PSYCHIATRIC OUTPATIENT CLINIC
123 Main Street
Anywhere, US 12345-6789

Complete Evaluation: Psychiatrist

Date of Exam: 6/8/2015
Time of Exam: 5:22:37 PM

Patient Name: Little, Aimee
Patient Number: 1000010659748

History: Mrs. Little is a widowed Canadian 38 year old woman. Her chief complaint is, "I am completely miserable since my dear husband died."
The following information was provided by:
Mrs. Little
Mrs. Little's family.
Mrs. Little describes symptoms of a depressive disorder. She reports that there is a precipitant for her depression. Mrs. Little's current depressive symptoms are attributed to the death of an important person in her life, details are as follows: "My husband died of cancer three months ago." Depressive symptoms began insidiously over a period of months. "I feel worse each day." She describes episodes of chronic or daily depression.
Current Symptoms: She reports that her appetite is decreased. Some weight loss has occurred. She reports a weight loss of more than five pounds. She reports the weight change as occurring over the following timeframe: One Month. Concentration difficulty associated with her depressive symptoms has been reported. Mrs. Little reports that her mind often wanders. She reports "Crying Spells" or episodes. Feelings of sadness have been reported. She reports difficulty sleeping.
Insomnia is reported.
Suicidality: She denies suicidal ideas or intentions. Denial is convincing.
Prior Depressive /Manic Episodes: She reports that there have been no prior depressive episodes. Mrs. Little does not have a history of manic or hypomanic episodes.
Severity/ Complexity: Based on the risk of morbidity without treatment and her description of interference with functioning, severity is estimated to be moderate.

Mrs. Little has symptoms of anxiety. Anxiety symptoms have been present for months. Anxiety symptoms are occurring daily. She reports occurrences of difficulty concentrating. Feelings of restlessness are described. Difficulty sleeping is occurring. There is difficulty falling asleep. She describes an exaggerated startle response.

Problem Pertinent Review of Symptoms/Associated Signs and Symptoms: No obsessive, intrusive and persistent thoughts or compulsive, ritualistic acts are reported. No hallucinations, delusions, or other symptoms of psychotic process are reported by her.

Other Systems Reviews: There is no recent history of weight loss, fever, malaise, or other abnormal constitutional symptoms. There is no history of disorder of muscle strength or tone, joint problems, or disturbances of gait or station. No Test Results were received.

Past Psychiatric History:
Withdrawal History:
There is no history of Mrs. Little ever having experienced withdrawal from any substance.

Psychiatric Hospitalization:
Mrs. Little has never been psychiatrically hospitalized.

Outpatient Treatment:
Mrs. Little received outpatient mental health treatment for anxiety problems. This occurred when she was in her 20's. This episode lasted for months. No medication was prescribed.

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

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

Psychotropic Medication History:
Psychotropic medications have never been prescribed for Mrs. Little.

Past psychiatric history is otherwise entirely negative.

Social/Developmental History:
Mrs. Little is a widowed 38 year old woman. She is Canadian. She is a Christian. Mrs. Little has three adult children.

Activities of Daily Living:
Leisure:
Past leisure Activities:
*Church Activities
*Card Games
*Volunteer Work

Barriers to Treatment:
Emotional:
*Emotional or psychological problems are a barrier to treatment success: Emotional problems will be addressed via the treatment plan. (Profound grief.)

Client's Goals:
"I just want to feel better."

Coping Strengths:
Family:
*Strong Family Ties
*Family is Intact and Financially and Emotionally Supportive
Financial:
*Financially secure
Housing Status:
Mrs. Little owns a condo. It is reportedly in good repair and safe.

Strengths/Assets:
Mrs. Little's strengths and assets are as follows:
Motivated for Treatment
Physical:
*Healthy

Family History:

Father known to have anxiety.
Sister thought to have depression.
Daughter treated as out patient for a learning disorder.

Family psychiatric history is otherwise negative. There is no other history of psychiatric disorders, psychiatric treatment or hospitalization, suicidal behaviors or substance abuse in closely related family members.

