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Document Title: Behavioral Health Admission Note
Performed by: [redacted], Advanced Practice Registered Nurse on September 20, 2021 13:44 EDT
Verified by: [redacted] - APRN,AHP,HP, Advanced Practice Registered Nurse on September 20, 2021 13:44 EDT
Encounter info: 40019773180, JBHH, Inpatient, 9/19/2021 -

* Final Report *

Document Contains Addenda

Duration of Session: 50 Minutes

General Information Given by: Patient

Information Given by: Patient

Legal Status: Voluntary

Chief Complaint:
" Everything is so confusing to me"

HPI:

This is a 56 year old male with prior behavioral health history of Major Depressive Dis. w/u psychosis that was brought in to the JMHBH ED by police (BA) due to bizarre type of behaviors. As per Backer Act report (Officer: Scott; badge#: 29388); " Om 9.18.2021 at approximately 2230hrs, I was dispatched to 6514 NW 13 Ave., apt.110 in reference to a crisis situation. Upon arrival, I made contact with Ms. Maricel who stated that Ms Herrera has living with her for the past two weeks. Ms Maricel further stated that Ms. Herrera has been acting abnormal, such as hearing voices, assuming that Ms Maricel will poison her, staring at the walls for hours, pacing back and forth and standing outside for hours talking to no one on the phone". Upon arrival to the crisis unit, this patient initial presentation consisted of paranoid and disorganized client that was transferred to medical ED for evaluation of AMS. While patient was at the medical ED, she attempted to elope, became aggressive requiring the administration of a ETO. The initial medical work up that included a Brain Ct scan, was negative except for a + UTI for which reason keflex 500mg PO TID was initiated and transferred back to crisis unit for further evaluation.

Patient was seen and evaluated in the room and found resting in bed in no acute distress. Patient expressed arriving from Michigan two months ago to visit friends and while staying at a friends house, she noticed like her surroundings were different, " I felt confused, I'm not sure why they called the police on me", " The last thing I remember is standing on the apt. steps with my belongings". Patient further states being previously admitted to another behavioral health hospital in Indiana due to clinical depression and prescribed antidepressants medications but not adherent after hospital discharged. She

denies using any type of drugs or alcohol and she could not explains how she tested positive for cannabis on this admission. However, she claims receiving electric cigarettes given to her by his friend with whom she was living during the past two weeks. Currently, this patient denies having auditory hallucinations, mood swings nor passive death wishes/plan/method/intent. Patient noticed guarded, suspicious with limited grooming, poor eye contact, thought blocking, anhedonia, psychomotor retardation, inappropriate guilt nearly and diminished ability to think or concentrate, or indecisiveness.
Based on current presentation and symptoms reported by patient and observed behaviors there is evidence of patient posing a danger to self or others if untreated therefore patient needs inpatient admission for behavioral observation and suicide risk assessment

There is evidence of symptoms and behavior reflecting significant risk /potential to harm self /others if not treated.

Reason for Admission: (From Crisis Unit by Carlos Dallera on 9.19.2021 at 1509)

History of Present Illness

Patient is a 56 year old female with PMHx of HTN and PPHx of Depression presenting under BA by police after the friend the patient has been staying with for the past 2 weeks contacted law enforcement due to observed bizarre behavior and acute psychosis. Patient was seen by her friend acting increasingly paranoid, bizarre, and showing signs of increased self-neglect. Patient was transferred to medical ER medical clearance due to AMS. ED workup revealed dirty UA with Leukocyte esterase, WBC and RBCs; possibly contaminated. Head CT wnl. Per BA police was contacted by patients friend Ms Maricel who has been residing with Ms Herrera for the past 2 weeks, patient was seen acting abnormal at the home, hearing voices, stating that Ms Maricel will poison her, staring at the wall for hours, pacing back and forth talking to no one on the phone for hours. On interview patient is cooperative, somnolent but arousable, AO x 3, not fully oriented to situation. Patient denies all events leading to her presentation to crisis, stating she did not act bizarrely at her friend's home. States her friend called the police "to spite her" as she refused marrying one of her friends, stating she already has a husband. Denies AVH. Endorses erotomanic delusions and paranoid delusions that her friend meant her harm by calling the police. Denies SI or HI. Denies past history of SA. Endorses using flavoured vaping pens without nicotine or marijuanna. Denies all other drug use. Of note DAU +for cannabinoids. Patient attempted to contact various friends and family members under staff supervision, but repeatedly dialed invalid numbers for friends and family (phone of her husband on contacts: 974-601-9399). Displays poor insight and judgement in the unit.

