Alena Rakhman
H&P #1
Rotation 8 – Psychiatry

Location: CPEP, Queens Hospital Center
Date: 10/10/19
Time: 2:43 PM
Source of Info: patient, chart review

CC: suicidal ideation

HPI
23-year-old Caucasian male, single, unemployed, domicile with supportive family, with history of bipolar 1 disorder (2013), OCD, anxiety disorder, and cannabis abuse, brought it by EMS, activated by Social Security office staff secondary to patient verbalizing suicidal ideations with a plan to jump in front of a moving train. Pt states that he has been depressed for the past several weeks with poor sleep, fatigue, feeling hopeless, helpless, with loss of interest in daily activities despite compliance with his medications. His depression increased recently without any precipitating trigger. Pt states that he is currently taking Lithium, Latuda, Seroquel, Klonopin and Luvox with last dose taken last night. Pt states he has attempted suicide in the same manner in 2016 by lying on the train tracks and was hospitalized at the Montefiore Nayak hospital. Pt denies any history or current homicidal ideations, auditory hallucinations, and visual hallucinations. Reports using cannabis in the distant past and denies any recent history of drug use. Reports hx of bipolar disorder for mother and maternal grandmother, and alcohol abuse for father and paternal grandfather. Writer spoke with pt's parents, father John and mother Jane (123-456-7890), who report that pt has extensive psychiatric history, has been depressed, hopeless, with poor activities of daily living and has been a danger to self. Father states that pt is currently under the care of a private psychiatrist (Dr. Elliot Reid 333-444-7777) who is aware of pt's current situation and is recommending patient to be transferred to LIJ health system which she is affiliated with. Pt currently receives his medications from CVS pharmacy in Bayside. Writer attempted to contact outpatient provider and message was left. Writer spoke with staff from pt's CVS pharmacy (987-654-3210) and verified pt's medications. Pt is currently on Lamictal 150 mg PO BID, Seroquel 500 mg PO BID (double checked), Lithium ER 450 mg daily, Luvox 250 mg daily, and Klonopin 1 mg PO BID PRN.

Past medical/psychiatric history
- Bipolar 1 disorder (2013)
- OCD
- Anxiety disorder

Immunizations
- Up to date
- No influenza vaccine this year

Past surgical hx
- None

Past hospitalizations
- Montefiore Nayak hospital in 2016 after suicidal attempt

Medications
- Lamictal 150 mg PO BID
- Seroquel 500 mg PO BID
- Lithium ER 450 mg daily
- Luvox 250 mg daily
- Klonopin 1 mg PO BID PRN

Allergies
- Penicillin (rash)
- No known food or seasonal allergies

Family history
- Mother (Bipolar disorder)

- Father (Alcohol abuse)
- Maternal Grandmother (Bipolar disorder)
- Paternal Grandmother (Alcohol abuse)

Social History
- He is single, lives with his parents, and does not have any siblings or pets.
- He currently does not work and does not attend school.
- Denies hx of smoking cigarettes or alcohol consumption. Reports experimentation with cannabis in the past.
- He does not follow any specific diet.

ROS **(completed by CPEP triage RN)**

General
- denies generalized weakness/fatigue, loss of appetite, recent weight loss or gain, fever or chills, or night sweats

Skin, hair and nails
- denies change in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus, or changes in hair distribution

Head
- denies HA, vertigo, or head trauma

Eyes
- denies visual disturbance, lacrimation, photophobia, or pruritus; does not wear glasses or contacts

Ears
- denies deafness, pain, discharge, or tinnitus

Nose/Sinuses
- denies congestion, rhinorrhea, epistaxis or obstruction

Mouth and throat
- denies sore tongue, sore throat, mouth ulcers, voice changes, or bleeding gums

Neck
- denies localized swelling/lumps, or stiffness/decreased range of motion

Breast
- denies lumps or pain

Pulmonary System
- denies cough, SOB, wheezing, DOE, orthopnea, hemoptysis, cyanosis, or PND

Cardiovascular System
- denies CP, palpitations, HTN, irregular heartbeat, edema/swelling of ankles or feet, syncope or known heart murmur

