Support System: Stacey has the social support of the following:

On line or Internet friends: This person or group provides only limited support.

Substance Abuse: Stacey has the following history of substance abuse. Stacey denies any history of substance abuse.

Strengths/Assets: Stacey is intelligent. She is verbal. Stacey is a good student. Stacey has good artistic skills. Stacey has good communicative skills. She is able to express feelings. She is financially secure.

Barriers to Treatment: Lack of motivation for treatment is a barrier and an obstacle to progress: Therapy will focus on motivational problems first.

Patient's Goals: "I want to go home."

Stacey was the product of a full term and uncomplicated pregnancy, labor and delivery.

FAMILY HISTORY:

Sister thought to have an eating disorder.

Cousin hospitalized for an eating disorder.

This family member is maternally related.

There is a significant family history in first and second degree relatives of the following: Family history is positive for psychiatric hospitalization. This is reported in the maternal side of the family.

Current Family Stressed include the following:

Relationship Problems with both parents over diet and exercise issues and her current lifestyle.

There is no history of any of Stacey's close family members having been abused.

MEDICAL HISTORY:

Adverse Drug Reactions: List of Adverse Drug Reactions:

(1) Added ADR to Ampicillin, Reaction(s) = Bronchospasm, Status = Active

Allergies :

Peanuts (Hives) (Dyspnea)

Current Medical Diagnoses:

None

Current Medications (non psychotropics) include: None

Past ***MEDICAL HISTORY:***

Past Medical History is essentially negative. Stacey reports immunizations are current.

Pain:

Stacey describes current pain. She describes pain in her lower back. The pain is of moderate intensity. It cannot be ignored and interferes with concentration.

(no pain)----------l----------(unbearable)

The pain occurs after exertion. The pain is described as burning. It occurs several times a day. When pain occurs it lasts for hours. Certain movements or positions worsen the pain when she dances. Stacey reports that physical therapy has helped relieve her pain. Stacey reports that a TENS unit helped with her pain. Current pain is felt to be under adequate control.

Stacey was asked to rate her pain on a scale of 0-10 where 0 is no pain and 10 is the worst pain imaginable. Current pain is rated as 5.

Cardiac: There is no family history of early death due to cardiac arrhythmia or conduction defect or other related cardiac issues.

Medical history is otherwise negative and Stacey has no other history of serious illness, injury, operation, or hospitalization. She does not have a history of asthma, seizure disorder, head injury, concussion or heart problems. No medications are currently taken.

MENTAL STATUS: Stacey presents as glum, listless, inattentive, well groomed, and slow to respond. normal in rate, volume, and articulation and is spontaneous. Language skills were not formally tested. Signs of moderate depression are present. She appears listless and anergic. Slowness of physical movement helps reveal depressed mood. Facial expression and general demeanor reveal depressed mood. She denies having suicidal ideas. Her affect is congruent with mood. There are no apparent signs of hallucinations, delusions, bizarre behaviors, or other indicators of psychotic process. Associations are intact, thinking is logical, and thought content appears appropriate. Cognitive functioning and fund of knowledge is intact and age appropriate. Short and long term memory are intact, as is ability to abstract and do arithmetic calculations. This patient is fully oriented. Clinically, IQ appears to be in the above average range. Insight into problems appears to be poor. Social judgment appears to be poor. There are no signs of anxiety. There are no signs of hyperactive or attentional difficulties. Stacey displayed defiant behavior during the examination. Stacey displayed uncooperative behavior during the examination. Stacey made poor eye contact during the examination. No signs of withdrawal or intoxication are in evidence.

DIAGNOSES: The following Diagnoses are based on currently available information and may change as additional information becomes available.

Axis I: **Anorexia Nervosa Restricting Type, 307.1 (F50.01) (Active)**
Axis II: Deferred Diagnosis 799.99
Axis III: See Medical History
Axis IV: Primary Support Group
Social Environment
Axis V: 60

CLINICAL SUMMARY:

RISK ASSESSMENT: SUICIDE/VIOLENCE

History of Risk Factors:

Stacey has a history of self injurious behavior. She has cut herself.

A family member has a history of suicidal behavior. A family member has committed suicide.