Target Symptoms:
Quality – depression, psychosis
Duration – days to weeks
Timing – increasing / acute
Severity - moderate
Context – adjustment in medications, noncompliance with medications, cannabis Use
Modifying factors:
Aggravating: medication noncompliance, cannabis use
Alleviating: hospitalization, compliance with meds, sleep

Interfering with daily functioning: Yes
Interfering with safety of self/others: Yes
Causing self-neglect: No

Associated signs and symptoms:

· Suicidal ideation – No
· Command type hallucination – No
· Delusions – No
· Depression– Yes
· Sleep disturbances – No

Past Psychiatric History:

Past inpatient hospitalizations: One previous admission in Indiana due to clinical depression last year.
Past state hospitalizations: Denied
Past outpatient: no formal f/u for past several months.
Compliance: non-compliance
ECT: No
Individual/group therapy: No
Past suicide attempts: denied
Past violence: denied

Past Substance Abuse History:

Type of Substance: UDS + cannabis

alcohol: denied
opiates: denied
cocaine: denied
cannabis: denied
benzodiazepines: denied
amphetamines: denied

Tobacco Prevention Metrics:

Have you smoked tobacco in the last 30 days:
Yes: Counseling provided during the hospital stay.

Was nicotine replacement therapy provided:
Patient received nicotine replacement therapy.

FDA smoking cessation medication: yes

Past Marchman Act: No
Past Rehabilitation Unit admissions: No
Past Detoxification Unit admissions: No
Past Outpatient Substance Use: No

AA/NA participation: No
Compliance: No

Past Medical History:

TBI / LOC / Black outs: None

Seizures: No

Allergies: NKA

Past Surgical History: None

Abuse and Neglect:

1. Trauma History: None
2. Physical Abuse: None
3. Domestic violence: None

4. Emotional Abuse: None
5. Neglectful relationship: None
6. Financially exploited: None
7. Exploitation: None

Homicide Risk assessment:

1. Thoughts of harming someone: None
2. Having you ever been so upset or angry that you thought of killing or harming someone: None
3. Have you ever tried to kill or harm anyone: None

A. Were you arrest: N/A

Nutritional Assessment:

1. Has there been a weight loss or gain of 10 pounds or more in the past three months: None
2. Changes in appetite: None
3. Dental problems in the last 3 to 6 months: None
4. Eating habits: None

Pain Assessment:

1. Pain present: No actual or suspected pain

Numeric score, if present (1-10): 0
Location if present:
Quality if present:

Family History:

Family history: negative
Mental illness: denies
Suicide attempts: denies
Substance abuse: denies
Medical problems: denies
Dementia: denies

Social/Legal History:

Legal: Denied
Employment: Unemployed
Living situation: Lives with family member
Support system: limited

REVIEW OF SYSTEM:

General: Denies Fever, chills, dizziness, weakness.
Eye: Denies redness, discharge, visual loss, blurred vision, vision change.
ENT: Denies Sore throat, Nosebleed, Rhinorrhea, Throat swelling, hearing loss.
Cardiovascular: Denies Chest Pain, Rapid heartbeat, lower extremities swelling, palpitations, orthopnea.
Respiratory: Denies SOB, productive cough, hemoptysis.
Gastrointestinal: Denies nausea, vomiting, diarrhea, constipation, bloating, melena.
Genitourinary: Denies dysuria, frequency, flank pain, hematuria.
Muscular: Denies myalgia, neck/back pain, arthralgia, redness.
Skin: Denies rash, swelling, lacerations, abrasions.
Neurologic: Denies headaches, numbness, change LOC, weakness, paresthesia, change in speech.
Hematologic: No bruising, no petechiae, no bleeding.

