PSYCHIATRIC HOSPITAL
2121 Main Street
Anywhere, USA

Date of Exam: 4/24/2015
Time of Exam: 11:59:56 AM

Patient Name: Jones, January
Patient Number: 1000010659260

PRE-ADMISSION ASSESSMENT

Presenting Problem: Psychosis
The following information was received from:
Jan
Family

Psychotic symptoms are described or reported. Family's history is reliable and the following signs are reported: Jan's behavior is described as bizarre. Inappropriate laughter is reported. Grandiose ideas of delusional intensity have been expressed. "She is spending thousands of dollars every weekend binge shopping. The police were called while she was at a bar due to inappropriate public sexual behaviors." Based on severity of symptoms and interference with functioning severity or complexity is considered high.

Jan has had at least one prior episode of psychotic process. Actually, there have been multiple prior episodes of psychotic process. At the time of the first episode Jan was in her teens. The length of episode was approximately three weeks. Jan was treated for a psychosis with hospitalization and Lithium.

Immediate Risk Factors:

Reliability of Information: Family presents as reliable.

Suicidality: Jan appears to be minimizing the extent of suicidal ideas or impulses.

Self Injurious Behavior: Jan convincingly denies danger to self through suicidal, self injurious, or dangerous behavior. She admits to stopping her Lithium.

Problems in Relationship:
A serious relationship problem is reported. Jan's emotional state has effected her relationships.

Financial Problems:
Significant financial problems are present. Her financial problems are seriously threatening her lifestyle.

Symptom Review:

Behavior Changes:
Bizarre or inappropriate behaviors are described.
Jan describes increased energy.
Impulsive or unpredictable behavior is reported.
Jan reports periods of extended insomnia.
Risk taking behavior has occurred.

Impulsive behavior of a sexual nature is reported.
Family describes escalating spending binges.

Sleep Changes:
Jan complains of insomnia. Jan typically does not nap. "I have not slept for weeks."

Past Psychiatric History:

Psychiatric Hospitalization:
Jan has been hospitalized on a number of occasions. She was first hospitalized in her twenties. First hospitalization was for a mood disturbance with psychotic features.

Out Patient Treatment:
Currently receiving out patient mental health treatment bipolar disorder. She is being prescribed medication but has a history of medication non-compliance.

Suicidal/Self Injurious:
Jan has made suicidal threats. She made non specific threats.

Acting Out:
*History of sexually promiscuous behavior.
*History of night absences.
Jan has acted out in the following way(s): "shopping, shopping, shopping."

Psychotropic Medication History:
*Lithium: This medication was previously taken but is not currently taken. It was stopped because of the patient's non compliance.

Family Psychiatric History:
Brother carries diagnosis of bipolar disorder.
Aunt hospitalized for bipolar disorder. This family member is maternally related.
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:
Infection or Disease:
None: There are no indications of current infectious disease or recent exposure to an infectious disease.

Adverse Drug Reactions:
There is no known history of adverse drug reactions.

Allergies:
*Soy: Hives

Exam: Jan appears irritable, distracted, and intrusive. Her speech is poorly articulated, pressured, rapid, and loud. Signs of manic psychosis appear to be present. She is grandiose. She is irritable. Labile mood has been observed. She is over talkative. Speech is pressured. Speech is rapid. Psychotic or borderline psychotic symptoms seem to be present. Bizarre behavior has been observed. She smiles inappropriately. Grandiose ideas are expressed. Suicidal ideas are described but intentions are denied. Homicidal ideas or intentions are denied. Insight into problems appears to be poor. Judgment appears to be poor. There are no signs of anxiety. She is easily distracted. Jan is fidgety. Jan is restless. Jan displayed oppositional behavior during the examination. Jan was intrusive during the examination.

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

Bipolar 1, Current or most recent episode Manic, Severe w/ Psychotic Features, 296.44 (F31.2) **(Active)**

Summary of Disposition:

Admission to Inpatient is recommended.
Precautions to prevent inappropriate sexual behavior is recommended.
Observation is recommended.
Legal Status: Involuntary
Level of Care Recommendation: Tier One
Acute In-Patient or Observation is recommended. Patient exhibits severe deterioration of functioning.

Notes & Risk Factors:
No known history of adverse drug reactions
Sexual acting-out behaviors in public
Grossly excessive spending
Extended insomnia

Elizabeth Lobao, Intake Coordinator

Electronically Signed
By: Elizabeth Lobao, Intake Coordinator
On: 4/24/2015 12:00:14 PM

PSYCHIATRIC HOSPITAL
2121 Main Street
Anywhere, USA

Date of Exam: 4/26/2015
Time of Exam: 4:00:45 PM

Patient Name: Jones, January
Patient Number: 1000010659260

BIO-PSYCHOSOCIAL ASSESSMENT

History: Jan is a married Caucasian 32 year old woman. Her chief complaint is, "There really is no reason for me to be here, I feel great. I cannot sleep but otherwise I am wonderful."

The following information was received from:
Jan.
Jan describes symptoms of an elevated mood. There is no apparent precipitant for this episode of manic-like symptoms. Jan's speed of onset has been gradual over a period of weeks. Symptoms suggestive of mania are occurring episodically. "This is so much better than being depressed."

Current Symptoms: Jan has been increasingly distractible. She reports that insomnia is present. An increase in libido is described. An increase in sociability has been observed. Jan has been over talkative. "Why worry about sleep when I can shop and party?"

Multiple prior episodes of elevated mood and other symptoms suggestive of possible manic process have occurred. Jan also has a history of multiple depressive episodes. She describes no depressive symptoms today.

Past Psychiatric History:

Information Received From:
*Jan

Psychiatric Hospitalization:
Jan has been hospitalized on a number of occasions. She was first hospitalized in her twenties. First hospitalization was for a mood disturbance with psychotic features.

Out Patient Treatment:
Currently receiving out patient mental health treatment bipolar disorder. She is being prescribed medication.

Suicidal/Self Injurious:
Jan has made suicidal threats. She made non specific threats.

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

Acting Out:
*History of sexually promiscuous behavior.
*History of night absences.
Jan has acted out in the following way(s):
"shopping, shopping, shopping."

