

Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

13099



6 - MD NOTES

000001

HISTORY AND PHYSICAL EXAMINATION

PAGE 1 of 10

07-02-98 @ 1800

Date of Exam:

7/2/98

Time:

1815

AM / PM

MEDICAL HISTORY:

20 Yr

MAJOR ILLNESSES:

PAST -

∅

PRESENT -

∅

SURGICAL HISTORY:

∅

TRAUMA:

MEDICATIONS:

∅

ALLERGIES:

∅

SUBSTANCE USE:

ETOH:

∅

COCAINE:

∅

CANNABIS:

+

OPIATE:

+

NICOTINE:

BENZODIAZEPINES:

PCP:

LSD

STIMULANTS:

DEPRESSANTS:

OTHER:

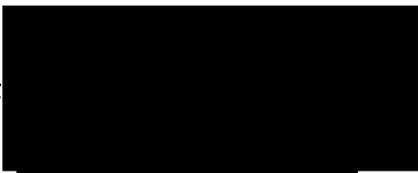
⊕ ephedrine
⊕ caffeine
⊕ BC powder

SIGNIFICANT SOCIAL ISSUES CONTRIBUTING TO CONDITION.

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HISTORY AND PHYSIC

PAGE 2 of 10 (Continued)



SIGNIFICANT FAMILY PSYCHIATRIC / ME



U... down psychiatric
DM - Diabetes

REVIEW OF SYSTEMS:

GENERAL:

INTEGUMENT:

HEENT:

BREASTS:

RESPIRATORY:

CARDIOVASCULAR:

GASTROINTESTINAL:

GYNECOLOGICAL:

GENITOURINARY:

OBSTETRICAL:

MUSCULOSKELETAL:

NEUROLOGICAL:

ENDOCRINE:

LYMPHATIC:

HEMATOLOGIC:

φ pharynx
φ pharynx
φ weight loss

DM

PHYSICAL EXAM:

VITAL SIGNS: BP 120/110 P 80 R _____ TEMP _____ HT _____ WT _____

GENERAL APPEARANCE:

INSPECTION: Patient is well-developed, well-nourished individual who does not appear to be acutely or chronically ill. Posture is appropriate, no visible disturbance of gait.

SPECIFY OTHERWISE:

SKIN:

PALPATION: Warm, moist, elastic.
 INSPECTION: Without significant eruptions or discoloration.

SPECIFY OTHERWISE:

HISTORY AND PHYSICAL EXAMINATION

PAGE 3 of 10 (Continued)

HEAD:

- INSPECTION: Scalp is clean. Hair is of normal distribution of color.
- SPECIFY OTHERWISE: _____

FACE:

- INSPECTION: Facial countour, mobility, and expression are normal. No marked asymmetry or sagging is noted.
- SPECIFY OTHERWISE: _____

EYES:

- INSPECTION: Pupils are equal, round, regular, and react to light and accommodation. Extraocular movements are normal. The sclera is white. Conjunctivae 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.
- SPECIFY OTHERWISE: _____

NOSE:

- INSPECTION: No obvious deformity. Mucous membranes are not inflamed. Turbinates are not swollen. Air ways are patent. There is no septal perforation.
- SPECIFY OTHERWISE: _____

EARS:

- INSPECTION: Canals are clear. Tympanic membranes intact and noninjected. Hearing is adequate for normal conversation. Auricles are free from tophi or other abnormalities. Weber _____ Rinne _____
- SPECIFY OTHERWISE: _____

MOUTH:

- INSPECTION: No unusual breath odors. There is no 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:

- INSPECTION: Mucosa is not inflamed. No evidence of swelling or exudate. Tonsils are present and not enlarged.
- SPECIFY OTHERWISE: _____

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HISTORY AND PHYSICAL EXAMINATION

PAGE 4 of 10 (Continued)

THYROID:

- INSPECTION / PALPATION: The thyroid gland is normal in size and consistency.
- SPECIFY OTHERWISE: _____

NECK:

- INSPECTION / PALPATION: There is no limitation of lateral, anteroposterior or rotating motion. Trachea is midline.
- SPECIFY OTHERWISE: _____

GLANDS:

- INSPECTION: There is no significant lymph gland enlargement in the neck, axillae, epitrochlear area, supraclavicular area or groin.
- SPECIFY OTHERWISE: _____

CHEST:

- INSPECTION: Normal contour and movement on inspiration / expiration.
- SPECIFY OTHERWISE: _____

LUNGS:

- AUSCULTATION: Breath sounds are audible. No rales, rhonchi, or wheezes are noted.
- PERCUSSION: Resonant in all fields.
- SPECIFY OTHERWISE: _____

BREASTS:

- INSPECTION / PALPATION: Free from masses and tenderness, discharge, dimpling, wrinkling or discoloration of the skin.
- SPECIFY OTHERWISE: _____

HEART:

- INSPECTION: Not enlarged to percussion.
- AUSCULTATION: Heart sounds are regular in rhythm and of normal rate. No murmurs, thrills, clicks, or rubs.
- SPECIFY OTHERWISE: _____

ABDOMEN:

- INSPECTION / PALPATION: Normal contour, no masses or tenderness, no palpable organomegaly (kidney, liver, spleen). There is no costovertebral angle tenderness. No guarding.
- PERCUSSION: No tympany nor free fluid.
- AUSCULTATION: Peristaltic sounds audible in four quadrants. No bruits.
- SPECIFY OTHERWISE (Include Scars): _____

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HISTORY AND PHYSICAL EXAMINATION

PAGE 5 of 10 (Continued)

