

This sample inpatient substance abuse chart was created in the [ICANotes Behavioral Health EHR](#). The only words typed when creating this chart are highlighted in yellow. All other text is generated using the ICANotes button-driven content library.

Holly Hill Residential Facility

Date of Exam: 9/1/2015

Time of Exam: 8:35:55 AM

Patient Name: Jones, Sheila

Patient Number: 1000010660967

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

Alcohol Withdrawal, with perceptual disturbances, F10.232 (ICD-10) (Active)

Opioid Use Disorder, severe, F11.20 (ICD-10) (Active)

Generalized Anxiety Disorder, F41.1 (ICD-10) (Active)

Chronic migraine without aura, intractable, with status migrainosus, G43.711 (ICD-10) (Active)

Dimension 1: INTOXICATION / WITHDRAWAL RISK RATING: 3, as evidenced by:

Client tolerates and copes with withdrawal discomfort poorly. Client has severe intoxication, such that the client endangers self or others, or intoxication has not abated with less intensive levels of services. Client displays severe signs and symptoms; or risk of severe, but manageable withdrawal; or withdrawal worsening despite detox at less intensive level.

Information Re Substance Abuse Received From:

Ms. Jones

Ms. Jones's Family

Ms. Jones reports that her current relapse began with exposure to a small amount of the substance.

Drugs Used:

Ms. Jones uses the following substance: **Alcohol**

The following pattern of use is described:

*Alcohol is often taken in larger amounts or over a longer period than was intended.

*There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.

*A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.

*Craving, or strong desire or urge to use alcohol.

*Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.

*Recurrent alcohol use in situations in which it is physically hazardous.

Tolerance:

*A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.

Withdrawal Symptoms, as manifested by the following:

*Alcohol is taken to relieve or avoid withdrawal symptoms.

Impression:

Ms. Jones has 6 or more symptoms/behaviors, therefore she is considered to have a Severe Alcohol Use Disorder.

When Ms. Jones uses the substance she uses until she is completely intoxicated.

Pattern of Use:

Ms. Jones's substance use is continuous. She uses multiple times a day.

Ms. Jones has been using this substance intermittently for years.

Ms. Jones reports having used this substance last, hours ago.

Ms. Jones also uses the following substance: **Oxycontin**.

Ms. Jones reports that her current relapse is, in part, due to stress. Details are as follows:

When Ms. Jones uses substance the quantity used typically is about 10 pills per day. She administers this substance by mouth.

Pattern of Use:

Ms. Jones's substance use is episodic. She uses a few times a week.

Ms. Jones has been using this substance since she was 32 after exposure to substance by her then boyfriend. She last used the substance about three days ago.

Withdrawal Symptoms:

Ms. Jones does describe at least one episode of withdrawal. The most recent occurred in the past year.

Symptoms Included:

- *Agitation
- *Irritability
- *Joint Pain
- *Muscle Spasms
- *Sweating
- *Shaking/Tremors
- *Unable to Sleep

CIWA:

The Clinical Institute Withdrawal Assessment for alcohol (revised) is a tool for monitoring alcohol withdrawal. The following subscale and total scores were today achieved by Ms. Jones:

- *Systolic Blood Pressure: 150
- *Diastolic Blood Pressure: 90
- *Pulse Rate: 100/min.
- *O2 Saturation: 97
- *Respiration Rate: 22/min.
- *Mild nausea is reported. (1 point)
- *A moderate tremor is visible when arms extended. (4 points)
- *Moderately anxious or guarded, so anxiety is inferred. (4 points)
- *Somewhat more than normal activity is present. (1 point)
- *No sweat is visible. (0 points)
- *Oriented. (0 points)
- *Mild itching, pins and needles, burning, or numbness. (2 points)
- *No auditory disturbances. (0 points)
- *Visual disturbances are denied. (0 points)
- *Severe headache. (5 points)

Total Score: 15+ (Scores of above 15 indicate severe withdrawal.) **Actual score is 17.**

Dimension 2: BIOMEDICAL CONDITION/COMPLICATION RISK RATING: 2, as evidenced by:

Client has some difficulty tolerating and coping with physical problems. Problems may interfere with recovery and mental health treatment. This patient may neglect care of serious problems.

Psychotropic Med History:

Buspar: This medication was previously taken but is not currently taken. It was stopped because of its cost.

Currently Prescribed Non Psychotropic Medications:

Dilantin (compliant)

Medical Screen:

Potential Medical Emergency: (List all that are present):

- *Active withdrawal symptoms

Infection or Disease:

- *Has had skin test for T.B. Details (date, results) are as follows:

- *Tested positive for T.B.

- *Chest X-ray completed annually.

- *Treatment for T.B. Completed: INH for six months.

Dimension 3: MENTAL HEALTH RISK RATING: 3, as evidenced by:

Client is functionally impaired during acute illness or from chronic symptoms, and illness interferes with treatment. Client has severe symptoms of emotional, behavioral, or cognitive problems, very poor impulse control and coping skills. Client may have had thoughts of suicide or harm to others, including a plan and the means to carry out the plan.

Global Assessment of Individual Needs:

Ms. Jones reports that she has the following:

- *Depression: Now

- *Sleep Difficulty: Now

- *Suicidal: Within the Past Month

- *Listening To Instruction: Now

- *Victim of Abuse: Never

Treatment History:

Ms. Jones reports the following treatment history:

Prior Psych Disorder:

She has a history of anxiety symptoms. She suffered from anxiety symptoms when she was age 18. The episode of anxiety symptoms lasted two years. She was treated.