Psychotropic Medication History:

*Lithium: This medication was previously taken but is not currently taken. It was stopped because of the patient's non-compliance.

Social/Developmental History:

Jan is a married 32 year old woman. She is Caucasian. She is a Christian.

Relationship/Marriage:

Times Married, Partnered:
*Married once
The current relationship has lasted:
*Three years
The current relationship is described as:
*Tolerable

Children:

Jan has no children.

Coping Strengths:

Academic:
*Well Educated
Cognitive:
*Intelligent
*Verbal Skills are Present
*Imaginative

Housing Status:

Jan owns a condo. It is reportedly in good repair and safe.

Addendum: The following details were reported to me today by Jan:

Barriers to Treatment:

Motivation:
*Lack of motivation for treatment is a barrier and an obstacle to progress: Therapy will focus on motivational problems first. "I don't need therapy or medications, I feel fabulous."

Client's Goals: "Keep me off of psychiatric medications."

Coping Strengths:

Family:
*Strong Family Ties
*Family is Intact and Financially and Emotionally Supportive

Employment History:

Jan is working as a bookkeeper.
She has been employed at this job for approximately three years. She last worked "a couple of weeks ago."
Work quality is described as poor.

Family History:

Brother carries diagnosis of bipolar disorder.
Aunt hospitalized for bipolar disorder. This family member is maternally related.

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.

Addendum: The following details were reported to me today by Jan:
Grandfather attempted suicide by gunshot. This family member is on the maternal side of the family.

Medical History:

Infection or Disease:

None: There are no indications of current infectious disease or recent exposure to an infectious disease.

Adverse Drug Reactions:

There is no known history of adverse drug reactions.

Allergies:

*Soy: (Hives)

Current Medical Diagnoses:

Cardiovascular:

*Hypertension

Endocrine/Metabolic:

*Hypothyroidism

Current Medications:

*Furosemide and KCL supplement.

*Synthroid

Medications Prescribed by:

Dr. Smith

Exam: Jan presents as friendly, distracted, disheveled, and intrusive. Her speech is pressured, rapid, with normal volume. Signs of manic psychosis appear to be present. She is excited. She is over talkative. Speech is rapid. Speech is pressured. Her affect is inappropriate. Jan laughs inappropriately. Psychotic or borderline psychotic symptoms seem to be present. Disorganized behavior has been observed. Grandiose ideas are expressed. Her reasoning is illogical. When asked about suicidal ideas or intentions, Jan presents as guarded. Homicidal ideas or intentions are denied. Insight into problems appears to be poor. Judgment appears to be poor. She is easily distracted. Jan is restless. Jan displayed oppositional behavior during the examination. Jan was intrusive during the examination.

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

Bipolar 1, Current or most recent episode Manic, Severe w/ Psychotic Features, 296.44 (F31.2) **(Active)**
Benign Hypertension, 401.1 **(Active)**
Hypothyroidism, 244.9 **(Active)**

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.

Crisis Focused Therapy
Recreational Therapy
Ward Activities

Notes & Risk Factors:
No known history of adverse drug reactions
Sleep deprived.

90791 Integrated Bio-Psychosocial Initial Assessment

Time spent face to face with patient and/or family and coordination of care: 60 min
Session start: 10:00 AM
Session end: 11:00 AM

Elizabeth Lobao, LCSW

Electronically Signed
By: Elizabeth Lobao, LCSW
On: 4/26/2015 4:01:42 PM

PSYCHIATRIC HOSPITAL
2121 Main Street
Anywhere, USA

Date of Exam: 4/25/2015
Time of Exam: 6:02:53 PM

Patient Name: Jones, January
Patient Number: 1000010659260

COMPLETE PSYCHIATRIC EVALUATION

History: Jan is a married Caucasian 32 year old woman. **Her chief complaint is,** "I don't know why I am here, the police brought me in."

The following information was received from:
Jan.
Family: "She tried to spend over $100,000 on a new watch."
She describes symptoms of an elevated mood. There appears to be a precipitant for her current episode of elevated mood and other symptoms suggestive of a possible manic episode. Jan admits to stopping her Lithium several weeks ago. "I would rather fly." Speed of onset has been rapid over a period of days. Symptoms suggestive of possible mania are present chronically or daily.

Current Symptoms: An increase in activity has been observed. An increase in energy is noted. Insomnia is present. Jan reports that mood elevation has been present. Jan describes racing thoughts. She describes signs of inflated self esteem. An increase in sociability has been observed. Speech has been pressured. Jan has been over talkative.

Multiple prior episodes of elevated mood and other symptoms suggestive of possible manic process have occurred. She has been having manic episodes since age 18. Episodes of mania typically lasted about six weeks. Jan has a history of multiple depressive episodes. Jan has been experiencing depressive episodes since age 18. Depressive episodes have typically lasted about three months. She has been hospitalized for treatment of mania and depression.

Based on the risk of morbidity without treatment and Jan's description of interference with functioning severity is estimated to be high.

Psychotic symptoms are described or reported. Psychotic symptoms appear to be chronically present. The onset of psychotic symptoms has been rapid over a period of days. Jan's behavior is described as bizarre. Inappropriate laughter is reported. Inappropriate smiles have occurred. Grandiose ideas of delusional intensity have been expressed. Unusual perceptual experiences are reported.

Based on severity of symptoms and interference with functioning severity or complexity is considered high.

Current Stressors:
Financial Problems:
Significant financial problems are present. Her financial problems are seriously threatening her lifestyle.

Symptom Review:
Behavior Changes:
Bizarre or inappropriate behaviors are described. Details are as follows:
Jan describes increased energy.
Impulsive or unpredictable behavior is reported.
Risk taking behavior has occurred.
Jan describes spending binges.
Jan admits to bar hopping to find multiple sexual partners on the weekends.

Sleep Changes:
Jan complains of insomnia. The number of hours she normally sleeps is less than five. Jan typically does not nap. "I have not slept since forever and I am loving it!"

Problem Pertinent Review of Symptoms/Associated Signs and Symptoms: She convincingly denied symptoms of depression.

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. Symptom reviews of all other systems are negative with the following exceptions:

Cardiac: Abnormality(s) noted:
Hypertension is reported
Otherwise, no symptoms referable to the cardiovascular symptoms are described.

