Document Type:	History and Physical
Date of Service/Receive Date:	June 13, 2022 08:38 EDT
Document Status:	Auth (Verified)
Document Title:	CAAP Admission Note
Performed by:	Stewart, Kendyl L - MD,Res,Psychiatry on June 13, 2022 08:43 EDT
Verified by:	Parker, Jonathan Matthew - MD,Attn,Psychiatry on June 14, 2022 15:26 EDT
Encounter info:	40020751162, JBHH, Inpatient, 6/13/2022 -

* Final Report *

CAAP RESIDENT INPATIENT INTAKE NOTE

Patient seen and discussed with Dr. Parker and the treatment team.

CHIEF COMPLAINT:
Parent- "She's not doing well."
Patient- "I was feeling overwhelmed."

HISTORY OF PRESENTING PROBLEM:
Quality: depression
Duration: years
Timing: increasing
Severity: severe
Interferes with daily activities: yes
Interferes with safety of self/others
Context: recent sexual assault
Modifying factors: medication adherence, IOP
Associated signs and symptoms: as per HPI

Other Clinical information (not for billing purposes):
Patient is a 14 year old girl with history of depression, anxiety, and ADHD who presents to CAAP following suicide attempt by cutting L wrist deep enough to require staples. Patient still with SI on arrival to CAAP and placed on 1:1 sitter on admission for safety.

Per patient:
Patient relates that she has been feeling "overwhelmed" recently, which led to her suicide attempt yesterday. She has had 5 prior suicide attempts; 2 by hanging, 2 by cutting, 1 by overdose; the first in 7th grade (~2 years ago); also with history of NSSI, multiple scars and recent cuts on bilateral forearms, also relates history of cutting on legs, though no new wounds there recently per patient report. Patient Patient endorses the following symptoms of depression for the past 3 years with worsening in past 6 months: low mood, anhedonia, guilt, helplessness, hopelessness, low energy, poor concentration, low appetite, suicidal thoughts. Patient reports history of physical abuse in the past, no ongoing, by individuals who no longer have access to patient. Patient reports history of sexual assault by peer in December. Patient endorses the following trauma-related symptoms: nightmares, flashbacks, avoidance of trauma related thoughts/external reminders, overly negative thoughts about self/world, negative affect, anhedonia, guilt/blame for trauma, hypervigilance, poor sleep, poor concentration. Patient relates history of anxiety and panic attacks, exhibits/endorses the following symptoms of anxiety: excessive worry, restlessness, fatigue, muscle tension, poor concentration, poor sleep. Patient additionally endorses history of disordered eating behaviors including restricting intake and purging via vomiting and laxatives.

Per parent: BALLADARES, VALESKA 714-622-8090
Patient depressive symptoms started around time patient began puberty. Patient has been depressed and had issues with self-harm. Does not ever say that she feels well. Following the incident that led to admission, patient called 911 herself. This is patient's 4th time being admitted on psych units, all prior admissions at Niklaus Children's Hospital. Patient currently follows with outpatient and IOP there. Patient had neuropsych evaluation 3 weeks ago. Patient currently does not have definitive

diagnosis, but differential has included ADHD, psychosis, depression, borderline personality disorder, and PTSD. Patient symptoms worsened following sexual assault in December, but especially worsening in past 1 week. Patient has been home-schooled past 3 weeks due to triggering at school. Patient currently taking Risperdal 1 mg Lexapro 20 mg. Previously on Risperdal 2 mg, but with oversedation, EPS, and galactorrhea at that dose.

Spoke with patient's outpatient psychiatrist Dr. Gilbert Smith, (305)-663-8439, ext. 3412 for input regarding patient history and treatment plan. Per report, patient has history of PNES in the past, also with history of minimizing issues with medication adherence.

PSYCHIATRIC HISTORY/PSYCHOLOGICAL EVALUATION:
Inpatient treatment- x4
Outpatient treatment- IOP at Niklaus, outpatient psychiatrist is Dr. Gilbert Smith, (305)-663-8439, ext. 3412
Suicide history- x5, as per above
Prior medications- mirtazapine (overdosed on), Geodon, sertraline, quetiapine, Cogentin, Abilify, atomoxetine, Vyvanse
Current psychiatric medications- Risperdal liquid 1 mg, Lexapro 20 mg

MEDICAL HISTORY:
Past medical history- denies, ?chromosomal abnormality?
Past surgical history- denies
Seizures- mother denies; per report from outpt psychiatrist, patient with history fo PNES
Traumatic Brain Injury- denies
Current nonpsychiatric medications- none