Medical History:

Adverse Drug Reactions: List of Adverse Drug Reactions:
(1) Added ADR to Penicillin, Reaction(s) = Respiratory Distress, Status = Active

Allergies:

There are no known allergies.

Compliance:

Mrs. Little reports good compliance with medical instructions including medication orders.

Current Medical Diagnoses:

Gynecologic/Obstetric:
*Endometriosis
*Not pregnant

Tobacco has never been used.
Mrs. Little reports immunizations are current.

Cardiac Disclaimer:

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

Exam: Mrs. Little presents as sad looking, inattentive, disheveled, 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. She appears downcast. She is tearful. Body posture and attitude convey an underlying depressed mood. Facial expression and general demeanor reveal depressed mood. She denies having suicidal ideas. Her affect is congruent with mood. 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. Suicidal ideas or intentions are denied. Homicidal ideas or intentions are denied. Cognitive functioning and fund of knowledge are 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. Vocabulary and fund of knowledge indicate cognitive functioning in the normal range. Insight into problems appears fair. Judgment appears fair.

There are signs of anxiety.

*Irritability
*Fidgety
*Startle Response

A short attention span is evident. Mrs. Little made poor eye contact during the examination.

VITAL SIGNS:
Sitting blood pressure is 120 / 68. Sitting pulse rate is 70. Respiratory rate is 20 per minute.
Temperature is 98+ degrees F.

Diagnoses:
Adjustment Disorder with Depressed Mood, 309.0 (F43.21) (Active)
Generalized Anxiety Disorder, 300.02 (F41.1) (Active)
Esophageal Reflux, 530.81 (Active)
R/O Histrionic Personality Disorder, 301.50 (F60.4) (Active)

RISK ASSESSMENT: SUICIDE/VIOLENCE

History of Risk Factors:

A family member has a history of suicidal behavior. Behavior includes suicidal attempts but completed suicide has not occurred.

Current Risk Factors:

Mrs. Little is experiencing severe anxiety or panic.
Feelings of hopelessness, worthlessness, or guilt are present.
A major depression is present.

Protective Factors:

Religious beliefs
Good family support

Suicide Risk:

Based on the above risk factors the risk of SUICIDE is considered LOW. Fleeting thoughts may be present but there is no intention or plan.

Violence Risk:

Based on the risk factors reviewed the current risk of VIOLENCE is considered VERY LOW or absent. There are no homicidal or aggressive or self injurious intentions or ideation.

Instructions / Recommendations / Plan:
A clinic or outpatient treatment setting is recommended because patient is impaired to the degree that there is relatively mild interference with interpersonal /occupational functioning.
Supportive therapy:
Psychopharmacology:

Start Celexa 20 mg PO QAM x30days # 30 (thirty) None refills (Depression)
Start Klonopin 0.25 mg PO TID x30days # 90 (ninety) None refills (Anxiety)
Start Ambien CR 6.25 mg PO QHS PRN x30days # 30 (thirty) None refills (Insomnia)

Return 1 week, or earlier if needed.

Notes & Risk Factors:
Acute Grief: Death of husband 4/1/15

99203AI (Office / Outpt, New)

John Smith, (MD)

Electronically Signed
By: John Smith, MD
On: 6/8/2015 5:23:38 PM

PSYCHIATRIC OUTPATIENT CLINIC
123 Main Street
Anywhere, US 12345-6789

Date of Exam: 6/8/2015
Time of Exam: 4:41:47 PM

Patient Name: Little, Aimee
Patient Number: 1000010659748

Bio-Psychosocial Assessment

History: Mrs. Little is a widowed Canadian 38 year old woman. Her chief complaint is, "I cannot eat, sleep, bathe or sit still since my husband died three months ago."

