DOMINION HOSPITAL
2960 Sleepy Hollow Road
Falls Church, Virginia 22044
Phone (703) 536-2000

WILLIAMS, LYNNAE D
J84090217483 ADM IN J.222-B
10/30/09 Roth.Richard L
DOB: 07/09/1976 F/33 MR# J000018122
Dominion Hospital

DISCHARGE PLAN FORM

Discharge Status
Admission Date: 10/30/09 Discharge Date: 10/31/09 Discharge To: Home c PHP or MC

FOLLOW-UP APPOINTMENTS

Name		Telephone	Appt Date	Appt Time	Date Faxed
Psychiatrist					
Fax Number	Address				
Therapist					
Fax Number	Address				
Other					

AFTERCARE PLAN

Mental Health/Social /Medical Issues
☐ Patient has been advised of the potential for Metabolic Syndrome and the need for follow up with the Psychiatrist and Primary Care Physician.

DISCHARGE DIAGNOSIS:

Axis I:	Axis III:
Axis: II	Axis IV:
	Axis: V:

Attending Physician: Dr. Roth Phone #: 703-821-2337

Physician Signature: R. Roth, M.D. Date: 10-31-09

Patient Signature: Lynnae Williams Date: 10-31-09

Patient/Guardian Signature: _____ Date: _____

Social Worker Signature: _____

MSW 10/31/09

Return Patient's
___ Medications
1 Belongings upon discharge
1 Valuables

DH-0147 (12/08) Original - Chart Yellow Copy to Patient

INITIAL SAFETY ASSESSMENT: ADU

Coded Allergies/Adverse Reactions

Name / Reaction	Category	Severity	Ver?	Date	Time	User
Allergies						
Fluoxetine HCl RASH	Drug	M	Y	10/30/09	1240	HEB

Adult Partial Safety Assessmnt 11/04/09 1548 EMW

What are your goals for this hospitalization: "Adequately address any concerns about my
: ability to return to work and cope with stress"

Any History of Abuse or Neglect: N

History of Aggressive/Assaultive Behavior: None
Access to Lethal Means: N
If Yes please explain:
Patients Social Worker notified: N

History of Suicide Attempts: N

Does the patient have any thoughts of suicide:DENIES
Does the patient have any intent of suicide: DENIES
Does the patient have a plan for suicide: DENIES

Does the patient have a history of self harm: N Types of Self Harm Behaviors:
Head Banging: N Scratching/Cutting: N Manipulating others to harm self: N
Fire Setting: N Hanging: N Overdosing: N Burning: N Self Strangulation: N
Jump in front of car, window, metro: N Poison: N Self Biting: N Other: N
Triggers: NA
:

Level of Impulsivity: Low

Admission history/symptoms indicate potential for self-harm: N
Commits to notify staff of self harm thoughts,intent, or plans:Y
Patient's Protective Barriers against Suicide/Self Harm: Coping Skills
Currently Employed/School
Positive Attitude
Social Supports
Ability Reality Test
Precipitating Factors:If applicable what does the pt identify as the cause
of loss of control or acting out behavior? "MY JOB'S CONCERN AFTER THE ACCIDENT REPORT
: FOLLOWING MY CAR ACCIDENT ON OCT 27, 2009"

Techniques used to help patient control behavior: "I HAVE BEEN IN CONTROL
: OF MY MOOD, NOT OUT OF CONTROL, EXCEPT WHEN DISORIENTED FEW DAYS AFTER ACC.

<<NURSING ADMISSION NOTE>>

Oriented to unit: Y
Appearance: WELL GROOM : PT ADMITTED TO ADULT PARTIAL PROGRAM TODAY. STATES
Additional Comments: SHE WAS DISORIENTED AFTER HER CAR ACCIDENT FOR A FEW DAYS BUT DENIES
: LOSS OF CONTROL OF MOOD OR BEHAVIOR RECENTLY. HAS AN INTERVIEW AT WORK

DOMINION HOSPITAL

Admission Medical History
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REVIEW OF SYSTEMS:

Head: ☑ No Abnormalities Identified ☐ Recent Trauma ☐ Other

Eyes: ☑ No Abnormalities Identified ☐ Corrective Lenses ☐ Other

Ears (hearing): ☑ No Abnormalities Identified ☐ Infection/Pain ☐ Other

Nose: ☐ No Abnormalities Identified ☐ Rhinitis ☐ Other

Mouth / Throat (with dental assessment): ☑ No Abnormalities Identified ☐ Sore Throat ☐ Other

Cardiovascular: ☑ No Abnormalities Identified ☐ Chest Pain ☐ Other

Respiratory: ☑ No Abnormalities Identified ☐ Cough ☐ Shortness of Breath ☐ Other

Gastrointestinal: ☑ No Abnormalities Identified ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Other

Genito-urinary: ☑ No Abnormalities Identified ☐ Urinary Frequency ☐ Urgency ☐ Other

Gynecological: ☐ No Abnormalities Identified ☐ Vaginal Discharge ☐ Other

LMP: Unk

Skeletomuscular (include motor development and functioning): ☐ No Abnormalities Identified ☐ Pain ☐ Other

Skin: ☐ No Abnormalities Identified ☐ Other

Neurological: ☐ No Abnormalities Identified ☐ Headaches ☐ Other

Weight Change / Dietary Habits: ☐ No Abnormalities Identified ☐ Weight Loss ☐ Weight Gain
☐ Appetite Loss ☐ Increased Appetite ☐ Other

DOMINION HOSPITAL

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Patient Name:	Date: 10/3/09	MR #:

CHIEF COMPLAINT AND PRESENT ILLNESS (INCLUDE IDENTIFYING INFORMATION):

Wed d/w

CURRENT MEDICATIONS: Add'l

PAST MEDICAL HISTORY: ADHD

(children include birth and maternal history, if available):

Surgery: G/B Removal

Illnesses: 0

Allergies: NKDA

Immunizations: UTD

SOCIAL HISTORY:

Tobacco Use ☐ Yes ☒ No

Drug Use ☐ Yes ☒ No

Alcohol Use ☐ Yes ☐ No

FAMILY HISTORY:

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ADMISSION PHYSICAL EXAMINATION

(Note: Examiner is to cross out any description of findings which do not apply to this patient. If any abnormality is noted during the examination, please describe under the "Specify otherwise" section.)

Pulse	Respirations	Blood Pressure

GENERAL APPEARANCE ☐ Patient is a well-developed, well-nourished individual who does not appear to be acutely or chronically ill. Posture is appropriate; no visible disturbance or gait.	☐ Specify otherwise
SKIN ☐ Palpation: warm, moist, elastic. Inspection: without significant eruptions or discoloration.	☐ Specify otherwise
HEAD ☐ Scalp is clean. Hair is of normal distribution and color, is not significantly fine or course to touch.	☐ Specify otherwise
FACE ☐ Facial contour, mobility and expression are normal. No marked asymmetry or sagging noted.	☐ Specify otherwise
EYES ☐ Pupils are equal, round, regular and react to light and accommodation. Extraocular movements are normal. The sclera is white. Conjunctiva are free from infection. The cornea and lens are clear. The Fundoscopic examination reveals sharp disc margins. Vessels are of normal caliber. No hemorrhages or exudates are present.	☐ Specify otherwise
NOSE ☐ No obvious deformity. Mucous membranes are not inflamed. Turbinates are not swollen. Airways are patent. There is no septal perforation. There is no significant rhinitis.	☐ Specify otherwise
EARS ☐ Canals are clear. Tympanic membranes are intact and noninjected. Hearing is adequate for normal conversation. External canals are free from tophi or other abnormalities.	☐ Specify otherwise

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MOUTH ☑ Breath odor is within normal variation. There is not significant change in the color or texture of the lips, tongue or buccal membrane. Tongue protrudes in the midline without unusual tremor. Teeth are in good repair and the gums appear healthy.	☐ Specify otherwise
PHARYNX ☑ Mucosa is not inflamed. No evidence of swelling or exudate. Tonsils are present and not enlarged or inflamed.	☐ Specify otherwise
THYROID ☑ The thyroid is not enlarged. No nodules are present.	☐ Specify otherwise
NECK ☑ There is no increased jugular venous pressure. Carotid pulsations are equal. No bruits are heard.	☐ Specify otherwise
GLANDS ☑ There is no significant lymph gland enlargement in the neck, axillae, epitrochlear area, supraclavicular area or groin.	☐ Specify otherwise
CHEST ☑ Normal contour and movement on inspiration / expiration. No chest wall tenderness.	☐ Specify otherwise
LUNGS ☑ Auscultation: Breath sounds are audible. No rales, rhonchi, or wheezes are noted. Percussion: Resonant in all fields.	☐ Specify otherwise
BREASTS ☐ Free from masses and tenderness, discharge, dimpling, wrinkling or discoloration of the skin.	☐ Specify otherwise not done
HEART ☑ Not enlarged. Heart sounds are normal regular in rhythm and of normal rate. No murmur, gallops, clicks or rub are heard.	☐ Specify otherwise

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TANNER STAGES (Adolescents Only)

	FEMALE	MALE
☐ Stage 1	Preadolescent pubic hair and breasts.	Preadolescent penis and testes, no pubic hair
☐ Stage 2	Sparse, lightly pigmented straight pubic hair; breasts papilla elevated as small mound; areolas diameter increased.	Scanty pubic hair, slightly enlarged penis; enlarged scrotum, pink texture altered.
☐ Stage 3	Pubic hair darker, beginning to curl, increased amount; breast and areola enlarged, no contour separation.	Pubic hair darker and curly. Penis, scrotum larger.
☐ Stage 4	Pubic hair coarse, curly, more abundant; areola and papilla form secondary mound.	Adult-type pubic hair, penis larger, wider; scrotum larger, darker.
☐ Stage 5	Pubic hair is adult feminine triangle; mature breast, nipple projects, areola part of general breast contour.	Adult-type pubic hair distribution; full growth of penis and testes.

RECTAL

(All patients, age 45 or older, or if specific symptoms indicate need for examination.)

☐ No evidence of hemorrhoids, fissures, bleeding or masses. Prostate is smooth of normal size, is non-tender and free from nodules (male only.) No masses present. Sphincter tone normal.

☐ Specify otherwise _____

NOT PERFORMED

☐ Patient less than age 45 and no specific symptoms indicating need for examination.

☐ Recent exam completed on _____ by _____.

☐ Patient wishes to have own physician perform exam. Physician name _____.

☐ Patient unable to cooperate because of psychiatric condition. Describe: _____.

☐ Other _____.

☐ Specify otherwise _____

DOMINION HOSPITAL

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ABDOMEN

☐ Normal contour - no masses to tenderness, no organomegaly (kidney, liver, spleen.) There is no costovertebral angle tenderness and no guarding. Peristaltic sounds are normal. No bruits are heard.

☐ Specify otherwise _____

GENITALIA / PELVIC - FEMALE

☐ No hernias. No lesions of the labia or introitus are noted. The vaginal mucosa is moist and normally elastic. Uterus is normal size, shape, position, freely moveable. Cervix is without lesions. There is no significant vaginal discharge.

☐ Specify otherwise _____

NOT PERFORMED

☐ Patient less than 18 and not sexually active.

☐ Recent exam completed on _____ by _____.

☐ Patient wishes to have own physician perform exam. Physician name _____.

☐ Patient unable to cooperate because of psychiatric condition. Describe: _____.

☐ Other _____.

☐ Specify otherwise _____

GENITALIA - MALE

☐ Both testes palpable. No abnormal masses. No hernias. No urethral discharge. No lesions of glans or shaft noted.

☐ Specify otherwise _____

NOT PERFORMED

☐ Patient less than 18 and not sexually active.

☐ Recent exam completed on _____ by _____.

☐ Patient wishes to have own physician perform exam. Physician name _____.

☐ Patient unable to cooperate because of psychiatric condition. Describe: _____.

☐ Other _____.

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RECTAL

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☐ Specify otherwise _____

NOT PERFORMED

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NEUROLOGICAL EXAM (cond.)	
☐ Eyelid Elevation: Able to retract eyelid fully.	☐ Specify otherwise
☐ Fundi flat, discs not elevated; no arteriovenous nicking, no hemorrhages, no retinal pigmentation.	☐ Specify otherwise
III, IV, VI Movement of Eyes (oculomotor, trochlear and abducens nerves): ☐ Smooth, symmetrical movement through all positions of gaze; no nystagmus present.	☐ Specify otherwise
V. Trigeminal (ophthalmic branch, maxillary branch, mandibular branch). ☐ With eyes closed, indicates facial and aural tacticle perception.	☐ Specify otherwise
Movement of muscles of mastication: ☐ Symmetrical tension in muscles of clenched jaw; able to move jaw laterally against resistance; symmetrical muscle mass of temporalis and masseters; absence of lip tremors, involuntary chewing movements and trismus; chews symmetrically.	☐ Specify otherwise
VII. Facial ☐ Normal facial inspection, frowns, and elevates eyebrows symmetrically (upper), tight closing of eyes (upper), adequate saliva production; able to show teeth; smiles symmetrically (lower).	☐ Specify otherwise
VIII. Acoustic ☐ Cochlear branch: Hears finger rubbing and snapping equally in both ears.	☐ Specify otherwise
Vestibular branch ☐ Finger to nose or finger to finger without past-pointing; normal tandem walk; stands with feet together without posture deviation (absent Romberg)	☐ Specify otherwise

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CIRCULATION ☐ No significant varicosities. Pulses are palpable and regular in neck, wrist, groin, popliteal, and tibial arteries. No audible bruits.	☐ Specify otherwise _____
EXTREMITIES ☐ Full range of motion of joints. No discolorations, tenderness, edema or evidence of impaired function.	☐ Specify otherwise _____
BACK ☐ There is normal curvature of the spine. There is no tenderness of the cervical, dorsal and lumbar spines.	☐ Specify otherwise _____

NEUROLOGICAL EXAMINATION	
Level of Consciousness	☐ Alert ☐ Drowsy ☐ Stupor ☐ Coma
Knowledge ☐ Appropriate to age, education, cultural background, life experiences.	☐ Specify otherwise _____
Speech and Language ☐ Clear articulation; no slurring, no stuttering, or other difficulties or impediments of speech; no bizarre intonation; able to use and interpret language with ease; no difficulty sending or receiving verbal or gestural messages.	☐ Specify otherwise _____
Examination of Cranial Nerves: II - XII ***II. Optic:*** ☐ Visual Fields: Full with no deficits on confrontation; able to distinguish number of fingers in central field; distinguishes movement in peripheral fields.	☐ Specify otherwise _____
☐ Pupillary Reactivity: Pupil size symmetrical; pupils neither widely dilated nor pinpoint in average room light; prompt constriction in reaction to direct light stimulus.	☐ Specify otherwise _____

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NEUROLOGICAL EXAM (cond.) ***IX, X. Glossopharyngeal and Vagus Nerves:*** ☐ Normal midline elevation of uvula and palate; laryngeal contour rising with swallowing; phonates without hoarseness or articulation difficulty.	☐ Specify otherwise _____
XI. Accessory Nerve: ☐ Normal strength and symmetry on turning head and elevation of shoulders.	☐ Specify otherwise _____
XII. Hypoglossal Nerve: ☐ Tongue protrudes in midline with absence of fasciculations, tremors or atrophy, normal muscle strength of tongue; normal lingual speech.	☐ Specify otherwise _____
Cerebellar Function: Balance: ☐ No abnormalities of gait (tandem and heel-toe.) Coordination: ☐ Able to touch finger to nose and heel to shin and vice versa rapidly and accurately with no past pointing; able to perform rapid alternating movements (supination and pronation of forearms) quickly and symmetrically.	☐ Specify otherwise _____ ☐ Specify otherwise _____
Motor Functions: ☐ Symmetrical on inspection; good tone without spasticity or rigidity; no contractures or hypotonus; no atrophy.	☐ Specify otherwise _____
Muscle Strength: ☐ Adequate and symmetrical muscle strength (5/5) on resistance to opposing force for upper and lower body muscle group on flexion and extension, abduction and adduction.	☐ Specify otherwise _____

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Involuntary Movements: ☐ Absence of tremors, twitches, tics, fibrillations, fasciculations, athetoid or choreiform movements, myoclonus or myotonia.	☐ Specify otherwise
Range of Motion: ☐ Full range of motion with no restrictions in upper and lower extremities, spine.	☐ Specify otherwise
Sensory System: ☐ Normal and symmetrical response to touch.	☐ Specify otherwise
Other Reflexes and Signs: Babinski's sign: ☐ Absent (great toes downgoing on right and/or left.) ☐ Present (toes upgoing on right and/or left.) ☐ Non-reactive or equivocal.	☐ Specify otherwise
Meningeal Signs: ☐ Present: ☐ Kernig ☐ Brudzinski	☐ Specify otherwise Absent

Deep Reflexes:

Please note results of tests of biceps, triceps, radial, quadriceps, and Achilles' reflexes.

