Progress Report Overview

Student:	**Susan Privoznik**
Activity:	Student Portfolio
Start Time:	11/03/2021 09:16:37
End Time:	11/03/2021 10:16:40
Total Time:	00:38:04

Actions

Note at 11/03/2021 10:16:35

Student Portfolio Documentation

Student:	Susan Privoznik
Activity Start:	11/03/2021 09:16:37
Activity Completion:	11/03/2021 10:16:40
Activity Completion:	00:38:04

Patient Data

Patient: Student Portfolio
Age/Sex: 31 yo F
Location: General Hospital

DOB: 03/01/1990
MR#: MR20045
Admit Date: 11/03/2021

Notes

Note at 11/03/2021 09:16:42

Mental Health Assessment

Basic Information

Date:
11/03/2021 09:16:42

Author:
Susan Privoznik

Location:
General Hospital

Demographics

Age:
22

Gender:
Male

Ethnicity:
Caucasian

Marital status:
Single

Employment status:
Full-time

Occupation:
Student

Clinical History

Presenting chief complaint:

"I was thinking about to end my life"

History of current illness:

The patient is a 22 y.o., single, Caucasian, male with a psychiatric history of GAD and OCD transferred from home and admitted on a voluntary basis at SV Behavioral Health Adult Inpatient Unit with c/c of SI without specific plan.
The patients reports SI started yesterday morning because his ex-girlfriend had blocked him from her phone. He reports they had been broken up since July and had no contact with each other until 3 days ago. She went to see him in person and told him that she wanted to get back together. The patient could not understand why she blocked him since she was the one to reach out first.

The pt reports he and his ex went to Mexico this early spring and she was sexually assaulted (she was abducted while walking away briefly from him). The pt states that he has been blaming himself for not being able to protect her. He states having frequent nightmares and flashbacks related to the incident. He states he woke up yesterday and was feeling "shity" and wanted to end his life. He denies a plan. He denies hx of suicide attempt or SIB.

He reports that he has been feeling very depressed since July due to the break-up. He started drinking heavily in July and has been drinking 1 pint to a 1/5th Vodka along with some beer at least 5-6 times a week. Pt reports he cannot sleep without alcohol. He reports symptoms of detox such as restless sleep, tremors, heart racing, palpitations, chest tightness, visual hallucinations, and sweating. Reports anxiety with panic attacks "go through the roof" when not drinking. He denied having seizures related to detox. His last alcohol use was on 10/31 (6 beers, 1/5th vodka). Pt reports decreased appetite/energy/interesting level. He reports sleeping disturbance, inattention, irritability, isolative and withdrawal. He reports decreased in school performance since July. He reports depression as 7-10/21. He reports VH: dark spots. Denies AH/delusional thinking.

He reports long hx of OCD behavior such ruminating, doing "weird things" to relieve obsessive thinking, such as tapping, counting steps. Reports he spend more than 1 to 2 hours ruminating. He reports having excessive worrying as well. He rates anxiety as 10/10. Patient denies any symptoms of mania, psychosis, social or specific phobia. Patient denies any homicidal ideation, auditory, visual or tactile hallucinations, delusions.

Past psychiatric history:

Previous psychiatric hospitalization: no and first psychiatric hospital admission
Current outpatient psychiatric services: no
Current therapy, case management: no

History of suicidal acts and self-harm:

denies

History of violence/ Assaulting others/ Legal problems:

denies

Substance use history:

yes.
hx of using marijuana 3 years ago for a few times
currently using 1 to 1.5 pint of Vodka daily for the last four months

---

Mental illness and substance abuse in family members:

Psychiatric illness: PGF depression, anxiety, PGM has depression. Father and sister has Depression and anxiety. Mother may have OCD. Maternal uncle has unknown mental health issues.
Illicit drug or alcohol use: PGF was heavy, maternal uncle drinking and drug use, his older sister has drug use.
Suicidal attempt: no

Psychosocial History

Childhood/ Developmental history:

raised by both parents, has one sister. denies hx of abuse. denies developmental issues.

Adult relationship history:

He is single, never been married or has any children

Current significant family and/or peer group relationships:

recent break up with girlfriend of 1 year.
has friends supports and lives in a fraternity house

Financial status, housing, employment, leisure time issues:

denies

Religious/ Spiritual or cultural issues that might influence treatment:

denies

Relevant community resources accessed by patient:

He has has therapy in a few times this year. He has medical insurance under his parents

---

Medical Information

Current medical problems:

☑ None

Current significant pain problems:

None

Nutrition assessment:

No concerns

Current medications:

Zoloft 50 mg daily (same dose since 12/2020.