Patient Identification

SEXUAL HISTORY:

- CIRCLE WHAT APPLIES: Heterosexual Homosexual Sexually Active
- NO HISTORY OF SEXUALLY TRANSMITTED DISEASES
- SPECIFY OTHERWISE: _____

GENITALIA / PELVIC - FEMALE:

- INSPECTION / PALPATION: No hernia. No lesions of the labia or introitus are noted. The vaginal mucosa is moist and normally elastic. Uterus is normal size, shape, position, freely movable. Cervix is without lesions. There is no significant vaginal discharge.
- SPECIFY OTHERWISE: _____
- DATE / RESULT OF LAST PELVIC EXAMINATION: _____
- DATE / RESULT OF LAST MAMMOGRAPHY: _____

If not performed:

- PATIENT IS LESS THAN 18 AND NOT SEXUALLY ACTIVE.
- RECENT EXAM COMPLETED ON _____ BY _____
- PATIENT WISHES TO HAVE OWN INTERNIST OR GYNECOLOGIST PERFORM EXAM.
Physican's Name: _____
- PATIENT UNABLE TO COOPERATE BECAUSE OF PSYCHIATRIC CONDITION; EXAM DEFERRED UNTIL (Date): _____
- SPECIFY OTHERWISE: _____

GENITALIA - MALE:

- INSPECTION / PALPATION: Both testes palpable. No abnormal masses. No hernia. No urethral discharge. No lesion of glans or shaft noted.
- SPECIFY OTHERWISE: _____
- DATE AND RESULTS OF LAST EXAMINATION: Recently Examined by urologist

If not performed:

- REASON: deferred

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HISTORY AND PHYSICAL EXAMINATION

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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, breast and papillae elevated as small mounds. Scanty pubic hair; slightly enlarged penis; enlarged scrotum, pink texture altered.
- STAGE 3: Pubic hair darker, beginning to curl, increased amount; breasts and areolae enlarged, no contour separation. Pubic hair darker and curly. Penis, scrotum larger.
- STAGE 4: Pubic hair coarse, curly, more abundant; areolae and papillae form secondary mound. Adult-type pubic hair; penis larger, wider; Scrotum larger, darker.
- STAGE 5: Pubic hair is adult feminine triangle; mature breast, nipples project, areolae part of general breast contour. Adult pubic hair distribution; full growth of penis and testes.

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

- INSPECTION: No evidence of hemorrhoids, fissures, bleeding or masses. Palpation: In male, prostate is smooth, non-tender, free from nodules, is of normal size. Sphincter tone normal.

SPECIFY OTHERWISE: _____

DATE / RESULTS OF LAST EXAMINATION: _____

SPECIFY OTHERWISE: _____

If not performed:

REASON: deferred

CIRCULATION:

- INSPECTION: No significant varicosities.
- PALPATION: Pulses are palpable and regular in neck, wrist, groin, popliteal and tibial arteries.
- AUSCULTATION: No audible bruits
- SPECIFY OTHERWISE: _____

EXTREMITIES:

- INSPECTION / PALPATION: Full range of motion of joints. No discoloration, tenderness, edema or evidence of impaired function.
- SPECIFY OTHERWISE: _____

BACK:

- INSPECTION: There is normal curvature of the spine. Able to bend from waist.
- PERCUSSION / PALPITATION: There is no tenderness of the cervical, dorsal and lumbar spines.
- SPECIFY OTHERWISE: _____

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HISTORY AND PHYSICAL EXAMINATION

PAGE 7 of 10 (Continued)

Patient Identification

NEUROLOGICAL EXAMINATION:

Level of Consciousness:

- ALERT
- DROWSY
- STUPOR
- COMA
- RIGHT
- LEFT
- AMBIDEXTROUS

Knowledge:

- APPROPRIATE TO AGE, EDUCATION, CULTURAL BACKGROUND, LIFE EXPERIENCES.
- SPECIFY OTHERWISE: masked faces. paranoid

Speech and Language:

- CLEAR ARTICULATION.
- SPECIFY OTHERWISE: slow - delayed

Examination of Cranial Nerves:

Olfactory (CN 1):

- ABLE TO PERCEIVE FAMILIAR ODORS.
- SPECIFY OTHERWISE: _____

Optic (CN 2):

Visual Fields:

- FULL WITH NO DEFICITS ON CONFRONTATION; ABILITY TO DISTINGUISH NUMBER OF FINGERS IN CENTRAL FIELD, DISTINGUISHES MOVEMENT IN PERIPHERAL FIELDS.
- SPECIFY OTHERWISE: Not done

Fundi:

- FLAT, DISCS NOT ELEVATED, NO ARTERIOVENOUS NICKING, NO HEMORRHAGES, NO RETINAL PIGMENTATION.
- SPECIFY OTHERWISE: No AV nicking or copper wiring

Pupillary Reactivity (CN 3):

- PUPIL SIZE SYMMETRICAL; PUPILS NEITHER WIDELY DILATED NOR PINPOINT IN AVERAGE ROOM LIGHT; PROMPT CONSTRICTION IN REACTION TO DIRECT LIGHT STIMULUS.
- SPECIFY OTHERWISE: _____

Movement of Eyes - Oculomotor (CN 3), Trochlear (CN 4), and Abducens Nerves (CN 6):

- SMOOTH, SYMMETRICAL MOVEMENT THROUGH ALL POSITIONS OF GAZE, NO NYSTAGMUS PRESENT.
- SPECIFY OTHERWISE: _____

Eyelid Elevation (CN 7):

- ABLE TO RETRACT EYELID FULLY.
- SPECIFY OTHERWISE: _____

Trigeminal (CN 5) - Ophthalmic Branch, Maxillary Branch, Mandibular Branch:

- WITH EYES CLOSED, INDICATES FACIAL AND AURAL TACTILE PERCEPTION.

