PSYCHIATRIC CLINIC
123 Main Street
Anywhere, US 12345
555-678-9100

Smith, Stacey

ID: 1000010651905 DOB: 9-5-1998

10/30/2013
3:34:09 PM

Nursing Note

INTERVAL HISTORY: Stacey shows slight treatment response as of today. Stacey continues to exhibit symptoms of anorexia. They are basically unchanged. Stacey has a fear of gaining weight. Denial of the seriousness of her medical condition continues unchanged. Stacey's distorted body image seems less severe, and is considered improved.

Nutrition :

Appetite/Weight: Stacey describes her appetite as "poor." She reports eating two meals per day. About 1/2 of each meals is consumed. She describes a recent weight loss. (5-10 pounds.) Weight loss is intentional and the result of dieting. This weight loss occurred over a period of a month or less.

Diet: Prior to Admission: Full Liquid.

Eating Disorder: Stacey has symptoms of an eating disorder, as follows: (3 points) Stacey refuses to maintain a normal body weight. She denies the seriousness of her medical condition. Amenorrhea has occurred. No purging, inappropriate use of laxatives, diuretics, enemas or pills are reported. Stacey carefully scrutinizes her body for signs of what she considers excess weight.
Malnutrition is present. (3 points)
A dietitian consult will be obtained.

Nutritional Risk: Nutritional risk is high. (3 or more points). (Medical and dietary consults should be obtained.)

Nursing Interventions: The following nursing interventions were performed:

Medication was administered to Stacey , compliance, symptoms, and possible side effects monitored and recorded as appropriate.

Response to medication is as follows:

Stacey's response to medication (specify) is considered fair. Details are as follows:

Stacey was engaged and encouraged to participate in activities.

Stacey was engaged and encouraged to attend meals.

Stacey was engaged and encouraged to self groom and maintain personal area.

Individual therapy was conducted with Stacey to identify and express feeling underlying

current problems.

Emotional support and encouragement was given to Stacey.

MENTAL STATUS:

Stacey appears glum, distracted, casually groomed, and slow to respond. There are signs of severe depression. She appears downcast. Slowness of physical movement helps reveal depressed mood. Her affect is blunted. The patient convincingly denies suicidal ideas or intentions. Insight into problems appears to be poor. Social judgment appears to be poor. There are signs of anxiety. She is easily distracted. Stacey made poor eye contact during the examination.

VITAL SIGNS:

Supine blood pressure is 100 / 61. Supine pulse rate is 99. Respiratory rate is 24 per minute. Temperature is 96+ degrees F. Height is 5' 5" (165 cm). Weight is 88 lbs. (39.9 Kg). BMI is 14.6. Edema: +2

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

Axis I: Anorexia Nervosa Restricting Type, 307.1 (F50.01) (Active)
Axis II: Deferred Diagnosis 799.99
Axis III: See Medical History
Axis IV: Primary Support Group
Social Environment
Axis V: 60

INSTRUCTIONS / RECOMMENDATIONS / PLAN:

LEVEL OF CARE JUSTIFICATION : Stacey needs continued Inpatient treatment. Stacey did not benefit or could not be managed in an outpatient setting which threatens to worsen co-morbid medical condition and needs careful supervision.

NOTES & RISK FACTORS:

History of cutting wrists when profoundly depressed.
High nutritional risk

Elizabeth Lobao RN

Smith, Stacey

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Nursing Note

Electronically Signed
By: Elizabeth Lobao (MD)
On: 10/30/2013 3:34:36 PM