Dimension 4: TREATMENT ACCEPTANCE RISK RATING: 3, as evidenced by:

Client displays inconsistent compliance, minimal awareness of either the client's addiction or mental disorder, and is minimally cooperative.

Defense Mechanisms: Ms. Jones minimizes the impact or severity of her illness.

Motivation for Change: Ms. Jones appears poorly motivated for change.

Addictive Behaviors: Ms. Jones describes drug problems, as is elsewhere described. Ms. Jones describes alcohol problems, as are elsewhere described. Ms. Jones describes a history of an eating disorder.

Self Help Groups Attended: None

Elopement Risk: Ms. Jones's Elopement Risk is considered to be low.

Dimension 5: RELAPSE POTENTIAL RISK RATING: 4, as evidenced by:

No awareness of the negative impact of mental health problems or substance abuse. No coping skills to arrest mental health or addiction illnesses, or prevent relapse.

Relapse History: Ms. Jones reports that this admission is relapse related.

Relapse Triggers: Ms. Jones reports that current relapse began with her exposure to a small amount of alcohol.

Relapse Frequency: She describes multiple previous relapses.

Ms. Jones reports that her longest period of sobriety is about six months

Dimension 6: RECOVERY ENVIRONMENT RISK RATING: 2, as evidenced by:

Client has minimal recognition and understanding of relapse and recidivism issues and displays moderate vulnerability for further substance use or mental health problems.

Health and Behavior:

Ms. Jones describes the following health and behavior practices: Tobacco:

- *Counseled regarding tobacco cessation
- *Counseling included consideration and discussion of nicotine replacement therapy.
- *Given advice about how to stop tobacco use

Legal History:

Ms. Jones's legal history is as follows:

Arrests: Details are as follows: for DUI.

Highest ASAM Risk Rating:

RELAPSE POTENTIAL RISK RATING: 4

No awareness of the negative impact of mental health problems or substance abuse. No coping skills to arrest mental health or addiction illnesses, or prevent relapse.

RECOMMENDATION: Send to Acute Inpatient Setting.
Less intensive treatment failed or is considered unsafe or not feasible.

RECOMMENDATION: Send to Acute Inpatient Setting.
Serious deterioration in functioning requires 24 hr/day monitoring, for safety.

RECOMMENDATION: Send to Acute Inpatient Setting.
Medically monitored detoxification is needed.

Joel Jones, LCSW

Electronically Signed

By: Joel Jones, LCSW

On: 9/1/2015 8:36:04 AM

Holly Hill Residential Facility

Date of Exam: 9/1/2015

Time of Exam: 9:35:55 AM

Patient Name: Jones, Sheila

Patient Number: 1000010660967

CHEMICAL DEPENDENCY SPECIFIC BIO-PSYCHOSOCIAL ASSESSMENT

History: Ms. Jones is a 37 year old woman. Her chief complaint is, "I am so anxious all the time that I cannot stop drinking."

Circumstances Leading Up to Treatment: "I am a miserable mother to my twin girls and I really want to get my drinking and anxiety under control."

Information Re Substance Abuse Received From:

Ms. Jones: Ms. Jones reports that her current relapse is, in part, due to stress. Details are as follows: "I am always anxious and drink to calm my nerves"

Drug Used:

Ms. Jones uses the following substance: **Alcohol**

The following pattern of use is described:

- * Craving, or strong desire or urge to use alcohol.
- * Using larger amounts to get high.
- * Missing important events due to drinking.
- * Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by effects of alcohol.

Tolerance:

- *A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.

Withdrawal Symptoms, as manifested by the following:

- *Alcohol is taken to relieve or avoid withdrawal symptoms.

Impression:

Ms. Jones has 6 or more symptoms/behaviors, therefore she is considered to have a Severe Alcohol Use Disorder.

When Ms. Jones uses substance the quantity used is two bottles of wine per evening.

Pattern of Use:

Ms. Jones's substance use is continuous. She uses daily.
Ms. Jones has been using this substance since she was a teenager.
Ms. Jones reports having used this substance last night.

Abused:

Ms. Jones denies ever having been physically, emotionally, or sexually abused or sexually assaulted.

Anxiety Symptoms:

Ms. Jones exhibits symptoms of anxiety. Her anxiety symptoms have been present for years.

Ms. Jones describes the following anxiety symptoms:

- *Choking sensations are described
- *Blushes when feeling anxious in a social setting
- *Difficulty concentrating occurs
- *Feels embarrassment
- *Sensations of excessive muscular tension
- *Shortness of breath

Past Psychiatric History:

Dimension 3: MENTAL HEALTH RISK RATING: 3, as evidenced by:

Client is functionally impaired during acute illness or from chronic symptoms, and illness interferes with treatment. Client has severe symptoms of emotional, behavioral, or cognitive problems, very poor impulse control and coping skills. Client may have had thoughts of suicide or harm to others, including a plan and the means to carry out the plan.

Global Assessment of Individual Needs:

Ms. Jones reports that she has the following:

- *Depression: Now
- *Sleep Difficulty: Now
- *Suicidal: Within the Past Month
- *Listening To Instruction: Now
- *Victim of Abuse: Never

Prior Psych Disorder:

She has a history of anxiety symptoms. She suffered from anxiety symptoms when she was age 18. The episode of anxiety symptoms lasted two years. She was treated.