Current Risk Factors:

A major depression is present.

Serious current medical problems are present related to her belief that she is overweight.

Protective Factors:

Strong Therapeutic Relationship

Suicide Risk:

Based on the above risk factors the risk of SUICIDE is considered MEDIUM.

Violence Risk:

Based on the risk factors reviewed the current risk of VIOLENCE is considered VERY LOW or absent.

INSTRUCTIONS / RECOMMENDATIONS / PLAN:

Psychiatric Hospitalization is recommended because this patient's condition requires 24 hour monitoring due to potential danger to self or others or severe deterioration of level of functioning or need for medically monitored detoxification, and less intensive treatment has failed or is likely to fail.

Behavioral Therapy:

Cognitive Therapy:
Encourage all activities:
Unit Meetings:
Family Therapy:

Start Prozac 20 mg PO QAM (Depression)
Start Abilify 5 mg PO QAM (Antidepr Augm.)
Start Ambien CR 6.25 mg PO QHS PRN (Insomnia)

NOTES & RISK FACTORS:
History of cutting wrists when profoundly depressed.

90791 Integrated Bio-Psychosocial Initial Assessment

Time spent face to face with patient and/or family and coordination of care: 45 minutes

Session start: 09:00
Session end: 09:45

Elizabeth Lobao LCSW

Electronically Signed
By: Elizabeth Lobao LCSW
On: 10/30/2013 1:49:30 PM

PSYCHIATRIC CLINIC
123 Main Street
Anywhere, US 12345
555-678-9100

Smith, Stacey

10/30/2013
1:56:26 PM

ID: 1000010651905 DOB: 9-5-1998

Treatment Plan

TREATMENT PLAN FOR STACEY SMITH

Treatment Plan

A Treatment Plan was created or reviewed today, 10/30/2013, for Stacey Smith.

Diagnosis:

Axis I: Anorexia Nervosa Restricting Type, 307.1 (F50.01) (Active)
Axis II: Deferred Diagnosis 799.99
Axis III: See Medical History
Axis IV: Primary Support Group
Social Environment
Axis V: 60

Current Psychotropics:

Prozac 20 mg PO QAM
Abilify 5 mg PO QAM
Ambien CR 6.25 mg PO QHS PRN

Problems:

Problem #1: eating disorder

Problem = EATING DISORDER

Stacey's eating disorder has been identified as an active problem in need of treatment. It is primarily manifested by:
Anorexia - with periods of fasting.
- with excessive exercising.
- with weight loss.

"I must stay lean to look beautiful on stage."

Treatment Plan

Long Term Goal(s):

- Gain one pound a week until ideal weight is achieved.

Target Date: 6/11/2014

Short Term Goal(s):

Stacey will not have an episode of exercise lasting more than 15 minutes, per day, three times a week until her target weight goal has been achieved. (112 lbs.)

Target Date: 11/20/2013

Intervention(s):

Therapist will conduct individual therapy to help patient better understand psychological causes of eating disorder This will occur once per day and will last 30 minutes.
Clinician's Initials: LL

Therapist will help patient explore behavior and feelings that lead to eating abnormalities. This will occur once per day and will last 30 minutes.
Clinician's Initials: LL

Therapist will provide Cognitive Therapy to help expose and extinguish irrational beliefs and conclusions that contribute to eating abnormalities. This will occur three times per week and will last for 45 minutes.
Clinician's Initials: LL

Status:

10/30/2013: The undersigned clinician met with the patient (and family, as appropriate) on the date above in a face to face meeting to work with him/her in developing this Treatment Plan.

The expected length of stay for this patient is Approx. 1 month.

The projected discharge date for this patient is 12/4/2013.
Continue with current therapist: Sandy Crowley.
Continue with current psychiatrist: Liz Lobao, (MD).

Expected step down services include: Advance to less restrictive environment as weight stabilizes.

Treatment Plan

Plan for transition/discharge: Transition to Partial Care Setting prior to discharge from this program.

SNAP: The patient has identified the following strengths, needs, abilities and preferences as well as goals and desired accomplishments. This information will be used in the development of the patient's personal achievement agenda.