0 = Absent 1 = Diminished 2 = Normal 3 = Increased 4 = Hyperactive 5 = Hyperactive with clonus

	LEFT	RIGHT
Biceps		
Triceps		
Radial	+2	+2
Quadriceps		
Achilles		

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PARTIAL HOSPITALIZATION PROGRAM
ADMISSION SUMMARY

To be completed by attending physician at the time of discharge from inpatient level of care to the partial hospitalization program.

Current Diagnosis: Axis 1: Psychosis, NOS
Axis 2: deferred
Axis 3: no diagnosis
Axis 4: none known
Axis 5: GAF: 60

Presenting Problem (target symptoms and behaviors): 3 separate incidents of bizarre behavior during the few days prior to her in-pt adm 10/30/09

Mental Status: since admission no overt evidence of psychosis noted

Treatment Planning:
Treatment Problem Statement: The behavior/relationship difficulties, which require change in order for the patient to function in a less restrictive setting, require that the patient will: show stable mood thinking and behavior

PHYSICIAN TREATMENT PLANNING INTERVENTIONS

Therapeutic Interventions: therapy: individual, group, possibly family

Other:

Estimated Length of Stay 4 to 8 days in PHP

Discharge Plan home, out-pt Tx

R Roth MD — 10-31-09

ATTENDING PHYSICIAN **DATE:**

Psychosocial Assessment ~std 11/04/09 1533 MXS

Reason For Admission^:
Patient was admitted to DH on 10/30/09 and left AMA on 10/31/09. In days/weeks prior to admission patient had reportedly been behaving in a bizarre way at work (State Dept) and was then in a road traffic accident which she is reported to have deliberately caused. Today patient presents stating that she is not sure why she has been admitted to PHP except "that the State Department has ordered this".

- Dr. Roth stated to me that I was being discharged & I specifically asked if it would be AMA, a friend whose mother works for VA advised it was best to comply even if I knew I did not belong there.

Does Patient Meet Criteria for Current Level of Care: Y
Supervisor Informed:

Primary Language: ENGLISH ENGLISH

Social/Cultural/Educational Influences^:
Patient is one of two sibs born to middle class parents, raised in suburb of Atlanta, attended Spellman College for undergrad, progressed to grad school at Georgetown SFS, was then employed by DOD, sent to Iraq for four months (2007) , returned to DOD where she reports having exceeded work performance expectations, then moved to State Dept in March 09. Patient has supportive parents (retired educators) Patient lives alone in apt in DC and currently works for State Dept as an analyst.

- I was born & raised in Mesa, AZ, I did not go to Atlanta until undergrad. My parents bought a home in Atlanta in 2006 (Fairburn, GA).
I told them I started at State in July 2009. They failed to include other work history - 1998-1999 Countrywide Financial, Peace Corps - 1999-2001, Japan Exchange & Teaching Program 2001-2003, Studied Japanese at Sophia University for 2 & 1/2 years from fall 2001 to 2004. I was an analyst at DoD and told them I was an FSO at the State Dept.

--FAMILY HISTORY----
Family Psych Hx: Y

Family Psych Relationship: Aunt

Describe Family Psych Hx^:
Schizophrenia in maternal aunt.

Family Hx of Suicide: N

Family Suicide Relationship:

Describe Family Hx of Suicide^:

Family CD Hx: N

Family CD Relationship:

Psychosocial Assessment ~std 11/04/09 1533 MXS

Religion: CHR CHRISTIAN

Spiritual Practices: Church

Pt Believes in Higher Power: Y
Describe Higher Power^:

Last Grade Completed: Graduate degree
Degrees/Certificates: Masters in Foreign Relati

Current Student: N
Where:

Change in School Performance:
Describe Change In School Performance^:

Problems with Behavior at School:
Truancy:

Learning Problems/Special Education: N
Describe Learning/Behavioral Problems^:

~~~~EMPLOYMENT HISTORY~~~~

Currently Employed: Y
Pt Occupation: Analyst
Time at Current Job: 4.5 years
Job Satisfaction: High
Longest Time at One Job: 4.5 years
Frequent Job Changes: N
Reason for Job Changes^:

I have only been employed at current employer since July 2009.
⇒ ≈ 2.5 years

Unemployed in Last Year: N
Reason for Unemployment^:

Parent Occupation:
Spouse Occupation:
Financial Needs: Denies any stressors
Denies debts
Denies compulsive spendin
States she manages
money "very well and
I have good savings"
Military Hx: N
Branch(es):
~~~~

Psychosocial Assessment ~std 11/04/09 1533 MXS

# of Years:
Military Reserve:
Discharge Type:

Year:

Discharge R/T Substance Abuse:
Discharge R/T Psych Condition:

~~~~ARREST HISTORY~~~~
Arrest or Pending Litigation/Civil Charges Hx: Y
Number of Arrests: 1
Reason for Arrest: leaving scene of accident
Arrests Involving Violence: N
DUI/DWI: N
When:
Public Intoxication: N
When:
Probation Hx: N
Why/When:
Parole Hx: N
Why/When:

Describe Pending Litigation/Civil Charges^:
above note re. recent charges.
Patient has retained an attorney

~~~~CAFFEINE HISTORY~~~~
Pt Use Caffeine: Y
Types of Caffeine: Coffee
Amt per Day: 1-2

I rarely drink caffeine, only time is Starbucks maybe a couple times a month. I will usually get a carmel frappucino when I do go to Starbucks.
↳ I have never drank this amount of caffeine except once or twice in college when I was staying up late to study for an exam.

Psychosocial Assessment ~std 11/04/09 1533 MXS

~~~~NICOTINE HISTORY~~~~

Nicotine Hx: N

Kind of tobacco:

Age First Used:
Packs/tins per day:

How many years:
Any Consequences:

Quit:
When:

Does Patient Drink Alcoholic Beverages: Y
Type of Alcohol: WINE
How Often: 1 - 2 times/month
How Long: 10 years
How Much: glass
Last Drink:
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:

Alcohol Comment^:
Patient denies any abuse of alcohol and states she seldom drinks

Pt Believes ETOH Use a Problem: N
Negative Effects on Life:

Medical Problems from CD Use:

Longest Sobriety:
When:
Sober Support System:
Who:
AA/NA:
Last Contact:
Sponsor:
Last Contact:

ETOH Sobriety/Support/Treatment Comments^:
None
~~~~

Psychosocial Assessment ~std 11/04/09 1533 MXS

Additional Drugs or Chemical Use: N
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Drug Use Comment^:

Believes Drug Use a Problem: N
Negative Effects on Life:

Medical Problems from CD Use:

Longest Sobriety:
When:
Sober Support System:
Who:
AA/NA:
Last Contact:
Sponsor:
Last Contact:

CD Sobriety/Support/Treatment Comments^:
Patient denies any CD recent or past

~~~~ABUSE HISTORY~~~~
(Emotional, Physical, Neglect, Sexual) Abuse: N

Physical:
Describe Physical Abuse^:

Emotional:
Describe Emotional Abuse^:

Sexual:
Describe Sexual Abuse^:
~~~~

Psychosocial Assessment ~std 11/04/09 1533 MXS

Neglect:
Describe Neglect^:

Patient Has Hx of Abuse to Others: N
Describe Hx of Abuse to Others^:

Was CPS/APS Report Made: N
Describe CPS/APS Report^:

Describe CPS/APS Involvement^:

Abuse Comments^:

~~~~STRENGTHS/WEAKNESSES~~~~
Stability of Home Environment: Strength

Motivation for Tx: Weakness

Insight into Current Problems: Weakness

Judgement Regarding Current Problems:
Weakness
Stability and Support of Employment:
Strength
Function of Marriage/Family System:
Strength
Support System in and Beyond Family:
Strength

Education Attainment: Strength

Intellectual Skills: Strength

Range of Leisure Activities^:
Mostly exercise — I stated in group & during inpatient that exercise, socializing w/ friends, talking on the phone, studying Jpn were regular parts of my social activities

Type of Recent Leisure Activities^:
running, working out in gym Also stated in daily worksheets & during groups that I had several leisure activities, including exercise, talking/socializing w/ friends, studying foreign language, watching TV.

What Do You Do When Bored/Lonely^:
Go running on the mall — I said I call friends/meet w/ friends
~~~~

Psychosocial Assessment ~std 11/04/09 1533 MXS

Does Your Work Schedule Interfere With Your Leisure Activities: N
Do You Belong to Any Social Groups/Community Organizations: N

Improvement Needed in ANY of the following areas:
Patient denies

Pt Perception of Illness^:
Patient is bewildered as to why she is here. Patient states that her co-worker who reported her bizarre behavior at work is disgruntled, leaving his job and moving to California. She contends that she has had a conflictual relationship with this co-worker.

Pt Perception of Needs^:
Patient states she will "do whatever you tell me here and whatever I need to get back to my job"

Pt's Goals for Treatment^:
Return to work
Have attorney advocate that legal charges be dropped
Be able to convince her boss that she is stable

Community Resources Current/Needed:
Unable to assess

Anticipated Treatment Mgr Role in TX/DC Planning:
FAMILY CONTACT
COORDINATION OF CARE/OPP
DISCHARGE PLANNING
REFERRAL TO COMM. RESOURC

Goals of Treatment: STABILIZE MOOD
IMPROVE COPING SKILLS

Monogram Initials	Name	Nurse Type
MXS	J.NUR.MFS1 SANDIFORD,MARY	SW

Administrative Data

TEMPORARY LOCATION

HOLD TRAY: DATE MEAL RELEASE HT ft in cm
CONDITION VISITORS ALLOWED WT lb oz kg
CMT
VISIT REASON PHP
--- Observation Patient ---
Dt in Tm in
Dt out Tm out

Coded Allergies/Adverse Reactions

Name / Reaction	Category	Severity	Ver?	Date	Time	User
Allergies						
Fluoxetine HCl RASH	Drug	M	Y	10/30/09	1240	HEB

Monogram	Initials	Name	Nurse Type
HEB	J.NUR.HEB	BLACK,ELIZABETH	RN

Run Date/Time: 10/31/09 1327 Printed by: J.NUR.GSL1

DISCHARGE - Patients Medication List
MEDICATION RECONCILIATION

WILLIAMS,LYNNAE D

ATTENDING: Roth,Richard L WEIGHT: 60.78 kg 134 lbs ACCOUNT: J84090217483
ALLERGIES: Fluoxetine HCl (From Prozac)
ADRs: ***NO ADRs ENTERED***

********* Home Medications *********

DRUG NAME	DOSE/ROUTE	FREQUENCY
No Home Medications Documented		

*** This is a complete list of your medications. Bring this list to your next ***
*** doctor's appt. ( )Prescriptions provided to patient/guardian at discharge ***
*** ( )No prescriptions required ( )Prescriptions called into pharmacy ***
*** Patient/Guardian Signature: Lynnae D Williams Date: 10/31/09 ***

WILLIAMS,LYNNAE D
AC# J84090217483 ADM IN J.222 B
MR# J000018122 ADM 10/30/09 SCH
Roth,Richard L
AGE 33 DOB 07/09/76 SEX F

********** This is a permanent part of the record. Please do not discard. **********

RUN DATE: 11/11/09
RUN TIME: 1217
RUN USER: J.NUR.EMW2

DOMINION HOSP ADMISSIONS
PARTIAL HOSPITALIZATION DISCHARGE LIST

WILLIAMS,LYNNAE D

DOCTOR: Roth,Richard L

Allergies: Fluoxetine HCl (From Prozac)
ADRS: ***NO ADRs ENTERED***

Patient Medication List

Medication	Dose	Frequency	Route
* no psychiatric medications ordered *			

I have reviewed the Medications listed above and understand that this is the list of Medications to be taken after Discharge.

Patient/Family/Guardian Signature: Lynnae Williams Date: 11/11/09 Time: 12:20

Nurse Signature: Elizabeth Mitchell, RN Date: 11/11/09 Time: 12:20

MD Signature: R Roth Date: 11/13/09 Time: _____

Copy to Patient. Original to Chart

WILLIAMS,LYNNAE D
J84090218118 REG RCR J.3PA
11/04/09 Roth,Richard L
DOB:07/09/1976 F/33 MR# J000018122
Dominion Hospital

DOMINION HOSPITAL

PHYSICIAN ADMISSION INSTRUCTION SHEET
ADULT PARTIAL PROGRAM

(CIRCLE THE ANSWER, YES OR NO)

(Y)	N	Admit to the Partial Hospitalization Program
(Y)	N	Regular Diet (specify other:_____)
Y	(N)	Medical History and Physical Examination (ONLY FOR A DIRECT ADMISSION)
Y	(N)	Vital Signs (B.P., TPR x1) Other:_____

DUAL DIAGNOSIS EDUCATION GROUPS

Y	N	Assessment
Y	N	Groups

I certify that the services identified as "partial hospitalization" are medically necessary to prevent further decompensation and subsequent admission to inpatient treatment.

Telephone Order Received By: (RN Signature)	per Physician Name	Date	Time	Read Back (RN Initials)
Robert Wolfe RN	Dr. Roth	11/4/09	1200	rbw

Transcribed By: (RN Signature)	Date	Time
Robert Wolfe RN	11/4/09	1533

Physician Signature	Date	Time
[signature]	11/4/09	

DH-207 (10/05)
(8/07)
(10/07)

USE BALL POINT PEN   PRESS FIRMLY   T 4003

Authorization is hereby given to dispense the generic equivalent unless otherwise indicated by the physician.

Date	Time	Complete top portion with each Level of Care change. Indicate order with a Check Mark.
		☐ Outpatient Procedure: ____________ (procedure) for ____________ (medical reason)
		☐ Place in Outpatient Observation Services for ____________ (medical reason).
		☐ Admit as Inpatient for ____________ (medical reason)

Physician Signature: ____________________

Date	Time	Additional Orders: (Dates/Times required)
11/4/09	1200	T.O. Dr. Roth / Elizabeth Mitt, RN (rb) Admit pt to adult partial program [signature] 11/4/09 noted E. Mitt, RN 11/4/09 1200
11/9/09		Pt. will not attend this PHP 11/10/09 due to a court appearance in DC Court [signature] noted 11/9/09 1000
11/11/09		Discharge Today [signature] noted E Mitt, RN 1200 11/11/09

Allergies & Sensitivities ☐ NKA

Weight	Height	Diagnosis

WILLIAMS, LYNNAE D
J84090218118 REG RCR J.3PA
11/04/09 Roth, Richard L
DOB: 07/09/1976 F/33 MR# J000018122
Dominion Hospital

Physician's Orders

T4003 Rev 4/00 (RC# 0914041)

DO NOT WRITE ORDERS UNLESS RED # APPEARS

DOMINION HOSPITAL

PARTIAL HOSPITALIZATION PROGRAM
ADMISSION SUMMARY

To be completed by attending physician at the time of discharge from inpatient level of care to the partial hospitalization program.