Withdrawal Symptoms:

Ms. Jones does describe at least one episode of withdrawal. The most recent occurred in the past year.

Symptoms Included:

- *Agitation
- *Irritability
- *Joint Pain
- *Muscle Spasms
- *Sweating
- *Shaking/Tremors
- *Unable to Sleep

CIWA:

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- *Mild nausea is reported. (1 point)
- *A moderate tremor is visible when arms extended. (4 points)
- *Moderately anxious or guarded, so anxiety is inferred. (4 points)
- *Somewhat more than normal activity is present. (1 point)
- *No sweat is visible. (0 points)
- *Oriented. (0 points)
- *Mild itching, pins and needles, burning, or numbness. (2 points)
- *No auditory disturbances. (0 points)
- *Visual disturbances are denied. (0 points)
- *Severe headache. (5 points)

Total Score: 15+ (Scores of above 15 indicate severe withdrawal.) **Actual score is 17.**

Social/Developmental History:

Dimension 4: TREATMENT ACCEPTANCE RISK RATING: 3, as evidenced by:

Client displays inconsistent compliance, minimal awareness of either the client's addiction or mental disorder, and is minimally cooperative.

Defense Mechanisms: Ms. Jones minimizes the impact or severity of her illness.

Motivation for Change: Ms. Jones appears poorly motivated for change.

Addictive Behaviors: Ms. Jones describes drug problems, as are elsewhere described. Ms. Jones describes alcohol problems, as are elsewhere described. Ms. Jones describes a history of an eating disorder.

Self Help Groups Attended: None

Elopement Risk: Ms. Jones's Elopement Risk is considered to be low.

Dimension 5: RELAPSE POTENTIAL RISK RATING: 4, as evidenced by:

No awareness of the negative impact of mental health problems or substance abuse. No coping skills to arrest mental health or addiction illnesses, or prevent relapse.

Relapse History: Ms. Jones reports that this admission is relapse related.

Relapse Triggers: Ms. Jones reports that current relapse began with her exposure to a small amount of alcohol.

Relapse Frequency: She describes multiple previous relapses.

Ms. Jones reports that her longest period of sobriety is about six months.

Dimension 6: RECOVERY ENVIRONMENT RISK RATING: 2, as evidenced by:

Client has minimal recognition and understanding of relapse and recidivism issues and displays moderate vulnerability for further substance use or mental health problems.

Health and Behavior:

Ms. Jones describes the following health and behavior practices:

Tobacco:

- *Counseled regarding tobacco cessation
- *Counseling included consideration and discussion of nicotine replacement therapy
- *Given advice about how to stop tobacco use

Legal History:

Ms. Jones's legal history is as follows:

Arrests: for DUI.

Relationships/Marriage:

Ms. Jones's relationship and/or marriage history is as follows:

Times Married, Partnered:

*Married once

The current relationship has lasted:

*More than ten years

The current relationship is described as:

*Good, with a supportive partner

Support System:

Ms. Jones has the social support of the following:

Spouse:

*Highly supportive

A Friend or a Group of Friends:

*Highly supportive

Family History:

Father thought to have alcoholism.

Uncle treated as outpatient for alcoholism. This family member is paternally related.

Cousin carries diagnosis of alcoholism. This family member is paternally related.

Ms. Jones's 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:

Dimension 1: INTOXICATION / WITHDRAWAL RISK RATING: 3, as evidenced by:

Client tolerates and copes with withdrawal discomfort poorly. Client has severe intoxication, such that the client endangers self or others, or intoxication has not abated with less intensive levels of services. Client displays severe signs and symptoms; or risk of severe, but manageable withdrawal; or withdrawal worsening despite detox at less intensive level.

Dimension 2: BIOMEDICAL CONDITION/COMPLICATION RISK RATING: 2, as evidenced by:

Client has some difficulty tolerating and coping with physical problems. Problems may interfere with recovery and mental health treatment. This patient may neglect care of serious problems.

Psychotropic Med History:

Buspar: This medication was previously taken but is not currently taken. It was stopped because of its cost.

Currently Prescribed Non Psychotropic Medications:

Dilantin (compliant)

Medical Screen:

Potential Medical Emergency:

- *Active withdrawal symptoms

Infection or Disease:

- *Has had skin test for T.B. Details are as follows:
- *Tested positive for T.B.
- *Chest X-ray completed annually.
- *Treatment for T.B. Completed: INH for six months.

Mental Status Exam: Ms. Jones presents as guarded, irritable, casually groomed, and tense. 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. 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 are described but 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. Clinically, IQ appears to be in the above average range. Insight into problems appears to be poor. Judgment appears to be poor. There are signs of anxiety.

Anxiety is present as evidenced by the following:

- *Restlessness
- *Trembling
- *Fidgety
- *Startle Response
- *Sweating

Ms. Jones is easily distracted. She is fidgety. Ms. Jones was sensitive to noise during the examination. Ms. Jones exhibits signs of withdrawal from a chemical. Signs of anxiety which appear to be secondary to withdrawal are present. She has been diuresing. She is tremulous.

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

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

Inventory:

The Beck Anxiety Inventory: (A multiple choice self report monitoring test that measures the severity of anxiety in adolescents and adults.)