Current nicotine and caffeine use:

yes. chews one can of tobacco daily

Allergies and adverse drug reactions:

N/A

Review of Systems (ROS)

Constitutional:

Alert, cooperative, appears stated age. Well developed, well nourished, no acute distress.

HEENT:

Normocephalic, atraumatic. Bilateral external ears and nose appear normal. No oral exudates.

Skin:

No erythema or rash noted.

Cardiovascular:

heart racing, palpitations related to alcohol withdrawal

Respiratory:

Respirations unlabored. No respiratory distress.

Gastrointestinal:

Nausea

Genitourinary:

denies concerns

Neurological:

Ambulates well. A&O x3, no motor deficit. No ataxia.

Musculoskeletal:

no concern

Hematologic:

no concern

Lymphatics:

no concern

Psychiatric:

see HPI

Endocrinologic:

negative for heat/cold intolerance,

Mental Status Exam

Orientation and consciousness:

☑ Alert and attentive
☑ Oriented x3

Appearance and behavior:

☑ Cooperative and reasonable

Speech:

☑ Normal rate/Rhythm

Language:

☑ Intact

Mood and affect:

☑ Mood anxious
☑ Mood depressed

Perceptual disturbance (hallucinations, illusions):

☑ None

Thought process and association:

☑ Normal, coherent
☑ Obsessive

Thought content (delusions, obsessions etc.):

☑ No unusual thought content
☑ Obsessions

Suicidal or violent ideation:

☑ None/Suicidal ideation passive without plan, contracts for safety
☑ Passive

Insight:
Limited

Judgment:
Impulsive

Memory:
Intact

Fund of Knowledge:
Above average

Mini Mental State Exam

Score questions (choose a number 0-5 for each statement)

What is: year, season, date, day, month. Give 1 point for each correct answer. (5 points)
5

What is: state, county, city, hospital, floor. Give 1 point for each correct answer. (5 points)
5

Name 3 objects: 1 second to say each, then ask patient all 3 objects after you have said them. Give 1 point for each correct answer. (3 points)
3

Serial 7's (counting down from one hundred by sevens) or spell "world" backwards. Stop after 5 answers. Give 1 point for each correct answer. (5 points)
5

Ask for the 3 objects repeated in question 3. Give 1 point for each correct answer. (3 points)

3

Name a pencil and a watch. Give 1 point for each correct answer. (2 points)

2

Repeat "No ifs, ands or buts". Give 1 point for the correct answer. (1 point)

1

Follow 3 stage command: "Take this piece of paper in your right hand, fold it in half, and put it on the floor". Give 1 point for each correct step that was followed. (3 points)

3

Read and obey written command, "Close your eyes". Give 1 point for the correct answer. (1 point)

1

Write a sentence. Give 1 point for the correct answer. (1 point)

1

Copy intersecting pentagons. Give 1 point for the correct answer. (1 point)

1

Total Score (max=30):

30

Assessment of Danger to Self

☑ No significant risk

Suicide risk checklist:

☑ Suicide ideation
☑ Access to means to implement a plan
☑ Sense of hopelessness
☑ History of impulsivity
☑ History of substance abuse

Protective factors:

☑ Evidence of accessible and positively motivated social supports
☑ Future-oriented plans and commitments

Assessment of suicide risk:

moderate risk

Assessment of Danger to Others

☑ No significant risk

Assessment of homicide risk:

No significant risk

Summary of findings:

Principal Diagnosis: Major Depressive Disorder, Single Episode Severe

Secondary Diagnoses:
Generalized Anxiety Disorder
Obsessive-Compulsive Disorder
PTSD
Relationship Problems
Alcohol-Related Disorder - Alcohol use Disorder
Alcohol-Related Disorder - Alcohol Withdrawal
Nicotine use Disorder

Additional: Generally healthy

Psychiatric Review Of Systems:
Sleep disturbance: Has difficulty falling asleep, has interrupted sleep, has restless sleep and is not rested upon awakening.
Appetite changes: Poor appetite
Weight changes: weight is unchanged
Lack of Energy: yes
Changes in interest/pleasure: yes
Somatic symptoms: no
Anxiety/panic: yes, weekly, palpitation, sweating, shaking, shortness of breath. 10/10.
Guilty/hopeless: yes, 7-10/10.
Self-injurious behavior: no
History of Mania: no
History of PTSD: Nightmares flashbacks, couple of nights per week.
History of OCD: yes.
Mood irritability: yes, isolative and withdrawn
Inattention, lack of focus and concentration: yes
History of perceptual disturbance: no psychosis, however, he has seen black specks floating during alcohol withdrawal