Gastrointestinal System
- denies loss of appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, flatulence, eructations, abdominal pain, abdominal distention, constipation, diarrhea, change in bowel habit, hemorrhoids, or melena

Genitourinary System
- denies urinary urgency, urinary frequency, flank pain, nocturia, oliguria, polyuria, dysuria, incontinence, or awakening at night to urinate

Nervous System
- denies HA, seizures, loss of consciousness, weakness, sensory disturbances, ataxia, loss of strength, or change in cognition/mental status/memory

Musculoskeletal System
- denies muscle/joint pain, deformity/swelling, redness, or arthritis

Peripheral Vascular System
- denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, or color change

Hematologic System
- denies easy bruising or bleeding, hx of blood transfusions, lymph node enlargement, or history of DVT/PE

Endocrine System
- denies polyuria/polydipsia/polyphagia, heat or cold intolerance, goiter, excessive sweating, or hirsutism

Psychiatric
- **reports depression/sadness and sees a mental health professional, has history of anxiety, OCD, and bipolar disorder**

Physical Exam

General appearance: Alert, cooperative, appears stated age, well-developed, casually groomed and well-nourished, in no distress.

Vitals:

BP → 99/69 (left arm, sitting)
HR → 76 bpm, regular
RR → 17 bpm, unlabored
Temp → 98.6 F (oral)
SpO2 → 98% (room air)
Height → 72.2 inches
Weight → 190.9 pounds
BMI → 24.5

Skin: Intact, warm, dry, nonicteric, no scars, or tattoos.
Head: Normocephalic and atraumatic, no specific facies, nontender to palpation.
Hair: Short hair.
Nails: No signs of clubbing.
Eyes: Pupils are equal, round, and reactive to light. Conjunctivae and EOM are normal. No discharge noted in both eyes. No scleral icterus.
Ears: Symmetrical and normal in size. No evidence of lesions, masses, trauma on external ears. No discharge or foreign bodies in external auditory canals AU. TMs unremarkable.
Nose: Symmetrical, no obvious masses, lesions, deformities, trauma, discharge, evidence of foreign bodies.
Sinuses: Non-tender to palpation.
Lips: Pink, moist, no evidence of cyanosis or lesions.
Mucosa: Pink, well hydrated. No masses or lesions noted. No evidence of leukoplakia.
Palate: Pink, moist. Palate intact with no lesions, masses, or scars.
Teeth: Good dentition.
Gingivae: Pink, moist. No evidence of hyperplasia, masses, lesions, erythema or discharge.
Tongue: Pink, well papillated, no masses, lesions or deviation noted.
Oropharynx: Well hydrated, no evidence of injection, exudate, masses, lesions, foreign bodies.
Neck: Good ROM. No masses, lesions, scars, pulsations noted, non-tender to palpation. No stridor noted. No thrills, bruits, palpable adenopathy.
Thyroid: Non-tender, no palpable masses, no thyromegaly, no bruits noted.
Chest: Symmetrical, no deformities, no evidence of trauma. Respirations unlabored and no paradoxical respirations or use of accessory muscles noted. Non-tender to palpation.
Lungs: Clear to auscultation and percussion bilaterally. No adventitious sounds. No rales, rhonchi, or wheezing.
Heart: No JVD noted. Carotid pulses are 2+ bilaterally without bruits. RRR; S1 and S2 are normal. No murmurs, rubs, or gallops noted.
Abdomen: Round, symmetrical, no evidence of scars, striae, caput medusae or abnormal pulsations. BS present in all 4 quadrants. No bruits. Non-tender to light & deep palpation. No evidence of hepatomegaly or splenomegaly. No masses noted. No evidence of guarding or rebound tenderness.
Peripheral Vascular: The lower extremities are warm and dry. Pulses are 2+ bilaterally in extremities. No bruits noted. No ulcerations noted bilaterally.
Musculoskeletal: Normal range of motion. No edema, tenderness or deformity.
Motor/Cerebellar: Full active/passive ROM of all extremities without rigidity or spasticity. Normal muscle bulk and tone. No atrophy, tremors or fasciculations. Strength equal and appropriate for age bilaterally, 5/5 throughout.
Neurological: Alert and oriented to person, place, and time. He has normal reflexes. He exhibits normal muscle tone. Coordination normal.