Current Diagnosis:
Axis 1: Psychosis, NOS
Axis 2: deferred (?)
Axis 3: no diagnosis
Axis 4: none known
Axis 5: GAF: 60

I was never asked for my opinion of this diagnosis, or was not told this was my diagnosis until they (Mary, + Elizabeth) attempted to get me to sign off on diagnosis the last day of Treatment

Presenting Problem (target symptoms and behaviors): 3 separate incidents of bizarre behavior during the few days prior to her in-pt adm 10/30/09 (Nobody specific) what the 3 incidents were, repeatedly gave conflicting stories of events in an attempt to confuse me?

Mental Status: since admission no overt evidence of psychosis noted

Treatment Planning: Was not discussed with me, Dr. Roth told me I was being dismissed / said it would not be right

Treatment Problem Statement: The behavior/relationship difficulties, which require change in order for the patient to function in a less restrictive setting, require that the patient will: show stable mood thinking and behavior

Dr. Roth said this after speaking w/ Dr. Hailes who said the only reason I was there was because of the car accident

PHYSICIAN TREATMENT PLANNING INTERVENTIONS

Therapeutic Interventions: therapy: individual, group, possibly family (This was not discussed, although I asked for a copy of discharge + he refused to provide any only provided Paperwork stating no medications were provided.

Other:

Estimated Length of Stay 4 to 8 days in PHP

Discharge Plan home, out-pt Tx

R Roth MD — 10-31-09

ATTENDING PHYSICIAN **DATE:**

I spoke to CSW (Anita Zelk) who was assigned to me + she said she could not imagine Dr. Roth would refuse to discharge me because it was clear I was not experiencing any symptoms, was coherent, and most likely needed a neurological exam to explain memory loss following the accident. She was the first person on Dominion's staff to express concern about the accident, everyone else focused on the alleged incident w/ my coworker. Ms. Zelk also met w/ my family when they arrived.

Administrative Data

TEMPORARY LOCATION

HOLD TRAY: DATE MEAL RELEASE HT ft in cm
CONDITION VISITORS ALLOWED WT lb oz kg
CMT
VISIT REASON PHP
--- Observation Patient ---
Dt in Tm in
Dt out Tm out

Coded Allergies/Adverse Reactions

Name / Reaction	Category	Severity	Ver?	Date	Time	User
Allergies						
Fluoxetine HCl RASH	Drug	M	Y	10/30/09	1240	HEB

Monogram	Initials	Name	Nurse Type
HEB	J.NUR.HEB	BLACK,ELIZABETH	RN

Coded Allergies/Adverse Reactions

Name / Reaction	Category	Severity	Ver?	Date	Time	User
Allergies						
Fluoxetine HCl RASH	Drug	M	Y	10/30/09	1240	HEB

Adult Partial Safety Assessmnt 11/04/09 1548 EMW

What are your goals for this hospitalization: "Adequately address any concerns about my
: ability to return to work and cope with stress" - I did not make any statements regarding stress. I was told by a nurse when I was discharged that I had to list someth under safety plan & I complied, saying/writing job stress.

Any History of Abuse or Neglect: N

History of Aggressive/Assaultive Behavior: None
Access to Lethal Means: N
If Yes please explain:
Patients Social Worker notified: N

History of Suicide Attempts: N

Does the patient have any thoughts of suicide:DENIES
Does the patient have any intent of suicide: DENIES
Does the patient have a plan for suicide: DENIES

Does the patient have a history of self harm: N Types of Self Harm Behaviors:
Head Banging: N Scratching/Cutting: N Manipulating others to harm self: N
Fire Setting: N Hanging: N Overdosing: N Burning: N Self Strangulation: N
Jump in front of car, window, metro: N Poison: N Self Biting: N Other: N
Triggers: NA
:

Level of Impulsivity: Low

Admission history/symptoms indicate potential for self-harm: N
Commits to notify staff of self harm thoughts,intent, or plans:Y - I repeatedly told staff & wrote on paperwork this this had never been an issue.
Patient's Protective Barriers against Suicide/Self Harm: Coping Skills
Currently Employed/School
Positive Attitude
Social Supports
Ability Reality Test

Precipitating Factors:If applicable what does the pt identify as the cause
of loss of control or acting out behavior? "MY JOB'S CONCERN AFTER THE ACCIDENT REPORT
: FOLLOWING MY CAR ACCIDENT ON OCT 27, 2009"

Techniques used to help patient control behavior: "I HAVE BEEN IN CONTROL
: OF MY MOOD, NOT OUT OF CONTROL, EXCEPT WHEN DISORIENTED FEW DAYS AFTER ACC.
Never made this statement.. I made no statements about my mood.

<<NURSING ADMISSION NOTE>>

Oriented to unit: Y
Appearance: WELL GROOM : PT ADMITTED TO ADULT PARTIAL PROGRAM TODAY. STATES
Additional Comments: SHE WAS DISORIENTED AFTER HER CAR ACCIDENT FOR A FEW DAYS BUT DENIES
: LOSS OF CONTROL OF MOOD OR BEHAVIOR RECENTLY. HAS AN INTERVIEW AT WORK

Psychosocial Assessment ~std 11/04/09 1533 MXS

Describe Family CD Hx^:

Patient Psych/CD Treatment Hx: Y

Describe Treatment Hx^:
Outpatient treatment at Georgetown Univ Counseling Center for depression, anxiety, sleep disturbance in 2006. Overnight in DH on 10/30/09 and then AMA discharge. I was told by Dr. Roth that the discharge was not AMA, he repeatedly threatened my job saying he could declare me" and if I did not do what he said (remain imputient) I likely would not go back to work.

Inaccurate, never reported this information.

Additional Suicide Risk Elements: Hx of risky behavior

Homicidal/Violence Risk Factors:
Patient denies

Marital Status: Single
Sexual Orientation:

# of Marriages: 0 How Long/Current: 0

How Long Previous Marriages^:

Number of Children: 0 Ages: 0

Living Arrangement: Own Place

Needs Alt Living Arrangement: N

Social Support Network: Good

Support Person(s): Family
Friends
Treatment Participants: Patient's parents who are in town

Support Comments^:
"My parents came because my cousin in Baltimore called them. My cousin took me to the ER at Georgetown two days after my accident because ..I did not receive any medical treatment ..I was just taken by the police and put in a cell, finger printed.. and then charged with leaving the scene of an accident"

When it was clear that Dr. Roth had no intentions of releasing me, I told my parents this was serious & I needed them to come here immediately. My mom asked my cousin took me to the hospital after my employer called (I was late asking for my whereabouts following the accident. My cousin BF Picked me up & took me to the hospital, my cousin met us at the hospital. My cousin went to buy 5 Guys for me while we were in the waiting room.

Describe Typical Day: Wake at 7.0 am
Work by 8.30 - 5.30
Evening - outdoor running or work out in gym
Dinner alone or with a friend
Bed 11.0 pm
Hobbies/Interests: Exercise

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's name: Lynnae Williams Birth Date: 7/9/1976

Social Security Number: 600991112 Phone Number: 202-577-6474

Date(s) of Service: 10/30 - 10/31 & 11/4 to 11/11

I authorize: **Dominion Hospital**

to release or disclose the following information to:

Lynnae Williams — Name of person, physician or agency to receive information

202-577-6474 — Phone Number of receiver

70 I. St. Apt. 1210 — Street Address

Washington — City

DC — State

20003 — Zip Code

Information to be Released/Disclosed:

- ☒ Admission History
- ☒ Discharge Summary
- ☒ History & Physical
- ☐ Operative Report
- ☒ Consultation
- ☒ Physician Orders
- ☐ Labs/EKG's/X-rays
- ☐ Medication Records
- ☒ Nursing Assessment
- ☒ Nursing Progress Notes
- ☐ Transfer Forms
- ☒ Psychosocial Assessment
- ☐ Emergency Room Record
- ☒ Psychological Evaluation
- ☐ Psycho-Educational Reports
- ☒ Physician Progress Notes
- ☐ Medical Abstract
- ☐ Itemized Bill/UB-92
- ☐ Other_____

Purpose:

- ☐ Medical Follow-up
- ☐ Attorney
- ☒ Individual Use
- ☐ Disability
- ☐ Insurance
- ☐ Other_____

Patient advised of charges: ☒ Yes ☐ No ☐ N/A

☐ **I prefer to pick up records** ☐ **I wish to review records (by appointment only)** ☐ **Please mail**

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LW **(Initial)**

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee.

I have read the above and authorize the disclosure of the protected health information as stated.

X Lynnae Williams — Signature of Patient (must be signed if age 14 years or older for Psychiatric records)

11/11/09 — Date (authorization will expire 6 months after date signed)

Signature of Parent/Guardian (if applicable)

Relationship to Patient

2960 SLEEPY HOLLOW ROAD; FALLS CHURCH, VA 22044; PHONE: 703-536-2000 FAX: 703-536-6135

FOR HOSPITAL USE ONLY

Completed by _____ Date _____

DOMINION HOSPITAL Admission Medical History and Physical Examination	WILLIAMS,LYNNAE D J84090217483 ADM IN J.222-B 10/30/09 Roth,Richard L DOB:07/09/1976 F/33 MR# J000018122 Dominion Hospital

☐ No Restrictions on Physical Activity

☐ Physical Activity restricted due to: ______

Impressions / Recommendations:

1) [illegible]

2) [illegible]

3) [illegible]

[illegible]

Signature: [illegible signature]

Date: [illegible]

Psychosocial Assessment ~std 11/04/09 1533 MXS

Reason For Admission^:
Patient was admitted to DH on 10/30/09 and left AMA on 10/31/09. In days/weeks prior to admission patient had reportedly been behaving in a bizarre way at work (State Dept) and was then in a road traffic accident which she is reported to have deliberately caused. Today patient presents stating that she is not sure why she has been admitted to PHP except "that the State Department has ordered this".

Does Patient Meet Criteria for Current Level of Care: Y
Supervisor Informed:

Primary Language: ENGLISH ENGLISH

Social/Cultural/Educational Influences^:
Patient is one of two sibs born to middle class parents, raised in suburb of Atlanta, attended Spellman College for undergrad, progressed to grad school at Georgetown SFS, was then employed by DOD, sent to Iraq for four months (2007) , returned to DOD where she reports having exceeded work performance expectations, then moved to State Dept March 09. Patient has supportive parents (tired educators) Patient lives alone in apt in DC and currently works for State Dept as an analyst.

~~FAMILY HISTORY~~~~
Family Psych Hx: Y

Family Psych Relationship: Aunt

Describe Family Psych Hx^:
Schizophrenia in maternal aunt.

Family Hx of Suicide: N

Family Suicide Relationship:

Describe Family Hx of Suicide^:

Family CD Hx: N

Family CD Relationship:

Psychosocial Assessment ~std 11/04/09 1533 MXS

Describe Family CD Hx^:

Patient Psych/CD Treatment Hx: Y

Describe Treatment Hx^:
Outpatient treatment at Georgetown Univ Counseling Center for depression, anxiety, sleep disturbance in 2006. Overnight in DH on 10/30/09 and then AMA discharge.

Additional Suicide Risk Elements: Hx of risky behavior

micidal/Violence Risk Factors:
atient denies

Marital Status: Single
Sexual Orientation:

# of Marriages: 0 How Long/Current: 0

Long Previous Marriages^:

Number of Children: 0 Ages: 0

Living Arrangement: Own Place

Needs Alt Living Arrangement: N

Social Support Network: Good

Support Person(s): Family
Friends
Treatment Participants: Patient's parents
who are in town

Support Comments^:
"My parents came because my cousin in Baltimore called them. My cousin took me to the ER at Georgetown two days after my accident because ..I did not receive any medical treatment ..I was just taken by the police and put in a cell, finger printed.. and then charged with leaving the scene of an accident"

Describe Typical Day: Wake at 7.0 am
Work by 8.30 - 5.30
Evening - outdoor running or work out in gym
Dinner alone or with a friend
Bed 11.0 pm

Hobbies/Interests: Exercise

Adult Partial Safety Assessmnt 11/04/09 1548 EMW

: TODAY; VERY ELEGANTLY AND NEATLY DRESSED IN BUSINESS SUIT. DENIES SI/HI/SIB
: GIVES SL=10
:
:
:

Monogram	Initials	Name	Nurse Type
EMW	J.NUR.EMW2	WITTING,ELIZABETH	RN
HEB	J.NUR.HEB	BLACK,ELIZABETH	RN

Psychosocial Assessment ~std 11/04/09 1533 MXS

Religion: CHR CHRISTIAN

Spiritual Practices: Church

Pt Believes in Higher Power: Y
Describe Higher Power^:

Last Grade Completed: Graduate degree
Degrees/Certificates: Masters in Foreign Relati

Current Student: N
Where:

Change in School Performance:
Describe Change In School Performance^:

Problems with Behavior at School:
Truancy:

Learning Problems/Special Education: N
Describe Learning/Behavioral Problems^:

~~~~EMPLOYMENT HISTORY~~~~

Currently Employed: Y
Pt Occupation: Analyst
Time at Current Job: 4.5 years
Job Satisfaction: High
Longest Time at One Job: 4.5 years
Frequent Job Changes: N
Reason for Job Changes^:

Unemployed in Last Year: N
Reason for Unemployment^:

Parent Occupation:
Spouse Occupation:
Financial Needs: Denies any stressors
Denies debts
Denies compulsive spendin
States she manages
money "very well and
I have good savings"
Military Hx: N
Branch(es):
~~~~

Psychosocial Assessment ~std 11/04/09 1533 MXS

# of Years:
Military Reserve:
Discharge Type:

Year:

Discharge R/T Substance Abuse:
Discharge R/T Psych Condition:

~~~~ARREST HISTORY~~~~
Arrest or Pending Litigation/Civil Charges Hx: Y
Number of Arrests: 1
Reason for Arrest: leaving scene of accident
Arrests Involving Violence: N
DUI/DWI: N
When:
Public Intoxication: N
When:
Probation Hx: N
Why/When:
Parole Hx: N
Why/When:

Describe Pending Litigation/Civil Charges^:
above note re. recent charges.
Patient has retained an attorney

~~~~CAFFEINE HISTORY~~~~
Pt Use Caffeine: Y

Types of Caffeine: Coffee

Amt per Day: 1-2

Psychosocial Assessment ~std 11/04/09 1533 MXS

~~~~NICOTINE HISTORY~~~~

Nicotine Hx: N

Kind of tobacco:

Age First Used:
Packs/tins per day:

How many years:
Any Consequences:

Quit:
When:

Does Patient Drink Alcoholic Beverages: Y
Type of Alcohol: WINE
How Often: 1 - 2 times/month
How Long: 10 years
How Much: glass
Last Drink:
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Alcohol Comment^:
Patient denies any abuse of alcohol and states she seldom drinks

Pt Believes ETOH Use a Problem: N
Negative Effects on Life:

Medical Problems from CD Use:

Longest Sobriety:
When:
Sober Support System:
Who:
AA/NA:
Last Contact:
Sponsor:
Last Contact:

ETOH Sobriety/Support/Treatment Comments^:
None
~~~~

Psychosocial Assessment ~std 11/04/09 1533 MXS

Additional Drugs or Chemical Use: N
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Drug Use Comment^:

Believes Drug Use a Problem: N
Negative Effects on Life:

Medical Problems from CD Use:

Longest Sobriety:
When:
Sober Support System:
Who:
AA/NA:
Last Contact:
Sponsor:
Last Contact:

CD Sobriety/Support/Treatment Comments^:
Patient denies any CD recent or past

~~~~ABUSE HISTORY~~~~
(Emotional, Physical, Neglect, Sexual) Abuse: N

Physical:
Describe Physical Abuse^:

Emotional:
Describe Emotional Abuse^:

Sexual:
Describe Sexual Abuse^:
~~~~

Psychosocial Assessment ~std 11/04/09 1533 MXS

Neglect:
Describe Neglect^:

Patient Has Hx of Abuse to Others: N
Describe Hx of Abuse to Others^:

Was CPS/APS Report Made: N
Describe CPS/APS Report^:

Describe CPS/APS Involvement^:

ıse Comments^:

~~~~STRENGTHS/WEAKNESSES~~~~
Stability of Home Environment: Strength

Motivation for Tx: Weakness

Insight into Current Problems: Weakness

Judgement Regarding Current Problems:
Weakness
Stability and Support of Employment:
Strength
Function of Marriage/Family System:
Strength
Support System in and Beyond Family:
Strength

Education Attainment: Strength

Intellectual Skills: Strength

Range of Leisure Activities^:
Mostly exercise

Tıme of Recent Leisure Activities^:
ıing, working out in gym

What Do You Do When Bored/Lonely^:
Go running on the mall
~~~~

Psychosocial Assessment -std 11/04/09 1533 MXS

Does Your Work Schedule Interfere With Your Leisure Activities: N
Do You Belong to Any Social Groups/Community Organizations: N

Improvement Needed in ANY of the following areas:
Patient denies

Pt Perception of Illness^:
Patient is bewildered as to why she is here.
Patient states that her co-worker who reported her bizarre behavior at work is disgruntled, leaving his job and moving to California. She contends that she has had a conflictual relationship with this co-worker.
Pt Perception of Needs^:
Patient states she will "do whatever you tell me here and whatever I need to get back to my job"
Pt's Goals for Treatment^:
Return to work
Have attorney advocate that legal charges be dropped
able to convince her boss that she is stable

Community Resources Current/Needed:
Unable to assess

Anticipated Treatment Mgr Role in TX/DC Planning:
FAMILY CONTACT
COORDINATION OF CARE/OPP
DISCHARGE PLANNING
REFERRAL TO COMM. RESOURC

Goals of Treatment: STABILIZE MOOD
IMPROVE COPING SKILLS

Monogram	Initials	Name	Nurse Type
MXS	J.NUR.MFS1	SANDIFORD,MARY	SW

WILLIAMS, LYNNAE D
J84090217483 ADM IN J.222-B
10/30/09 Roth, Richard L
DOB: 07/09/1976 F/33 MR# J000018122
Dominion Hospital

DOMINION HOSPITAL

Physician' Admission Instruction Sheet
Adult Services (Inpatient)

(CIRCLE THE ANSWER, YES OR NO)

(Y) N ADMIT TO THE ADULT UNIT
(Y) N REGULAR DIET (SPECIFY OTHER:_____)
(Y) N MEDICAL HISTORY AND PHYSICAL EXAMINATION
(Y) (N) PATIENT MAY SMOKE:
Rationale:
_____ Poly-Drug Withdrawal Treatment Complications
_____ Exacerbates Psychiatric Symptoms
_____ Deviates Focus of Inpatient Treatment Goals

DUAL DIAGNOSIS SERVICES:
Y (N) DUAL DIAGNOSIS EDUCATION GROUPS

PRECAUTIONS: ALL APPLY YES OR NO
LOCKED UNIT
15 MINUTE CHECKS
BELONGINGS/CLOTHES SEARCH
SHARPS RESTRICTIONS

LABS:
Y (N) CBC with differential
Y (N) CMP (fasting)
Y (N) TSH
Y (N) LIPID PANEL (fasting)
Y (N) URINE DRUG SCREEN
Y (N) SERUM BETA HCG (women of childbearing potential)
Y (N) OTHER: _____

OTHER: _____
_____
_____

I certify that Inpatient psychiatric services are medically necessary to prevent further decompensation.

_____ per _____				
Telephone Order Received by: (RN Signature)	Physician Name	Date	Time	Read Back (RN Initials)
C Stanton RN		10/30/09	1723	
Transcribed By: (RN Signature)		Date	Time	
S Slothum		10/30/09	5:00 PM	
Physician Signature		Date	Time	

DH-205 (3/05) rev 10/05 rev 8/07 rev 10/07 rev 01/09

POINT PEN FIRMLY T 4003

Authorization is hereby given to dispense the generic equivalent unless otherwise indicated by the physician.

Date	Time	Complete top portion with each Level of Care change. Indicate order with a Check Mark.
		☐ Outpatient Procedure: ____________ (procedure) for ____________ (medical reason)
		☐ Place in Outpatient Observation Services for ____________ (medical reason)
		☐ Admit as Inpatient for ____________ (medical reason)

Physician Signature: ____________________

Date	Time	Additional Orders: (Dates/Times required)
10/30/09 @	1135	Please admit pt to Adult Unit and call MD for orders ō nsg assessment
		T.O. Dr Roth / [illegible] Black, RN, RBV @ 1135 10/30/09 [signature] 10/30/09
		Noted @ 1440 [signature]
10/31/09		Discharge Today
		Obtain approval for PHP [signature]
		noted [illegible] RN 10/31/09 1330

Allergies & Sensitivities ☐ NKA

298.9

Weight	Height	Diagnosis
134	5'8"	Mood Disorder & Psychosis NOS

WILLIAMS,LYNNAE D
J84090217483 ADM IN J.222-B
10/30/09 Roth,Richard L
DOB:07/09/1976 F/33 MR# J000018122
Dominion Hospital

Dr Roth
Rm 222B

DO NOT WRITE ORDERS UNLESS RED # APPEARS

Physician's Orders

T4003 Rev 4/00 (RC# 0914041)

Administrative Data

TEMPORARY LOCATION

HOLD TRAY: DATE MEAL RELEASE HT 5 ft 8 in 172.72 cm
CONDITION VISITORS ALLOWED WT 134 lb 0.02 oz 60.782 kg
CMT
VISIT REASON IP SERVICES
--- Observation Patient ---
Dt in Tm in
Dt out Tm out

Coded Allergies/Adverse Reactions

Name / Reaction	Category	Severity	Ver?	Date	Time	User
Allergies						
Fluoxetine HCl RASH	Drug	M	Y	10/30/09	1240	HEB

Monogram Initials	Name	Nurse Type
HEB J.NUR.HEB	BLACK,ELIZABETH	RN

Psychosocial Assessment ~std 10/31/09 0948 AXZ

Reason For Admission^:
Pt is psychotic.

Does Patient Meet Criteria for Current Level of Care: Y
Supervisor Informed:

Primary Language: ENGLISH ENGLISH

Social/Cultural/Educational Influences^:
Pt works in the State Department. She gratuated from GTU from the School of Foreign Services. She was in a car accident 10/27/09. She reported to police that she wanted to know what it would feel like to be in a car accident. Later she did not recall saying that. Pt suspicious, talking to herself, and is exhibiting anxiety. Pt denies A/V hallucinations.

- According to police report that I have allegedly

~~FAMILY HISTORY~~~~
Family Psych Hx: Y

Family Psych Relationship: MA AUNT C SCHIZOPHRENIA

Describe Family Psych Hx^:

E ABOVE

Family Hx of Suicide: N

Family Suicide Relationship: N/A

Describe Family Hx of Suicide^:
N/A

Family CD Hx: N

Family CD Relationship: N/A

Describe Family CD Hx^:

Patient Psych/CD Treatment Hx: N

Describe Treatment Hx^:

Adult Partial Safety Assessmnt 11/04/09 1548 EMW

: TODAY; VERY ELEGANTLY AND NEATLY DRESSED IN BUSINESS SUIT. DENIES SI/HI/SIB
: GIVES SL=10
:
:
:

Monogram	Initials	Name	Nurse Type
EMW	J.NUR.EMW2	WITTING,ELIZABETH	RN
HEB	J.NUR.HEB	BLACK,ELIZABETH	RN

Psychosocial Assessment ~std 10/31/09 0948 AXZ

N/A

Additional Suicide Risk Elements: Hx of risky behavior
Sev. anxiety/panic/agitat
IDS WORK AS STRESSOR

Homicidal/Violence Risk Factors:
N/A

Marital Status: Single
Sexual Orientation:

# of Marriages: 0 How Long/Current: N/A

How Long Previous Marriages^:
N/A

Number of Children: 0 Ages: N/A

Living Arrangement: Own Place

Needs Alt Living Arrangement: Y

Social Support Network: Excellent

Support Person(s): Family
Friends
Treatment Participants: Parents

Support Comments^:
Pt states that she expects to be d/c today, but if she are to stay, she would like her parents to be involved in her tx here.

Describe Typical Day: work, shower, eat, talk with friends on the phone
Hobbies/Interests: Reading
Exercise
Watching movies
Studying languages

Religion: CHR CHRISTIAN

Spiritual Practices: None

Pt Believes in Higher Power: Y
Describe Higher Power^:
God

Last Grade Completed: MS
Degrees/Certificates: FOREIGN SERVICE FROM GTU

Current Student: N

Psychosocial Assessment ~std 10/31/09 0948 AXZ

Where: N/A

Change in School Performance: N
Describe Change In School Performance^:

Problems with Behavior at School: N
Truancy: N

Learning Problems/Special Education: N
Describe Learning/Behavioral Problems^:
N/A

~~~~EMPLOYMENT HISTORY~~~~
Currently Employed: Y
Pt Occupation: Foreign Service
Time at Current Job: 5 months
Job Satisfaction: High
Longest Time at One Job: 2.5 years
Frequent Job Changes: N
Reason for Job Changes^:

Unemployed in Last Year: N
Reason for Unemployment^:

Parent Occupation:
Spouse Occupation:
Financial Needs: Finances are not a problem for pt.
Military Hx: N
Branch(es):

# of Years:
Military Reserve:
Discharge Type:

Year:

Discharge R/T Substance Abuse:
Discharge R/T Psych Condition:

~~~~ARREST HISTORY~~~~
Arrest or Pending Litigation/Civil Charges Hx: N

Psychosocial Assessment ~std 10/31/09 0948 AXZ

Number of Arrests:
Reason for Arrest:
Arrests Involving Violence:
DUI/DWI:
When:
Public Intoxication:
When:
Probation Hx:
Why/When:
Parole Hx:
Why/When:

Describe Pending Litigation/Civil Charges^:

~~~~CAFFEINE HISTORY~~~~

Pt Use Caffeine: N

Types of Caffeine: None

Amt per Day:

~~~~NICOTINE HISTORY~~~~

Nicotine Hx: N

Kind of tobacco:

Age First Used:
Packs/tins per day:

How many years:
Any Consequences:

Quit:
When:

Psychosocial Assessment ~std 10/31/09 0948 AXZ

Does Patient Drink Alcoholic Beverages: N
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Alcohol Comment^:

Pt Believes ETOH Use a Problem: N
Negative Effects on Life: N/A

dical Problems from CD Use:N/A

Longest Sobriety:
When:
Sober Support System:
Who:
AA/NA:
Last Contact:
Sponsor:
Last Contact:

ETOH Sobriety/Support/Treatment Comments^:
N/A

Additional Drugs or Chemical Use: N
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:

Psychosocial Assessment ~std 10/31/09 0948 AXZ

Drug Use Comment^:

Pt Believes Drug Use a Problem: N
Negative Effects on Life:

Medical Problems from CD Use:

Longest Sobriety:
When:
Sober Support System:
Who:
AA/NA:
Last Contact:
Sponsor:
Last Contact:

CD Sobriety/Support/Treatment Comments^:
N/A

~~~~ABUSE HISTORY~~~~
motional, Physical, Neglect, Sexual) Abuse: N

Physical:
Describe Physical Abuse^:

Emotional:
Describe Emotional Abuse^:

Sexual:
Describe Sexual Abuse^:

Neglect:
Describe Neglect^:

Patient Has Hx of Abuse to Others: N
Describe Hx of Abuse to Others^:

Was CPS/APS Report Made: N
Describe CPS/APS Report^:

Describe CPS/APS Involvement^:
N/A
~~~~

Psychosocial Assessment ~std 10/31/09 0948 AXZ

Abuse Comments^:
N/A

~~~~STRENGTHS/WEAKNESSES~~~~
Stability of Home Environment: Strength

Motivation for Tx: Weakness ?

Insight into Current Problems: Weakness

Judgement Regarding Current Problems:
Weakness
Stability and Support of Employment:
Strength
Function of Marriage/Family System:
Strength
Support System in and Beyond Family:
Strength

Education Attainment: Strength

Intellectual Skills: Strength

Range of Leisure Activities^:
Adequate

Type of Recent Leisure Activities^:
Reading, learning languages, watching movies.

What Do You Do When Bored/Lonely^:
"I'll call someone on the phone or go out to eat with friends."

Does Your Work Schedule Interfere With Your Leisure Activities: N
Do You Belong to Any Social Groups/Community Organizations: Y

Improvement Needed in ANY of the following areas:
Pt does not identify needing any improvements.

Pt Perception of Illness^:
"I think the car accident precipitated me being here. I don't think I need to be here. I think there are misunderstandings, which caused me to be here."
Pt Perception of Needs^:
"Nothing."

Pt's Goals for Treatment^:
"To be discharged as soon as possible."
~~~~

Psychosocial Assessment -std 10/31/09 0948 AXZ

Community Resources Current/Needed:
N/A. Pt seems totally
clear in her thinking at
this time.
Anticipated Treatment Mgr Role in TX/DC Planning:
DISCHARGE PLANNING
FAMILY CONTACT

Goals of Treatment: IMPROVE COPING SKILLS

Monogram Initials		Name	Nurse Type
AXZ	J.NUR.AXZ	ZALK,ANITA	SW

Coded Allergies/Adverse Reactions

Name / Reaction	Category	Severity	Ver?	Date	Time	User
Allergies						
Fluoxetine HCl RASH	Drug	M	Y	10/30/09	1240	HEB

Adult Safety Assessment 10/30/09 1420 MVP

<< HOSPTIAL WIDE PRECAUTIONS >>		<< LESS RESTRICTIVE TO RESTRICTIVE >>	
Locked Unit	Y	Lounge Restriction	N
Unit Restriction	Y	Sign-In Requirement	N
Building Restriction	Y	Sharps Restriction	Y
15 Minute Checks	Y	Open Quiet Room	N
Belongings Searched	Y	1:1 Constant Observation (M.D. ordered)	N
Clothes Searched	Y	:	
afety Search (M.D. Ordered)	N	:	
Sharps Precautions	Y		
Elopement Precautions	N		
Mouth Checks	Y		
Fall Precautions	N		

Triage - NUR/CON ~std 10/30/09 1239 HEB

~~~~TRIAGE ASSESSMENT~~~~

Alerts: None

Document Allergies now? Y

Legal Status: Voluntary
Marital Status: Single

REFERRAL SOURCE: STATE DEPARTMENT
Specify Referral Source: Name, Location, Phone #:
DR LITOVITZ CALLED

Wt - Lb: 134
Oz:
Temperature: 97.8
Kg: 60.78
Pulse: 89
Ht - Ft: 5
Respirations: 17
In: 8.00
Blood Pressure: 127/76
Cm: 172.720
BMI: 20.3

Mode of Arrival: Public Transportation
Accompanied by: Self
General Appearance: Alert

Patient admitted/arriving from= WORK
Name of facility- STATE DEPARTMENT
Skin: Rashes or Bites: N
Describe: NONE

Breathing: Normal
Verbal: Confused
MEDICAL Hospitalization^:
GALL BLADDER 2005
~~~~

Triage - NUR/CON ~std 10/30/09 1239 HEB

Medical Conditions^:
CRRENT COLD

PSYCH Hospitalizations^:
NONE

OUTPATIENT TEAM:

Primary Care Physician: DR PAYTON
How Often: AS NEED Last Seen: SPRING 2009

Psychiatrist: NONE
How Often: Last Visit:
Length of time with: Phone Number:

Therapist: NONE
How Often: Last Visit:
Length of time with: Phone Number:

Sleep/Appetite Pattern: SLEEP P ACCIDENT DIFFICULT, PRIOR TO ACCIDENT IT WAS FINE; APPETITE DECLINED P ACCIDENT BUT PRIOR WAS NORMAL

~~~~MENTAL STATUS EXAM~~~~

Appearance: APPROPRIATE ATTIRE
DRESSED IN SUIT

Behavior: COOPERATIVE
TEARFUL
SUSPICIOUS
RESTLESS
"I HAVE A LOT ENERGY"
HAS ADD

Mood: ANXIOUS
"I FEEL GOOD"
SUPERFICIAL

Affect: RESTRICTED
ANXIOUS

Orientation: Oriented X3

Thought Process: INDECISIVE
BLOCKING
RAMBLING
DENIES RACING THOUGHTS
DISORGANIZED
CIRCUMSTANTIAL

Thought Content: PARANOIA
PERSEVERATIVE
CONCERN FOR JOB SECURITY
POOR MEMORY
POOR CONCENTRATION

Perceptual: DENIES

Speech: COHERENT
HESITANT
~~~~

Triage - NUR/CON ~std 10/30/09 1239 HEB

REPEATS QUESTIONS

Motor/Activity: Normal

Insight: Poor
Judgement: Poor
Impulse Control: High

~~~~~Chemical Dependency History~~~~~

~~~~CAFFEINE HISTORY~~~~

Types of Caffeine: None

Amt per Day:

Additional Drugs or Chemical Use: N
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:

Does Patient Drink Alcoholic Beverages: N
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Type of Alcohol:
How Often:
How Long:

Triage - NUR/CON -std 10/30/09 1239 HEB

How Much:
Last Drink:
Drug Use Comment^:

Alcohol Comment^:

Takes Daily Medications, Vitamins, Herbal or OTC Medications: Y

Suicidal Ideation: N Suicide Plan? N
Describe Suicidal Thoughts/Plan/Means^:

Previous Suicide Attempts: Y
When/How^:
IMPULSIVIELY DROVE INTO CAR AND CAUSED 2 CAR COLLISION
ON WED 10/27/09, WENT TO GEORGETOWN UNIVERSITY HOSP
YESTERDAY. HAS EXHIBITED BIZARRE BEHAVIOR SINCE THAT
TIME BUT PT IS POOR HISTORIAN AND DENIES REPORTED

Triage - NUR/CON ~std 10/30/09 1239 HEB

BEHAVIORS

Have you known someone who has attempted/committed suicide? N

When/How/Relation/Impact^:

Additional Suicide Risk Elements: Hx of risky behavior
Sev. anxiety/panic/agitat
IDS WORK AS STRESSOR

Homicidal Ideation: N Homicidal Plan? N
Describe Homicidal Thoughts/Plans/Means^:

Homicidal/Violence Risk Factors:
N/A

Self Destructive Behavior: Y
Self Destructive/Harm Behaviors:
INTENTIONAL CAR ACCIDENT
THIS WEEK
Describe Self-Destructive Behaviors^:
SEE ABOVE

Intoxicated: N Breathalyzer: N/A
Last Use^:

Psychotic: Y
Describe Psychosis^:
REPORTEDLY PARANOID BY STATE DEPT PSYCHIATRIST,
BIZARRE BEHAVIORS R/T CAR ACCIDENT THAT ARE NOT

Triage - NUR/CON ~std 10/30/09 1239 HEB

TYPICAL OF PT---CURSING, FEELING THAT PEOPLE WERE FOLLOWING HER, PT C MANY, MANY QUESTIONS RE HER JOB SECURITY TO THIS WRITER.

Physical/Sexual/Emotional/Verbal Abuse or Neglect Hx: N
Describe Abuse^:

Altered Mental Status: Y
Describe Mental Status^:
PSYCHOSIS, ANXIETY, SUSPICION, TALKING TO SELF DURING ASSESSMENT, DENIES A/V HALLUCINATIONS
Chief Complaint^:
PT UNDERSTANDING OF COMING TO HOSP IS TO HAVE AN ASSESSMENT D/T HER DISORGANIZATION FOLLOWING HER CAR ACCIDENT WAS PRIMARY REASON. ACCORDING TO POLICE STATEMENT SHE SAID SHE WANTED TO KNOW HOW IT WOULD FEEL TO BE IN A CAR ACCIDENT, STATES THAT SHE MADE SEVERAL INCONSISTENT STATEMENTS, SHE CANNOT REMEMBER THE STATEMENTS AT THE TIME OF ASSESSMENT. STATES THAT SHE SAW DR NEWMAN, A PSYCHIATRIST AT STATE DEPT AND WAS MAKING LOUD STATEMENTS, CURSING IN THE STATE DEPARTMENT CAFETERIA. DID NOT CALL INTO WORK THE DAY AFTER SHE HER CAR ACCIDENT. HAD FRIEND CALLED DAY LATER. DR NEWMAN CONTACTED DR LITOVITZ RE NEED FOR HOSPITALIZATION FOR PSYCHOSIS, NOS. PT C A HX OF DEPRESSION, HAS BEEN ON PROZAC IN PAST (HAD A RASH REACTION TO PROZAC). PT STATES THAT SHE WENT TO CABINET LEVEL ADMINISTRATOR'S OFFICE AT STATE DEPT TO ACCESS COMPUTER INFO ON HERSELF. SHE IS NOT A GOOD HISTORIAN ABOUT HERSELF. SHE RECOGNIZES NOW THAT WAS POOR JUDGEMENT ON HER PART. PT IS NEW EMPLOYEE AT THE STATE DEPT AND FEARS HER JOB SECURITY.

~~~~FAMILY HISTORY~~~~
Family Psych Hx: Y

Family Psych Relationship: MA AUNT C SCHIZOPHRENIA

Describe Family Psych Hx^: SEE ABOVE

Family Hx of Suicide: N

Family Suicide Relationship: N/A

Describe Family Hx of Suicide^: N/A
~~~~

Triage - NUR/CON ~std 10/30/09 1239 HEB

Family CD Hx: N

Family CD Relationship: N/A

Patient Psych/CD Treatment Hx: N

Describe Treatment Hx^: N/A

Last Grade Completed: MS
Degrees/Certificates: FOREIGN SERVICE FROM GTU

Current Student: N
Where: N/A

Change in School Performance: N
Describe Change In School Performance^:

Problems with Behavior at School: N
Truancy: N

Learning Problems/Special Education: N
Describe Learning/Behavioral Problems^:
N/A

Is Patient Present? Y
Able to perform TB & Contagious Respiratory Infection Point of Entry Screen Y
Reason-

Is patient currently experiencing any of following in last 7 days:

Fever greater than 100.4? N (37.8 C)
Cough? N (not related to allergy or COPD)
Persistent Cough greater than 3 weeks?
Cough with blood produced?
Sore Throat? Y
Night sweats? N
Unexplained weight loss? N
Fatigue? N

Triage - NUR/CON ~std 10/30/09 1239 HEB

Body Aches? N
Rash? N

Nasal Congestion (not related to allergies or sinus infections)? N

Pt reports prior history of TB or positive TB skin test? N
Close contact with a person who has TB? N
Close contact with any person having an Influenza-like Illness? N

TB Point of Entry Screen: NEGATIVE
Contagious Respiratory Infection Point of Entry Screen- NEGATIVE
Mask applied, patient isolated, and receiving unit/department notified?

Psychiatric Consultation: MD Consulted: DR ROTH
Time: 1135 On-Call: N Attending: N
Comments regarding phone consult with MD: DR ROTH
: RE RECENT CAR ACCIDENT, NEW ONSET PSYCHOSIS S/P CAR ACCIDENT

Axis 1-V I: PSYCHOSIS, NOS
II: DEF
III: COLD
IV: EMPLOYMENT, RECENT CAR ACCIDENT
V: GAF 30

Final Disposition Inpatient: Y
Home: N
Partial Hospitalization: N
Medical Hospital: N

>>Additional Admission Assessment Comments/Information/Summary<<
: PT IN RECENT CAR ACCIDENT, CONFUSED AND DISORGANIZED, CHANGED BEHAVIORS P THE ACCIDENT, SEEN BY STATE DEPT PSYCHIATRIST WHO RECOMMENDED INPATIENT PSYCH FOR FURTHER ASSESSMENT, EVALUATION FOR TREATMENT. PT PRESENTS AS ANXIOIUS, GUARDED, FEARS SECURITY OF HER JOB, NOTED TO TALK TO HERSELF DURING ASSESSMENT. ADMITS TO DISORGANIZED STATEMENTS AND CONFUSION P ACCIDENT. REPORTED STATED THAT SHE WANTED TO SEE HOW IT WOULD FEEL TO BE IN A CAR ACCIDENT. PT MEDICALLY CLEARED AT GTU HOSP ER ON WED 10/28/09. SAW STATE DEPT PSYCHIATRIST THIS MORNING THEN TOOK A CAB TO HOSP.
Left prior to triage: Direct Inpatient Admit

Home Medications:

~~~ PATIENT'S HOME MEDICATION LIST ~~~

Medication-Strength	Dose/Route	Frequency (Last Dose Taken)
ADDERALL	30 MG ORAL	DAILY
~~~

Triage - NUR/CON ~std 10/30/09 1239 HEB

(10/30/09)

End of Medication List

Sources Used For This Documentation: PATIENT REPORTED

Routine Pharmacies Used: CVS

Clarification needed for any Medication: N

Home Medication Disposition: AT HOME

:

INPT Admission Assessment ~std 10/30/09 1412 MVP

~~~ Inpatient Admission History & Assessment ~~~
Alerts: None

Time of arrival to unit: 1200

Chief Complaint^:

PT UNDERSTANDING OF COMING TO HOSP IS TO HAVE AN ASSESSMENT D/T HER DISORGANIZATION FOLLOWING HER CAR ACCIDENT WAS PRIMARY REASON. ACCORDING TO POLICE STATEMENT SHE SAID SHE WANTED TO KNOW HOW IT WOULD FEEL TO BE IN A CAR ACCIDENT, STATES THAT SHE MADE SEVERAL INCONSISTENT STATEMENTS, SHE CANNOT REMEMBER THE STATEMENTS AT THE TIME OF ASSESSMENT. STATES THAT SHE SAW DR NEWMAN, A PSYCHIATRIST AT STATE DEPT AND WAS MAKING LOUD STATEMENTS, CURSING IN THE STATE DEPARTMENT CAFETERIA. DID NOT CALL INTO WORK THE DAY AFTER THE HER CAR ACCIDENT. HAD FRIEND CALLED DAY LATER. DR NEWMAN CONTACTED DR LITOVITZ RE NEED FOR HOSPITALIZATION FOR PSYCHOSIS, NOS. PT C A HX OF DEPRESSION, HAS BEEN ON PROZAC IN PAST (HAD A RASH REACTION TO PROZAC). PT STATES THAT SHE WENT TO CABINET LEVEL ADMINISTRATOR'S OFFICE AT STATE DEPT TO ACCESS COMPUTER INFO ON HERSELF. SHE IS NOT A GOOD HISTORIAN ABOUT
~~~

INPT Admission Assessment ~std 10/30/09 1412 MVP

HERSELF. SHE RECOGNIZES NOW THAT WAS POOR JUDGEMENT ON HER PART. PT IS NEW EMPLOYEE AT THE STATE DEPT AND FEARS HER JOB SECURITY.

Isolation: STND

Code Status: FULL CODE

Age Categories: YOUNG ADULT 18-40 years
Developmentally Delayed:

Primary Language: ENGLISH ENGLISH
Language Barrier:
Interpreter Needed: Language Line Used:

Patient admitted/transferred from=

Cultural/Religious Beliefs affecting care:

Does Patient have any Mental Health Advance Directives: N
:
Name pt prefers to be called:

Is Patient Currently Participating in Research Projects:
Where:
Wt - Lb: 134 Ht - Ft: 5 Kg: 60.782
Oz: In: 8.00 Cm: 172.7200000
Wt Source: STANDING

BSA: 0.00 BSA Method: Haycock BMI: 20.3
History of Chronic pain: N
Chronic pain location:

Describe pain:

~~~ Pain Assessment ~~~
Presence of Pain: NO
Observed Behavior/Indication:

Pain Level: Pain Tool:
Patients Functional Pain Goal:
Pain Quality:

Pain Location:

Pain Comment^:

Neurological Hx: Denies ~~~ Neurological Assessment ~~~

Neurological Assessment WDP: Y No
Oriented To:

Hand Grips:
~~~

INPT Admission Assessment ~std 10/30/09 1412 MVP

Eyes Open:
Best Motor Response:
Best Verbal Response:
Total: .

Movement Right Arm:
Movement Left Arm:
Movement Right Leg:
Movement Left Leg:

Neuro Comment^:

~~~ Eye/Ear/Nose/Throat Assessment ~~~
EENT Hx: GLASSES

EENT Assessment WDP: Y N
Visual Impairment:

Hearing Impairment:

Throat Complaint:

Mucous Membranes:
Left Nares:

Right Nares:

EENT Comment^:

~~~ Cardiovascular Assessment ~~~
Cardiovascular Hx: DENIES

Cardiovascular Assessment WDP: Y

Skin Color:

Skin:

Associated Signs & Symptoms:

Does Patient Have a Pacemaker:
Implantable Defibrillator:

Cardiovascular Comment^:

Circulatory Assessment WDP: Y
Altered Circulatory Site:

INPT Admission Assessment ~std 10/30/09 1412 MVP

Proximal Pulse to Affected Site Evaluated:

Proximal Pulse Character:
Amount of Edema Noted Proximal to Affected Site:

Capillary Refill Proximal to Affected Site:

Skin Proximal to Affected Site:

Skin Color Proximal to Affected Site:

Sensation Proximal to Affected Site:

Distal Pulse to Affected Site Evaluated:

Distal Pulse Character:
Amount of Edema Noted Distal to Affected Site:

Capillary Refill Distal to Affected Site:

Skin Distal to Affected Site:

Skin Color Distal to Affected Site:

Sensation Distal to Affected Site:

Circulatory Comment^:

~~~ Respiratory Assessment ~~~
Respiratory Hx: DENIES

Previous treatment of asthma:
Tobacco Use Now or in Previous 12 Months:
NONE
Kind of tobacco:

Packs/tins per day:

How many years:
Quit? When:
Smoking Referral:

Smoking cessation instruction given to the patient and/or caregiver-

Smoking Comment^:
~~~

INPT Admission Assessment ~std 10/30/09 1412 MVP

Is Patient Present? Y
Able to perform TB & Contagious Respiratory Infection Point of Entry Screen Y
Reason-

Is patient currently experiencing any of following in last 7 days:

Fever greater than 100.4? N (37.8 C)
Cough? N (not related to allergy or COPD)
Persistent Cough greater than 3 weeks?
Cough with blood produced?
Sore Throat? Y
Night sweats? N
Unexplained weight loss? N
Fatigue? N
Body Aches? N
Rash? N

Nasal Congestion (not related to allergies or sinus infections)? N

Pt reports prior history of TB or positive TB skin test? N
Close contact with a person who has TB? N
Close contact with any person having an Influenza-like Illness? N

TB Point of Entry Screen: NEGATIVE
Contagious Respiratory Infection Point of Entry Screen- NEGATIVE
Mask applied, patient isolated, and receiving unit/department notified?