DSM 5 Diagnosis

Diagnosis:

MDD (major depressive disorder), single episode, severe , no psychosis • Nicotine use disorder Mixed obsessional thoughts and acts • PTSD (post-traumatic stress disorder)• GAD (generalized anxiety disorder) Alcohol use disorder, moderate, dependence• Suicidal ideation •Alcohol withdrawal syndrome without complication

Diagnosis code:

MDD (major depressive disorder), single episode, severe , no psychosis (HCC) [F32.2] • Nicotine use disorder [F17.200] • Mixed obsessional thoughts and acts [F42.2] • PTSD (post-traumatic stress disorder) [F43.10] • GAD (generalized anxiety disorder) [F41.1] • Alcohol use disorder, moderate, dependence (HCC) [F10.20] • Suicidal ideation [R45.851] • Alcohol withdrawal syndrome without complication (HCC)

Categorize disorder:

- [x] Schizophrenia spectrum and other psychotic disorder
- [x] Depressive disorder
- [x] Anxiety disorder
- [x] Obsessive-compulsive and related disorder
- [x] Trauma-and stressor-related disorder
- [x] Sleep-wake disorder
- [x] Substance use and addictive disorder

Psychosocial and environmental factors:

raised in middle classes causation family, male, college student, lives in fraternity house, dating, relational problems.

Contextual factors:

family mental illness, heavy alcohol use in family. recent trauma while traveling to Mexico

Disability:

none

Conclusion

Assessment/ Summary:

current dx including : SI, MDD, GAD, OCD, PTSD, Alcohol use disorder, nicotine use disorder, decline in school performance, and relational issues.
He is calm, cooperative, complaint with treatments, willing to get treatments. The patient desires to be well.
recommend follow up with outpatient providers and start individual therapy.
He prognosis is fair

Treatment Plan:

Treatment Plan/Recommendations:
Admit for safety and crisis stabilization
Placed on SW/CO with frequent rounds
Multidisciplinary treatment planning

Bio: 1. Medication Changes (1 with w/u/2/4): Discussed with the patient in detail about the above diagnostic impression. The patient has been admitted with severe exacerbation of suicidal ideation, anxiety and depression, with suicidal ideation with not clear plan. There is a recent change of mood, safety status required an ED visit and inpatient psychiatric admission.

Discussed with the patient in detail about the options with antidepressants, SSRI's, mood stabilizers and anxiolytics . Reviewed with the patient the potential benefits and risks of dose adjustment of the medications. The patient agreed to

MDD/GAD/OCD/PTSD
==increase Zoloft to 100 mg daily
==C/w gabapentin 300 mg tid for anxiety and for alcohol withdrawal
==Recommend individual therapy as an outpatient

Alcohol Use Disorder
==CIWA protocol

Nicotine Use
==Nicotine replacement

Nausea
==Zofran 4 mg q 6 hours prn

Other prn's per unit protocol and CIWA protocol

3. Discussed with the patient risks, benefits of the medications and therapy, alternative treatment options. Discussed off label use(s) where indicated. Discussed risks of polypharmacy, non-compliance. Patient verbalized understand, agreed with the plan and consented for treatment.

4. Routine follow-up with primary care physician. Encouraged to do routine physical exercise, healthy diet.

5. Patient education provided. Treatment plan reviewed with the patient and the patient consented.

6. Reviewed safety plan and behavioral interventions.

7. Discussed ways to improve coping skills, stress management and relaxation techniques.

8. Also discussed black box warnings, substance use: risk of alcohol use, risk of street drug use, referral for alcohol/drug treatment as indicated and counseled to stop/avoid using drugs and drinking alcohol with the patient.

Psych: Supportive Milieu
Psycho-education provided. Behavioral therapy, individual, group, milieu therapies and family therapy recommended. Medication managements, safety plan development, support system identification, after care planning.
Encouraged to participate in group and unit activities. Addressed cognitive, behavioral interventions for depression, anxiety, process of building self-esteem and positive support system. We will work on the process of developing suicide safety plan.

Social: Liaison with outpatient treators

Treatment options, alternative, black box warning(s), and off label use(s) were reviewed with the patient where indicated and patient concurred with the above plan.

Estimated length of stay: 3-5 days

---

1) Assessment

a) List a minimum of eight differential diagnoses from the chief complaint.

Major Depressive Disorder

Bipolar Disorder

Generalized Anxiety Disorder

Social Anxiety Disorder

OCD

PTSD

ADHD

Schizoaffective Disorder

b) What would you have done differently to aid in diagnostics? (e.g., additional lines of inquiry, collateral information, etc.).