STRENGTHS:

A stable environment

Supportive spiritual beliefs.

NEEDS:

An explanation of my diagnoses.

Education on improving my health.

ABILITIES:

I am trustworthy.

I have faith in God or a higher power.

I care about my own well being and the well being of others.

PREFERENCES:

Group Therapy

Education Classes

Individual Therapy

Specific Issues: "Understand why I need to be here in order to gain weight."
Goals: "I just want to feel better and go home."
Desired Outcome: "Feel healthy and have the ability to dance like the other girls in my studio."

The Brief Psychiatric Rating Scale (BPRS) is a rating scale that measures psychiatric symptoms such as depression, anxiety, hallucinations and unusual behavior. Sub scores are as follows:

Somatic Concerns: The degree to which physical health is perceived as a problem to the patient. 4 (Moderate)

Anxiety: The patient's report of worry, fear, or over concern for the present or future. 5 (Moderately Severe)

Depressive Mood: Despondency in mood, sadness. 6 (Severe)

Motor Retardation: Observed reduction in energy level evidenced in slowed moments. 5 (Moderately Severe)

Blunted Affect: Reduced emotional tone, apparent lack of normal feeling or involvement. 4

(Moderate)

Total Score: 24

Comprehensive Treatment Plan Barriers

Stacey's barriers include:

Emotional issues interfere with treatment.
- Emotional problems and concerns will be addressed during individual and group therapy sessions.

Motivational issues interfere with treatment.
- Assist in finding community support

Comprehensive Treatment Plan Strengths

Stacey's strengths include:

Cognitive
- Intellectually bright
- Verbally articulate
- Engaged in the treatment plan process.

Spiritual
- Has sustaining spiritual beliefs

Upon completion of Long Term Goal, Discharge or Transition Plan includes:

Expected length of stay: Approx. 1 month
Continue with current therapist: Sandy Crowley
Continue with current psychiatrist: Liz Lobao, (MD)

Electronically Signed
By: Elizabeth Lobao LCSW
On: 10/30/2013 1:57:59 PM

Smith, Stacey

ID: 1000010651905 DOB: 9-5-1998

10/30/2013
1:56 PM

Treatment Plan

PSYCHIATRIC CLINIC
123 Main Street
Anywhere, US 12345
555-678-9100

Smith, Stacey

10/30/2013
2:36:04 PM

ID: 1000010651905 DOB: 9-5-1998

Dietitian Daily Progress Note
Liz Lobao, Registered Dietitian

Measurements:

Height = 5' 5" (165 cm)
Weight = 100 lbs. (45.4 Kg)
BMI = 16.6, < 10th Percentile, considered Healthy Weight
Ideal Weight Range = 118-131
% Ideal Weight = 80
Current Kcal =

Current Dietary Orders / Meal Plan:

Gentle Diet
Add 200 300 400 kcal snack for total of kcal / day.
Add Benecal to 10 AM 3 PM 8 PM Scandishake snack for a total of kcal / day. Change 10 AM 3 PM 8 PM snack to 200 300 400 kcal snack for a total of kcal / day.

Session Notes:

Dietitian's Notes:

Meal Behavior: Meals have been eaten slowly with some reluctance apparent. Stacey's affect during meals tends to be tense or unhappy. Stacey did not complete a meal today.

Response To Program: Stacey continues to deny the Eating Disorder diagnosis. Stacey is resistant to the program, diets, and activities. Stacey expresses the desire to leave the program.

Verbal Content: Stacey expressed ideas that reveal a distorted perception of her body shape and weight. Stacey spoke of feelings having to do with striving for perfectionism and power as a method of self control. Feelings of lethargy are today described. Feelings of depression were today described by Stacey. Stacey today spoke of feeling of anxiety.

Counseling/Assignments: Stacey was counseled regarding her current weight and dietary needs. the dietary plan and its goals were reviewed and explained to Stacey. She was given explanatory dietary literature. Educational explanations and literature regarding a healthy and nutritious diet was given to Stacey. Stacey was assisted in creating a healthy and nutritious meal plan.