Ms. Jones scored between 30-63, indicating severe anxiety. **Her exact score on the BAI is 50.**

Client Safety Plan:

Ms. Jones has identified the following aspects of her behavior and staff support as significant in regard to her safety:

Triggers That May Lead to Acting Out:

*Urges to Become Intoxicated (Use Substances):

Warning Signs:

*Physical Restlessness

*Resistance to Rules

Ways of Acting Out:

*Non Compliance with Rules

Coping Skills:

*Talking to Others

*Activities for Distraction

Helpful Staff Interventions:

*Listening and Talking to Ms. Jones.

Emotional Regulation Group is recommended for Ms. Jones.

Relapse Prevention Group is recommended for Ms. Jones.

Women's Intimacy Group is recommended for Ms. Jones.

Ms. Jones describes the following 3 goals:

1. Stay calm
2. Meet new people
3. Find a Sponsor

Ms. Jones describes the following motivation for treatment: "I need to really be present as a parent for my kids." This is considered an internal motivation.

NOTES AND RISK FACTORS

History of Subst. Abuse

Ken Thompson, LCSW

Electronically Signed

By: Ken Thompson, LCSW

On: 9/2/2015 9:11:26 AM

Holly Hill Residential Facility

Date of Exam: 9/3/2015

Time of Exam: 9:35:55 AM

Patient Name: Jones, Sheila

Patient Number: 1000010660967

COMPLETE EVALUATION: PSYCHIATRIST

History: Ms. Jones is a 37 year old woman. Her chief complaint is, "My husband has told me I have to stop drinking or he will take our children away."

Information Re Substance Abuse Received From:

Ms. Jones

Ms. Jones's Family

Ms. Jones reports that her current relapse is, in part, due to stress. Details are as follows:

Drug Used:

Ms. Jones uses the following substance: **Alcohol**

The following pattern of use is described:

- *Alcohol is often taken in larger amounts or over a longer period than was intended.
- *There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
- *Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
- *Important social, occupational, or recreational activities are given up or reduced because of alcohol use.

Tolerance:

- *A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.

Withdrawal Symptoms, as manifested by the following:

- *Alcohol is taken to relieve or avoid withdrawal symptoms.

Impression:

Ms. Jones has 6 or more symptoms/behaviors, therefore she is considered to have a Severe Alcohol Use Disorder.

Ms. Jones reports that she uses until she is completely intoxicated.

Pattern of Use:

Ms. Jones's substance use is continuous. She uses daily.

Ms. Jones has been using this substance for years.

Ms. Jones reports having used this substance last night.

Anxiety Symptoms:

Ms. Jones exhibits symptoms of anxiety. Her anxiety symptoms have been present for years.

Ms. Jones describes the following anxiety symptoms:

- *Apprehensiveness
- *Avoidance
- *Difficulty concentrating
- *Sleep disturbance, she has early morning awakening
- *Trembling or shaking

Ms. Jones's symptoms are occurring daily. She reports previous episodes of anxiety symptoms. Ms. Jones's first episode of anxiety occurred at age 16. Ms. Jones has never been treated for anxiety symptoms.

Severity is estimated to be high based on Ms. Jones's risk of morbidity without treatment and her description of interference with functioning.

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.

Test Results: List of Test Results received today:

Test(s) Performed on 9/3/2015:

(1) Blood Alcohol Level: >.50 % by Volume (1798-8)

(2) Pregnancy Test: Negative (N/A)

Past Psychiatric History:

Withdrawal History:

Ms. Jones's most recent episode of withdrawal occurred in the past year.

Symptoms Included:

*Agitation

*Confused Speech

*Diarrhea

*Nausea/Vomiting

*Unable to Sleep

Psychiatric Hospitalization:

Ms. Jones has never been psychiatrically hospitalized.

Outpatient Treatment:

Has never received outpatient mental health treatment.

Suicidal/Self Injurious:

Ms. Jones describes having had self injurious thoughts.

Medication Compliance:

There is no history of medication noncompliance.

Psychotropic Medication History:

*Buspar: This medication is currently prescribed and has been taken for some weeks.

Current dose is 5 mg. This medication is considered partially effective.

Social/Developmental History:

Health and Behavior:

Ms. Jones describes the following health and behavior practices:

Tobacco:

- *Counseled regarding tobacco cessation
- *Counseling included consideration and discussion of nicotine replacement therapy
- *Given advice about how to stop tobacco use

Legal History:

Ms. Jones's legal history is as follows:

Arrests: for DUI.

Relationships/Marriage:

Ms. Jones's relationship and/or marriage history is as follows:

Times Married, Partnered:

- *Married once

The current relationship has lasted:

- *More than ten years

The current relationship is described as:

- *Good, with a supportive partner

Support System:

Ms. Jones has the social support of the following:

Spouse:

- *Highly supportive

A Friend or a Group of Friends:

- *Highly supportive

Family History:

Father thought to have alcoholism.

Uncle treated as outpatient for alcoholism. This family member is paternally related.

Cousin carries diagnosis of alcoholism. This family member is paternally related.

Ms. Jones's 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:

Medical Screen:

Potential Medical Emergency:

- *Active withdrawal symptoms

Infection or Disease:

- *Has had skin test for T.B. Details are as follows:

- *Tested positive for T.B.