Endocrine: Abnormality noted
A thyroid condition is known to exist.
(Hypothyroidism)
Otherwise, no symptoms referable to the endocrine symptoms are described.

Past Psychiatric History:
Information Received From:
Jan
The family

Psychiatric Hospitalization:
Jan has been hospitalized on a number of occasions. She was first hospitalized in her twenties. First hospitalization was for a mood disturbance with psychotic features.

Out Patient Treatment:
Currently receiving outpatient mental health treatment for bipolar disorder. She is being prescribed medication.

Suicidal/Self Injurious:
Jan has made suicidal threats. She made non specific threats.

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

Acting Out:
*History of sexually promiscuous behavior.
*History of night absences.
Jan has acted out in the following way(s): "Shopping, shopping, shopping and bar hopping."

Psychotropic Medication History:
*Lithium: This medication was previously taken but is not currently taken. It was stopped because of the patient's non compliance.

Social/Developmental History:
Jan is a married 32 year old woman. She is Caucasian. She is a Christian.
Relationship/Marriage:
Times Married, Partnered:
*Married once
The current relationship has lasted:
*Three year
The current relationship is described as:
*Tolerable
Children:
Jan has no children.

Coping Strengths:
Academic:
*Well Educated
Cognitive:
*Intelligent
*Imaginative

Housing Status:
Jan owns a condo. It is reportedly in good repair and safe.

Family History:
Brother carries diagnosis of bipolar disorder.
Aunt hospitalized for bipolar disorder. This family member is maternally related.

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:
Infection or Disease:
None: There are no indications of current infectious disease or recent exposure to an infectious disease.

Adverse Drug Reactions:
There is no known history of adverse drug reactions.

Allergies:
*Soy: (Hives)

Current Medical Diagnoses:
Cardiovascular:
*Hypertension
Endocrine/Metabolic:
*Hypothyroidism

Current Medications:
*Furosemide and KCL supplement.
*Synthroid

Medications Prescribed by:
Dr. Smith

Cardiac Disclaimer:
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:
Jan 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 other medications are currently taken.

Exam: Jan presents as irritable, distracted, casually groomed, and intrusive. Her speech is pressured, rapid, and loud. There is no difficulty naming objects or repeating phrases. Signs of manic psychosis appear to be present. Easy distractibility and a short attention span are in evidence. She is grandiose. She is over talkative. Speech is pressured. Speech is rapid. Her affect is inappropriate. She smiles inappropriately. The patient laughs inappropriately. Psychotic or borderline psychotic symptoms seem to be present. Bizarre behavior has been observed. There is a thought disorder. When asked about suicidal ideas or intentions, Jan presents as guarded. 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. Clinically, IQ appears to be in the above average range. Insight into problems appears to be poor. Judgment appears to be poor. There are no signs of anxiety. She is easily distracted. Jan is restless. Jan was intrusive during the examination. No signs of withdrawal or intoxication are in evidence.

Vital Signs:
Sitting blood pressure is 128 / 76. Sitting pulse rate is 80. Respiratory rate is 18 per minute. Temperature is 98+ degrees F. Height is 5' 5" (165 cm). Weight is 135 lbs. (61.2 Kg). BMI is 22.5.

Musculo-skeletal Exam:
Muscle strength, muscle tone, gait and station are all normal.

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

Bipolar 1, Current or most recent episode Manic, Severe with Psychotic Features, 296.44 (F31.2) **(Active)**
Benign Hypertension, 401.1 **(Active)**
Hypothyroidism, 244.9 **(Active)**

Clinical Summary:

RISK ASSESSMENT: SUICIDE/VIOLENCE

History of Risk Factors: Jan has a history of multiple psychiatric hospitalizations.
Current Risk Factors: There is impaired impulse control.
Jan is exhibiting psychotic symptoms with sexual preoccupation.
Jan carries a bipolar diagnosis.
Protective Factors: Good family support
A strong social support system is in place
Suicide Risk: Based on the above risk factors the risk of SUICIDE is considered MODERATE.
Persistent passive wishes to be dead without actual intent or plan is present.
Violence Risk: Based on the above risk factors the risk of VIOLENCE is considered LOW.
Aggressive or violent impulses are intermittent or fleeting without plan or intent.

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.

The following information was discussed today regarding medications changes ordered for Jan.
- Risks
- Benefits
- Alternatives
- Side Effects
- Pregnancy Warning (if indicated)

Start Depakote ER 1500 mg. PO QPM (Mood Stabilization)
Start Zyprexa 10 mg PO QAM (Psychosis)
Start Ambien CR 12.5 mg PO at Hour of Sleep (Insomnia)
Start Dyazide 37.5 / 25 mg capsule PO QAM (Hypertension)
Start Synthroid 100 mcg. PO QAM (Hypothyroidism)

Notes & Risk Factors:
No known history of adverse drug reactions
Has not slept in > 72 hours.

99223 AI Initial Hosp. / In Pt Care

Elizabeth Lobao (MD)
Electronically Signed
By: Elizabeth Lobao (MD)
On: 4/25/2015 6:05:43 PM

PSYCHIATRIC HOSPITAL
2121 Main Street
Anywhere, USA

Date of Exam: 4/25/2015
Time of Exam: 2:17:17 PM

Patient Name: Jones, January
Patient Number: 1000010659260

MEDICAL HISTORY AND PHYSICAL EXAM
INPATIENT SETTING
Mary Jones, MD (PCP)

History:

Jan is a married Caucasian 32 year old woman. Her chief complaint is hypertension, hypothyroidism and recurrent urinary tract infection. Admitted for acute onset of manic psychosis.

The following information was received from:
Jan.

Problem Pertinent Review of Symptoms: Symptoms of bingeing, purging and other indications of an eating disorder are convincingly denied.

Symptom reviews of all other systems are negative with the following exceptions:

Cardiac: Abnormality(s) noted:
Hypertension is reported
Varicosities are reported.
Otherwise, no cardiac abnormalities are described.

Endocrine: Abnormality noted
A thyroid condition is known to exist.
(Hypothyroidism) x 5 years.
Otherwise, no symptoms referable to the endocrine symptoms are described.

Skin: Abnormality(s):
A skin disorder is present:
Eczema
Otherwise, no symptoms referable to the skin are present.