I agree with his diagnosis, and I couldn't think of anything to do differently.

c) Do you agree with the current diagnosis? Why or why not? Are there any additional diagnoses that should be included?

Current diagnosis

MDD (major depressive disorder), single episode, severe, no psychosis [F32.2]

Mixed obsessional thoughts and acts [F42.2]

PTSD (post-traumatic stress disorder) [F43.10]

GAD (generalized anxiety disorder) [F41.1]

Alcohol use disorder, moderate, dependence (HCC) [F10.20]

Nicotine use disorder [F17.200]

Suicidal ideation [R45.851]

Alcohol withdrawal syndrome without complication (HCC)

I agree with the current diagnosis except adding a couple of Z codes (Academic Underachievement (Z55.3) and Relational Issues (Z63.0).

2) Treatment

a) Identify 2 (at minimum) professional guidelines/practices for your patient's diagnosis.

VA/DoD Management of Major Depressive Disorder Working Group. (2016). *VA/DoD clinical practice guidelines for the management of the major depressive disorder. (Version* 3.0).

Veterans Health Administration and Department of Defense. Retrieved from https://www.healthquality.va.gov/guidelines/mh/mdd/index.asp

Winslow, B. T., Onysko, M., & Hebert, M. (2016). Medications for Alcohol Use Disorder. *American family physician*, *93*(6), 457–465.

Reddy, Y. C., Sundar, A. S., Narayanaswamy, J. C., & Math, S. B. (2017). Clinical practice guidelines for Obsessive-Compulsive Disorder. *Indian journal of psychiatry*, *59*(Suppl 1), S74–S90. https://doi.org/10.4103/0019-5545.196976

b) Identify 2 (at minimum) recent peer-reviewed articles that are relevant to this patient's care.

Charles, N. E., Strong, S. J., Burns, L. C., Bullerjahn, M. R., & Serafine, K. M. (2021). Increased mood disorder symptoms, perceived stress, and alcohol use among college students during the COVID-19 pandemic. *Psychiatry Research*, 296, 113706. https://doi.org/10.1016/j.psychres.2021.113706

Baker, T.B., Piper M.E., Smith, S.S., Bolt, D.M., Stein, J.H., Fiore, M.C. (2021). Effects of Combined Varenicline with Nicotine Patch and of extended treatment duration on smoking cessation: A randomized clinical trial. *JAMA*, *326*(15), 1485–1493. https://doi.org/10.1001/jama.2021.15333

c) How would you proceed specifically with treating this patient using these resources? In-text citations are expected.

SSRIs and CBT are considered first-line treatments for people with MDD, GAD, OCD, and PTSD (Reddy et al., 2017; VA/DoD, 2016). ==increase Zoloft to 100 mg daily

==C/w gabapentin 300 mg three times a day for anxiety and alcohol withdrawal; gabapentin may reduce alcohol ingestion (Winslow, 2016). Recommend the patient discuss with the outpatient provider about taking either acamprosate, disulfiram, or naltrexone medication to treat alcohol use disorder and psychotherapy (Winslow, 2016).

Nicotine Use Disorder: either use varenicline or nicotine patch therapy, as there is no solid evidence for combining those two (Baker et al., 2021).

References

Baker, T. B., Piper, M. E., Smith, S. S., Bolt, D. M., Stein, J. H., & Fiore, M. C. (2021). Effects of Combined Varenicline With Nicotine Patch and of Extended Treatment Duration on Smoking Cessation: A Randomized Clinical Trial. *JAMA*, *326*(15), 1485–1493. https://doi.org/10.1001/jama.2021.15333

Charles, N. E., Strong, S. J., Burns, L. C., Bullerjahn, M. R., & Serafine, K. M. (2021). Increased mood disorder symptoms, perceived stress, and alcohol use among college students during the COVID-19 pandemic. *Psychiatry research*, 296, 113706. https://doi.org/10.1016/j.psychres.2021.113706

Reddy, Y. C., Sundar, A. S., Narayanaswamy, J. C., & Math, S. B. (2017). Clinical practice guidelines for Obsessive-Compulsive Disorder. *Indian journal of psychiatry*, *59*(Suppl 1), S74–S90. https://doi.org/10.4103/0019-5545.196976

VA/DoD Management of Major Depressive Disorder Working Group. (2016). *VA/DoD clinical practice guidelines for the management of the major depressive disorder. (Version* 3.0). Veterans Health Administration and Department of Defense. Retrieved from https://www.healthquality.va.gov/guidelines/mh/mdd/index.asp

Winslow, B. T., Onysko, M., & Hebert, M. (2016). Medications for Alcohol Use Disorder. *American family physician*, *93*(6), 457–465.