Movement of Muscles of Mastication:

- SYMMETRICAL TENSION IN MUSCLES OF CLENCHED JAW; ABLE TO MOVE JAW Laterally AGAINST RESISTANCE; SYMMETRICAL MUSCLE MASS OF TEMPORALS AND MASSETER; INVOLUNTARY CHEWING MOVEMENTS AND TRISMUS; CHEWS SYMMETRICALLY.
- SPECIFY OTHERWISE: _____

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HISTORY AND PHYSICAL EXAMINATION

PAGE 8 of 10 (Continued)



NEUROLOGICAL EXAMINATION: (Continued)

Facial (CN 7):

- NORMAL FACIAL INSPECTION; FROWNS AND ELEVATION OF EYELIDS TIGHTLY, ADEQUATE SALIVA PRODUCTION; ABLE TO SHOW TEETH; SMILES. EYELIDS TIGHTLY, ADEQUATE MORS.
- SPECIFY OTHERWISE: _____

Acoustics (CN 8):

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 POSTURAL DEVIATION (Absent Romberg).
- SPECIFY OTHERWISE: _____

Glossopharyngeal (CN 9) and Vagus Nerves (CN 10):

- NORMAL MIDLINE ELEVATION OF UVULA AND PALATE; GAG REFLEX PRESENT; LARYNGEAL CONTOURS RISE WITH SWALLOWING; PHONATE WITHOUT HOARSENESS OR ARTICULATION DIFFICULTY.
- SPECIFY OTHERWISE: _____

Accessory Nerve (CN 11):

- NORMAL STRENGTH AND SYMMETRY ON TURNING HEAD AND ELEVATION OF SHOULDERS.
- SPECIFY OTHERWISE: _____

Hypoglossal Nerve (CN 12):

- TONGUE PROTRUDES IN MIDLINE WITH ABSENCE OF FASCICULATION, 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 RAPIDLY AND ACCURATELY WITH NO PAST-POINTING; ABLE TO PERFORM RAPID ALTERNATING MOVEMENTS (Suspination and Pronation of Forearms) QUICKLY AND SYMMETRICALLY.
- SPECIFY OTHERWISE: _____

MOTOR FUNCTIONS:

Muscle Tone and Mass:

- SYMMETRICAL ON INSPECTION, GOOD TONE WITHOUT SPASTICITY OR RIGIDITY; NO CONTRACTURE 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 GROUPS ON FLEXION AND EXTENSION, ABDUCTION AND ADDUCTION.
- SPECIFY OTHERWISE: _____



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HISTORY AND PHYSICAL EXAMINATION

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MOTOR FUNCTIONS (Continued):

Involuntary Movements:

ABSENCE OF TREMORS, TWITCHES, TICS, FIBRILLATIONS, 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 AND PIN PRICK.

SPECIFY OTHERWISE: _____

OTHER REFLEXES AND SIGNS:

Babinski's Sign:

ABSENT (Great Toes Down Going on Right and/or Left).

PRESENT (Toes Up Going on Right and/or Left).

NON REACTIVE OR EQUIVOCAL.

Meningeal Signs:

PRESENT KERNIG BRUDZINSKI

Abdominal Reflexes:

NORMAL ABDOMINAL REFLEXES.

SPECIFY OTHERWISE: _____

Primitive Reflexes:

PRESENT Describe: _____

Deep Reflexes:

Please Note Results of Tests of Biceps, Triceps, Radiohumeral, Quadriceps, and Achilles Reflexes.

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

	Left	Right
BICEPS	_____	_____
TRICEPS	_____	_____
RADIOHUMERAL	_____	_____
QUADRICEPS	_____	_____
ACHILLES	_____	_____

Patent Reflexes

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HISTORY AND PHYSICAL EXAMINATION

PAGE 10 of 10 (Continued)



Clinical Impressions / Diagnoses:

- ① psychotic / paranoid 63
- ② substance abuse
- ③ HTN

Recommendations / Course of Action:

- ① recheck BP in 29° if still elevated
must begin Verapamil SR 180 qd
- ② ✓ SMA 70 - BUN / creat
✓ JATMICO

Medical Problems Which Should Be Addressed During This Episode of Treatment:

ABOVE

1)

Medical Problems Which Should Be Addressed After Discharge:

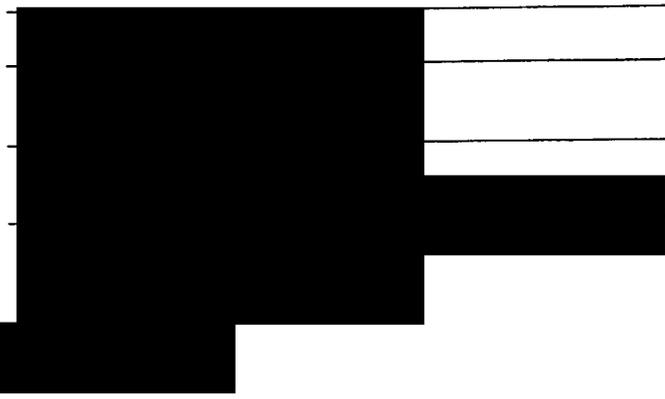
further medical care

Patient Physically Able To Participate In All Aspects of Programming?