Urinary: Abnormality
Urinary tract infection x 4 weeks, untreated.
Otherwise, there are no symptoms referable to the urinary system.

Past Psychiatric History:

Psychiatric Hospitalization:
Jan has been hospitalized on a number of occasions. She was first hospitalized in her twenties. First hospitalization was for a mood disturbance with psychotic features.

Outpatient Treatment:
Currently receiving outpatient mental health treatment bipolar disorder. She is being prescribed medication.

Suicidal/Self Injurious:
Jan has made suicidal threats. She made non specific threats.

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

Acting Out:
*History of sexually promiscuous behavior.
*History of night absences.
Jan has acted out in the following way(s):
"shopping, shopping, shopping."

Psychotropic Medication History:
*Lithium: This medication was previously taken but is not currently taken. It was stopped because of the patient's noncompliance.

ADDENDUM: The above psychiatric history was reviewed and confirmed with Jan.

Social/Developmental History:
Jan is a married 32 year old woman. She is Caucasian. She is a Christian.
Relationship/Marriage:
Times Married, Partnered:
*Married once
The current relationship has lasted:
*Three years
The current relationship is described as:
*Tolerable
Children:
Jan has no children.

ADDENDUM: The above social history was reviewed and confirmed with Jan.

Abuse/Protective Services:
There is no known history of physical or sexual abuse or emotional abuse.

Community Providers:
Jan's primary care provider is John Smith, MD.

Substance Abuse:
Jan denies any history of substance abuse.

Family History:
Brother carries diagnosis of bipolar disorder.
Aunt hospitalized for bipolar disorder. This family member is maternally related.
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.

ADDENDUM: The above psychiatric family history was reviewed and confirmed with Jan.

Medical History:

Adverse Drug Reactions:
There is no known history of adverse drug reactions.

Allergies:
*Soy: Hives

Current Medical Diagnoses:

Cardiovascular:

*Hypertension

Endocrine/Metabolic:

*Hypothyroidism

Infection or Contagious:

*Urinary Tract Infection

Current Medications:

*Furosemide and KCL supplement. (compliant)

*Synthroid (compliant)

Ciprofloxacin HCL (start today)

Medications Prescribed by:

Dr. Smith (PCP)

Cardiac Disclaimer:

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:

Jan 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.

PHYSICAL EXAM:

Jan appears friendly, distracted, normal weight, and irritable. No signs of withdrawal or intoxication are in evidence

Cardio-Vascular: ABNORMALITY NOTED:

Pedal pulses exam reveals diminished, 2+ pedal pulses bilaterally.

Varicosities present

Otherwise, no abnormal findings were present on examination of the cardiovascular system.

Breast/Chest/Back: Examination normal with no lumps, nodes, irregularities or discharge. Spine is midline and no areas of swelling or tenderness of the back are present. Extremities

Extremities: Abnormalities found. Details are as follows: 1+ ankle edema.

Dental: There are no obvious dental abnormalities. Neither caries nor enamel loss is in evidence. Mucosa is normal color and without lesions.

ENT: No ENT abnormalities are found. The external auditory canals are clear and the tympanic membranes are intact and normally colored. The nasal septum is midline and the turbinates are normally colored and not swollen. Mucous membranes, including the posterior pharynx, are of normal color and appearance. No swellings or pain or abnormalities of appearance are apparent.

Eye: Exam of the eye reveals no abnormalities. Pupils react equally to light and accommodation and optic discs and conjunctiva are clear. Vision and extra ocular movements are grossly intact, as is field of vision.

Abdomen: Examination of the abdomen reveals no abnormalities. There is no tenderness or guarding, no masses or enlarged organs, and no hernias.

Head: Head is normal in shape and size and there is no swelling or tenderness.

GU Female: Deferred.

Musculo-Skeletal: Examination is normal. Muscle strength, tone, gait and station are all normal.
Neck: No abnormalities were found on examination of the neck. There was no adenopathy and the thyroid was of normal size and consistency.

Rectal Exam: Deferred.

Cranial Nerve findings are as follows:

1: She is able to perceive common odors.
2: Visual Fields are full with no deficits on confrontation and intact ability to distinguish number of fingers in central field and movement in peripheral field.
3.4.6: Eye movements are symmetrical through all positions of gaze with no nystagmus present.
5. Can indicate facial and aural tactile stimulation. There is symmetrical tension in muscles of clenched jaw and she is able to move jaw laterally against resistance .
7. She is able to retract eyelids fully and frowns and elevates forehead symmetrically, closes eyelids normally, has adequate saliva, able to show teeth, smiles symmetrically, and has no lip tremor.
8: Jan hears fingers rubbing and snapping equally in both ears and can do finger to nose or finger to finger without past pointing. There is a normal tandem walk and she can stand with feet together without postural deviation.
9 & 10: There is normal midline elevation of the uvula and palate with a normal gag reflex present. Laryngeal contours rise with swallowing and there is no hoarseness or articulation difficulty.
11: There is normal strength and symmetry on turning head and elevation of shoulders.
12: Tongue protrudes in midline with absence of fasciculation, tremors, or atrophy. There is normal muscle strength of tongue and normal lingual speech.

Reproductive: Female:
She is not pregnant.

Respiratory: There are no abnormalities of the respiratory system. Respiratory rate is normal and there are no abnormal respiratory noises or dullness to percussion.

Skin: No skin abnormalities are found. No abnormal lesions are seen, and color, pigmentation, texture, turgor and temperature are all normal.

VITAL SIGNS:
Supine blood pressure is 126 / 76. Supine pulse rate is 75.
Upright Blood pressure is 112 / 70. Upright pulse rate is 80.
Pulse is *regular.*
Respiratory rate is 17 per minute.
Oxygen saturation is 98% (normal).
Temperature is 98.3 degrees F.
Height is 5' 5" (165.1 cm).
Weight is 135 lbs. (61.2 Kg).
BMI is 22.5.
Fasting blood sugar: 100.

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

Bipolar 1, Current or most recent episode Manic, Severe w/ Psychotic Features, 296.44 (F31.2) **(Active)**
Benign Hypertension, 401.1 **(Active)**
Hypothyroidism, 244.9 **(Active)**
Urinary Tract Infection NOS, 599.0 (N39.0) **(Active)**

Instructions / Recommendations / Plan:
Thyroid Panel in AM
Urine for culture and sensitivity in 96 hours.

