Holly Hill Residential Facility

Date of Exam: 9/5/2015
Time of Exam: 12:35:55 PM
Patient Name: Jones, Sheila
Patient Number: 1000010660967

INPATIENT DISCHARGE SUMMARY: PSYCHIATRIST

Date Admitted: 9/1/2015
Date Discharged: 9/14/2015

This discharge summary consists of

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

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1. Clinician's Narrative

ADDITIONAL RISK FACTORS CONSIDERED AT TIME OF DISCHARGE:
Patient 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: Ms. Jones seems to be recovering. Substance use is denied.

Problem Pertinent Review of Symptoms/Associated Signs and Symptoms: She denies all current symptoms of drug withdrawal. Feelings of anxiety are denied.

Constitutional Review of Symptoms: There is no recent history of weight loss, fever, malaise, or other abnormal constitutional symptoms.

Musculoskeletal Review of Symptoms: There is no history of disorder of muscle strength or tone, joint problems, or disturbances of gait or station.

Behavior: Behavior has been stable and uneventful and medication compliance is good.

Adverse Drug Reactions: Adverse Drug Reactions were reviewed and no ADRs were reported.

Therapy Content/Clinical Summary:

Final Exam, Mental Status Exam

Exam: Examination of Ms. Jones reveals her to have no apparent serious mental status abnormalities. She is normal in appearance with age appropriate dress and grooming and she appears to be her stated age. Neither

depression nor mood elevation is evident. Her speech is normal in rate volume and articulation and her language skills are intact. She convincingly denies suicidal and self-injurious ideas or intentions. Homicidal or assaultive ideas or intentions are also denied. Hallucinations and delusions are denied and her behavior is generally appropriate. Associations are intact, thinking is basically logical and thought content is appropriate. There are no signs of cognitive difficulty, based on vocabulary and fund of knowledge. Memory is intact for recent and remote events and the patient is oriented to time, place, and person. There are no apparent signs of anxiety. A normal attention span is in evidence and she exhibits no signs of hyperactivity. Insight and judgment appear intact.

Discharge Diagnosis
Alcohol Withdrawal, with perceptual disturbances, 291.81 (F10.232) (Resolved)
Opioid Use Disorder, severe, 304.00 (F11.20) (Resolved)
Generalized Anxiety Disorder, 300.02 (F41.1) (Chronic)
Migraine Specified, 346.90 (Chronic)

Type of Discharge: Regular

Condition on Discharge: Greatly improved

Prognosis: Good

Medications at Discharge:
Antabuse 500 mg. PO QAM (ETOH Deterrent) (Discharge Only)
Ambien CR 6.25 mg PO QHS PRN (Insomnia) (Discharge Only)
Buspar 15 mg PO QAM (Anxiety) (Discharge Only)

Diagnostic Test Results:
Tests Performed from 9/7/2015 to 9/14/2015:
(1) Glucose, Blood, Fasting (Performed = 9/13/2015): 100 mg/dL (70-100 mg/dl)
(2) Platelet Count (Performed = 9/13/2015): 160,000 / uL (140,000-450,000/uL)

Medication Instructions: Patient was instructed to take medications as prescribed and was informed about potential side effects.

Consent: Patient was advised regarding the risks and benefits of treatment.

Physical Activity: As tolerated.

Dietary Instructions: Regular diet.

Other Instructions: The patient was strongly admonished to abstain from alcohol.

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

Elizabeth Lobao (MD)

Electronically Signed
By: Elizabeth Lobao (MD)
On: 9/14/2015 12:25:21 AM