YES NO

If not, list limitations:

No commensurate distress noted



7/2/98

Date / Time

1825

Date / Time

7/3/98

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TREATMENT PLAN - PROBLEM SHEET

PAGE 1 of 2

PROBLEM: OUT OF CONTACT WITH REALITY

AS MANIFESTED BY: CONFUSION:

(Please specify)

- DELUSIONS: *believes [redacted] island (of) pregnant, [redacted]*
- PARANOIA:
- HALLUCINATIONS: *see a man*
- OTHER: *quit 2 jobs recently, attended
grad school, abuses medication,
Caffeine, RC powder, MT*

LONG-TERM GOALS: (Discharge Criteria)

- Patient's symptomatology will be controlled to the point that patient can be discharged back to an independent living or structured living situation in the community.
- Patient and/or family verbalizes understanding of medication compliance for continued stabilization.

SHORT-TERM GOALS:

Date	Number	Goals	Target Date	Date Resolved
<i>7/2/98</i>	<i>1</i>	<input checked="" type="checkbox"/> Patient accepts help from staff and others. <input checked="" type="checkbox"/> Patient is oriented x 4 for <i>7</i> consecutive days. <input checked="" type="checkbox"/> Patient states hallucinations are decreased or eliminated. <i>dealt with</i> <input checked="" type="checkbox"/> Patient will no longer state delusions related to [redacted] <input type="checkbox"/> Patient will no longer display paranoid behavior of <i>other people</i> <input type="checkbox"/> Patient will state why he/she is taking meds and side effects to look for. <input type="checkbox"/> Patient can tell when thoughts / conversation is becoming delusional. <input type="checkbox"/> Patient knows 2 ways to distract self from hallucinations / delusional thinking.	<i>7/9/98</i>	

**INITIAL EVALUATION OF RISK
TO SELF / OTHERS**

PAGE 1 of 2

Patient Identification

(Please check all that apply)

Informant was Patient Family Friends Hospital Health Professional
 Other Health Professional Other

SECTION I - CURRENT RISK TO SELF / OTHERS:

Does patient or do others report:

the patient having suicidal ideation or making suicidal threats?

Yes

No

the patient having homicidal ideation or making homicidal threats?

Yes

No

If the answers to the above questions are NO, then go to Section II;
Otherwise, answer the following questions:

Is the ideation repetitive or persistent?

Yes

No

Does the patient have a specific plan?

Yes

No

Does the ideation involve serious / lethal intent?

Yes

No

Does the ideation have delusional or hallucinatory content?

Yes

No

If the answer to any of the above questions is YES, then describe the basis for such answer below.
Comments: (Describe the patient's plan, ideation, hallucination, etc.)

SECTION II - HISTORY OF SUICIDAL / HOMICIDAL IDEATION / BEHAVIORS:

Is there a history of suicidal / self-injuring ideation / behavior?

Yes

No

Is there a history of homicidal / assaultive ideation / behavior?

Yes

No

Is there a history of serious physical harm to self / others while in an
intensive treatment setting?

Yes

No

If the answers to any of the above questions are NO, then go to Section III.

If the answer to any of the above questions is YES, then describe this history of suicidal/homicidal/assaultive - ideation/behaviors.

SECTION III - ACCURACY OF REPORTS AND HISTORY OF RISK

Is there any evidence or concern that the patient or others may be concealing or denying current
or past suicide / homicide / assaultive - ideation / behaviors?

Yes

No

If the answer is YES, describe the evidence and/or concerns below:

This guideline is not intended to preclude any additional assessment tool, nor is it a substitute for clinical judgement.

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INITIAL EVALUATION OF RISK
TO SELF / OTHERS



SECTION IV - SUICIDE & HOMICIDE/VIOLENCE RISK FACTORS

The following risk factors are not completely exhaustive.

Suicide Risk Factors:

- 19 years or younger or 45 and older
- Single, widowed, divorced, or separated
- Lack of social or religious support
- History of suicide in immediate family
- Possession or access to gun
- Significant loss of employment
- Severe financial difficulties
- Severe problems with significant others
- Severe school difficulties
- Significant legal difficulties
- Severe worry / rumination
- Calm after agitated depression

- History of major depression
- History of schizophrenia or bipolar disorder
- Alcohol or heavy drug use
- Borderline personality disorder
- Organic brain syndrome
- Severe anxiety / panic
- Organized plan with lethal intent
- Blunted / flat affect
- Hopelessness
- Rapid mood shifts
- Command hallucinations
- Severe insomnia

Homicide / Violence Risk Factors:

- Violence / threats toward others
- Possession or access to gun
- Paranoid ideation
- Organic brain syndrome
- Heavy alcohol or drug use
- Previous history of violence
- Violent social environment
- Command hallucinations or delusions
- Borderline or antisocial personality disorder

Comments:

SUMMARY EVALUATION OF RISK OF SUICIDE / HOMICIDE / ASSAULTIVE BEHAVIOR:

Rank below your conclusion regarding this patient's SUICIDAL risk and make any comments:

- Low to No Risk
- Moderate Risk
- Imminent Risk

Rank below your conclusion regarding this patient's HOMICIDAL / ASSAULTIVE risk and make any comments:

- Low to No Risk
- Moderate Risk
- Imminent Risk

Comments: Pt + (m) deny any past or current S.I. Pt.'s (m) feels Pt is at 0 risk but this writer does not rule out that Pt is having a psychotic break and danger is difficult to assess

Evaluation completed by Date / Time: 7/2/98 1200

Reviewed with Physician: Date / Time: _____

Reviewing Physician's Signature Date / Time: 7/3/98 (0900)

This guideline is not intended to preclude any additional assessment tool, nor is it a substitute for clinical judgement.