Orthostatic B/P with VS q shift.
Encourage fluids for UTI.
Cranberry juice at bedside.
No activity restrictions; follow unit policy.

The following information was discussed today regarding medications changes ordered for Jan.
- Risks
- Benefits
- Alternatives
- Side Effects
- Pregnancy Warning (if indicated)

Current Medications
4/30/2015 Started Depakote ER 1500 mg. PO QPM (Mood Stabilization)
4/30/2015 Started Zyprexa 10 mg PO QAM (Psychosis)
5/5/2015 Increased Dyazide 37.5 / 25 mg capsule PO BID (Hypertension) (read back)
5/5/2015 Increased Synthroid 150b mcg. PO QAM (Hypothyroidism) (read back)
Start Ciprofloxacin HCL 250 mg. PO BID x3 days (UTI)

Notes & Risk Factors:
No known history of adverse drug reactions.
Acute UTI: encourages fluids

99233 Inpatient Medical History & Physical Exam

Mary Jones, MD

Electronically Signed
By: Mary Jones, MD
On: 4/25/2015 2:18:17 PM

PSYCHIATRIC HOSPITAL
2121 Main Street
Anywhere, USA

Date of Exam: 5/3/2015
Time of Exam: 10:03:45 AM

Patient Name: Jones, January
Patient Number: 1000010659260

Verbal Orders

Instructions / Recommendations / Plan:

Dietary Orders
NPO at midnight tonight for lab tests.
Verbal Order given by Liz Lobao, (MD) recorded by Liz Lobao, RN on 5/5/2015 9:55:20 AM.

Lab & Imaging Requisition/Order (Updated Today 5/5/2015)
Lithium Level Routine x1 (5/5/2015 until 5/5/2015) Dx = 296.44 (Check for therapeutic range)
Verbal Order given by Liz Lobao, (MD) recorded by Liz Lobao, RN on 5/5/2015 9:55:20 AM (read back)

Medication Changes
4/30/2015 Started Depakote ER 1500 mg. PO QPM (Mood Stabilization)
4/30/2015 Started Zyprexa 10 mg PO QAM (Psychosis)
Stop Ambien CR 12.5 mg PO at Hour of Sleep (Insomnia)
Verbal Order given by Liz Lobao, (MD) recorded by Liz Lobao, RN on 5/5/2015 9:55:20 AM (read back)
Increase Dyazide 37.5 / 25 mg capsule PO BID (Hypertension)
Verbal Order given by Liz Lobao, (MD) recorded by Liz Lobao, RN on 5/5/2015 9:55:20 AM (read back)
Increase Synthroid 150b mcg. PO QAM (Hypothyroidism)
Verbal Order given by Liz Lobao, (MD) recorded by Liz Lobao, RN on 5/5/2015 9:55:20 AM (read back)

Liz Lobao, RN

Electronically Signed
By: Liz Lobao, RN
On: 5/3/2015 10:03:54 AM

PSYCHIATRIC HOSPITAL
2121 Main Street
Anywhere, USA

Date of Exam: 4/26/2014
Time of Exam: 10:18:35 AM

Patient Name: Jones, January
Patient Number: 1000010659260

MASTER TREATMENT PLAN

Treatment Plan
A Treatment Plan was created or reviewed today, 5/4/2015, for January Jones.

Diagnosis:
Axis I: Bipolar 1, Current or most recent episode Manic, Severe w/ Psychotic Features, 296.44 (F31.2) **(Active)**
Benign Hypertension, 401.1 **(Active)**
Hypothyroidism, 244.9 **(Active)**

Current Medications:
Depakote ER 1500 mg PO QPM
Zyprexa 10 mg PO QAM
Ambien CR 12.5 mg PO at Hour of Sleep
Dyazide 37.5 / 25 mg capsule PO QAM
Synthroid 100 mcg. PO QAM

Problems:
Problem #1: psychotic symptoms

Problem: psychotic symptoms

Jan's psychotic symptoms have been identified as an active problem in need of treatment. They are primarily manifested by: Disorganized Behaviors - characterized by inappropriate sexual behavior and overspending.

Long Term Goal(s):
Will be able to attend and act appropriately in a day program.
Target Date: 6/8/2015

Short Term Goal(s):
Jan will not exhibit disorganized behavior for a period of 50% of the time for one week.
Target Date: 5/11/2015

In addition, Jan will not display or complain of racing thoughts for a period of 48 hours within the next week.
Target Date: 5/11/2015

Intervention(s):
Therapist/Counselor to confront, as appropriate, paranoid delusions, ideas, or attitudes with reality based interpretations. This will occur daily.
Clinician's Initials: LL

Therapist/Counselor will attempt to establish a trusting relationship with patient. This will occur daily.
Clinician's Initials: LL

Therapist/Counselor will provide Cognitive Therapy to help patient overcome disorganizing effect of psychotic symptoms on normal cognition. This will occur three times per week and will last 20 minutes per session.
Clinician's Initials: LL

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.
2 (Very Mild)

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

Emotional Withdrawal: The degree to which the patient gives the impression of family to be in emotional contact in the interview situation. 5 (Moderately Severe)

Conceptual Disorganization: Degree to which thought processes are confused, disconnected, or disorganized. 5 (Moderately Severe)

Guilt Feelings: Over concern or remorse for past behavior.
1 (Not Present)

Tension: Physical and motor manifestation of tension, "nervousness", and heightened activation level.
4 (Moderate)

Mannerisms and Posturing: Unusual and unnatural motor behavior.
1 (Not Present)

Grandiosity: Exaggerated self opinion, conviction of unusual ability or powers.
6 (Severe)

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

Hostility: Animosity, contempt, belligerence, disdain for other people.
2 (Very Mild)

Suspiciousness: Belief (delusional or otherwise) that others have or have had malicious or discriminatory intent toward the patient. 4 (Moderate)

Hallucinatory Behavior: Recent perceptions without normal external stimulus correspondence.
6 (Severe)

Motor Retardation: Observed reduction in energy level evidenced in slowed moments.
4 (Moderate)

Uncooperativeness: Evidence of resistance, unfriendliness, resentment and lack of readiness to cooperate.
6 (Severe)

Unusual Thought Content: Unusual, odd, strange, or bizarre thought content.
7 (Extremely Severe)

Blunted Affect: Reduced emotional tone, apparent lack of normal feeling or involvement.
1 (Not Present)

Excitement: Heightened emotional tone, agitation, increased reactivity.
7 (Extremely Severe)

Disorientation: Confusion or lack of proper association for person, place or time.
2 (Very Mild)

Total Score: 72

TRANSITION PLAN
The expected length of stay for this patient is Approx. 1 month.
The projected discharge date for this patient is 6/4/2015.
Refer to Therapist or Facility: Joy MacLauren.
Refer to Psychiatrist/Prescriber: Rae Morris, (MD).
Anticipated Post Discharge Services include: To be arranged.
Plan for transition/discharge: To be arranged.