Goals: Stacey will gain five pounds. Stacey will learn and follow a healthier diet, as outlined

Smith, Stacey

ID: 1000010651905 DOB: 9-5-1998

10/30/2013
2:36 PM

Dietitian Daily Progress Note
Liz Lobao, Registered Dietitian

by dietitian. Stacey will accept Eating Disorder Diagnosis. She will eat the following percentage of meals: 75%. She will participate in assigned activities.

Mental Status Exam: Today Stacey appears depressed. She is glum and unanimated. Her demeanor is sad. Thought content is depressed. There are signs of anxiety. She is fidgety and restless. There are no signs of hallucinations, delusions, a thought disorder or other signs of psychotic process. Stacey's speech is normal in rate, volume and articulation and is coherent and spontaneous. She was distracted and inattentive today. Stacey's associations are congruent with content. No signs of cognitive loss are present.

90837 Psychotherapy 60 min.

Time spent on patient: 60 minutes
Session start: 14:00
Session end: 15:00

Elizabeth Lobao, RD

Electronically Signed
By: Elizabeth Lobao, RD
On: 10/30/2013 2:37:47 PM

PSYCHIATRIC CLINIC
123 Main Street
Anywhere, US 12345
555-678-9100

Smith, Stacey

10/30/2013
2:48:19 PM

ID: 1000010651905 DOB: 9-5-1998

Progress Note/ Psychiatrist
Elizabeth Lobao (MD)

INTERVAL HISTORY: Stacey has had an inadequate response to treatment as yet. Stacey continues to exhibit symptoms of anorexia. They are basically unchanged. Stacey refuses to maintain body weight. Stacey's fear of gaining weight has increased and is considered worse. Stacey denies the seriousness of her medical condition. Distortions of body image continue unchanged. Amenorrhea is present. Continued depressive symptoms are reported by Stacey. They are better in that they have lessened in frequency or intensity. Anhedonia is described. There is less irritability. Stacey describes continued difficulty thinking. Stacey convincingly denies suicidal ideas or intentions.

Test Results: List of Test Results received today:

Test(s) Performed on 10/30/2013:
(1) Potassium: 2.9 mEq/L (3.5-5 mEq/L) (N/A)

Good medication compliance is noted. She is paying less attention to self care. She reports the feeling of having to force self to socialize with others. There have been some outbursts or expressions of anger. Impulsive behaviors are still occurring. A fair night's sleep is described. Sleep was not continuous and not completely restful. "Ambien does not work for me."

A Review of this patient's personal, family, social histories was performed today.
She describes no side effects and none are in evidence.

MENTAL STATUS: Stacey appears glum, doleful, minimally communicative, and looks unhappy. She exhibits speech that is normal in rate, volume, and articulation and is coherent and spontaneous. Language skills are intact. There are signs of severe depression. Thought content is depressed. Slowness of physical movement helps reveal depressed mood. Facial expression and general demeanor reveal depressed mood. Her affect is inappropriate. Her affect is blunted. Associations are intact and logical. There are no apparent signs of hallucinations, delusions, bizarre behaviors, or other indicators of psychotic process. Associations are intact, thinking is logical, and thought content appears appropriate. Cognitive functioning and fund of knowledge is intact and age appropriate. Short and long term memory

are intact, as is ability to abstract and do arithmetic calculations. This patient is fully oriented. Clinically, IQ appears to be in the above average range. Insight into problems appears to be poor. Social judgment appears to be poor. There are signs of anxiety. She is easily distracted. Stacey made poor eye contact during the examination.

The Tanner Scale reveals the following pubescent staging in this patient :

Female breast development:

Tanner III: Breast has become more elevated and extends beyond the borders of the areola. The areola has begun to widen but remains in contour with the surrounding breast tissue.

Pubic hair growth:

Tanner III: Pubic hair is course and curly and is beginning to extend laterally.

Muscle strength is diffusely weak. Gait is unsteady. Station is erect and normal.

VITAL SIGNS:

Sitting blood pressure is 100 / 55. Sitting pulse rate is 59. Respiratory rate is 24 per minute. Temperature is 96+ degrees F. Height is 5' 5" (165 cm). Weight is 100 lbs. (45.4 Kg). BMI is 16.6. Edema: +2.