CNI: smell → Intact
CNII: visual acuity → OS: Intact, OD: Intact
CNII: visual fields → Full to confrontation
CNII: pupils → Equal, round, reactive to light
CNIII, VII: ptosis → None
CNIII, IV, VI: extraocular muscles → Full ROM
CNV: mastication → Normal
CNV: facial light touch sensation → Normal
CNV, VII: corneal reflex → Present
CNVII: facial muscle function – upper → Normal
CNVII: facial muscle function – lower → Normal
CNVIII: hearing → Intact
CNIX: soft palate elevation → Normal

CNIX, X: gag reflex → Present
CNXI: trapezius strength → 5/5
CNXI: sternocleidomastoid strength → 5/5
CNXI: neck flexion strength → 5/5
CNXII: tongue strength → Normal

Mental Status Exam
Appearance: tall Caucasian male, casually groomed, dressed in clean clothes, no prominent scars of tattoos
Behavior: decreased activity, poor eye contact, hunched posture
Attention: alert
Attitude: cooperative
Speech: clear speech, monotone, soft volume
Mood: Sad/depressed
Affect: dysphoric, flat, mood-congruent, stable
Thought Pattern/Process: no thought disorder present, linear and goal directed
Though Content: suicidal ideation
Suicidal Ideation: active ideation with plan, described plan
Suicidal Ideation Remarks: to jump in front of a moving train
Homicidal Ideation: none
Delusions: none
Perception: unimpaired
Hallucinations: none
Orientation To: time, place, person
Concentration: fair
Memory: remove and recent memory unimpaired
Ability to Abstract: fair
Intellectual Functioning: average, consistent with level of education
Insight: understands his psychiatric conditions and is compliant with his medication
Judgement: limited, suicidal ideation and no plans for the future
Impulse Control: impaired, has suicidal but no homicidal urges

Labs
Lithium Level

	Ref Range & Units	**10/10/19**
Lithium	0.60 – 1.20 mmol/L	**0.38** ↓

CBC and differential

	Ref Range & Units	**10/10/19**
WBC	4.80 – 10.80 x10(3)/mcL	6.30
RBC	4.70 – 6.10 x10(6)/mcL	4.82
HGB	14.0 – 18.0 g/dL	**13.9** ↓
HCT	42.0 – 52.0 %	43.3
MCV	80.0 – 99.0 fL	89.8
MCH	27.0 – 31.0 pg	28.8
MCHC	29.8 – 35.2 g/dL	32.1
MPV	8.7 – 12.9 fL	9.5
RDW	12.0 – 15.0 %	13.5
PLT	150 – 450 x10(3)/mcL	179
Neutrophil %	44.0 – 70.0 %	**70.8** ↑
Lymphocyte %	20.2 – 45.0 %	20.5
Monocyte %	2.0 – 10.0 %	8.1
Eosinophil %	1.0 – 4.0 %	**0.0** ↓
Basophil %	0.0 – 2.0 %	0.0
Imm Gran %	0.0 – 2.0 %	0.6
Neutrophil Abs	2.10 – 7.60 x10(3)/mcL	4.46
Lymphocyte Abs	1.00 – 4.90 x10(3)/mcL	1.29
Monocyte Abs	0.10 – 1.10 x10(3)/mcL	0.51

Eosinophil Abs	0.10 – 0.40 x10(3)/mcL	**0.00 ↓**
Basophil Abs	0.00 – 0.20 x10(3)/mcL	0.00
Immature Gran Abs	0.00 – 0.20 x10(3)/mcL	0.04
NRBC Abs	<=0.00 x10(3)/mcL	0.00
NRBC %	0.0 – 0.0 %	0.0