Respiratory Assessment WDP: Y
RUL Breath Sounds:
RLL Breath Sounds:
LUL Breath Sounds:
LLL Breath Sounds:
Respiratory Effort:
Cough:
Sputum Color:
Sputum Consistency:
Sputum Amount:

INPT Admission Assessment ~std 10/30/09 1412 MVP

Capillary Refill:

~~~ Oxygen/Respiratory Assessment ~~~

On Oxygen:
O2 Delivered Per:
O2 Liters / Minute:
SpO2 Continuous Monitoring:
SpO2% After Oxygen Applied:

Respiratory Comment^:

~~~ Gastrointestinal Assessment ~~~
Gastrointestinal Hx: DENIES

Gastrointestinal Assessment WDP: Y

GI Complaint:

Vomiting Episodes in Previous 24 Hours:
Content/Appearance of Emesis:

RUQ Bowel Sounds:
RLQ Bowel Sounds:
LUQ Bowel Sounds:
LLQ Bowel Sounds:

Last Bowel Movement: 10/30/09
Description of Stool: Normal

Abdomen Soft & Non-Tender:
Abdomen Firm/Rigid: N
Distention:
Guarding:

Rebound Tenderness:
Tenderness to Palpation:

Palpable Mass:

INPT Admission Assessment ~std 10/30/09 1412 MVP

GI Comment^:

~~~ Nutritional Assessment ~~~
Signs of Nutritional Risk: Nutrition Consult:
None

Nutritional Comments^:

Total:

~~~ Genitourinary Assessment ~~~
GU Hx: DENIES

Genitourinary Assessment WDP: Y
Sexual History: NOT Sexually Active

Sexual Orientation:

Condom used?
Reproductive-Female:

INPT Admission Assessment ~std 10/30/09 1412 MVP

Reproductive-Male:

LMP:
Abnormal Urination:

Urine Appearance:

Catheter:
Catheter Type:

Description of Catheter Function:

Associated Signs & Symptoms:

GU Comment^:

~~~ Endocrine Assessment ~~~
Endocrine Hx: DENIES

Endocrine System WDP: Y

Endocrine Comment^:

Immune System:

Immune System Comment^:

~~~ Musculoskeletal Assessment ~~~
Musculoskeletal Hx: DENIES

Musculoskeletal Assessment WDP: Y

Generalized Weakness:
Right Upper Extremity:

INPT Admission Assessment ~std 10/30/09 1412 MVP

Left Upper Extremity:
Right Lower Extremity:

Left Lower Extremity:

Balance/Gait:

Paralysis:

Amputee:

Complaints of Joint Swelling/Tenderness:

Musculoskeletal Comment^:

~~~ Functional Assessment ~~~
Functional Assessment WDP: Y

Functional Comment^:

Physical Limitations Interfering with Recreational Activities: N
Describe:

Other Limitations Interfering With Recreational Activities: N
Describe:

Need special equipment/supplies for routine care? N
Special Equipment:

Do you Exercise on a Regular Basis: Y
Type of Exercise: RUNNING, WEIGHTS

Frequency of Exercise: THREE TIMES A WEEK

Any Change in Sleep patterns:
NO SLEEP PROBLEMS

~~~ Integumentary Assessment ~~~
Integumentary Hx: DENIES

Prior history of chronic wounds, non healing wounds? N

INPT Admission Assessment ~std 10/30/09 1412 MVP

Prior history of staph infection? N

Integumentary Assessment WDP: Y

Presence of open or draining wounds?
Presence of wounds that resemble spider bites?

Integumentary Comments^:

#1 Incision/Wound Location:
#1 Incision/Wound Type:
#1 Incision/Wound Dressing Clean/Dry/Intact:
#1 Incision/Wound Dressing Change Date:
#1 Incision Approximated Without Redness:
#1 Incision/Wound Size (cm):
#1 Incision/Wound Depth (cm):
#1 Incision/Wound Edges:
#1 Incision/Wound Odor:

#1 Incision/Wound Drainage Amount:
#1 Incision/Wound Dressing/Treatment:

#1 Incision/Wound Comment:

#2 Incision/Wound Location:
#2 Incision/Wound Type:

INPT Admission Assessment ~std 10/30/09 1412 MVP

#2 Incision/Wound Dressing Clean/Dry/Intact:
#2 Incision/Wound Dressing Change Date:
#2 Incision Approximated Without Redness:
#2 Incision/Wound Size (cm):
#2 Incision/Wound Depth (cm):
#2 Incision/Wound Edges:
#2 Incision/Wound Odor:

#2 Incision/Wound Drainage Amount:
#2 Incision/Wound Dressing/Treatment:

#2 Incision/Wound Comment:

MEDICAL Hospitalization^:
GALL BLADDER 2005

Medical Conditions^:
CRRENT COLD

PSYCH Hospitalizations^:
NONE

Precautions:

Physical/Sexual/Emotional/Verbal Abuse or Neglect Hx: N
Evidence of Physical and/or Psychological Abuse: N
Does the Patient Feel Safe at Home: Y

Describe Abuse^:

INPT Admission Assessment ~std 10/30/09 1412 MVP

Appearance:	APPROPRIATE ATTIRE
~~MENTAL STATUS EXAM~~~~	DRESSED IN SUIT
Behavior:	COOPERATIVE
	TEARFUL
	SUSPICIOUS
	RESTLESS
	"I HAVE A LOT ENERGY"
	HAS ADD
Mood:	ANXIOUS
	"I FEEL GOOD"
	SUPERFICIAL
Affect:	RESTRICTED
	ANXIOUS
Orientation:	Oriented X3
Thought Process:	INDECISIVE
	BLOCKING
	RAMBLING
	DENIES RACING THOUGHTS
	DISORGANIZED
	CIRCUMSTANTIAL
Thought Content:	PARANOIA
	PERSEVERATIVE
	CONCERN FOR JOB SECURITY
	POOR MEMORY
	POOR CONCENTRATION
Perceptual:	DENIES
Speech:	COHERENT
	HESITANT
	REPEATS QUESTIONS
Motor/Activity:	Normal

~~~~RISK ASSESSMENT~~~~

Suicidal Ideation: N Suicide Plan? N

Describe Suicidal Thoughts/Plan/Means^:

Previous Suicide Attempts: Y

When/How^:

IMPULSIVIELY DROVE INTO CAR AND CAUSED 2 CAR COLLISION ON WED 10/27/09, WENT TO GEORGETOWN UNIVERSITY HOSP YESTERDAY. HAS EXHIBITED BIZARRE BEHAVIOR SINCE THAT TIME BUT PT IS POOR HISTORIAN AND DENIES REPORTED BEHAVIORS

Have you known someone who has attempted/committed suicide?N

When/How/Relation/Impact^:
~~~~

INPT Admission Assessment ~std 10/30/09 1412 MVP

Additional Suicide Risk Elements: Hx of risky behavior
Sev. anxiety/panic/agitat
IDS WORK AS STRESSOR

Homicidal Ideation: N Homicidal Plan? N
Describe Homicidal Thoughts/Plans/Means^:

Homicidal/Violence Risk Factors:
N/A

Self Destructive Behavior: Y
Self Destructive/Harm Behaviors:
INTENTIONAL CAR ACCIDENT
THIS WEEK
Describe Self-Destructive Behaviors^:
SEE ABOVE

Any Recent Losses?
Recent Loss, Explain^:

Intoxicated: N
Last Use^:

Psychotic: Y
Describe Psychosis^:
REPORTEDLY PARANOID BY STATE DEPT PSYCHIATRIST,
BIZARRE BEHAVIORS R/T CAR ACCIDENT THAT ARE NOT
TYPICAL OF PT---CURSING, FEELING THAT PEOPLE WERE
FOLLOWING HER, PT C MANY, MANY QUESTIONS RE HER JOB
SECURITY TO THIS WRITER.
==RESTRAINTS==
Technique/Methods/Tools to Help Pt Control their Behavior:

As Appropriate, Pt/Family helps in identifying such Techniques:

INPT Admission Assessment ~std 10/30/09 1412 MVP

Medical Cond. that places Pt at > Risk During Restraint/Seclus.:

Hx of Abuse that Would Increase Psychological Risk w/Restraint/Seclusion:
Pt/Family Educated on Hospitals Philosophy on Restraint/Seclusion:
Family's Role, Including Notification is Discussed as Appropriate:

~~~~CAFFEINE HISTORY~~~~

Types of Caffeine: None

Amt per Day:

Additional Drugs or Chemical Use: N
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Drug Use Comment^:

Does Patient Drink Alcoholic Beverages: N
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Type of Alcohol:
How Often:
How Long:
How Much:
~~~~

INPT Admission Assessment ~std 10/30/09 1412 MVP

Last Drink:
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Alcohol Comment^:

CDU DETOXIFICATION PROTOCOL WITHDRAWAL SEVERITY ASSESSMENT (WSAP)
Nausea/Vomiting:
Tremor:
Paroxysmal Sweats:
Anxiety:
Agitation:
Tactile Disturbances:
Auditory Disturbances:
Visual Disturbances:
Headache/Fullness in Head:
Orientation,Clouding Sensorium:
Score:

Detox Comment^:

FALL RISK ASSESSMENT:

=IMMUNIZATION/COMMUNICABLE DISEASE SCREEN=
Pneumoccal vaccination status-

Date:

Influenza vaccination status-

INPT Admission Assessment ~std 10/30/09 1412 MVP

Date:

Patient candidate for vaccine(s)?

Last Tetanus:

Hx/Assessment Comments^:

x-Source of Information:

~~ Adolescent Specific ~~

Immunizations Current?
Recent Exposures:

Pre or Perinatal Event:

Disease:

PT functioning affecting Family/Guardian:

Currently receiving help from any agencies?

Special educational needs?

Difficulty learning new things?

Easiest way for pt to learn?

How does pt exhibit anger:

INPT Admission Assessment ~std 10/30/09 1412 MVP

Exhibit frustration:

Exhibit sadness:

Respond to authority figures:

Discipline techniques used:

What works:

What doesn't work:

Anything preventing visiting pt:

Family/guardian involvement in treatment:

Family/guardian expectations for treatment:

Adolescent Comment^:

Education provided at this time:
Title of educator:

Person(s) educated:

Readiness to learn:

Identified learning needs:

Learning preference:

Barriers to learning:

Teaching method:

INPT Admission Assessment ~std 10/30/09 1412 MVP

New/Reinforcement teaching:

Specific topic(s) taught:

Response/evaluation:

Educ Content^:

~~ Medication Reconciliation ~~

Patient Compliance:
Why is Patient Non-Compliant:

Takes Daily Medications, Vitamins, Herbal or OTC Medications: Y

Home Medications:

~~~ PATIENT'S HOME MEDICATION LIST ~~~

Medication-Strength	Dose/Route	Frequency (Last Dose Taken)
ADDERALL	30 MG ORAL	DAILY (10/30/09)

End of Medication List
~~~

INPT Admission Assessment ~std 10/30/09 1412 MVP

Sources Used For This Documentation: PATIENT REPORTED

Routine Pharmacies Used: CVS

Clarification needed for any Medication: N

Home Medication Disposition: NONE

****
* Home Medication queries have been *
* reviewed/updated by J.NUR.MP RN *
****

Is patient Responsive:

Fall Risk Elements:

Add'l Fall Risk Elements:

Is patient following fall prevention directions:

Update Date of Last Fall:
Month/Year of Last Fall:

Fall Risk Comment:

High Risk for Falls:

Fall Precautions:

Fall Precautions Comment:

Fall this account/visit:

Monogram	Initials	Name	Nurse Type
HEB	J.NUR.HEB	BLACK,ELIZABETH	RN
MVP	J.NUR.MP	PERRY,MARILYN	RN

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1239

1002001 NURSE/TRIAGE std + A AS
- Create 10/30/09 1239 HEB 10/30/09 1312 HEB
- Document 10/30/09 1239 HEB 10/30/09 1312 HEB

~~~~TRIAGE ASSESSMENT~~~~

Alerts: None

Document Allergies now? Y

Legal Status: Voluntary
Marital Status: Single

REFERRAL SOURCE: STATE DEPARTMENT
Specify Referral Source: Name, Location, Phone #:
DR LITOVITZ CALLED

Wt - Lb: 134
Oz:
Kg: 60.78
Ht - Ft: 5
In: 8.00
Cm: 172.720 BMI: 20.3

Temperature: 97.8
Pulse: 89
Respirations: 17
Blood Pressure: 127/76
Mode of Arrival: Public Transportation
Accompanied by: Self
General Appearance: Alert

Patient admitted/arriving from= WORK
Name of facility- STATE DEPARTMENT
Skin: Rashes or Bites: N
Describe: NONE

Breathing: Normal
Verbal: Confused
MEDICAL Hospitalization^:
GALL BLADDER 2005

Medical Conditions^:
CRRENT COLD

PSYCH Hospitalizations^:
NONE

OUTPATIENT TEAM:

Primary Care Physician: DR PAYTON
How Often: AS NEED Last Seen: SPRING 2009

Psychiatrist: NONE
How Often: Last Visit:
Length of time with: Phone Number:

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1239 (continued)

1002001 NURSE/TRIAGE std + (continued)

Therapist: NONE
How Often: Last Visit:
Length of time with: Phone Number:

Sleep/Appetite Pattern: SLEEP P ACCIDENT DIFFICULT. PRIOR TO ACCIDENT IT WAS FINE; APPETITE DECLINED P ACCIDENT BUT PRIOR WAS NORMAL

~~~~MENTAL STATUS EXAM~~~~

Appearance: APPROPRIATE ATTIRE
DRESSED IN SUIT
Behavior: COOPERATIVE
TEARFUL
SUSPICIOUS
RESTLESS
"I HAVE A LOT ENERGY"
HAS ADD
Mood: ANXIOUS
"I FEEL GOOD"
SUPERFICIAL
Affect: RESTRICTED
ANXIOUS
Orientation: Oriented X3

Thought Process: INDECISIVE
BLOCKING
RAMBLING
DENIES RACING THOUGHTS
DISORGANIZED
CIRCUMSTANTIAL
Thought Content: PARANOIA
PERSEVERATIVE
CONCERN FOR JOB SECURITY
POOR MEMORY
POOR CONCENTRATION
Perceptual: DENIES

Speech: COHERENT
HESITANT
REPEATS QUESTIONS
Motor/Activity: Normal

Insight: Poor
Judgement: Poor
Impulse Control: High

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Charge

Activity Date: 10/30/09 Time: 1239 (continued)

1002001 NURSE/TRIAGE std + (continued)

~~~~~Chemical Dependency History~~~~~

~~~~CAFFEINE HISTORY~~~~

Types of Caffeine: None

Amt per Day:

Additional Drugs or Chemical Use: N
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:

Does Patient Drink Alcoholic Beverages: N
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Type of Alcohol:
How Often:
How Long:

Activity Date: 10/30/09 Time: 1239 (continued)

1002001 NURSE/TRIAGE std + (continued)

How Much:
Last Drink:
Drug Use Comment^:

Alcohol Comment^:

Takes Daily Medications, Vitamins, Herbal or OTC Medications: Y

Suicidal Ideation: N Suicide Plan? N
Describe Suicidal Thoughts/Plan/Means^:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1239 (continued)

1002001 NURSE/TRIAGE std + (continued)

Previous Suicide Attempts: Y
When/How^:
IMPULSIVIELY DROVE INTO CAR AND CAUSED 2 CAR COLLISION
ON WED 10/27/09. WENT TO GEORGETOWN UNIVERSITY HOSP
YESTERDAY. HAS EXHIBITED BIZARRE BEHAVIOR SINCE THAT
TIME BUT PT IS POOR HISTORIAN AND DENIES REPORTED
BEHAVIORS

Have you known someone who has attempted/committed suicide? N

When/How/Relation/Impact^:

Additional Suicide Risk Elements: Hx of risky behavior
Sev. anxiety/panic/agitat
IDS WORK AS STRESSOR

Homicidal Ideation: N Homicidal Plan? N
Describe Homicidal Thoughts/Plans/Means^:

Homicidal/Violence Risk Factors:
N/A

Self Destructive Behavior: Y
Self Destructive/Harm Behaviors:

Activity Date: 10/30/09 Time: 1239 (continued)

1002001 NURSE/TRIAGE std + (continued)
INTENTIONAL CAR ACCIDENT
THIS WEEK
Describe Self-Destructive Behaviors^:
SEE ABOVE

Intoxicated: N Breathalyzer: N/A
Last Use^:

Psychotic: Y
Describe Psychosis^:
REPORTEDLY PARANOID BY STATE DEPT PSYCHIATRIST.
BIZARRE BEHAVIORS R/T CAR ACCIDENT THAT ARE NOT
TYPICAL OF PT---CURSING, FEELING THAT PEOPLE WERE
FOLLOWING HER, PT C MANY, MANY QUESTIONS RE HER JOB
SECURITY TO THIS WRITER.