Comprehensive Treatment Plan Barriers
Cognitive limitations interfere with treatment.
- Instructions will be geared to level of patient's understanding.

Motivational issues interfere with treatment.
- Therapy will focus on motivational problems first.

Comprehensive Treatment Plan Strengths
Jan's strengths include:

Physical
- Is physically healthy
- Good medical care

Spiritual
- Has strong religious beliefs

Status:
5/4/2015: The undersigned clinician met with the patient on the date above in a face to face meeting to work with her in developing this Treatment Plan.

Electronically Signed
By: Elizabeth Lobao, LCSW
On: 4/26/2015 10:21:14 AM

PSYCHIATRIC HOSPITAL
2121 Main Street
Anywhere, USA

Date of Exam: 4/28/2015
Time of Exam: 5:11:55 PM

Patient Name: Jones, January
Patient Number: 1000010659260

NURSING PROGRESS NOTE

Interval History: Symptoms of manic process continue. Episodes of elevated mood are occurring daily. Jan is experiencing decreased sleep. She paced the hallways for six hours last night despite receiving Ambien CR. Jan's mood is elevated. Mood irritability is present. An increase in sociability is present. Her speech is pressured. She talks excessively. Symptoms of depression are convincingly denied.

Behavior:
Good medication compliance is noted. She continues to express worries that medications will lead to another episode of depression. She needs cues or other assistance to perform ADLs and dress appropriately. She regularly participates in scheduled activities. PRNs are used occasionally and are described as effective. Impulsive behaviors are being displayed less frequently. Jan has diminished food and fluid intake. Sleep problems continue.

Somatic Symptoms: No somatic symptoms are reported or in evidence.

Education Needs:
Jan has the following educational needs:
*Medication Instruction
Learning Ability: Emotional Barriers: Do not interfere with educational needs.

Nursing Interventions:
Medication was administered to Jan; compliance, symptoms, and possible side effects monitored and recorded as appropriate.
Response to Medication: Good.
Details are as follows: "I will stick with what medications the doctor thinks are best even though I worry about becoming depressed."
Jan was engaged and encouraged to participate in activities. Comprehension appears to have been fair.
This was evidenced by her demonstrated skill. She is working hard at not interrupting her peers.
Emotional support and encouragement was given to Jan. Response to this intervention appeared to be good.

Exam: Jan appears friendly, distracted, disheveled, but less intrusive today. Her speech is less pressured or rapid with normal volume. Mood appears moderately elevated and patient presents as manic. She is intrusive. She is irritable. Labile mood has been observed. Thinking is tangential. She smiles inappropriately. Associations are intact and increasingly logical. The patient convincingly denies suicidal ideas or intentions. Homicidal ideas or intentions are denied. Insight into problems appears fair. Judgment appears fair. There are no signs of anxiety. A short attention span is evident.

Vital Signs:
Vital Signs taken earlier today: Sitting blood pressure is 108 / 62. Sitting pulse rate is 77. Respiratory rate is 21 per minute. Temperature is 98+ degrees F. Height is 5' 5" (165.1 cm). Weight is 135 lbs. (61.2 Kg). BMI is 22.5.

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

Bipolar 1, Current or most recent episode Manic, Severe with Psychotic Features, 296.44 (F31.2) **(Active)**
Benign Hypertension, 401.1 **(Active)**
Hypothyroidism, 244.9 **(Active)**

Notes & Risk Factors:
No known history of adverse drug reactions
Remains sleep deprived.

Elizabeth Lobao, RN

Electronically Signed
By: Elizabeth Lobao, RN
On: 4/28/2015 5:13 PM

PSYCHIATRIC HOSPITAL
2121 Main Street
Anywhere, USA

Date of Exam: 4/27/2015
Time of Exam: 10:26:55 AM

Patient Name: Jones, January
Patient Number: 1000010659260

PSYCHIATRIC PROGRESS NOTE

Interval History: Jan seems slightly improved, thus far. Symptoms of manic process are unchanged and she is the same. An elevated mood is chronically present. The amount of physical over activity continues unchanged. She is experiencing decreased sleep. Her mood is elevated. Grandiosity is still present. Jan continues to describe her thoughts as “racing." Her speech is pressured. She is still talking excessively.

Jan continues to describe signs and symptoms of psychotic process. Jan's symptoms are less frequent or intense, and she is considered better. Staff describe Jan's affect as inappropriate. Inappropriate behavior is described by others. Episodes of inappropriate behavior have been occurring less frequently than previously. “I am still flying but prepared to crash land.”

Behavior:
Compliance with medication is good. She independently does ADLs but dresses inappropriately. She participates regularly in scheduled activities. Peers describe her behavior as intrusive during groups. PRNs are used occasionally and are described as effective. Impulsive behaviors continue to be displayed. A poor night's sleep is described. Sleep was not continuous and not completely restful and less than three hours of sleep was achieved.

No side effects are reported or in evidence.

Exam: Jan presents as irritable, distracted, normal weight, and intrusive. Her speech is pressured, rapid, and loud. Language skills were not formally tested. Signs of manic psychosis appear to be present. She is over talkative. Speech is pressured. Speech is rapid. Easy distractibility and a short attention span are in evidence. Her affect is labile. Borderline psychotic symptoms seem to be present. She smiles inappropriately. The patient laughs inappropriately. Grandiose ideas are expressed. The patient denies suicidal ideas or intentions. Denial is convincing. Homicidal ideas or intentions are denied. Insight into problems appears to be poor. Judgment remains poor. There are no signs of anxiety. A short attention span is evident. She is easily distracted. Jan was intrusive during the examination.

