PSYCHIATRIC HOSPITAL
1234 Main Street
Anywhere, USA

INPATIENT NURSING NOTE

Date of Exam: 6/29/2012
Time of Exam: 2:12:24 PM

Patient Name: Smiley, Jennifer
Patient Number: 1000010645495

HISTORY: Jennifer shows slight treatment response as of today. Jennifer reports that depressive symptoms continue. They are unchanged in frequency and intensity. Anhedonia has worsened. Jennifer's difficulty with concentrating has not changed. She reports that excessive worrying continues unchanged. Jennifer reports irritability. Sleep difficulty has worsened. Suicidal ideas are acknowledged but suicidal intentions or plans are convincingly denied. Jennifer states, "I am Catholic and would never really want to hurt myself."

Problem Pertinent Review of Symptoms/Associated Signs and Symptoms: She denies all current symptoms of drug withdrawal. Good medication compliance is noted. She is generally compliant with rules. Impulsive behaviors are being displayed less frequently. Jennifer has diminished food and fluid intake. Regular bowel movements are reported. Tobacco has never been used. A slight weight loss is noted. Patient reports restless sleep with many awakenings.
She describes no side effects and none are in evidence.

Nursing Interventions: The following nursing interventions were performed:

Medication was administered to Jennifer, compliance, symptoms, and possible side effects monitored and recorded as appropriate.
Response to medication is as follows:
Jennifer's response to medication (specify) is considered fair. Details are as follows:
Jennifer was engaged and encouraged to participate in activities.
Jennifer was engaged and encouraged to participate in socialization with other patients.
Jennifer was engaged and encouraged to self-groom and maintain personal area.
Jennifer was engaged in conversation and encouraged to verbalize her feelings.
Emotional support and encouragement was given to Jennifer.

Nursing Education: The following educational information was provided to Jennifer:
Medication Information: Comprehension appeared to be good. This was evidenced by her verbalized understanding of the presented information. Current pain is denied.

MENTAL STATUS: Jennifer presents as calm, attentive, casually groomed, and is tearful during breakfast today. Her speech is monotonal, scanty, slow, and soft. She appears to be near tears. Slowness of physical movement helps reveal depressed mood. Facial expression and general demeanor reveal depressed mood. Wishes to be dead have been occurring but suicidal intentions are not present. There are no signs of hallucinations, delusions, bizarre behaviors, or other indicators of psychotic process. Associations are intact, thinking is logical, and thought content is appropriate. Insight into illness is fair. Social judgment is fair. There are signs of anxiety. She is trembling or shaking, suggestive of inner tension or anxiety. Jennifer was sensitive to noise during the examination. Blood pressure is 100 / 66. Pulse rate is 62 and regular. Respiratory rate is 20 per minute. Oxygen saturation is 99% (normal). Height is 5' 8" (173 cm). Weight is 122 lbs. (55.3 Kg). BMI is 18.5, considered Normal.

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

Axis I: Major Depressive Disorder, Single, Severe w/o Psychotic Features, 296.23 (Active)

NOTES & RISK FACTORS:
History of Subst. Abuse
Has been self-injurious

Susan Hamilton, RN

Electronically Signed
By: Susan Hamilton, RN
On: 6/29/2012 2:18:31 PM