PSYCHIATRIC HOSPITAL
2121 Main Street
Anywhere, USA

Date of Exam: 5/5/2015
Time of Exam: 11:21:19 AM

Patient Name: Jones, January
Patient Number: 1000010659260

PHYSICIAN DISCHARGE SUMMARY

Date Admitted: 4/30/2015
Date Discharged: 5/5/2015

This discharge summary consists of:

1. Clinician's Narrative
2. Discharge Status and Instructions

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1. Clinician's Narrative

Course During Treatment:
(5/1/2015) Has not slept in > 72 hours
(5/2/2015) Continues to display psychotic features. Compliant with medications
(5/3/2015) Slept 7 hours last night.
(5/4/2015) Manic symptoms quickly resolving. Discharge planning implemented
(5/5/2015) Compliant with medications. Mood has stabilized. Discharge to sister's care.

ADDITIONAL RISK FACTORS CONSIDERED AT TIME OF DISCHARGE:
January has no history of suicidal attempts soon after a past discharge. There is no history of concealing or denying past suicide/homicide/assaultive ideation or behaviors. No clinical indicators for a second opinion concerning discharge risk are present.

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2. Discharge Status and Instructions

Final Exam, Interval History
Interval History: Improvement is noted. Symptoms of manic process continue. Jan's symptoms of manic process have lessened and she is better. Her sleep patterns have improved and are better. Less grandiosity is present. Jan's speech is less pressured. Excessive talking has decreased. Problem Pertinent Review of Symptoms/Associated Signs and Symptoms: No hallucinations, delusions, or other symptoms of psychotic process are reported.

Final Exam: Mental Status Exam
Exam: Jan appears calm, attentive, casually groomed, and relaxed. She exhibits speech that is normal in rate, volume, and articulation and is coherent and spontaneous. Language skills are intact. Mood presents as normal with no signs of either depression or mood elevation. Affect is appropriate, full range, and 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. Insight into problems appears normal. Judgment appears intact. There are no signs of anxiety. There are no signs of hyperactive or attentional difficulties. Jan's behavior in the session was cooperative and attentive with no gross behavioral abnormalities.

Discharge Diagnosis
Bipolar disorder, current episode manic severe with psychotic features, F31.2 (ICD-10) (Active)
Essential (primary) hypertension, I10 (ICD-10) (Active)
Hypothyroidism, unspecified, E03.9 (ICD-10) (Active)

Type of Discharge: Regular

Condition on Discharge: Greatly improved

Prognosis: Good

Disposition: Care of Family

Medications at Discharge:
Depakote ER 1500 mg. PO QPM (Mood Stabilization)
Zyprexa 10 mg PO QAM (Psychosis)
Dyazide 37.5 / 25 mg capsule PO BID (Hypertension)
Synthroid 150b mcg. PO QAM (Hypothyroidism)

Diagnostic Test Results:
Tests Performed from 5/1/2015 to 5/5/2015:
(1) BUN (Performed = 5/1/2015): 18 mg/dl (7-21mg/dl)
(2) Creatinine (Performed = 5/1/2015): 0.7 mg/dl
(3) Glucose, Blood, Fasting (Performed = 5/1/2015): 90 mg/dL (70-100 mg/dl)
(4) Platelet Count (Performed = 5/1/2015): 140,000 / uL (140,000-450,000/uL)
(5) Urine Drug Screen (Performed = 5/1/2015): Cocaine: Positive

Medication Instructions: Patient and/or guardian were informed of risk/benefit of medication, alternative treatment and no treatment. Medication instructions were given.

Consent: Informed consent for release of information related to counseling obtained in writing.

Physical Activity: No limitations on physical activity.

Dietary Instructions: Regular diet.

Other Instructions: The family was informed that the attending MD would provide coverage for 1 month's prescriptions until they were seen by their own physician.

Emergency Contact: Phone: 213-454-6677 (Sister)

History of Notes and Risk Factors: No known history of adverse drug reactions.

Elizabeth Lobao (MD)

Electronically Signed
By: Elizabeth Lobao (MD)
On: 5/5/2015 11:30:41 AM