The following information on her depression was provided by:
Mrs. Little
Symptoms of a depressive disorder are described by Mrs. Little. Her depressive symptoms began insidiously over a period of months. She describes episodes of chronic or daily depression.
Current Symptoms: She reports that her appetite is decreased. Mrs. Little is no longer enjoying previously enjoyed activities. She reports "Crying Spells" or episodes. Feelings of sadness have been reported.
Suicidality: Mrs. Little denies suicidal ideas or intentions.

Mrs. Little exhibits symptoms of anxiety. Anxiety symptoms are occurring daily. She reports occurrences of difficulty concentrating. When anxious, she reports fears of losing control or of dying. Mrs. Little describes an exaggerated startle response.

Mrs. Little denies any chemical dependency problems.
Mrs. Little denies any symptoms of ADHD.
Mrs. Little denies ever having been sexually, physically or emotionally abused.

Past Psychiatric History:
To be completed by Dr. Smith.

Social/Developmental History:
Mrs. Little is a widowed 38 year old woman. She is Canadian. She is a Christian.
Children:
Mrs. Little has three adult children.
Activities of Daily Living:
Leisure:
Past leisure Activities:
*Church Activities
*Card Games
*Volunteer Work

Barriers to Treatment:
Emotional:
*Emotional or psychological problems are a barrier to treatment success: Emotional problems will be addressed via the treatment plan. (Profound grief.)

Client's Goals:
"I just want to feel better."
Coping Strengths:
Family:
*Strong Family Ties
*Family is Intact and Financially and Emotionally Supportive
Financial:
*Financially secure
Housing Status:
Mrs. Little owns a condo. It is reportedly in good repair and safe.
Strengths/Assets:
Mrs. Little's strengths and assets are as follows:
Motivated for Treatment
Physical:
*Healthy

Family History:
Father known to have anxiety.
Sister thought to have depression.
Daughter treated as outpatient for a learning disorder.
Family psychiatric history is otherwise negative. There is no other history of psychiatric disorders, psychiatric treatment or hospitalization, suicidal behaviors or substance abuse in closely related family members.

Medical History:
To be completed by Dr. Smith.

Exam: Mrs. Little appears glum, inattentive, disheveled, and is tearful during our interview. Her speech is mumbled, scanty, slow, and soft. Language skills were not formally tested. There are signs of severe depression. Demeanor is sad. Demeanor is glum. She appears listless and anergic. Thought content is depressed. Slowness of physical movement helps reveal depressed mood. Facial expression and general demeanor reveal depressed mood. She denies having suicidal ideas. Affect is restricted in range. Mrs. Little stares down at the floor during entire interview. 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.
Suicidal ideas or intentions are denied. Insight into problems appears to be poor. Judgment appears fair.
There are signs of anxiety.
Anxiety is present as evidenced by the following:
*Restlessness
*Trembling
*Startle Response

A short attention span is evident. Mrs. Little made poor eye contact during the examination.

Instructions / Recommendations / Plan:
A clinic or outpatient treatment setting is recommended because patient is impaired to the degree that there is relatively mild interference with interpersonal /occupational functioning.
Crisis Focus therapy:
The risks and benefits of outpatient therapy were explained to Mrs. Little.

Return 1 week, or earlier if needed.

Notes & Risk Factors:
Acute Grief: Death of husband 4/1/15

90791 Bio-Psychosocial Initial Assessment

Time spent face to face with patient and/or family and coordination of care: 45 minutes
Session start: 10:00 AM
Session end: 10:45 AM

Jane Smith, LCSW

Electronically Signed
By: Jane Smith, LCSW
On: 6/8/2015 4:43:32 PM

PSYCHIATRIC OUTPATIENT CLINIC
2121 Main Street
Anywhere, USA

Date of Exam: 6/9/2015
Time of Exam: 4:23:39 PM

Patient Name: Little, Aimee
Patient Number: 1000010659748

Med Check Note (MD)

Interval History: Mrs. Little has had a partial response to treatment. Symptoms of depression continue to be described. Mrs. Little's depressive moods are episodically present. Symptoms, as noted, have improved as they are less frequent or less intense. Anhedonia is described. She describes continued difficulty concentrating. Mrs. Little is still having difficulties sleeping. Mrs. Little denies suicidal ideas or intentions. Denial is convincing.