DIAGNOSES: The following Diagnoses are based on currently available information and may change as additional information becomes available.

Axis I:	**Anorexia Nervosa Restricting Type, 307.1 (F50.01) (Active)**
Axis II:	Deferred Diagnosis 799.99
Axis III:	See Medical History
Axis IV:	Primary Support Group Social Environment
Axis V:	60

INSTRUCTIONS / RECOMMENDATIONS / PLAN:

Psychiatric Hospitalization is recommended because this patient's condition requires 24 hour monitoring due to potential danger to self or others or severe deterioration of level of functioning or need for medically monitored detoxification, and less intensive treatment has failed or is likely to fail.

Family Therapy:

Smith, Stacey

ID: 1000010651905 DOB: 9-5-1998

10/30/2013
2:48 PM

Progress Note/ Psychiatrist
Elizabeth Lobao (MD)

Psychopharmacology:

10/30/2013 Started Prozac 20 mg PO QAM (Depression)
10/30/2013 Started Abilify 5 mg PO QAM (Antidepr Augm.)
Increase Ambien CR 12.5 mg PO QHS PRN (Insomnia)

NOTES & RISK FACTORS:
History of cutting wrists when profoundly depressed.

99232 Subseq Hosp, E/M

Elizabeth Lobao (MD)

Electronically Signed
By: Elizabeth Lobao (MD)
On: 10/30/2013 2:49:17 PM

PSYCHIATRIC CLINIC
123 Main Street
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555-678-9100

Smith, Stacey

10/30/2013
3:34:09 PM

ID: 1000010651905 DOB: 9-5-1998

Nursing Note

INTERVAL HISTORY: Stacey shows slight treatment response as of today. Stacey continues to exhibit symptoms of anorexia. They are basically unchanged. Stacey has a fear of gaining weight. Denial of the seriousness of her medical condition continues unchanged. Stacey's distorted body image seems less severe, and is considered improved.

Nutrition :

Appetite/Weight: Stacey describes her appetite as "poor." She reports eating two meals per day. About 1/2 of each meals is consumed. She describes a recent weight loss. (5-10 pounds.) Weight loss is intentional and the result of dieting. This weight loss occurred over a period of a month or less.

Diet: Prior to Admission: Full Liquid.

Eating Disorder: Stacey has symptoms of an eating disorder, as follows: (3 points) Stacey refuses to maintain a normal body weight. She denies the seriousness of her medical condition. Amenorrhea has occurred. No purging, inappropriate use of laxatives, diuretics, enemas or pills are reported. Stacey carefully scrutinizes her body for signs of what she considers excess weight.

Malnutrition is present. (3 points)

A dietitian consult will be obtained.

Nutritional Risk: Nutritional risk is high. (3 or more points). (Medical and dietary consults should be obtained.)

Nursing Interventions: The following nursing interventions were performed:

Medication was administered to Stacey , compliance, symptoms, and possible side effects monitored and recorded as appropriate.

Response to medication is as follows:

Stacey's response to medication (specify) is considered fair. Details are as follows:

Stacey was engaged and encouraged to participate in activities.

Stacey was engaged and encouraged to attend meals.

Stacey was engaged and encouraged to self groom and maintain personal area.

Individual therapy was conducted with Stacey to identify and express feeling underlying current problems.

Nursing Note

Emotional support and encouragement was given to Stacey.

MENTAL STATUS:

Stacey appears glum, distracted, casually groomed, and slow to respond. There are signs of severe depression. She appears downcast. Slowness of physical movement helps reveal depressed mood. Her affect is blunted. The patient convincingly denies suicidal ideas or intentions. Insight into problems appears to be poor. Social judgment appears to be poor. There are signs of anxiety. She is easily distracted. Stacey made poor eye contact during the examination.

VITAL SIGNS:

Supine blood pressure is 100 / 61. Supine pulse rate is 99. Respiratory rate is 24 per minute. Temperature is 96+ degrees F. Height is 5' 5" (165 cm). Weight is 88 lbs. (39.9 Kg). BMI is 14.6. Edema: +2

DIAGNOSES: The following Diagnoses are based on currently available information and may change as additional information becomes available.