CMP

	Ref Range & Units	**10/10/19**
BUN	6 – 23 mg/dL	10
Sodium	136 – 145 mmol/L	139
Potassium	3.5 – 5.1 mmol/L	4.0
Chloride	98 – 108 mmol/L	101
CO2	22 – 29 mmol/L	27
Glucose	74 – 110 mg/dL	104
Creatinine	0.70 – 1.20 mg/dL	**1.21 ↑**
Calcium	8.6 – 10.0 mg/dL	9.6
Total Protein	6.6 – 8.7 g/dL	7.3
Albumin	3.5 – 5.2 g/dL	5.1
Total Bilirubin	0.0 – 1.2 mg/dL	0.5
ALK PHOS	40 – 129 U/L	111
AST (SGOT)	5 – 40 U/L	24
ALT (SGPT)	0 – 41 U/L	26
Anion Gap	8 – 16 mEq/L	11
eGFR, Non-African-American	>=60 ml/min/1.73m2	>60

UA w/Rflx Micro

	Ref Range & Units	**10/11/19**
PH Urine	5.0 – 7.5	6.0
Color Urine	Yellow	**Dark Yellow**
Appearance Urine	Clear	Clear
Glucose Qualitative Urine	Negative mg/dL	Negative
Bilirubin Urine	Negative	Negative
Ketones Urine	Negative mg/dL	**Trace**
Specific Gravity Urine	1.005 – 1.030	**>=1.030**
Blood Urine	Negative	Negative
Protein Urine	Negative mg/dL	**30**
Urobilinogen Urine	0.2 – 1.0 mg/dL	1.0
Nitrite Urine	Negative	Negative
Leukocyte Esterase Urine	Negative	**Trace**
White Blood Cells Urine	0 – 4 HPF	0 - 4
Red Blood Cells Urine	0 – 3 HPF	0 - 3
Bacteria Urine	Negative	Negative
Squamous Epithelial Cells Urine	0 – 4 HPF	0 - 4
Hyaline Cast Urine	0 – 4 /lpf	0 - 4

Drug Screen Qual 5 Panel, Urine

	Ref Range & Units	**10/11/19**
Barbituates QUAL Urine	Cut-off = 200 ng/mL	Negative
Benzodiazepines QUAL Urine	Cut-off = 200 ng/mL	Negative
Cocaine Qual Urine	Cut-off = 300 ng/mL	Negative
Methadone Qual Urine	Cut-off = 300 ng/mL	Negative
Opiates Urine	Cut-off = 300 ng/mL	Negative
Creat, Urine (DAU)	mg/dL	469.0

THC Urine Qualitative 10/11/19 - Negative

Blood Alcohol Level (ordered, not collected)

Amphetamines Urine Qualitative (ordered, not collected)

ECG 10/10/19 – Normal sinus rhythm

Differential Diagnosis

Major depressive disorder

- 23 y/o, poor sleep, fatigue, feeling hopeless, helpless, with loss of interest in daily activities, suicidal ideation for at least 2 weeks

Bipolar I disorder

- Family hx (first degree relatives), 23 y/o, diagnosed in 2013, major depressive episode

Assessment

23-year-old Caucasian male, single, unemployed, domicile with supportive family, with history of bipolar 1 disorder (2013), OCD, anxiety disorder, and cannabis abuse, brought it by EMS, activated by Social Security office staff secondary to patient verbalizing suicidal ideations with a plan to jump in front of a moving train. Pt has been depressed for the past several weeks with poor sleep, fatigue, feeling hopeless, helpless, with loss of interest in daily activities despite compliance with his medications. He has attempted suicide in the same manner in 2016 by lying on the train tracks and was hospitalized. Pt denies any history or current homicidal ideations, auditory hallucinations, and visual hallucinations. Pt is a moderate suicide risk, depressed with suicidal thoughts and might be a danger to self.

Plan

- Admit to CPEP for observation/stabilization
- Q15 observation
- Consider 1:1 as needed
- Restart medications to aid with improving mood and reduce suicidal tendencies
- Labs and urine tox to rule out substance induced symptoms
- Re-evaluate in AM for higher level of care and inpatient admission
- Heart healthy diet
- Individual/Group/Milieu therapy
- Psychoeducation