Problem Pertinent Review of Symptoms/Associated Signs and Symptoms:
Feelings of anxiety are denied.

Exam: Mrs. Little presents as calm, attentive, casually groomed, but slow to respond. She exhibits speech that is normal in rate, volume, and articulation and is coherent and spontaneous. Language skills are intact. Signs of moderate depression are present. Thought content is depressed. Facial expression and general demeanor reveal depressed mood. Suicidal ideas are denied. Her affect is congruent with mood. Associations are intact and logical. Cognitive functioning and fund of knowledge are intact and age appropriate. This patient is fully oriented. Insight into problems appears fair. Judgment appears fair. There are no signs of anxiety. There are no signs of hyperactive or attentional difficulties. Mrs. Little's behavior in the session was cooperative and attentive with no gross behavioral abnormalities.

Diagnoses:
Adjustment Disorder with Depressed Mood, 309.0 (F43.21) (Active)
Generalized Anxiety Disorder, 300.02 (F41.1) (Active)
Esophageal Reflux, 530.81 (Active)
R/O Histrionic Personality Disorder, 301.50 (F60.4) (Active)

Instructions / Recommendations / Plan:
A clinic or outpatient treatment setting is recommended because patient is impaired to the degree that there is relatively mild interference with interpersonal /occupational functioning.

6/8/2015 Started Celexa 20 mg PO QAM x30days # 30 (thirty) None refills (Depression)
Stop Klonopin 0.25 mg PO TID x30days # 90 (ninety) None refills (Anxiety)
Increase Ambien CR 12.5 mg PO QHS x30days # 30 (thirty) None refills (Insomnia)

Notes & Risk Factors:
Acute Grief: Death of husband 4/1/15

99214 (Office Pt, Established)

Elizabeth Jones (MD)

Electronically Signed
By: Elizabeth Jones (MD)
On: 6/9/2015 4:23:43 PM

PSYCHIATRIC OUTPATIENT CLINIC
123 Main Street
Anywhere, US 12345-6789

Date of Exam: 6/9/2015
Time of Exam: 4:56:01 PM

Patient Name: Little, Aimee
Patient Number: 1000010659748

Medication Samples Picked-Up

The following medication(s) were picked up:

7 (seven) - Celexa 20 mg PO QAM x30days # 30 (thirty) None refills

Elizabeth Lobao, PA

Electronically Signed
By: Elizabeth Lobao, PA
On: 6/9/2015 4:56:26 PM

PSYCHIATRIC OUTPATIENT CLINIC
2121 Main Street
Anywhere, USA

Date of Exam: 6/10/2015
Time of Exam: 9:51:38 AM

Patient Name: Little, Aimee
Patient Number: 1000010659748

Outpatient Nursing Note

Adverse Drug Reactions: Updated list of Adverse Drug Reactions:
(1) Added ADR to Sulfa Drugs, Reaction(s) = Urticaria, Status = Active

Nutrition:
Appetite/Weight:
Mrs. Little describes her appetite as "good."
Mrs. Little reports eating three meals per day. Appears to be at or near ideal weight. A recent weight gain is not reported.

Pain:
Mrs. Little describes current pain. Mrs. Little describes head pain. The pain is of moderate intensity. It cannot be ignored and interferes with concentration. "I get migraines."
(no pain)----------l----------(unbearable)
Pain interferes with:
Sleep

The pain is described as intermittent. Pain is described as an ache. The pain is helped with certain analgesic medications. Pain is not considered to be well controlled and a more comprehensive assessment will be obtained.
Mrs. Little 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 6.

Nursing Education:
The following educational information was provided to Mrs. Little:
Medication Information: Comprehension appeared to be good. This was evidenced by her verbalized understanding of the presented information.