Drug allergies-
NKDA

REVIEW OF SYSTEMS-
General: does not endorse fevers or weight change
HEENT: does not endorse sore throat or congestion
Cardiovascular: does not endorse chest pain or palpitations
Respiratory: does not endorse cough or wheezing
Gastrointestinal: does not endorse nausea, vomiting, or changes in bowel habits
Genitourinary: does not endorse dysuria or change in bladder habits
Neurological: does not endorse dizziness or numbness
MSK: does not endorse muscle or joint pain
Integumentary: does not endorse rash or itching; +lacerations, pain at wound site
Psychiatric: does not endorse mood changes or suicidal thoughts

DEVELOPMENTAL HISTORY:
Birth History- c-section due to nuchal cord, 2 weeks early, ?chromosomal abnormality
Developmental Milestones- all on time

FAMILY/MEDICAL/ PSYCHIATRIC HISTORY:
Mental illness- none
Substance abuse- none
Suicide- none
Medical- DM

DRUG, ALCOHOL, NICOTINE USE:
denies

SOCIAL HISTORY:
Born- Texas
Raised- mother and grandmother, father not present since age 3
Siblings- 1 brother
Lives with- mother, grandmother, brother, and great-aunt

EDUCATIONAL HISTORY:
Grade- 9th
School- virtual school
Grades- poor this year due to frequent hospitalizations
Suspensions- none
Bullies- yes, esp. due to father abandoning her at age 3

LEGAL HISTORY:
Legal guardian- mother
History of arrest- none

EXPOSURE TO TRAUMA:
Physical- denies
Sexual- denies
Neglect- denies

MENTAL STATUS EXAM:
Appearance/Behavior: patient seen in the milieu, calm, withdrawn, somewhat unkempt, multiple superficial linear scratches seen on bilateral forearms with large lacertion on L wrist
Eye Contact: poor
Speech: soft
Motor: restless and fidgety
Mood/Affect: "depressed"/mood-congruent, restricted
Thought Process: linear
Thought Content: symptoms as per HPI, helpless, hopeless, +Suicidal ideation
Perceptual Disturbance: does not appear to be responding to internal stimuli; endorses history of AH of sounds of animals
Orientation: grossly oriented x3
Attention/Concentration: fair/fair, attentive to interview
Insight/Judgement: fair/limited
Memory: grossly intact

Last Month

Lipid Profile:	**Basic Metabolic Panel:**	**Hematology:**
Triglyceride: 69 mg/dL (06/13/22)	Sodium: 138 mmol/L (06/12/22)	Hemoglobin: 12.3 g/dL (06/12/22)
Cholesterol, Total: ------	Potassium: 4.2 mmol/L (06/12/22)	: ()
HDL POC: ------	: ()	WBC Count: 9.6 x10(3)/mcL (06/12/22)
LDL POC: ------	Magnesium Level: ------	Platelet Count: 242 x10(3)/mcL (06/12/22)
	Blood Urea Nitrogen: 11 mg/dL (06/12/22)	INR POC: ------
	Creatinine POC: 0.50 mg/dL (06/12/22)	
	: ()	

Additional - Last Month

Absolute Basophil: 0.04 x10(3)/mcL (06/12/22)	Absolute Eosinophil: 0.08 x10(3)/mcL (06/12/22)	Absolute Immature Granulocyte: 0.04 x10(3)/mcL (06/12/22)
Absolute Lymphocyte: 2.0 x10(3)/mcL (06/12/22)	Absolute Monocyte: 0.6 x10(3)/mcL (06/12/22)	Absolute Neutrophil: 6.9 x10(3)/mcL (06/12/22)
Acetaminophen Level: <10.0 mg/L (06/12/22)	Amphetamine Class: Negative (06/12/22)	Anion Gap: 10 (06/12/22)
Basophil (%): 0.4 % (06/12/22)	Benzodiazepine Class: Negative (06/12/22)	Calcium Level: 8.7 mg/dL (06/12/22)
Calculated LDL: 107 mg/dL (06/13/22)	Cannabinoid: Negative (06/12/22)	Chloride: 105 mmol/L (06/12/22)
Cholesterol: 168 mg/dL (06/13/22)	Cocaine & Metabolites: Negative (06/12/22)	CPK: 63 unit/L (06/12/22)
eGFR (African-American): 168 (06/12/22)		Eosinophil (%): 0.8 % (06/12/22)