Vital Signs:
Sitting blood pressure is 108 / 62. Sitting pulse rate is 77. Respiratory rate is 21 per minute. Temperature is 98+ degrees F. Height is 5' 5" (165.1 cm). Weight is 135 lbs. (61.2 Kg). BMI is 22.5.

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

Bipolar 1, Current or most recent episode Manic, Severe with Psychotic Features, 296.44 (F31.2) **(Active)**
Benign Hypertension, 401.1 **(Active)**
Hypothyroidism, 244.9 **(Active)**

Instructions / Recommendations / Plan:

LEVEL OF CARE JUSTIFICATION: Jan needs continued Inpatient treatment. Jan is psychotic with disturbed reality testing and needs careful supervision to ensure her safety and the safety of others.

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.

Psychopharmacology:
Encourage all activities:
Ward Activities:

4/30/2015 Started Depakote ER 1500 mg. PO QPM (Mood Stabilization)
4/30/2015 Started Zyprexa 10 mg PO QAM (Psychosis)
4/30/2015 Started Ambien CR 12.5 mg PO at Hour of Sleep (Insomnia)
4/30/2015 Started Dyazide 37.5 / 25 mg capsule PO QAM (Hypertension)
4/30/2015 Started Synthroid 100 mcg. PO QAM (Hypothyroidism)

Notes & Risk Factors:
No known history of adverse drug reactions
Psychotic w/poor impulse control.
Remains sleep deprived.

99233 Subseq. Hosp. Care

Elizabeth Lobao (MD)

Electronically Signed
By: Elizabeth Lobao (MD)
On: 4/27/2015 10:27:16 AM

PSYCHIATRIC HOSPITAL
2121 Main Street
Anywhere, USA

Date of Exam: 5/1/2015
Time of Exam: 5:48:44 PM

Patient Name: Jones, January
Patient Number: 1000010659260

GROUP THERAPY NOTE

Session Remarks:
Group Therapy Note

Group Type: Focus: The focus of today's group was the concept of social skills. The purpose was to familiarize the group members with certain techniques and skills needed to establish and maintain healthy relationships. Group members were encouraged to share life experiences that illustrated the use of those skills.
Present at today's session were the following:
Four members of the group were present today.

Group Leader Interventions:
Group Leader facilitated discussion about providing peer support through common themes.
Extrapolated to life experiences
Facilitated group process
Involved all group members
Kept group focused
Helped group members set limits and boundaries
Therapist provided psycho-education regarding providing structure and support.
Assigned worksheet/activity with topic of improving peer support through common themes.

Plan: Encourage increased participation.

Individual Behavior During This Session:

Appearance and Behavior: In today's session Jan appeared friendly, communicative, and happy. She tended to monopolize discussions today and was intrusive until redirected. She stayed the entire session. Jan comprehended well what was happening in today's session. In today's session Jan was over talkative or hyper verbal. Jan was restless and fidgety today. Jan today spoke of feelings of depression she has experienced in the past. "I never want to feel like that again." In addition, Jan spoke today in the session of problems in her relationships. Jan today spoke of self defeating behavior.

Exam:
Jan's mood is moderately elevated and she presents as manic. Jan is intrusive. She is over talkative. Her speech is pressured. She is increasingly aware of how her behavior impacts on her peers.

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

Bipolar 1, Current or most recent episode Manic, Severe with Psychotic Features, 296.44 (F31.2) **(Active)**
Benign Hypertension, 401.1 **(Active)**
Hypothyroidism, 244.9 **(Active)**

Level of Care Justification: Jan needs continued Inpatient treatment. (Jan is voluntary.) She is inattentive and impulsive with behavioral disturbance and she is unable to alleviate these symptoms on her own.

Instructions/Recommendations/Plans
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.

Notes & Risk Factors:
No known history of adverse drug reactions
Remains sleep deprived.

90853 Group psychotherapy

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

Elizabeth Lobao, LCSW

Electronically Signed
By: Elizabeth Lobao, LCSW
On: 5/1/2015 5:49:23 PM

PSYCHIATRIC HOSPITAL
2121 Main Street
Anywhere, USA

Date of Exam: 4/29/2015
Time of Exam: 4:37:02 PM

Patient Name: Jones, January
Patient Number: 1000010659260

PSYCHOTHERAPY NOTE

Jan is partially improved. Symptoms of manic process have lessened and she is better. Jan's episodes of elevated mood are occurring daily. Jan is experiencing decreased sleep. Jan seems less distractible. Jan's mood is still elevated. Less grandiosity is present. Her libido is more nearly normal. Jan gives evidence of an inflated self esteem. Jan's speech is still pressured. Excessive talking is present.

Behavior:
Medication has been taken regularly. She needs no help doing ADLs. She regularly participates in scheduled activities. Her compliance with rules is erratic and irregular. PRN's are used on an almost daily basis and are described as effective. There have been fewer instances of impulsive behaviors. A poor night's sleep is described. Sleep was not continuous and not completely restful and less than three hours of sleep was achieved. "Will I ever sleep normally again?"

CONTENT OF THERAPY: Relationship problems were discussed. Instances of impulsivity was also discussed, focusing on how they impact excessive spending and her personal safety. The problem of non compliance was also discussed in session today. Self defeating problems were also spoken about. Problems coping with manic episodes were also discussed by the patient. "The meds are hard for me to take, they make me flat. I worry that I will become depressed again, so staying on meds is scary."

THERAPEUTIC INTERVENTION: This session the therapeutic focus was on assessing the type and severity of the problem. This session the therapeutic also focused was on helping to increase insight and understanding. The main therapeutic techniques used involved the confrontation and reflection of certain irrational beliefs. Jan was counseled regarding the need for compliance with all medical instructions, particularly having to do with medication. Discussed about relationship issues with spouse since acquiring chronic illness.