Mental Status Exam:

Appearance: anxious / limited or poor hygiene and groomed /
Behavior: cooperative
Alert and oriented : WNL / AAO x 3
Eye contact: intermittent
Speech: coherent, relevant, low tone and volume
Mood: dysphoric
Affect: congruent
Thought process: thought blocking
Thought content: Denied paranoia / persecutory / IOR / grandiose
Perceptual disturbances: Denied auditory hall / not RTIS
Suicidal ideation/intention/plan: no
Homicidal ideation/intention or plan: no
Insight: limited
Judgement: limited
Attention and Concentration poor

Columbia Suicide Severity Rating Scale Since Last Visit Wish to be Dead:

Since Last Visit Wish to be Dead: No
Since Last Visit Suicidal Thoughts: No
Since Last Visit Idea w-Method No Intent: No
Since Last Visit Idea w-Intent No Plan: No
Since Last Visit Suicide Intent w-Plan: No
Since Last Visit Suicide Behavior: No

Homicidal T/I/P:

Medications:

Medication List

Active Medications

Ordered

acetaminophen: 650 mg, 2 tab, ORAL, Q6H, PRN: Pain - Mild.
cephalexin: 500 mg, 1 cap, ORAL, TID.
FLUoxetine: 20 mg, 1 cap, ORAL, DAILY.
haloperidol: 5 mg, 1 tab, ORAL, Q6H, PRN: Agitation.
haloperidol: 5 mg, 1 mL, IM, Q6H, PRN: Agitation.
ibuprofen: 600 mg, 1 tab, ORAL, Q6H, PRN: Pain - Moderate.
LORazepam: 2 mg, 1 tab, ORAL, Q6H, PRN: Anxiety.
LORazepam: 2 mg, 1 mL, IM, Q6H, PRN: Anxiety.
magnesium hydroxide: 30 mL, ORAL, Q12H, PRN: Constipation.
nicotine: 2 mg, 1 lozenge, TRANSMUCOSAL, Q2H, PRN: See Comment.
OLANZapine: 10 mg, 2 mL, IM, Q6H, PRN: See MH ETO Restrain Seclusion Form.
risperiDONE: 1 mg, 1 tab, ORAL, BEDTIME.
TrazODONE: 50 mg, 1 tab, ORAL, BEDTIME, PRN: Insomnia.

Prescribed

cephalexin: 500 mg, 1 cap, ORAL, TID, for 5 day(s), 15 cap, 0 Refill(s).

Medications Inactivated in the Last 72 Hours

cephalexin: 500 mg, 1 cap, ORAL, ONCE.
cephalexin: OVERRIDE, ONCE.
cephalexin: OVERRIDE, ONCE.
LORazepam: OVERRIDE, ONCE.
LORazepam: 2 mg, IM, ONCE.
OLANZapine: OVERRIDE, ONCE.
Sterile Water: OVERRIDE, ONCE.

Immunizations:

Immunizations

No Immunizations Documented This Visit

Vital Signs/Measurements/Pain Intensity:

No qualifying data available.

Lab Results:

Last Month

Basic Metabolic Panel:	**Hematology**:
Sodium: 144 mmol/L (09/19/21)	Hemoglobin: 13.7 g/dL (09/19/21)
Potassium: 4.2 mmol/L (09/19/21)	: ()
: ()	WBC Count: 11.0 x10(3)/mcL (09/19/21)
Magnesium Level: ----	Platelet Count: 291 x10(3)/mcL (09/19/21)
Blood Urea Nitrogen: 16 mg/dL (09/19/21)	INR POC: ----
Creatinine POC: 0.70 mg/dL (09/19/21)	
: ()	