- *Chest X-ray completed annually

- *Treatment for T.B. Completed: INH for six months

Adverse Drug Reactions:

There is no known history of adverse drug reactions.

Allergies:

There are no known allergies.

Current Medical Diagnoses:

Cardiovascular:

*Hypertension

Current Medications:

*Lasix and KCL supplement.

Cardiac Disclaimer:

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

Mental Status Exam: Ms. Jones presents as calm, distracted, casually groomed, but appears anxious. 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. 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. 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. Clinically, IQ appears to be in the above average range. Insight into problems appears to be poor. Judgment appears to be poor.

There are signs of anxiety:

*Restlessness

*Irritability

*Fidgety

*Startle Response

Ms. Jones is fidgety. She is easily distracted. Ms. Jones is restless. She made poor eye contact during the examination. Ms. Jones exhibits signs of withdrawal from a chemical. Agitation, seemingly secondary to withdrawal, is present. She is diaphoretic. She is tremulous.

Vital Signs

Sitting blood pressure is 152 / 67. Sitting pulse rate is 72. Pulse is regular. Respiratory rate is 21 per minute. Temperature is 98.4 degrees F. 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.

Alcohol Withdrawal, with perceptual disturbances, 291.81 (F10.232) (Active)

Opioid Use Disorder, severe, 304.00 (F11.20) (Active)

Generalized Anxiety Disorder, 300.02 (F41.1) (Active)

Migraine Specified, 346.90 (Active)

Clinical Summary:**RISK ASSESSMENT: SUICIDE/VIOLENCE****History of Risk Factors:**

Ms. Jones has a history of alcohol or substance abuse.

Ms. Jones has a history of Severe Anxiety or Panic Attacks.

Current Risk Factors:

Ms. Jones is experiencing severe anxiety or panic.
There is impaired impulse control.

Protective Factors:

Religious beliefs
Good family support
Feeling of responsibility to children, family or other loved entities.

Suicide Risk:

Based on the above risk factors, Ms. Jones's 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, Ms. Jones's 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 high residential program is recommended, as patient is not in need of intensive 24 hour monitoring but needs 24 hour supervision.

Encourage all activities
Unit Meetings
Ward Activities
Psychopharmacology

Antabuse Teaching:

The effective use of Antabuse as a deterrent to impulsive drinking was explained in detail today. Patient is told this agent is safe to use with after-shaves, lotions, soaps and mouthwash (unless ingested). It is reinforced that Antabuse is an excellent deterrent against impulsive intake of alcohol. It is also explained that Antabuse can be especially effective if the patient has a history of using ETOH as a "portal of entry" for other substances but would not otherwise abuse other substances if not primed with alcohol

Start Antabuse 500 mg. PO QAM (ETOH Deterrent)

Increase Buspar 10 mg PO BID (Anxiety)

Start Ambien CR 6.25 mg PO QHS PRN (Insomnia)

Start Klonopin 2 mg PO BID x2 days (Withdrawal)

Then Klonopin 1 mg PO QAM x2 days (Withdrawal)

Then Klonopin 0.25 mg PO QAM x1 day (Withdrawal)

Then Stop Klonopin 0.25 mg PO QAM (Withdrawal)

Notes and Risk Factors

History of Subst. Abuse
No known history of adverse drug reactions

99223AI Initial Hosp. / In Pt Care

Tom Jones, MD
Electronically Signed
By: Tom Jones, MD
On: 9/3/2015 9:47:55 AM

Holly Hill Residential Facility

Date of Exam: 9/4/2015

Time of Exam: 11:35:55 AM

Patient Name: Jones, Sheila

Patient Number: 1000010660967

CHEMICAL DEPENDENCY INITIAL NURSING EVALUATION

History: Ms. Jones is a 37 year old woman. Her chief complaint is, "I cannot seem to stop drinking."

Information Re Substance Abuse Received From:

Ms. Jones: Ms. Jones reports that her current relapse began with exposure to a small amount of the substance. Ms. Jones reports that her current relapse is, in part, due to stress. Details are as follows:

Drug Used:

Ms. Jones uses the following substance: **Alcohol**

The following pattern of use is described:

- *Alcohol is often taken in larger amounts or over a longer period than was intended.
- *There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
- *A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
- *Craving, or strong desire or urge to use alcohol.
- *Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by effects of alcohol.
- *A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.

Withdrawal Symptoms, as manifested by the following:

- *The characteristic withdrawal syndrome for alcohol.

Impression:

Ms. Jones has 6 or more symptoms/behaviors, therefore she is considered to have a Severe Alcohol Use Disorder.

When Ms. Jones uses substance the quantity used is two bottles of wine per evening.

Pattern of Use:

Ms. Jones's substance use is continuous. She uses daily.

Ms. Jones has been using this substance intermittently for years.

Ms. Jones reports having used this substance last, hours ago.

Past Psychiatric History:

Withdrawal History:

Ms. Jones's most recent episode of withdrawal occurred in the past year.

Symptoms Included:

- *Agitation
- *Confused Speech
- *Diarrhea
- *Nausea/Vomiting
- *Unable to Sleep

Psychiatric Hospitalization:

Ms. Jones has never been psychiatrically hospitalized.

Outpatient Treatment:

Has never received outpatient mental health treatment.

Suicidal/Self Injurious:

Ms. Jones describes having had self injurious thoughts.

Medication Compliance:

There is no history of medication noncompliance.