Mental Status Exam: Jan appears irritable, distracted, casually groomed, and intrusive. Her speech is pressured, rapid, and loud. Bizarre behavior has been observed less frequently. Grandiose ideas are expressed on occasion. The patient convincingly denies suicidal ideas or intentions. Homicidal ideas or intentions are denied. Clinically, IQ appears to be in the above average range. Insight into problems appears to be poor. Judgment appears to be poor. She is easily distracted. Jan was less intrusive during the examination when compared to her admission baseline.

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

Bipolar 1, Current or most recent episode Manic, Severe with Psychotic Features, 296.44 (F31.2) **(Active)**
Benign Hypertension, 401.1 **(Active)**
Hypothyroidism, 244.9 **(Active)**

Instructions / Recommendations / Plan:
Jan is encouraged to attend therapy sessions three times a week.
She is encouraged to not interrupt her peers when they are speaking.

Notes & Risk Factors:
No known history of adverse drug reactions
Psychotic w/poor impulse control slowly resolving
Remains sleep deprived.

90832 Psychotherapy 30 min.

Time spent face to face with patient and/or family and coordination of care: 30 min
Session start: 12:00 PM
Session end: 12:30 PM

Elizabeth Lobao, LCSW

Electronically Signed
By: Elizabeth Lobao, LCSW
On: 4/29//2015 4:38:55 PM

PSYCHIATRIC HOSPITAL
2121 Main Street
Anywhere, USA

Date of Exam: 5/4/2015
Time of Exam: 12:22:25

Patient Name: Jones, January
Patient Number: 1000010659260

SUBSEQUENT TREATMENT PLAN

Treatment Plan

A Treatment Plan was created or reviewed today, 5/4/2015, for January Jones.
Diagnosis:
Axis I: Bipolar 1, Current episode Manic, Severe w/ Psychotic Features, 296.44 (F31.2) **(Active)**
Benign Hypertension, 401.1 **(Active)**
Hypothyroidism, 244.9 **(Active)**

Current Medications:
Depakote ER 1500 mg PO QPM
Zyprexa 10 mg PO QAM
Ambien CR 12.5 mg PO at Hour of Sleep
Dyazide 37.5 / 25 mg capsule PO QAM
Synthroid 100 mcg. PO QAM

Problems:
Problem #1: psychotic symptoms

Problem: psychotic symptoms

Jan's psychotic symptoms have been identified as an active problem in need of treatment. They are primarily manifested by: Disorganized Behaviors - characterized by inappropriate sexual behavior and overspending.
"I am starting to feel like my old self again. I slept 6 hours last night."

Long Term Goal(s):
- Will be able to attend and act appropriately in a day program.
Target Date: 6/8/2015

Short Term Goal(s):
Jan will not exhibit disorganized behavior for a period of 50% of the time per day for one week.
Target Date: 5/11/2015 **GOAL MET: 5/4/2015**

In addition, Jan will not display or complain of racing thoughts for a period of 48 hours within the next week.
Target Date: 5/11/2015 **GOAL MET: 5/4/2015**

In addition, Jan will initiate and carry through a goal directed activity 75% of the time for one week.
Target Date: 5/18/2015

Intervention(s):
Therapist/Counselor to confront, as appropriate, paranoid delusions, ideas, or attitudes with reality based interpretations. This will occur daily.
Clinician's Initials: LL

Therapist/Counselor will attempt to establish a trusting relationship with patient. This will occur daily.
GOAL MET: 11/4/2015
Clinician's Initials: LL

Therapist/Counselor will provide Cognitive Therapy to help patient overcome disorganizing effect of psychotic symptoms on normal cognition. This will occur three times per week and will last 20 minutes.
Clinician's Initials: LL

Therapist/Counselor to confront, as appropriate, paranoid delusions, ideas, or attitudes with reality based interpretations. Clinician's Initials: LL

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.
Help in managing my feelings.
ABILITIES:
I attend social support groups.
I care about my own well being and the well being of others.
PREFERENCES:
Group Therapy
Individual Therapy
SPECIFIC ISSUES: Manic on admission with psychotic features.

GOALS: Medication compliance.

DESIRED OUTCOME: "I just want to feel better and go home."

Comprehensive Treatment Plan Barriers
Cognitive limitations interfere with treatment.
- Instructions will be geared to level of patient's understanding.

Motivational issues interfere with treatment.
- Therapy will focus on motivational problems first.

Comprehensive Treatment Plan Strengths
Jan's strengths include:

Physical
- Is physically healthy
- Good medical care

Spiritual
- Has strong religious beliefs

Status:
5/4/2015: Moderate progress in reaching goals and resolving this problem seemed present today. New short term goals have been established. 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.

Electronically Signed
By: Elizabeth Lobao (MD)
On: 5/4/2015 12:23 PM

PSYCHIATRIC HOSPITAL
2121 Main Street
Anywhere, USA

Date of Exam: 5/2/2015
Time of Exam: 6:09:27 PM

Patient Name: Jones, January
Patient Number: 1000010659260

CASE MANAGEMENT PROGRESS NOTE

Presenting Problem:
Psychotic process continues to be experienced by Jan.

Social Support Changes:
The following changes in her social support network or family have occurred: Jan is welcome to return to her sister's home for an extended stay if she is compliant with her medications and psychiatric appointments.

Family Input:
Jan's family has provided the following input: Family agrees with and will help implement discharge treatment plan post discharge.

Provider Input:
"Please encourage Jan to maintain compliance with her medications and appointments to my office."

The following Case Management Services were provided today:

Case Manager today coordinated discharge planning with client's sister, Melody Jones.

An appointment was made with client's psychiatrist.

Jan today appeared friendly, pressured, overly talkative and tangential in her thinking. She was restless and fidgety.

Summary: Prepare for discharge to her sister's home after psychotic features clear and Jan demonstrates ability to maintain medication compliance.

Time spent on patient: 30 min

Session start: 2:00 PM
Session end: 2:30 PM

Elizabeth Lobao, LCSW

Electronically Signed
By: Elizabeth Lobao. LCSW
On: 5/2/2015 6:10:35 PM

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

---

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.

---

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
Axis I: Bipolar 1, Current or most recent episode Manic, Severe w/Psychotic Features, 296.44 (F31.2) (Active)
Benign Hypertension, 401.1 (Active)
Hypothyroidism, 244.9 (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