Urinalysis:	
: ()	Urine Blood: 0.1 mg/dL (09/19/21)
Nitrites: Neg (09/19/21)	Protein: 30 (09/19/21)
Ketones: 20 mg/dL (09/19/21)	Urine Color Urine Dipstick: ----
Leukocyte Esterase: 500 (09/19/21)	: ()
Bilirubin: Neg mg/dL (09/19/21)	Urine pH: 5.5 (09/19/21)
Urobilinogen: Negative mg/dL (09/19/21)	Specific Gravity: 1.023 (09/19/21)

Additional - Last Month

Absolute Basophil: 0.02 x10(3)/mcL (09/19/21)	Absolute Eosinophil: 0.04 x10(3)/mcL (09/19/21)	Absolute Immature Granulocyte: 0.03 x10(3)/mcL (09/19/21)
Absolute Lymphocyte: 2.7 x10(3)/mcL (09/19/21)	Absolute Monocyte: 0.9 x10(3)/mcL (09/19/21)	Absolute Neutrophil: 7.4 x10(3)/mcL (09/19/21)
Albumin Level: 4.4 g/dL (09/19/21)	Alkaline Phosphatase: 122 unit/L (09/19/21)	ALT (SGPT): 14 unit/L (09/19/21)
Amphetamine Class: Not Detected (09/19/21)	Anion Gap: 15 (09/19/21)	AST (SGOT): 28 unit/L (09/19/21)
Bacteria: 1+ (09/19/21)	Basophil (%): 0.2 % (09/19/21)	Benzodiazepine Class: Not Detected (09/19/21)
Calcium Level: 9.7 mg/dL (09/19/21)	Cannabinoid: Presumptive Positive (09/19/21)	Chloride: 105 mmol/L (09/19/21)
Clarity: Turbid (09/19/21)	Cocaine & Metabolites: Not Detected (09/19/21)	Color: Orange (09/19/21)

eGFR (African-American): 112 (09/19/21)	eGFR (Non African-American): 97 (09/19/21)	Eosinophil (%): 0.4 % (09/19/21)
Ethanol Level: <10 mg/dL (09/19/21)	Glucose: 97 mg/dL (09/19/21)	Glucose: Negative mg/dL (09/19/21)
Hematocrit: 43.2 % (09/19/21)	Hyaline Cast: 10-20 /LPF (09/19/21)	Immature Granulocyte (%): 0.3 % (09/19/21)
Lymphocyte (%): 24.4 % (09/19/21)	MCH: 28.6 pg (09/19/21)	MCHC: 31.7 g/dL (09/19/21)
MCV: 90.2 fL (09/19/21)	Monocyte (%): 7.8 % (09/19/21)	MPV: 9.3 fL (09/19/21)
Mucous: 1+ (09/19/21)	Neutrophil (%): 66.9 % (09/19/21)	NRBC%: 0.0 /100WBC (09/19/21)
NRBC(Abs): 0.00 x10(3)/mcL (09/19/21)	Opiate Class: Not Detected (09/19/21)	Osmolality Calculated: 287 mOsm/kg (09/19/21)
RBC Count: 4.79 x10(6)/mcL (09/19/21)	RDW-CV: 14.1 % (09/19/21)	SARS CoV 2 RNA, RT PCR: Negative (09/19/21)
Slide Review: Not Indicated (09/19/21)	Squamous Epithelial Cell: 21 (09/19/21)	Total Bilirubin: 0.6 mg/dL (09/19/21)
Total CO2 Content: 24 mmol/L (09/19/21)	Total Protein: 7.8 g/dL (09/19/21)	TSH: 1.400 mcIU/mL (09/19/21)
U Barbiturate Class: Not Detected (09/19/21)	U Methadone: Not Detected (09/19/21)	U Phencyclidine: Not Detected (09/19/21)
Urine Microscopic: Indicated (09/19/21)	Urine RBC's: 15 /HPF (09/19/21)	Urine WBC's: 79 /HPF (09/19/21)

Diagnosis:

Diagnoses

1.Major depressive disorder, single episode, severe with psychotic features (F32.3)