Physical/Sexual/Emotional/Verbal Abuse or Neglect Hx: N
Describe Abuse^:

Altered Mental Status: Y
Describe Mental Status^:
PSYCHOSIS, ANXIETY, SUSPICION. TALKING TO SELF DURING
ASSESSMENT. DENIES A/V HALLUCINATIONS
Chief Complaint^:
PT UNDERSTANDING OF COMING TO HOSP IS TO HAVE AN
ASSESSMENT D/T HER DISORGANIZATION FOLLOWING HER
CAR ACCIDENT WAS PRIMARY REASON. ACCORDING TO
POLICE STATEMENT SHE SAID SHE WANTED TO KNOW HOW
IT WOULD FEEL TO BE IN A CAR ACCIDENT. STATES THAT
SHE MADE SEVERAL INCONSISTENT STATEMENTS. SHE
CANNOT REMEMBER THE STATEMENTS AT THE TIME OF
ASSESSMENT. STATES THAT SHE SAW DR NEWMAN, A
PSYCHIATRIST AT STATE DEPT AND WAS MAKING LOUD
STATEMENTS. CURSING IN THE STATE DEPARTMENT
CAFETERIA. DID NOT CALL INTO WORK THE DAY AFTER
THE HER CAR ACCIDENT. HAD FRIEND CALLED DAY LATER.
DR NEWMAN CONTACTED DR LITOVITZ RE NEED
FOR HOSPITALIZATION FOR PSYCHOSIS, NOS. PT C A HX
OF DEPRESSION, HAS BEEN ON PROZAC IN PAST (HAD A
RASH REACTION TO PROZAC). PT STATES THAT SHE
WENT TO CABINET LEVEL ADMINISTRATOR'S OFFICE
AT STATE DEPT TO ACCESS COMPUTER INFO ON
HERSELF. SHE IS NOT A GOOD HISTORIAN ABOUT
HERSELF. SHE RECOGNIZES NOW THAT WAS POOR
JUDGEMENT ON HER PART. PT IS NEW EMPLOYEE AT THE
STATE DEPT AND FEARS HER JOB SECURITY.

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1239 (continued)

1002001 NURSE/TRIAGE std + (continued)

~~~~FAMILY HISTORY~~~~
Family Psych Hx: Y

Family Psych Relationship: MA AUNT C SCHIZOPHRENIA

Describe Family Psych Hx^: SEE ABOVE

Family Hx of Suicide: N

Family Suicide Relationship: N/A

Describe Family Hx of Suicide^: N/A

Family CD Hx: N

Family CD Relationship: N/A

Patient Psych/CD Treatment Hx: N

Describe Treatment Hx^: N/A

Last Grade Completed: MS
Degrees/Certificates: FOREIGN SERVICE FROM GTU

Current Student: N
Where: N/A

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Comment | Documented Units | Change

Activity Date: 10/30/09 Time: 1239 (continued)

1002001 NURSE/TRIAGE std + (continued)

Change in School Performance: N
Describe Change In School Performance^:

Problems with Behavior at School: N
Truancy: N

Learning Problems/Special Education: N
Describe Learning/Behavioral Problems^:
N/A

Is Patient Present? Y
Able to perform TB & Contagious Respiratory Infection Point of Entry Screen Y
Reason-

Is patient currently experiencing any of following in last 7 days:

Fever greater than 100.4? N (37.8 C)
Cough? N (not related to allergy or COPD)
Persistent Cough greater than 3 weeks?
Cough with blood produced?
Sore Throat? Y
Night sweats? N
Unexplained weight loss? N
Fatigue? N
Body Aches? N
Rash? N

Nasal Congestion (not related to allergies or sinus infections)? N

Pt reports prior history of TB or positive TB skin test? N
Close contact with a person who has TB? N
Close contact with any person having an Influenza-like Illness? N

TB Point of Entry Screen: NEGATIVE
Contagious Respiratory Infection Point of Entry Screen: NEGATIVE
Mask applied, patient isolated, and receiving unit/department notified?
~~~~

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1239 (continued)

1002001 NURSE/TRIAGE std + (continued)

Psychiatric Consultation: MD Consulted: DR ROTH
Time: 1135 On-Call: N Attending: N
Comments regarding phone consult with MD: DR ROTH
: RE RECENT CAR ACCIDENT, NEW ONSET PSYCHOSIS S/P CAR ACCIDENT

Axis 1-V I: PSYCHOSIS, NOS
II: DEF
III: COLD
IV: EMPLOYMENT, RECENT CAR ACCIDENT
V: GAF 30

Final Disposition Inpatient: Y Partial Hospitalization: N
Home: N Medical Hospital: N

>>Additional Admission Assessment Comments/Information/Summary<<
: PT IN RECENT CAR ACCIDENT, CONFUSED AND DISORGANIZED, CHANGED BEHAVIORS P THE ACCIDENT. SEEN BY STATE DEPT PSYCHIATRIST WHO RECOMMENDED INPATIENT PSYCH FOR FURTHER ASSESSMENT. EVALUATION FOR TREAIMENT. PT PRESENTS AS ANXIOIUS, GUARDED, FEARS SECURITY OF HER JOB. NOTED TO TALK TO HERSELF DURING ASSESSMENT. ADMITS TO DISORGANIZED STATEMENTS AND CONFUSION P ACCIDENT. REPORTED STATED THAT SHE WANTED TO SEE HOW IT WOULD FEEL TO BE IN A CAR ACCIDENT. PT MEDICALLY CLEARED AT GTU HOSP ER ON WED 10/28/09. SAW STATE DEPT PSYCHIATRIST THIS MORNING THEN TOOK A CAB TO HOSP.
Left prior to triage: Direct Inpatient Admit

Home Medications:
~~~ PATIENT'S HOME MEDICATION LIST ~~~

Medication-Strength	Dose/Route	Frequency (Last Dose Taken)
ADDERALL	30 MG ORAL	DAILY (10/30/09)

End of Medication List

Sources Used For This Documentation: PATIENT REPORTED

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1239 (continued)

1002001 NURSE/TRIAGE std + (continued)
Routine Pharmacies Used: CVS

Clarification needed for any Medication: N

Home Medication Disposition: AT HOME

Activity Date: 10/30/09 Time: 1240

MRI Allergies: 10/30/09 1240 HEB 10/30/09 1240 HEB
Starting Values
No allergy record on file.
Edited and Verified
Coded Allergies/Adverse Reactions

Activity	Name	Category	Type	Severity	Ver?
Reaction				Edit Activity	
ADD	Fluoxetine HCl	Drug	Allergy	M	Y
RASH					10/30/09 1240 HEB

Activity Date: 10/30/09 Time: 1400

1051009-A CARE AREA STATEMENT: MH Adult + A . At End of shift CP
~~DOCUMENT AT END OF EVERY SHIFT~~
To be documented every shift, to review current Pt. problems and to verify that the MH Adult Patient Population Care Standards have been followed.
- Document 10/30/09 1400 JLW 10/30/09 1530 JLW
1) Review of Patient PROBLEMS w/Status on PLAN of CARE

1:	Developmental Age 18-40 yrs-YOUNG ADLT	A13:	
2:	CARE GOALS: Dominion MH Adult	A14:	
3:	STANDARD: DOMINION HOSPITAL WIDE CARE	A15:	
4:	PSY.PROBLEM: Anxiety	A16:	
5:	PSY:PROBLEM: Alteration in Thought Proc	A17:	
6:		18:	
7:		19:	
8:		20:	
9:		21:	
10:		22:	
11:		23:	
12:		24:	

I have reviewed the Pt problems listed above and the Treatment Plan for pt: Y
The Pt Care Standards appropriate for this patient defined for his/her patient population have been met throughout the shift (unless otherwise documented): YES (Review-SHFT Fa)
Did the pt. start a new medication this shift? N
~~~

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 10/30/09 Time: 1400 (continued)

1051009-A CARE AREA STATEMENT: MH Adult + (continued)
Did pt have any adverse reaction to med this shift? N If yes, follow ADR Policy to report
Comment:
Enter Note? Shift: 7AM-3PM Signature: WRIGHT,JESSICA L - RN

Activity Date: 10/30/09 Time: 1410

1051009-A CARE AREA STATEMENT: MH Adult + A . At End of shift CP
~~DOCUMENT AT END OF EVERY SHIFT~~
To be documented every shift, to review current Pt. problems and to verify that the MH Adult Patient Population Care Standards have been followed.
- Create 10/30/09 1410 MVP 10/30/09 1411 MVP

1751000 VS: Monitor + A .Daily or per MD order. CP
- Create 10/30/09 1410 MVP 10/30/09 1411 MVP

2120363 MH Daily Nursing Assessment + A .Every 24 hours CP
- Create 10/30/09 1410 MVP 10/30/09 1411 MVP

2120365 ASSESSMENT: AT Evaluation + A . 1 Time CP
- Create 10/30/09 1410 MVP 10/30/09 1411 MVP

9100004 QUICK ADMISSION DATA + A AS
Nursing Quick Start
- Create 10/30/09 1410 MVP 10/30/09 1410 MVP
- Document 10/30/09 1410 MVP 10/30/09 1410 MVP
*** QUICK ADMIT ***

Location/Service: J.2A
Patient Care Type: ADT AGE: 33
Arrival Time: 1200

Activity Date: 10/30/09 Time: 1411

1001083 ADMISSION: Medication History + A AS
* Medication History to be done on Admission *
- Create 10/30/09 1411 MVP 10/30/09 1412 MVP
- Document 10/30/09 1411 MVP 10/30/09 1412 MVP
Home Medications:
~~~ PATIENT'S HOME MEDICATION LIST ~~~

Medication-Strength	Dose/Route	Frequency (Last Dose Taken)
ADDERALL	30 MG ORAL	DAILY (10/30/09)

End of Medication List

Activity Date: 10/30/09 Time: 1411 (continued)

1001083 ADMISSION: Medication History + (continued)

Sources Used For This Documentation: PATIENT REPORTED

Routine Pharmacies Used: CVS

Clarification needed for any Medication: N

Home Medication Disposition: NONE

****
* Home Medication queries have been *
* reviewed/updated by J.NUR.MP RN *
****

1001451-A CARE PLAN : MH ADDITIONS + A CP
~~Use in place of Add Interventions~~
Allows customization of Patient Care Plan.
- Create 10/30/09 1411 MVP 10/30/09 1411 MVP

1002003 Psychosocial Assessment std + A CP
- Create 10/30/09 1411 MVP 10/30/09 1411 MVP

1009999 UPDATE: Clarification of Medications + A CP
- Create 10/30/09 1411 MVP 10/30/09 1411 MVP

1300006 Age Specific Care: Young Adulthood + A CP
1. Assess patient's self-perception for motivation.
2. Assess body image.
3. Assist with identifying useful coping mechanisms and support systems.
4. Encourage to talk about illness/injury - how it may affect plans,family/finances.
5. Encourage patient and family in decision making and patient care, if wanted.
6. Educate re injury prevention and healthy lifestyle.
- Create 10/30/09 1411 MVP 10/30/09 1411 MVP
~~~

Intervention Description								Sts	Directions	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units		Change
Activity Date: 10/30/09 Time: 1411										
1572301	ASSESS: Weight as Ordered and Record +							A		CP
- Create	10/30/09	1411	MVP	10/30/09	1411	MVP				
2120366	MH Psycho-Educational Group +							A		CP
- Create	10/30/09	1411	MVP	10/30/09	1411	MVP				
2120370	MH SW Group Therapy Session +							A		CP
- Create	10/30/09	1411	MVP	10/30/09	1411	MVP				
2120752	Preceptor Documentation Co-Sign +							A		CP
- Create	10/30/09	1411	MVP	10/30/09	1411	MVP				
3766530	NUTRITION: Monitor Meals, Record % +							A		CP
- Create	10/30/09	1411	MVP	10/30/09	1411	MVP				
4136600	MEDS: Administer PAIN-MEDS(prn/standing)							A		CP
	1. Monitor effectiveness/side effects (and any adverse reactions).									
- Create	10/30/09	1411	MVP	10/30/09	1411	MVP				
4801200	EDUCATION: Interdisciplinary +							A		CP
- Create	10/30/09	1411	MVP	10/30/09	1411	MVP				
5021010	DISCHARGE: Complete Discharge Form +							A		CP
	ALSO: Complete paper form-when going home									
- Create	10/30/09	1411	MVP	10/30/09	1411	MVP				
5021012	DISCHARGE: MED REC PATIENT MED List +							A		CP
- Create	10/30/09	1411	MVP	10/30/09	1411	MVP				
Activity Date: 10/30/09 Time: 1412										
1002002	PSY: Admit History/Systems Assessment +							A		AS
- Create	10/30/09	1412	MVP	10/30/09	1420	MVP				
- Document	10/30/09	1412	MVP	10/30/09	1420	MVP				

~~~ Inpatient Admission History & Assessment ~~~

Alerts: None

Time of arrival to unit: 1200

Chief Complaint^:

PT UNDERSTANDING OF COMING TO HOSP IS TO HAVE AN ASSESSMENT D/T HER DISORGANIZATION FOLLOWING HER CAR ACCIDENT WAS PRIMARY REASON. ACCORDING TO POLICE STATEMENT SHE SAID SHE WANTED TO KNOW HOW IT WOULD FEEL TO BE IN A CAR ACCIDENT. STATES THAT SHE MADE SEVERAL INCONSISTENT STATEMENTS. SHE CANNOT REMEMBER THE STATEMENTS AT THE TIME OF ASSESSMENT. STATES THAT SHE SAW DR NEWMAN, A PSYCHIATRIST AT STATE DEPT AND WAS MAKING LOUD STATEMENTS, CURSING IN THE STATE DEPARTMENT CAFETERIA. DID NOT CALL INTO WORK THE DAY AFTER

Intervention Description								Sts	Directions	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units		Change
Activity Date: 10/30/09 Time: 1412 (continued)										
1002002	PSY: Admit History/Systems Assessment + (continued)									

THE HER CAR ACCIDENT. HAD FRIEND CALLED DAY LATER. DR NEWMAN CONTACTED DR LITOVITZ RE NEED FOR HOSPITALIZATION FOR PSYCHOSIS, NOS. PT C A HX OF DEPRESSION, HAS BEEN ON PROZAC IN PAST (HAD A RASH REACTION TO PROZAC). PT STATES THAT SHE WENT TO CABINET LEVEL ADMINISTRATOR'S OFFICE AT STATE DEPT TO ACCESS COMPUTER INFO ON HERSELF. SHE IS NOT A GOOD HISTORIAN ABOUT HERSELF. SHE RECOGNIZES NOW THAT WAS POOR JUDGEMENT ON HER PART. PT IS NEW EMPLOYEE AT THE STATE DEPT AND FEARS HER JOB SECURITY.

Isolation: STND

Code Status: FULL CODE

Age Categories: YOUNG ADULT 18-40 years
Developmentally Delayed:

Primary Language: ENGLISH ENGLISH
Language Barrier:
Interpreter Needed: Language Line Used:

Patient admitted/transferred from=

Cultural/Religious Beliefs affecting care:

Does Patient have any Mental Health Advance Directives: N
:
Name pt prefers to be called:

Is Patient Currently Participating in Research Projects:
Where:

Wt - Lb: 134 Ht - Ft: 5 Kg: 60.782
Oz: In: 8.00 Cm: 172.7200000
Wt Source: STANDING

BSA: 0.00 BSA Method: Haycock BMI: 20.3
History of Chronic pain: N
Chronic pain location:

Describe pain:

~~~ Pain Assessment ~~~

Presence of Pain: NO
Observed Behavior/Indication:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)
Pain Level: Pain Tool:
Patients Functional Pain Goal:
Pain Quality:

Pain Location:

Pain Comment^:

Neurological Hx: Denies --- Neurological Assessment ---

Neurological Assessment WDP: Y
Oriented To:

Hand Grips:

Eyes Open:
Best Motor Response:
Best Verbal Response:
Total:

Movement Right Arm:
Movement Left Arm:
Movement Right Leg:
Movement Left Leg:

Neuro Comment^:

--- Eye/Ear/Nose/Throat Assessment ---
EENT Hx: GLASSES

EENT Assessment WDP: Y
Visual Impairment:

Hearing Impairment:

Throat Complaint:

Mucous Membranes:
Left Nares:

Right Nares:

EENT Comment^:

--- Cardiovascular Assessment ---

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)
Cardiovascular Hx: DENIES

Cardiovascular Assessment WDP: Y

Skin Color:

Skin:

Associated Signs & Symptoms:

Does Patient Have a Pacemaker:
Implantable Defibrillator:

Cardiovascular Comment^:

Circulatory Assessment WDP: Y
Altered Circulatory Site:

Proximal Pulse to Affected Site Evaluated:

Proximal Pulse Character:
Amount of Edema Noted Proximal to Affected Site:

Capillary Refill Proximal to Affected Site:

Skin Proximal to Affected Site:

Skin Color Proximal to Affected Site:

Sensation Proximal to Affected Site:

Distal Pulse to Affected Site Evaluated:

Distal Pulse Character:
Amount of Edema Noted Distal to Affected Site:

Capillary Refill Distal to Affected Site:

Skin Distal to Affected Site:

Skin Color Distal to Affected Site:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Sensation Distal to Affected Site:

Circulatory Comment^:

--- Respiratory Assessment ---
Respiratory Hx: DENIES

Previous treatment of asthma:
Tobacco Use Now or in Previous 12 Months:
NONE
Kind of tobacco:

Packs/tins per day:

How many years:
Quit? When:
Smoking Referral:

Smoking cessation instruction given to the patient and/or caregiver-

Smoking Comment^:

Is Patient Present? Y
Able to perform TB & Contagious Respiratory Infection Point of Entry Screen Y
Reason-

Is patient currently experiencing any of following in last 7 days:

Fever greater than 100.4? N (37.8 C)
Cough? N (not related to allergy or COPD)
Persistent Cough greater than 3 weeks?
Cough with blood produced?
Sore Throat? Y
Night sweats? N
Unexplained weight loss? N
Fatigue? N
body Aches? N
Rash? N

Nasal Congestion (not related to allergies or sinus infections)? N

Intervention Description | Sts | Directions | From | Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Documented Units | Change

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Pt reports prior history of TB or positive TB skin test? N
Close contact with a person who has TB? N
Close contact with any person having an Influenza-like Illness? N

TB Point of Entry Screen:
NEGATIVE
Contagious Respiratory Infection Point of Entry Screen-
NEGATIVE
Mask applied, patient isolated, and receiving unit/department notified?

Respiratory Assessment WDP: Y
RUL Breath Sounds:

RLL Breath Sounds:

LUL Breath Sounds:

LLL Breath Sounds:

Respiratory Effort:

Cough:
Sputum Color:

Sputum Consistency:

Sputum Amount:
Capillary Refill:

--- Oxygen/Respiratory Assessment ---

On Oxygen:
O2 Delivered Per:
O2 Liters / Minute:
SpO2 Continuous Monitoring:
SpO2% After Oxygen Applied:

Respiratory Comment^:

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

~~~ Gastrointestinal Assessment ~~~
Gastrointestinal Hx: DENIES

Gastrointestinal Assessment WDP: Y

GI Complaint:

Vomiting Episodes in Previous 24 Hours:
Content/Appearance of Emesis:

RUQ Bowel Sounds:
RLQ Bowel Sounds:
LUQ Bowel Sounds:
LLQ Bowel Sounds:

Last Bowel Movement: 10/30/09
Description of Stool: Normal

Abdomen Soft & Non-Tender:
Abdomen Firm/Rigid: N
Distention:
Guarding:

Rebound Tenderness:
Tenderness to Palpation:

Palpable Mass:

GI Comment^:

~~~ Nutritional Assessment ~~~

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)
Signs of Nutritional Risk: Nutrition Consult:
None

Nutritional Comments^:

Total:

~~~ Genitourinary Assessment ~~~
GU Hx: DENIES

Genitourinary Assessment WDP: Y
Sexual History: NOT Sexually Active

Sexual Orientation:

Condom used?
Reproductive-Female:
~~~

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Reproductive-Male:

LMP:
Abnormal Urination:

Urine Appearance:

Catheter:
Catheter Type:

Description of Catheter Function:

Associated Signs & Symptoms:

GU Comment^:

--- Endocrine Assessment ---
Endocrine Hx: DENIES

Endocrine System WDP: Y

Endocrine Comment^:

Immune System:

Immune System Comment^:

--- Musculoskeletal Assessment ---

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Musculoskeletal Hx: DENIES

Musculoskeletal Assessment WDP: Y

Generalized Weakness:
Right Upper Extremity:
Left Upper Extremity:
Right Lower Extremity:

Left Lower Extremity:

Balance/Gait:

Paralysis:

Amputee:

Complaints of Joint Swelling/Tenderness:

Musculoskeletal Comment^:

--- Functional Assessment ---
Functional Assessment WDP: Y

Functional Comment^:

Physical Limitations Interfering with Recreational Activities: N
Describe:

Other Limitations Interfering With Recreational Activities: N
Describe:

Need special equipment/supplies for routine care? N
Special Equipment:

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Do you Exercise on a Regular Basis: Y
Type of Exercise: RUNNING, WEIGHTS

Frequency of Exercise: THREE TIMES A WEEK

Any Change in Sleep patterns:
NO SLEEP PROBLEMS

~~~ Integumentary Assessment ~~~
Integumentary Hx: DENIES

Prior history of chronic wounds, non healing wounds? N
Prior history of staph infection? N

Integumentary Assessment WDP: Y

Presence of open or draining wounds?
Presence of wounds that resemble spider bites?

Integumentary Comments^:

#1 Incision/Wound Location:
#1 Incision/Wound Type:
#1 Incision/Wound Dressing Clean/Dry/Intact:
#1 Incision/Wound Dressing Change Date:
#1 Incision Approximated Without Redness:
#1 Incision/Wound Size (cm):
#1 Incision/Wound Depth (cm):
#1 Incision/Wound Edges:
#1 Incision/Wound Odor:

#1 Incision/Wound Drainage Amount:

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)
#1 Incision/Wound Dressing/Treatment:

#1 Incision/Wound Comment:

#2 Incision/Wound Location:
#2 Incision/Wound Type:
#2 Incision/Wound Dressing Clean/Dry/Intact:
#2 Incision/Wound Dressing Change Date:
#2 Incision Approximated Without Redness:
#2 Incision/Wound Size (cm):
#2 Incision/Wound Depth (cm):
#2 Incision/Wound Edges:
#2 Incision/Wound Odor:

#2 Incision/Wound Drainage Amount:
#2 Incision/Wound Dressing/Treatment:

#2 Incision/Wound Comment:
~~~

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

MEDICAL Hospitalization^:
GALL BLADDER 2005

Medical Conditions^:
CRRENT COLD

PSYCH Hospitalizations^:
NONE

Precautions:

Physical/Sexual/Emotional/Verbal Abuse or Neglect Hx: N
Evidence of Physical and/or Psychological Abuse: N
Does the Patient Feel Safe at Home: Y

Describe Abuse^:

Appearance: APPROPRIATE ATTIRE
~~~~MENTAL STATUS EXAM~~~~ DRESSED IN SUIT
Behavior: COOPERATIVE
TEARFUL
SUSPICIOUS
RESTLESS
"I HAVE A LOT ENERGY"
HAS ADD
Mood: ANXIOUS
"I FEEL GOOD"
SUPERFICIAL
Affect: RESTRICTED
ANXIOUS
Orientation: Oriented X3

Thought Process: INDECISIVE
BLOCKING
RAMBLING
DENIES RACING THOUGHTS
DISORGANIZED
CIRCUMSTANTIAL

Intervention Description | Sts | Directions | From | Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Documented Units | Change

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Thought Content: PARANOIA
PERSEVERATIVE
CONCERN FOR JOB SECURITY
POOR MEMORY
POOR CONCENTRATION
Perceptual: DENIES

Speech: COHERENT
HESITANT
REPEATS QUESTIONS
Motor/Activity: Normal

~~~~RISK ASSESSMENT~~~~
Suicidal Ideation: N Suicide Plan? N
Describe Suicidal Thoughts/Plan/Means^:

Previous Suicide Attempts: Y
When/How^:
IMPULSIVIELY DROVE INTO CAR AND CAUSED 2 CAR COLLISION
ON WED 10/27/09. WENT TO GEORGETOWN UNIVERSITY HOSP
YESTERDAY. HAS EXHIBITED BIZARRE BEHAVIOR SINCE THAT
TIME BUT PT IS POOR HISTORIAN AND DENIES REPORTED
BEHAVIORS

Have you known someone who has attempted/committed suicide?N
When/How/Relation/Impact^:

Additional Suicide Risk Elements: Hx of risky behavior
Sev. anxiety/panic/agitat
IDS WORK AS STRESSOR

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Charge

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Homicidal Ideation: N Homicidal Plan? N
Describe Homicidal Thoughts/Plans/Means^:

Homicidal/Violence Risk Factors:
N/A

Self Destructive Behavior: Y
Self Destructive/Harm Behaviors:
INTENTIONAL CAR ACCIDENT
THIS WEEK
Describe Self-Destructive Behaviors^:
SEE ABOVE

Any Recent Losses?
Recent Loss, Explain^:

Intoxicated: N
Last Use^:

Psychotic: Y
Describe Psychosis^:
REPORTEDLY PARANOID BY STATE DEPT PSYCHIATRIST.
BIZARRE BEHAVIORS R/T CAR ACCIDENT THAT ARE NOT
TYPICAL OF PT---CURSING, FEELING THAT PEOPLE WERE
FOLLOWING HER. PT C MANY, MANY QUESTIONS RE HER JOB
SECURITY TO THIS WRITER.
==RESTRAINTS==
Technique/Methods/Tools to Help Pt Control their Behavior:

As Appropriate, Pt/Family Helps in Identifying such Techniques:
Medical Cond. that places Pt at > Risk During Restraint/Seclus.:

Hx of Abuse that Would Increase Psychological Risk w/Restraint/Seclusion:
Pt/Family Educated on Hospitals Philosophy on Restraint/Seclusion:
Family's Role, Including Notification is Discussed as Appropriate:
~~~~CAFFEINE HISTORY~~~~

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Charge

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Types of Caffeine: None

Amt per Day:

Additional Drugs or Chemical Use: N
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Drug Use Comment^:

Does Patient Drink Alcoholic Beverages: N
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
~~~~

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Charge

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Alcohol Comment^:

CDU DETOXIFICATION PROTOCOL WITHDRAWAL SEVERITY ASSESSMENT (WSAP)

Nausea/Vomiting:
Tremor:
Paroxysmal Sweats:
Anxiety:
Agitation:
Tactile Disturbances:
Auditory Disturbances:
Visual Disturbances:
Headache/Fullness in Head:
Orientation,Clouding Sensorium:
Score:

Detox Comment^:

FALL RISK ASSESSMENT:

=IMMUNIZATION/COMMUNICABLE DISEASE SCREEN=

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Pneumoccal vaccination status-

Date:

Influenza vaccination status-

Date:

Patient candidate for vaccine(s)?

Last Tetanus:

Hx/Assessment Comments^:

Hx-Source of Information:

-- Adolescent Specific --

Immunizations Current?
Recent Exposures:

Pre or Perinatal Event:

Disease:

PT functioning affecting Family/Guardian:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)
Currently receiving help from any agencies?

Special educational needs?

Difficulty learning new things?

Easiest way for pt to learn?

How does pt exhibit anger:

Exhibit frustration:

Exhibit sadness:

Respond to authority figures:

Discipline techniques used:

What works:

What doesn't work:

Anything preventing visiting pt:

Family/guardian involvement in treatment:

Family/guardian expectations for treatment:

Adolescent Comment^:

Education provided at this time:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)
Title of educator:

Person(s) educated:

Readiness to learn:

Identified learning needs:

Learning preference:

Barriers to learning:

Teaching method:

New/Reinforcement teaching:

Specific topic(s) taught:

Response/evaluation:

Educ Content^:

-- Medication Reconciliation --

Patient Compliance:
Why is Patient Non-Compliant:

Takes Daily Medications, Vitamins, Herbal or OTC Medications: Y

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Home Medications:

--- PATIENT'S HOME MEDICATION LIST ---

Medication-Strength	Dose/Route	Frequency (Last Dose Taken)
ADDERALL	30 MG ORAL	DAILY (10/30/09)

End of Medication List

Sources Used For This Documentation: PATIENT REPORTED

Routine Pharmacies Used: CVS

Clarification needed for any Medication: N

Home Medication Disposition: NONE

****
* Home Medication queries have been *
* reviewed/updated by J.NUR.MP RN *
****

Is patient Responsive:

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1412 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Fall Risk Elements:

Add'l Fall Risk Elements:

Is patient following fall prevention directions:

Update Date of Last Fall:
Month/Year of Last Fall:

Fall Risk Comment:

High Risk for Falls:

Fall Precautions:

Fall Precautions Comment:

Fall this account/visit:

Activity Date: 10/30/09 Time: 1420

1001070 Admission Initial Safety Assessment + A AS
* To be done on Admission *
- Create 10/30/09 1420 MVP 10/30/09 1421 MVP
- Document 10/30/09 1420 MVP 10/30/09 1421 MVP

<< HOSPTIAL WIDE PRECAUTIONS >>

Locked Unit Y
Unit Restriction Y
Building Restriction Y
15 Minute Checks Y
Belongings Searched Y
Clothes Searched Y
Safety Search (M.D. Ordered) N
Sharps Precautions Y

<< LESS RESTRICTIVE TO RESTRICTIVE >>

Lounge Restriction N
Sign-In Requirement N
Sharps Restriction Y
Open Quiet Room N
1:1 Constant Observation (M.D. ordered) N

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 10/30/09 Time: 1420 (continued)

1001070 Admission Initial Safety Assessment + (continued)
Elopement Precautions N
Mouth Checks Y
Fall Precautions N

1002030 PSY: Anxiety Disorder, Assess — A — CP
* Physician to assess mental status and effectiveness of medications.

* RN to assess anxiety and patient perception of effectiveness of medications.

* Patient education related to effects and side effects of medications administered to treat illness.

* Patient education regarding management of anxiety [], coping skills.

* Encourage Patient to attend group therapy related to [].

* Assist patient to identify anxiety-producing situations and plan for such events.

* Assist in the development of coping skills to manage anxiety.

- Create 10/30/09 1420 MVP 10/30/09 1420 MVP

1002051 PSY: Thought Disorder, Assess — A — CP
* Physician to assess mental status, and effectiveness of medications.

* RN to assess mental status and patient perception of effectiveness of medications.

* Patient education related to thought disorder and effects and side effects of medications administered to treat illness.

* Encourage patient to attend group therapy related to [].

* Assist pt to ID behaviors that alienate significant others and family members

* Collaborate with pt to identify anxious behavior and coping techniques

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 10/30/09 Time: 1420 (continued)

1002051 PSY: Thought Disorder, Assess (continued)

* Collaborate with pt to establish a daily, achievable routine

* Encourage pt to explore adaptive behaviors that increase socialization

* Encourage pt to explore adaptive behaviors that help to accomplish ADL's

- Create 10/30/09 1420 MVP 10/30/09 1420 MVP

Activity Date: 10/30/09 Time: 1432

1001083 ADMISSION: Medication History + — A — AS
* Medication History to be done on Admission *

- Document 10/30/09 1432 MVP 10/30/09 1433 MVP

Home Medications:

~~~ PATIENT'S HOME MEDICATION LIST ~~~

Medication-Strength	Dose/Route	Frequency (Last Dose Taken)
ADDERALL	30 MG ORAL	DAILY (10/30/09)

End of Medication List

Sources Used For This Documentation: PATIENT REPORTED

Routine Pharmacies Used: CVS

Clarification needed for any Medication: N
~~~