Axis I:	**Anorexia Nervosa Restricting Type, 307.1 (F50.01) (Active)**
Axis II:	Deferred Diagnosis 799.99
Axis III:	See Medical History
Axis IV:	Primary Support Group
	Social Environment
Axis V:	60

INSTRUCTIONS / RECOMMENDATIONS / PLAN:

LEVEL OF CARE JUSTIFICATION: Stacey needs continued Inpatient treatment. Stacey did not benefit or could not be managed in an outpatient setting which threatens to worsen co-morbid medical condition and needs careful supervision.

NOTES & RISK FACTORS:

History of cutting wrists when profoundly depressed.
High nutritional risk

Elizabeth Lobao RN

Smith, Stacey

ID: 1000010651905 DOB: 9-5-1998

10/30/2013
3:34 PM

Nursing Note

Electronically Signed
By: Elizabeth Lobao (MD)
On: 10/30/2013 3:34:36 PM

PSYCHIATRIC CLINIC
123 Main Street
Anywhere, US 12345
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Smith, Stacey

10/30/2013
3:15:34 PM

ID: 1000010651905 DOB: 9-5-1998

Group Therapy Note

Session Remarks: Group Type: *Eating Disorder Group*: The focus of today's group with the subject maintaining a healthy weight and lifestyle while dealing with societies pressure for each young woman to be "perfect". Group members were encouraged to describe individual pressures they feel to be ultra-thin. They were also encouraged to think about the physical trade off including lack of energy and impaired immune system. Group members were then directed to share and explore methods and strategies for maintaining a healthy lifestyle post discharge.

Present at today's session were the following:
Four members of the group were present today.

Therapist Intervention:
Therapist facilitated discussion about behavior management techniques.
Extrapolated to Life
Facilitated Group Process
Involved all Group
Kept Group Focused
Helped group members set limits and boundaries
Made Therapeutic Interpretations

Plan: Encourage increased attendance.

(STACEY'S) INDIVIDUAL BEHAVIOR DURING THIS SESSION

Appearance and Behavior: In today's session Stacey appeared calm, glum, minimally communicative, and slow. Stacey was relatively inactive today and did not fully participate in discussions. She stayed the entire session. Stacey was restless and fidgety today. Her body language and movements suggested a sad mood. Today Stacey spoke of family issues. Also, Stacey today spoke of self defeating behavior.
Suicidal ideas are convincingly denied.
Homicidal ideas are convincingly denied.

Smith, Stacey

ID: 1000010651905 DOB: 9-5-1998

10/30/2013
3:15 PM

Group Therapy Note

Mental Status Exam:

She is glum and unanimated. Her facial expression and body posture suggest an underlying depressed mood. There are signs of anxiety. There are no signs of hallucinations, delusions, a thought disorder or other signs of psychotic process. Stacey's speech is monotonal, scanty, and soft. She was distracted and inattentive today. Affect is blunted.

DIAGNOSES: The following Diagnoses are based on currently available information and may change as additional information becomes available.

Axis I: **Anorexia Nervosa Restricting Type, 307.1 (F50.01) (Active)**
Axis II: Deferred Diagnosis 799.99
Axis III: See Medical History
Axis IV: Primary Support Group
Social Environment
Axis V: 60

INSTRUCTIONS/RECOMMENDATIONS/PLANS
The risks and benefits of outpatient therapy were explained to Stacey. She is encouraged to take advantage of all group activities, both structured and unstructured that are available daily on the unit. She is also encouraged to actively participate in outdoor recreational activities.

Stacey request a family session with both parents but does not want her younger brother to attend.

NOTES & RISK FACTORS:
History of cutting wrists when profoundly depressed.

90853 Group psychotherapy

Time spent face to face with patient and/or family and coordination of care: 60 minutes
Session start: 12:00
Session end: 13:00

Elizabeth Lobao LCSW

Electronically Signed

Smith, Stacey

ID: 1000010651905 DOB: 9-5-1998

10/30/2013
3:15 PM

Group Therapy Note

By: Elizabeth Lobao, LCSW
On: 10/30/2013 3:19:05 PM