2.Cannabis dependence (F12.20)

End of Diagnoses List

Assessment/Plan:

Disposition: Admit to inpatient treatment

Problem #1: depression
Response to treatment: Worsening
Medications, Labs and Plan: prozac 20mg Po QD

Problem #2: psychosis
Response to treatment: Worsening
Medications, Labs and Plan: risperdal 1mg Po QHs

Therapy: Milieu / brief supportive

Consultations: n/a

Risk: High

Justification for continued inpatient stay:
Continued danger to self and/or others
Continued behavior intolerable to patient or society
High probability of danger to self or others recurring if patient were to be discharged, and imminent re-hospitalization likely

Goals of treatment while in inpatient:
Increased level of functioning
Reestablish healthy coping skills
Identify external support system
Increased self esteem
Improved mood and affect
Monitor medication compliance
Develop effective social relationships
Improve communications skills
Decreased agitation if present
Decreased delusional/paranoid thought pattern if present
Provide safety for patients
Decrease hallucinations if present
Decrease feelings of suicidality if present upon admission

COUNSELING/PSYCHOEDUCATION:
Provided with: Patient
Diagnostic results
Risk and Benefits of treatment options
Medication management including treatment options, potential benefits and side effects
Importance of compliance with chosen treatment options
Drug-drug interactions
Risk factor reduction
Prognosis

Patient Instructions:
Encouraged compliance with medications
Benefits and side effects of medications re-discussed
Encouraged reporting side effects to nursing and medical staff

Nursing Instructions: Universal

Social Work instructions: assessment for placement/aftercare

Precautions: elopement / behavioral

[redacted]

AIMS:
AIMS (Mental Health Instrument)
The patient was evaluated for symptoms of tardive dyskinesia using the AIMS.

Abnormal Involuntary Movement Scale

1) AIMS Muscles of Facial Expression : none

2) AIMS Lips and Perioral Area : none
3) AIMS Jaw Area Involuntary Movements : none

4) AIMS Tongue Involuntary Movements : none
5) AIMS Upper Arms, Wrists, Hands, Fingers : none

6) AIMS Lower Legs, Knees, Ankles, Toes : none

7) AIMS Neck, Shoulder, Hips : none

8) AIMS Overall Abnormal Movement Severity : none

Total score for items 1-7: 0

Signature Line
Author: [redacted] - APRN,AHP,HP, Advanced Practice Registered Nurse On: 09/20/2021 13:44 EDT
Co-Signed By: [redacted] - MD,Attn,PsychiatryOn: 09/20/2021 21:25 EDT

Addendum by Dreize, Richard Michael - MD,Attn,Psychiatry on September 20, 2021 21:25 EDT (Verified)
Patient seen this AM, and I was present with A. Vazquez, ARNP, for full Initial Psychiatric Evaluation. We then discussed the history, full examination, and medication plan. I agree the Assessment and Plan documented in the note.

Signature Line
Author: [redacted] - MD,Attn,Psychiatry On: 09/20/2021 21:25 EDT

Completed Action List:
* [redacted] - APRN,AHP,HP, Advanced Practice Registered

Nurse on September 20, 2021 13:44 EDT
* Sign by Vazquez Rodriguez, Andres Jesus - APRN,AHP,HP, Advanced Practice Registered Nurse on September 20, 2021 13:44 EDT
* VERIFY by Vazquez Rodriguez, Andres Jesus - APRN,AHP,HP, Advanced Practice Registered Nurse on September 20, 2021 13:44 EDT
* Sign by Dreize, Richard Michael - MD,Attn,Psychiatry on September 20, 2021 21:25 EDT Requested by Vazquez Rodriguez, Andres Jesus - APRN,AHP,HP, Advanced Practice Registered Nurse on September 20, 2021 13:45 EDT
* Modify by Dreize, Richard Michael - MD,Attn,Psychiatry on September 20, 2021 21:25 EDT
* Sign by Dreize, Richard Michael - MD,Attn,Psychiatry on September 20, 2021 21:25 EDT