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COMPREHENSIVE ASSESSMENT TO

NEEDS ASSESSMENT
PART 1 PAGE 1 of 6

PATIENT NAME: [REDACTED] OF BIRTH: [REDACTED]
 MARITAL STATUS: [REDACTED] LEGAL STATUS: [REDACTED]
 OCCUPATION: [REDACTED] PRIMARY CARE PHYSICIAN: Dr. [REDACTED]
 ACCOMPANIED BY: (m) [REDACTED] REFERRAL SOURCE: [REDACTED]

CHIEF COMPLAINT (In patient's own words)

WHY ARE YOU HERE TODAY? Depressed, anxious, worried. ↑ stress
 knowal who. Pt 'disoriented to time' "I believe
 that I'm working for [REDACTED]" and "I'm
 hoping someone will hear me" who? "The govern
 meet (m) reports of putting a lot of pressure to speed time
 w/ her.

PRECIPITATING EVENT

EVENTS WHICH OCCURRED IN PREVIOUS 24 - 72 HOURS WHICH PROMPTED ASSESSMENT:
 quit 2 jobs on
 Sunday quit weekend job last Sat + was "fired"
 from [REDACTED] on Tues. Unable to speed time w/
 at recently. When pressed Pt says he keeps re-
 membering the name [REDACTED] - says he seen
 a therapist and people. he gave him a pill
 Stopped taking phedrine + caffeine 2-3 wks ago

PRESENTING PROBLEMS / SOMATIC SYMPTOMS

1. MAJOR LIFE AREAS	ADMITTED	DENIED	D.N.A.*	AS EVIDENCED BY FREQUENCY, INTENSITY, DURATION
PROBLEMS AT WORK OR SCHOOL Per (m): They barely know [REDACTED]				dearly s/s Sat.
DETERIORATION IN HYGIENE AND / OR GROOMING				Pt denies any current problems.
LOSS OF ENERGY OR INTEREST IN ACTIVITIES				
SOCIAL WITHDRAWAL				
ABILITY TO PARENT NA				
OTHER				

2. BEHAVIOR CHANGES	ADMITTED	DENIED	D.N.A.*	AS EVIDENCED BY FREQUENCY, INTENSITY, DURATION
i.e., IRRITABILITY, POOR IMPULSE CONTROL				Pt (alone) + peaceful
OTHER				

3. SLEEP	ADMITTED	DENIED	D.N.A.*	AS EVIDENCED BY FREQUENCY, INTENSITY, DURATION
NOT SLEEPING				
DIFFICULTY GOING TO SLEEP (INITIAL INSOMNIA)				worried. Admits
FREQUENT AWAKENING DURING NIGHT (MID INSOMNIA)				that he has been sleeping
EARLY MORNING AWAKENING (TERMINAL INSOMNIA)				(m) reports Pt not sleeping
SLEEPS ALL DAY				Pt Δ's answers
USUAL NUMBER OF HOURS OF SLEEP				
OTHER				

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*DNA = Did Not Ask

2/14/08 at 9:30am
 X 200 Slobo.
 0 1000
 1/10/08

Pt. told (m) that he quit job 20 @ [REDACTED]

COMPREHENSIVE ASSESSMENT TOOL

NEEDS ASSESSMENT
PART 1 PAGE 2 of 6

4. EATING

	ADMITS	DENIES	D.N.A.*	AS EVIDENCED BY FREQUENCY, INTENSITY, DURATION
BINGING				
PURGING				
EXCESSIVE EXERCISING				
LAXATIVE USE				
ABSENCE OF MENSES				
COMPULSIVE OVEREATING				
IPECAC USE				
OTHER:				
CHANGES IN EATING HABITS (DESCRIBE):				

not eating thru contra
dictory. Self. Says. is
eating normally since
first job.

WEIGHT: LOSS GAIN NUMBER OF POUNDS: _____ WITHIN: (Check One) Days Weeks Months
FREQUENCY OF WEIGHING SELF: _____

5. ANXIETY

	ADMITS	DENIES	D.N.A.*	AS EVIDENCED BY FREQUENCY, INTENSITY, DURATION
PANIC ATTACKS				
OBSESSIVE / COMPULSIVE THOUGHTS				
OBSESSIVE / COMPULSIVE BEHAVIORS				
OTHER:				

pt. suspects he's having
a panic attack ever-
reently. - heart flutter
ing, sweating palms

6. PSYCHOSIS

	ADMITS	DENIES	D.N.A.*	AS EVIDENCED BY FREQUENCY, INTENSITY, DURATION
HALLUCINATIONS				
Visual, Tactile, Olfactory, Auditory				
Command				
DELUSIONS				
Bizarre				
PARANOID IDEATIONS				
OTHER				

pt. (w/ denial) but was "talkin'
to self" in lobby, ~~being~~
inappropriate in lobby
pt. has bizarre ideas of
[redacted]
possible
When asked re' (A) "he's
[redacted] at home view now"
pt. thinks [redacted] had him LSD in
"let's dead"

7. RISK ASSESSMENT - DUE TO THE IMPORTANCE OF RISK ASSESSMENT, THE SEPARATE "RISK EVALUATION FORM" (CS003-01) IS COMPLETED AND ATTACHED.