Psychotropic Medication History:

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- Current dose is 5 mg. This medication is considered partially effective.

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Health and Behavior:

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Tobacco:

- *Counseled regarding tobacco cessation
- *Counseling included consideration and discussion of nicotine replacement therapy.
- *Given advice about how to stop tobacco use

Legal History:

Ms. Jones's legal history is as follows:

Arrests: for DUI.

Relationships/Marriage:

Ms. Jones's relationship and/or marriage history is as follows:

Times Married, Partnered:

- *Married once

The current relationship has lasted:

- *More than ten years

The current relationship is described as:

- *Good, with a supportive partner

Support System:

Ms. Jones has the social support of the following:

Spouse:

- *Highly supportive

A Friend or a Group of Friends:

- *Highly supportive

Female Issues:

Women of Child Bearing Age Risk Assessment:

Ms. Jones reports that she is not pregnant.

Birth Control is used, as follows: She uses birth control pills.

Last Menstrual Period was about one month ago.

Medical History:**Current Medical Diagnoses:**

Hypertension

Surgical History: Ms. Jones reports having undergone the following surgical procedures:

Appendectomy 2009

Adverse Drug Reactions:

There is no known history of adverse drug reactions.

Current Non Psychotropic Medications:

Lasix with KCL supplement.

Allergies:

There are no known allergies.

Mental Status Exam: Ms. Jones appears calm, inattentive, casually groomed, but appears anxious. 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. Her affect is appropriate to verbal content. 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. 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. Judgment appears to be poor. There are signs of anxiety.

*Irritability

*Trembling

*Fidgety

*Startle Response

She is easily distracted. Ms. Jones is restless. She is easily distracted. Ms. Jones is fidgety. Ms. Jones made poor eye contact during the examination. Ms. Jones exhibits signs of withdrawal from a chemical. Signs of anxiety which appear to be secondary to withdrawal are present.

She is diaphoretic.

She is tremulous.

Vital Signs:

Vital Signs taken earlier today: Sitting blood pressure is 152 / 67. Sitting pulse rate is 72. Pulse is regular. Respiratory rate is 21 per minute. Temperature is 98.4 degrees F.

Discharge Planning:

Barriers to Medical Care, according to Ms. Jones include the following: There are no barriers to Ms. Jones receiving post discharge medical care.

Medical Funding Source: Ms. Jones has private medical insurance.

Continuing Medical Care: After discharge Ms. Jones will receive medical care from the following: Dr. Susan Smith.

Discharge Plan Check List to be implemented just prior to day of discharge.

9/13/2015 Started Antabuse 500 mg. PO QAM (ETOH Deterrent)

9/13/2015 Increased Buspar 10 mg PO BID (Anxiety)

9/13/2015 Started Ambien CR 6.25 mg PO QHS PRN (Insomnia)

9/13/2015 Started Klonopin 2 mg PO BID x2 days (Withdrawal)
9/13/2015 Then Klonopin 1 mg PO QAM x2 days (Withdrawal)
9/13/2015 Then Klonopin 0.25 mg PO QAM x1 day (Withdrawal)
9/13/2015 Then Stopped Klonopin 0.25 mg PO QAM (Withdrawal)

NOTES AND RISK FACTORS

History of Subst. Abuse

No known history of adverse drug reactions

Liz Lobao, RN

Electronically Signed

By: Liz Lobao, RN

On: 9/4/2015 1:15:55 AM

Holly Hill Residential Facility

Date of Exam: 9/4/2015

Time of Exam: 11:35:55 AM

Patient Name: Jones, Sheila

Patient Number: 1000010660967

INITIAL TREATMENT PLAN

A Treatment Plan was created or reviewed today, 9/13/2015, for Sheila Jones.

Participants developing the Plan were:

Betty Morgenstern, MD (Psychiatrist)

Janina Russian, LCSW (Counselor)

Liz Lobao, RN (Nurse)

Diagnosis:

Alcohol Withdrawal, with perceptual disturbances, 291.81 (F10.232) (Active)

Opioid Use Disorder, severe, 304.00 (F11.20) (Active)

Generalized Anxiety Disorder, 300.02 (F41.1) (Active)

Migraine Specified, 346.90 (Active)

Current Medications:

Antabuse 500 mg. PO QAM

Buspar 10 mg PO BID

Ambien CR 6.25 mg PO QHS PRN

Klonopin 2 mg PO BID (x2 days)

Klonopin 1 mg PO QAM (x2 days)

Klonopin 0.25 mg PO QAM (x1 day)

Problems:

Problem #1: Withdrawal

Problem #2: Anxiety

Problem: Withdrawal

Ms. Jones's withdrawal has been identified as an active problem in need of treatment.

It is primarily manifested by:

ANS Instability - with swings in blood pressure.

ANS Instability - with swings in heart rate.

ANS Instability - with fluctuations in body temperature.

Long Term Goal:

- Will experience complete alleviation of withdrawal symptoms.

Target Date: 9/20/2015

Short Term Goals:

Will monitor VS q 30 minutes during acute phase of withdrawal.

Target Date: 9/13/2015

Will be alert for symptoms of DTs.

Target Date: 9/13/2015

Provide quiet environment to reduce level of anxiety.

Target Date: 9/13/2015

Intervention(s):

Prescriber/Psychiatrist to evaluate for presence of withdrawal symptoms and obtain medical consult as appropriate. This will occur once per day and will last 20 minutes.