Vital Signs:
Sitting blood pressure is 140 / 85. Sitting pulse rate is 79. Respiratory rate is 19 per minute. Temperature is 98.2 degrees F. Height is 5' 5" (165 cm). Weight is 130 lbs. (59 Kg). BMI is 21.6. Fasting blood sugar: 95.

Notes & Risk Factors:
Acute Grief: Death of husband 4/1/15

Elizabeth Gallagher, RN

Electronically Signed
By: Elizabeth Gallagher, RN
On: 6/10/2015 9:51:57 AM

PSYCHIATRIC OUTPATIENT CLINIC
2121 Main Street
Anywhere, USA

Date of Exam: 6/9/2015
Time of Exam: 3:38:08 PM

Patient Name: Little, Aimee
Patient Number: 1000010659748

Psychotherapy Progress Note

Mrs. Little seems to have had an inadequate response to treatment as yet. Symptoms of depression continue to be described. Her symptoms, as noted, are unchanged and they are just as frequent or intense as previously described. Mrs. Little describes feeling sad. Mrs. Little denies suicidal ideas or intentions. Mrs. Little's anxiety symptoms continue. Mrs. Little reports the symptoms of this disorder continue unchanged. The subjective feeling of apprehension is occurring. Hypervigilance is occurring more frequently.

BEHAVIOR:
Her self care is reduced and less attention is being paid to these tasks. She reports the feeling that the performance of domestic tasks has to be forced and are performed with difficulty. She is socially isolated. Sleep problems are reported. Difficulty staying asleep is reported.

CONTENT OF THERAPY: The patient today spoke mainly about issues involving coping with depression. Problems in the family were also discussed by the patient. Mrs. Little shared the following pertinent details during this session: "I miss my husband terribly and wonder if I will ever get over this." Feelings of loss were also expressed. Feelings of grief were also expressed.

THERAPEUTIC INTERVENTION: This session the therapeutic focus was on facilitating communication of feelings. Patient urged to ask for help and support from staff member or therapist when feeling depressed. Aimee will use session to deal with grief over loss as demonstrated by the expression of painful feelings along with associated affect. She was encouraged to ventilate. Ways to reduce stress were also discussed with the patient.

Diagnoses:

Adjustment Disorder with Depressed Mood, 309.0 (F43.21) (Active)
Generalized Anxiety Disorder, 300.02 (F41.1) (Active)
Esophageal Reflux, 530.81 (Active)
R/O Histrionic Personality Disorder, 301.50 (F60.4) (Active)

Instructions / Recommendations / Plan:
The risks and benefits of outpatient therapy were explained to Mrs. Little.
She was encourage to join a grief support group held at her church.

Return 1 week, or earlier if needed.

Notes & Risk Factors:
Acute Grief: Death of husband 4/1/15

90834 Psychotherapy 45 min.

Time spent face to face with patient and/or family and coordination of care: 45 minutes
Session start: 9:00 AM
Session end: 9:45 AM

Anita Iten, LCSW

Electronically Signed
By: Anita Iten, LCSW
On: 6/9/2015 3:46:59 PM

PSYCHIATRIC OUTPATIENT CLINIC
2121 Main Street
Anywhere, USA
555-678-9100

Referral Form

Patient's Name/Address/Home Phone: **Date of Birth** **Medicare Number**

Little, Aimee 5/4/1977
1908 Stevely Avenue
Long Beach, CA

Reason for Referral:
Seizure Disorder

Diagnoses:
Adjustment Disorder with Depressed Mood, 309.0 (F43.21) (Active)
Generalized Anxiety Disorder, 300.02 (F41.1) (Active)
Esophageal reflux, 530.81 (F60.4) (Active)

Current Medications:
Celexa 20 mg PO QAM
Ambien CR 12.5 mg PO QHS

Referral To:
Joel King, MD

Address:
77 Deerfield Lane
Covina, CA
90815

Telephone:
213-555-8899

Appointment Date:
7/6/2015
11:00 AM

Specialty:
Neurologist

Directions:
Exit 16 off 405 Hwy South

Referring Clinician:
Mary Ann Smith, MD

Signature: _____