8. CHILD ADOLESCENT ASSESSMENT

	ADMITS	DENIES	D.N.A.*	AS EVIDENCED BY FREQUENCY, INTENSITY, DURATION
RUNNING AWAY RISK				
BEDWETTING				
DESTRUCTION OF PROPERTY				
CRUELTY TO ANIMALS				
STEALING				
REBELLIOUS / DEFIES FAMILY / AUTHORITY				
SATANIC INVOLVEMENT				
FIRE SETTING				
PROBLEMS AT SCHOOL				
GANG INVOLVEMENT				
OTHER				

Per (u): [redacted] over
a wood working shop
wants pt. to do some
drawings for him.
pt repeatedly states he is
under stress but is
unable to name any
stressors.

*DNA = Did Not Ask

COMPREHENSIVE ASSESSMENT TOOL

NEEDS ASSESSMENT
PART 1 PAGE 3 of 6

Patient Identification

9. ALCOHOL / DRUG USE *pt. denies.*

- | | | | |
|---------------------------------------|---|--|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Stimulants | <input type="checkbox"/> Barbituates |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Hallucinogens (Acid / LSD) | <input type="checkbox"/> Methadone | <input type="checkbox"/> Pain Meds |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Opiates | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Over-The-Counter Meds |
| <input type="checkbox"/> Caffeine | <input type="checkbox"/> Inhalants | <input type="checkbox"/> Sedatives | |
| <input type="checkbox"/> Other: _____ | | | |

Substance Checked	Amount / Frequency	Duration of Use	Last Use	Amount Used in Last 24 Hours
<i>Pt. took Ephedrine + caffeine pills</i>				
<i>Stopped 2-3 wks. ago. - pt reports stress + anxiety -</i>				
<i>causing it. Started them. (M) reports pt. took</i>				
<i>other supplements in addition, quantities + type</i>				
<i>unknown.</i>				

DOES PATIENT HAVE A HISTORY OF WITHDRAWAL, DTs, BLACKOUTS (LOSS OF TIME), SEIZURES, ETC.? _____

WHAT IS LONGEST PERIOD OF SOBRIETY? _____ WHEN? _____

WITHDRAWAL SYMPTOMS / BEHAVIORS FROM ALCOHOL / DRUG USE:

- | | | | | |
|---|-----------------------------------|---------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Aggression / Assaultive | <input type="checkbox"/> Cramps | <input type="checkbox"/> Agitation | <input type="checkbox"/> Weakness | <input type="checkbox"/> Diaphoresis |
| <input type="checkbox"/> Change in Blood Pressure | <input type="checkbox"/> Tingling | <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Fever / Chills |
| <input type="checkbox"/> Nausea / Vomiting | <input type="checkbox"/> Tremors | <input type="checkbox"/> Irritability | <input type="checkbox"/> Delirium | <input type="checkbox"/> Anorexia |

Symptoms Checked	Frequency	Duration	Most Recent Complaint

MedWatch #13099 Investigation
Exhibit# / Part 7 of 13
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BREATHALYZER _____

10. MEDICATIONS / HEALTH

Current Medications	Dosage	Prescribed By	Last Use	Is Medication Being Taken as Prescribed
<i>Ø</i>				

000017

COMPREHENSIVE ASSESSMENT TOOL

NEEDS ASSESSMENT
PART 1 PAGE 4 of 6

10. MEDICATIONS / HEALTH (Continued)

CURRENT MEDICAL / PHYSICAL PROBLEMS (LIST): 0

ALLERGIES? _____

VITAL SIGNS (When Indicated): _____

B/P _____ PULSE _____ RESPIRATION _____ TEMPERATURE _____

11. PREVIOUS TREATMENT: Psychiatric / Substance Abuse

Facility	Level of Continuum	Dates	MD / Therapist	DX if Known	Outcome
pt. thinks he recalls working w/ therapist who gave him aid	— (u)	reports 0-0 prior tx, therapist.			

12. SUPPORT SYSTEMS (Availability of Family / Friends to Participate in Treatment, Special Family Concerns)

CURRENT LIVING ARRANGEMENTS: m + bro Parents divorced
 but pt said "I live w/ my (m) + (f) but my (f) is dead"

MARITAL HISTORY: Support system: [redacted] Grand, GF.

CHILDREN: _____

13. FAMILY HISTORY:

SUBSTANCE ABUSE: (D) EtOH ic

PSYCHIATRIC: 0 known

14. LEGAL HISTORY

CURRENT ILLNESS HAS AFFECTED LEGAL HISTORY: 2 Yes ___ No ___

DESCRIBE: _____

COMPREHENSIVE ASSESSMENT TOOL

NEEDS ASSESSMENT
PART 1 PAGE 5 of 6

Patient Identification

15. MENTAL STATUS

APPEARANCE: NEAT / WELL GROOMED DISHEVELED UNCLEAN BIZARRE OTHER
EXPLAIN: _____

SPEECH: NORMAL ABNORMAL
EXPLAIN: _____

MOOD / AFFECT (Describe): LABILE FLAT OTHER *calm but somewhat impatient + slightly hostile*
EXPLAIN: _____

FLIGHT OF IDEAS: YES NO *non-sensical statements
bizarre statements, per (u)*
EXPLAIN: _____

JUDGMENT: GOOD FAIR POOR *biggie 7/11. Pt. a very
poor historian, either*
EXPLAIN: _____

INSIGHT: GOOD FAIR POOR *cannot remember or
knows contradicts self*
EXPLAIN: _____

MEMORY: RECENT: GOOD FAIR POOR *repeatedly.*
REMOTE: GOOD FAIR POOR
OTHER: _____

LEVEL OF CARE DETERMINATION

The level of care decision (excluding outpatient) was made by the physician. Check the following which support the level of care assigned.