Clinician's Initials: BM

Nurse will monitor for signs of impending DTs. This will occur once per hour and will last 5 minutes.

Clinician's Initials: LL

Therapist/Counselor/Counselor to meet with family to update on the status of Ms. Jones. This will occur 1-3 times per week and will last ten minutes.

Clinician's Initials: JM

Problem: Anxiety

Ms. Jones's anxiety has been identified as an active problem in need of treatment.

It is primarily manifested by:

Generalized Anxiety Disorder - with impairment in functioning.

Long Term Goal(s):

- Will speak in an optimistic way about ability to cope with problems.

Target Date: 9/27/2015

Short Term Goal(s):

Ms. Jones will not suffer restrictions in activities because of anxiety for at least 24 hours.

Target Date: 9/17/2015

Intervention(s):

Therapist/Counselor will train patient in anxiety control techniques. This will occur 1-4 times per week and will last 20 minutes.

Clinician's Initials: JM

Nurses to perform medication and illness education regarding anxiety. This will occur 1-4 times per week and will last ten minutes.

Clinician's Initials: LL

Prescriber will examine patient, assess condition and order lab and appropriate consultations to determine if there is imminent DANGER to self or others. This will occur once per day and will last 15 minutes.

Clinician's Initials: BM

Status:

The undersigned clinicians met with the patient on the date above in a face to face meeting to work with him/her in developing this Treatment Plan.

TRANSITION PLAN

The expected length of stay for this patient is Approx. 1 month.

The projected discharge date for this patient is 10/13/2015.

Refer to Therapist or Facility: Janina Russian.

Refer to Psychiatrist/Prescriber: Betty Morgenstern.

Anticipated Post Discharge Services include: To Be Arranged

Plan for transition/discharge: To Be Arranged

Comprehensive Treatment Plan Barriers

Motivational issues interfere with treatment.

- Therapy will focus on motivational problems first.

Emotional problems interfere with treatment.

- Emotional problems will be dealt with via group therapy.

Comprehensive Treatment Plan Strengths

Ms. Jones's strengths include:

Family

- Patient is able to use strong family ties
- Patient has ability to use family support
- Patient has established good relationship with family

Electronically Signed

By: Liz Lobao, RN

On: 9/13/2015 10:41:55 AM

Electronically Signed

By: Betty Morgenstern, MD

On: 9/13/2015 10:43:23 PM

Electronically Signed

By: Janina Russian, LCSW

On: 9/13/2015 10:43:27 PM

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 NURSING NOTE

Ms. Jones describes an unimproved appetite. Anxiety, which she associates with withdrawal, is described as lessened. She reports continued drug cravings. She reports worsening nightmares. "I am having using dreams."

Ms. Jones's anxiety symptoms continue. Ms. Jones reports that anxiety attacks occur many times a day. Feelings of depersonalization are occurring. When anxious, Ms. Jones has fears of losing control. Irritability is present. Patient is experiencing increased startle response episodes.

Behavior:

Good medication compliance is noted. She needs cues or other assistance to perform ADLs. PRN's are rarely if ever needed. Impulsive behaviors are occurring, but less frequently

Somatic Symptoms: She describes no somatic symptoms and none are in evidence.

Hygiene:

Ms. Jones needs assistance with the following:

- *Hair Care: Supervision Required
- *Laundry: Supervision Required
- *Toileting: Assistance Required

The Clinical Institute Withdrawal Assessment of Alcohol, Revised:

CIWA-AR is a tool for monitoring alcohol withdrawal. The following subscale and total scores were today achieved by Ms. Jones:

Systolic Blood Pressure: 140

Diastolic Blood Pressure: 80

Pulse Rate: 80 / min

O2 Saturation: 97

Respiration Rate: 17 / minute

Nausea: Mild (1 pt)

Tremors: Moderate with arms extended. (4 points)

Anxiety Level: Moderate (4 points)

Agitation: Somewhat Normal Activity (1 point)

Paroxysmal Sweats: Barely Perceptible (1 point)

Orientation: Oriented (0 points)

Tactile Disturbances: Not Present (0 points)

Auditory Disturbances: Not Present (0 points)

Visual Disturbances: Not Present (0 points) Very Mild Sensitivity (1 point)

Total Score: Ms. Jones's total score is 10. Scores 8-15 indicate mild to moderate withdrawal. Medication may be indicated.

Mental Status Exam

Ms. Jones presents as listless, distracted, casually groomed, and appears anxious. Her affect is appropriate to verbal content. 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. The patient convincingly denies suicidal ideas or intentions. Judgment appears fair. She is easily distracted. Ms. Jones made poor eye contact during the examination. Ms. Jones exhibits signs of withdrawal from a chemical. Signs of anxiety which appear to be secondary to withdrawal are present:

She is diaphoretic.

She is tremulous.

Instructions / Recommendations / Plan:

LEVEL OF CARE JUSTIFICATION: Ms. Jones needs continued inpatient treatment. Ms. Jones has a high relapse potential due to inability to control substance abuse, even with active participation in a less restrictive care setting.

LINK TO TREATMENT PLAN:

Link to Treatment Plan Problem: Withdrawal

Short Term Goals:

Will monitor VS q 30 minutes during acute phase of withdrawal.

Target Date: 9/13/2015

Will be alert for symptoms of DTs.

