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OUTPATIENT PSYCHIATRIC CLINIC

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Date of Exam: 3/15/2012

Time of Exam: 11:32:03 AM

Patient Name: Dey, Diane

Patient Number: 1000010443901

HISTORY: Mrs. Dey shows inadequate treatment response as of today. "Get your hands off of me!!" Continued depressive symptoms are reported by Mrs. Dey. Her symptoms are unchanged in frequency and intensity. She said she has had symptoms of anger and angry episodes. Anhedonia continues unchanged. Mrs. Dey's difficulty with concentrating has not changed. She describes excessive worrying. Irritability continues unchanged. Mrs. Dey convincingly denies suicidal ideas or intentions. Anxiety symptoms are present. She reports that anxiety symptoms have worsened. Difficulty concentrating is occurring more frequently. Sleep is interrupted according to her daughter.

Test Results: List of Test Results received today:

Test(s) Performed on 3/14/2012:

(1) BUN: 18 mg/dl (7-21mg/dl) (Normal)

(2) Creatinine: 1.0 mg/dl (N/A)

(3) Glucose: Blood, Fasting: 105 mg/dL (70-100 mg/dl) (N/A)

Good medication compliance is noted. She depends on others to help perform self-care. She is dependent on others for domestic tasks. Her relationships with family and friends have decreased. More angry outbursts are occurring. Impulsive behaviors are still occurring. She needs to be coaxed to eat and drink. Mrs. Dey is often confused. A poor night's sleep is described. Sleep was not continuous and not completely restful and less than three hours of sleep was achieved. She describes no side effects and none are in evidence.

MENTAL STATUS: Mrs. Dey is irritable, distracted, and minimally communicative, disheveled, and looks unhappy. Her speech is dysfluent, garbled, and loud. There is difficulty naming objects. Difficulty repeating phrases is noted. There are signs of severe depression. Body posture and attitude convey an underlying depressed mood. Slowness of physical movement helps reveal depressed mood. Speech and thinking appear slowed by depressed mood. Facial expression and general demeanor reveal depressed mood. She denies having suicidal ideas. Psychotic or borderline psychotic process is present. Disorganized behavior has been observed. She expresses inappropriate anger. Her associations are loose. Homicidal ideas or intentions are convincingly denied.

Severe cognitive loss is present. Simple arithmetic calculations are not correctly performed. 8+6 was not correctly calculated. She is disoriented to date and location today. This patient is not aware of current events. The current president could not be named. There is difficulty thinking abstractly. Simple proverbs are not correctly interpreted or are interpreted concretely. Word retrieval problems are evident. Speech apraxia is present. Language skills are intact but the words cannot be formed. Diffuse memory loss for recent and remote events is present. Severe cognitive loss is present. Insight into illness is poor. Social judgment is poor. There are signs of anxiety. Mrs. Dey is restless. Mrs. Dey displayed oppositional behavior during the examination.

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

Axis I: Alzheimer's Dementia with Depression, 290.21 (Active)
Mood Disorder, NOS, 296.90 (Active)

INSTRUCTIONS / RECOMMENDATIONS / PLAN:

Behavioral Therapy

Family Therapy with Mrs. Day and her daughter.

Start Ambien CR 6.25 mg PO QHS

Change to Klonopin 0.5 mg PO TID

Continue Dyazide 37.5 / 25 mg capsule PO QAM

Change to Aricept 10 mg PO QHS

Continue Alphatocopherol 400 IU PO QAM

Change to Namenda 10 mg PO BID

Change to Remeron 30 mg PO QAM **# x 3 days ONLY**

Then Remeron 45 mg PO QAM

NOTES & RISK FACTORS:

Has been assaultive

No known history of adverse drug reactions

99214 (Office Pt, Established)

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