	eGFR (Non African-American): 145 (06/12/22)	
Ethanol Level: <10 mg/dL (06/12/22)	Flu A: Not Detected (06/12/22)	Flu B: Not Detected (06/12/22)
Free T4: 1.25 ng/dL (06/13/22)	Glucose: 98 mg/dL (06/12/22)	HDL: 47 mg/dL (06/13/22)
Hematocrit: 37.8 % (06/12/22)	Immature Granulocyte (%): 0.4 % (06/12/22)	Lymphocyte (%): 20.4 % (06/12/22)
MCH: 30.6 pg (06/12/22)	MCHC: 32.5 g/dL (06/12/22)	MCV: 94.0 fL (06/12/22)
Monocyte (%): 6.5 % (06/12/22)	MPV: 10.1 fL (06/12/22)	Neutrophil (%): 71.5 % (06/12/22)
NRBC%: 0.0 /100WBC (06/12/22)	NRBC(Abs): 0.00 x10(3)/mcL (06/12/22)	Opiate Class: Negative (06/12/22)
Osmolality Calculated: 275 mOsm/kg (06/12/22)	RBC Count: 4.02 x10(6)/mcL (06/12/22)	RDW-CV: 12.7 % (06/12/22)
RSV: Not Detected (06/12/22)	Salicylate Level: <1.0 mg/dL (06/12/22)	SARS CoV 2 RNA, RT PCR: Negative (06/12/22)
Serum Pregnancy (QUALITATIVE): Negative (06/12/22)	Slide Review: Not Indicated (06/12/22)	Total CO2 Content: 23 mmol/L (06/12/22)
TSH: 3.750 mcIU/mL (06/13/22)	U Barbiturate Class: Not Performed (06/12/22)	U Methadone: Not Performed (06/12/22)
U Phencyclidine: Not Performed (06/12/22)		

MEDICAL DECISION MAKING:
Diagnoses

1.Unspecified mood [affective] disorder (F39)

2.Post-traumatic stress disorder, unspecified (F43.10)

3.Other specific personality disorders (F60.89)

4.Suicide attempt, initial encounter (T14.91XA)

End of Diagnoses List
TARGET SYMPTOMS:
1) suicidal behavior/ideation
2) self-injurious behavior
3) depression
4) anxiety

TREATMENT RECOMMENDATIONS/PLAN:
1) Occupational/Recreational/Activity Therapy: will participate
2) School: will attend
3) Scales: CDI, SCARED
4) Information: previous records, school information
5) Studies to be ordered: routine labs ordered
6) Precautions: level 1
7) Individual sessions: psychoeducation, safety, coping skills
8) Family sessions: psychoeducation, safety, length of stay
9) Medications:
    acetaminophen: 325 mg, 1 tab, ORAL, Q6H, PRN: Pain - Mild.
    bacitracin/neomycin/polymyxin B topical: 1 app, TOPICAL, BID.
    escitalopram: 20 mg, 1 tab, ORAL, DAILY.
    lurasidone: 20 mg, 1 tab, ORAL, DINNER.
    multivitamin: 1 tab, ORAL, DAILY.
    risperiDONE: 0.5 mg, 1 tab, ORAL, BEDTIME. Plan to discontinue tomorrow.
    TrazODONE: 25 mg, 0.5 tab, ORAL, BEDTIME, PRN: Insomnia.
10) Aftercare planning: medication management, individual therapy, family therapy, DBT referral
11) Estimated length of stay: guarded

Psychiatry Attending Attestation for Admission Notes
I performed a history and physical examination of the patient and discussed the management plan with the resident Dr. Stewart I reviewed the resident's note and agree with the documented findings and plan of care for the diagnosis of Mood disorder, possible PTSD, possible Cluster B personality disorder, Suicide attempt

Visitor restrictions due to Covid-19 are in place.
Patient with no notable/reported exposures, no known sick contacts, no reported recent travel and is not stated to be an at-risk population. Patient has not displayed any symptoms of cough, GI distress, Rhinorrhea, Anosmia, or fever while on the unit. COVID testing was negative.

The patient was assessed and was determined to be high suicide risk. The patient does require 1-1 observation and suicide precautions are appropriate at this time.

Signature Line
Author: Stewart, Kendyl L - MD,Res,Psychiatry On: 06/13/2022 16:51 EDT
Co-Signed By: Parker, Jonathan Matthew - MD,Attn,PsychiatryOn: 06/14/2022 15:26 EDT

Completed Action List:
* Perform by Stewart, Kendyl L - MD,Res,Psychiatry on June 13, 2022 08:43 EDT
* Modify by Stewart, Kendyl L - MD,Res,Psychiatry on June 13, 2022 14:38 EDT
* Modify by Stewart, Kendyl L - MD,Res,Psychiatry on June 13, 2022 14:39 EDT
* Modify by Stewart, Kendyl L - MD,Res,Psychiatry on June 13, 2022 16:51 EDT
* Sign by Stewart, Kendyl L - MD,Res,Psychiatry on June 13, 2022 16:51 EDT Requested by Stewart, Kendyl L - MD,Res,Psychiatry on June 13, 2022 08:43 EDT
* Modify by Parker, Jonathan Matthew - MD,Attn,Psychiatry on June 14, 2022 15:26 EDT
* Sign by Parker, Jonathan Matthew - MD,Attn,Psychiatry on June 14, 2022 15:26 EDT Requested by Stewart, Kendyl L - MD,Res,Psychiatry on June 13, 2022 16:51 EDT
* VERIFY by Parker, Jonathan Matthew - MD,Attn,Psychiatry on June 14, 2022 15:26 EDT