Target Date: 9/13/2015

Provide quiet environment to reduce level of anxiety.

Target Date: 9/13/2015

Intervention(s):

Prescriber/Psychiatrist to evaluate for presence of withdrawal symptoms and obtain medical consult as appropriate. This will occur once per day and will last 20 minutes.

Clinician's Initials: BM

Nurse will monitor for signs of impending DTs. This will occur once per hour and will last 5 minutes.

Clinician's Initials: LL

Therapist/Counselor/Counselor to meet with family to update on the status of Ms. Jones. This will occur 1-3 times per week and will last ten minutes.

Clinician's Initials: JM

Some progress toward reaching these goals and resolving problems seemed evident today.

Recommend continuing the current intervention and short term goals. It is felt that more time is needed for the intervention to work.

NOTES AND RISK FACTORS

History of Subst. Abuse

No known history of adverse drug reactions

Liz Lobao, RN

Electronically Signed

By: Liz Lobao, RN

On: 9/5/2015 12:06:41 PM

Holly Hill Residential Facility

Date of Exam: 9/6/2015

Time of Exam: 2:35:55 PM

Patient Name: Jones, Sheila

Patient Number: 1000010660967

INDIVIDUAL PSYCHOTHERAPY NOTE

Dimension 3: Behavioral or Mental Health Problem:

*Last Week Rating: 3: (Can poorly tolerate and cope with behavioral or emotional problems.)

*This Week Rating: 2: (Can tolerate and cope with behavioral or emotional problems. with difficulty.)

*Comment: Progress made with feedback from peers and during individual therapy.

Continuing anxiety symptoms have been observed. They have improved in that they are less frequent or less intense. Difficulty concentrating is described. There are less frequent episodes of hypervigilance. The frequency of irritability episodes remains the same. Her startle response occurs less frequently.

Problem Pertinent ROS: She describes an improved appetite. She reports continued drug cravings. She reports improved sleep. She complains of fewer nightmares.

CONTENT OF THERAPY:

Ways of coping with impulsivity was the main issue this session. The problem of low frustration tolerance was also discussed. Substance abuse problems were also discussed by the patient. Feelings of anxiety were also expressed. Feelings of shame were also expressed.

THERAPEUTIC INTERVENTION:

The focus of today's session was on assessing the type and severity of the problem. The focus of today's session was also on helping to increase insight and understanding and education about symptoms. The main therapeutic techniques used involved the confrontation and reflection of certain irrational beliefs. Ms. Jones was counseled and educated in ways to reduce risk factors. The meaning and importance of abstinence was also explored with the patient. Therapeutic efforts also included a discussion of stress reduction techniques.

Instructions / Recommendations / Plan:

Obtain an AA sponsor prior to discharge.

Attend daily AA meetings on the unit.

90834 Psychotherapy 45 min.

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

Electronically Signed

By: Janina Russian, LCSW

On: 9/6/2015 2:25:13 PM

Holly Hill Residential Facility

Date of Exam: 9/5/2015

Time of Exam: 12:35:55 PM

Patient Name: Jones, Sheila

Patient Number: 1000010660967

GROUP THERAPY NOTE: SUBSTANCE ABUSE

Session Remarks:

Group Type: The focus of today's group was the subject of sobriety management. Group members were first encouraged to examine the ways substance abuse has adversely effected their lives. Group members were then directed to share and explore methods and strategies for remaining sober in the outpatient setting.

Present at today's session were the following:

Six members of the group were present today.

Group Leader Interventions:

Group Leader facilitated discussion about behavior management techniques.

Extrapolated to Life

Facilitated Group Process

Involved all Group

Kept Group Focused

Helped group members set limits and boundaries

Therapist provided psycho-education regarding clarifying areas of difficulty and identifying coping skills.

Made Therapeutic Interpretations

Therapist provided support and structure

Assigned worksheet/activity with topic of finding a sober peer group after discharge.

Appearance and Behavior: In today's session Ms. Jones appeared calm, friendly, communicative, and relaxed. Her participation today was normal, with responses to others and sharing of personal experiences and feelings. She was active and participated fully in discussions today. She stayed the entire session. Ms. Jones comprehended well what was happening in today's session. A normal amount of physical activity was exhibited by Ms. Jones today. Ms. Jones today spoke of issues associated with substance abuse. Ms. Jones denies experiencing dysphoric moods. An appetite change was not reported. Sleep disturbance was not reported.

Ms. Jones denies substance cravings. She denies the temptation to use.

Ms. Jones reports that she has been regularly attending AA meetings.

Ms. Jones reports that she has been regularly attending group therapy meetings.

Suicidal ideas or intentions are not in evidence and not expressed.

Homicidal ideas are convincingly denied.

Mental Status Exam:

Mood appears normal with no signs of depression or mood elevation.

Stage of Change:

Action

Instructions/Recommendations and Plans:

Ms. Jones is identified by her peers as a strong group leader.

Encouraged to continue attending at least 4 group therapy sessions per week.

NOTES AND RISK FACTORS

History of Subst. Abuse

No known history of adverse drug reactions

Time spent face to face with patient and/or family and coordination of care: 60 min

Session start: 3:00 PM

Session end: 4:00 PM

Janina Russian, LCSW

Electronically Signed

By: Janina Russian, LCSW

On: 9/5/2015 2:37:45 PM

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
-

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.

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