ACUTE MEDICAL HOSPITAL REFERRAL

- ___ Life threatening or potentially life threatening medical condition which prohibits the initiation of treatment.
- ___ Medical evaluation indicated based on symptoms identified at time of assessment.

INPATIENT ACUTE CARE

- ___ Behavior which is life threatening, destructive or disabling to self or others.
- ___ Symptoms / behaviors indicative of need for 24 hours monitoring and assessment of the patient's condition: *(Circle all that apply)*
 - ___ Vegetative Sx
 - ___ Sig Wt. Loss
 - ___ Inability to Sleep
 - ___ Inability to Care for Self
 - ___ Self-mutilation
 - ___ Psychotic Depression
 - ___ Hallucinations
 - ___ Psychomotor Retardation / Agitation
 - ___ Acute Onset Confusion / Memory Loss
- ___ Active psychiatric disorder with potential to interfere with treatment of serious medical condition.
- ___ Failure at outpatient or partial hospitalization treatment evidenced by clinical instability or an MD consult indicates a condition which precludes safe treatment at a lesser level of care
- ___ Condition requires a medically monitored detoxification process.
- ___ Severe deterioration of level of functioning.

23 HOUR INTENSIVE EVALUATION

- ___ Extensive evaluation and assessment to determine most appropriate level of care.
- ___ Identified need for acute crises intervention to stabilize patient.
- ___ Deterioration of existing support systems.

000019

COMPREHENSIVE ASSESSMENT TOOL

NEEDS ASSESSMENT
PART 1 PAGE 6 of 6

PARTIAL HOSPITALIZATION

- Symptoms / behaviors manifestations of such severity that there is interference with social, family, vocational functioning.
- Symptoms / behaviors indicative of need for increased intensity and frequency of services.
- For those patients no longer requiring 24 hour acute care but are not capable of assuming responsibility for their lives. Without partial hospitalization, there would be an exacerbation of symptoms.
- Failure of treatment at lesser level of care (i.e.; unmanageable in outpatient treatment requiring protected observation and coordination of therapeutic resources of an active partial program).
- Demonstration of alcohol / drug use resulting in impairment of functioning.
- Moderate deterioration of usual level of functioning.

INTENSIVE OUTPATIENT

- Minimal risk of behavior which is life threatening / destructive to self or others.
- Behavior indicative of need for increased intensity of services.
- Depressed mood not related to a chronic condition.
- Increase in frequency of panic attacks.
- Obsessions / compulsions or stress / anxiety causing marked distress.
- Chronic psychotic disorder compensated by medication requiring psychotherapy and management at a higher level of out-pt. Tx.
- Impaired to the degree that there are manifestations of disability and mild deterioration of usual level of functioning.
- Failure in outpatient aftercare.
- Significant increase in drug / alcohol use.

OUTPATIENT

- Symptoms / behaviors indicative of need for services:
 Depressed Mood Panic Attacks Obsessions / Compulsions Stress / Anxiety Causing Distress
- Impaired to the degree that there are mild manifestations of disability in interpersonal and / or occupational functioning.
- Failure of other treatment programs, aftercare, support groups, etc.
- Increase in alcohol / drug use.
- Minimal deterioration of usual level of functioning.

INITIAL PROBLEMS IDENTIFIED / JUSTIFICATION FOR LEVEL OF CARE CHOSEN: *Pt. actively psychotic, impaired judgment unpredictable, re danger to self or others - Rec. i.p. admit.*

ASSESSMENT COMPLETED BY: [REDACTED] Date / Time: 7/2/98 1321

PHYSICIAN DETERMINATION: [REDACTED]

DISPOSITION: _____

ADMISSION TO: Inpatient Unit: _____

Other: _____ PHP _____ IOP _____ OP _____ 23 Hour _____

PROVISIONAL DIAGNOSIS:

AXIS I: _____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

AXIS V: Current GAF Score: _____

On Site Evaluation by Dr.: _____

Reviewed with Physician (as indicated): _____ Date / Time: _____

Reviewing Physician's Signature: _____ Date / Time: _____

(*per local requirements)

000020

PSYCHIATRIST ADMISSION NO

COMPREHENSIVE ASSESSMENT
PART 2

Patient Identification

Date of Evaluation: 7/2/98

Time: (21.00)

I believe this patient requires inpatient hospitalization. I do not believe this patient could be adequately and appropriately treated in a less restrictive environment. I have based my decision on the following information:

BRIEF HISTORY OF PRESENT ILLNESS & SYMPTOMS (to support diagnosis and severity of illness):

20 yr old son of [redacted] & [redacted] appears psychotic. Recompensates over no mood for 3-4 wks & acute worsening. Pt has been using phedrine / caffeine mixture in context of gym workouts. He denies steroid use. Pt was on [redacted] at [redacted] & strong affective reaction. (+) visual hallucinations

JUSTIFICATION FOR 24 HOUR CARE (check all that apply):

- Hallucinations, delusions, agitation, anxiety, depression resulting in significant loss of functioning
- Inability to meet basic life and health needs
- Dangerous to self, others, or property with need for controlled environment
- Toxic effect of therapeutic psychotropic drugs
- Failure of treatment at lower level of care
- Needs treatment for acute intoxication or withdrawal *par. 36*
- Biomedical conditions and complications requiring 24 hour medical and nursing care
- Need for ECT, special drug therapy, or other specific therapeutic program requiring continuous hospitalization
- Emotional or behavioral conditions and complications requiring 24 hour medical and nursing care
- High relapse potential due to inability to control substance use despite active participation in less restrictive care
- Recovery environment includes detrimental family structure, logical impediments to outpatient treatment
- Patient's occupation presents danger to public safety if they continue to use drugs or alcohol
- Failure of social or occupational functioning
- Legally mandated admission
- Other (specify): _____

[redacted]
Admission
Justification #

Past Psychiatric History: Pt by current DT have had no history psychiatric hx at present he at psychiatric Tx.

Drug / Alcohol Abuse History: Denies

Medical History / Personal MD: [redacted] MD

Positive Physical Findings:

See [redacted] per [redacted]

Allergies:

NKA

Current Medications:

Ø

Mental Status Exam (to include orientation, intellectual functioning, and memory function):

Large you - what made, very intense affect. Not will - or able to sit this time to focus on mental questions. He is oriented to [redacted] hospital by staff to this unit. (+) delirious - A hallucinations.

Patient Assets and Strengths:

Denies suicide / homicidal ideation / intent

Involved family

In school

Relationships of several years & PCP

Admitting Diagnosis (DSM-IV):

Axis I:

Psychotic Disorder NOS

Axis II:

Delirium

② MA drug induced delirium
disturbance

Axis III:

4 hr of ↑ BP

Axis IV:

moderate

② insomnia

Axis V:

20/65

Estimated Length of Inpatient Treatment:

1 wk.

Initial Discharge Plans:

Home

Placement

Other:

Initial Plan of Care:

Safety containment

Control & PR [redacted]

Prepared date hand & family

7/2/98 2200

Date / Time

ADMISSION / ORIENTATION DATA BASE

INTEGRATED ASSESSMENT - PART 3

Data may be obtained by RN / LVN / LPT / LPN / MHW

PAGE 1 of 8

ADMIT DATE	TIME	UNIT	STATUS	SEX	AGE
7-2-98	1520	[REDACTED]	Voluntary	M	20

Vital Signs:

Temperature 99° Weight 240
 Pulse 82 Height 6'2 1/2
 Respirations 16 Color of Hair Brown
 B / P 100/80 Color of Eyes Green
 Allergies: Seasonal Sinusitis, NKA

Patient / Family Orientation to:

Room Visiting Hours Patient Rights Explained
 Unit Phone Patient Rights Given
 Program Staff If Involuntary - Patient Rights Explained and Advisement Completed.
 Smoking Policy

Pictures Taken: Yes No

PERSONAL ESSENTIALS LIST

Valuables to Safe No Contraband Contraband Marked / Placed in Contraband Room Contraband Sent Home

Jewelry / Essentials Kept by Patient:

Rings: Plain Yellow Metal Yellow Metal with Stone
 Plain White Metal White Metal with Stone

Watches: _____

Hearing Aid: Left _____ Right _____

Eyeglasses: Yes _____ No _____ Contacts: Right _____ Left _____

Dentures: Full: Upper _____ Lower _____ Partial: Upper _____ Lower _____

Other: _____

General Appearance:

Grooming: Neatly Groomed Casual Disheveled Age Appropriate
 Hygiene: Clean Unkempt Offensive Odor Soiled Clothing

S. "Do we all know now?"
 S. "Did [REDACTED] have her baby?"
 S. "Is my Dad ~~the~~ dead?"

CODES: A - Non-applicable C - Patient Refused to Respond
 B - Patient Unable to State D - Question Not Appropriate for the Patient

000023

ADMISSION / ORIENTATION DATA BASE

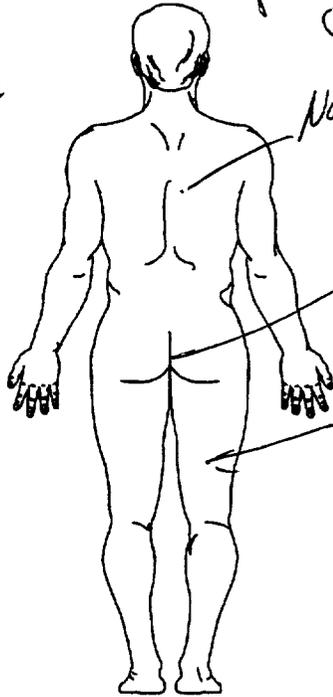
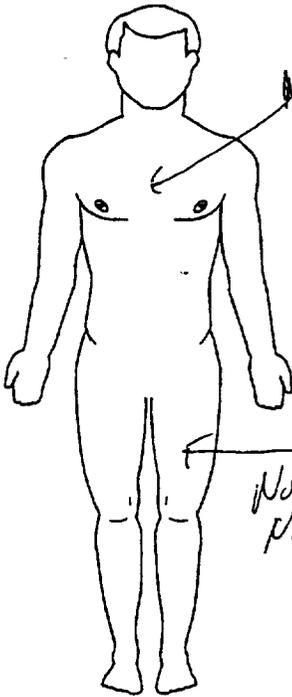
INTEGRATED ASSESSMENT

Data may be obtained by RN / LVN / LPT / LPN / MHW

PAGE 2 of 8

BODY IDENTIFICATION MARKS

Label all Scars, Bruises, etc.



Body checked done

ACERATIONS: _____

ABRASIONS: _____

SCARS: _____

BURNS: _____

MOLES / BIRTHMARKS: _____

BRUISES: _____

OTHER (Specify): _____

FAMILY PHYSICIAN: *Dr.* _____ Phone No.: _____

RELIGION

What are your spiritual needs? _____

Are you actively involved in a church / religion? Yes No

Will someone from your church be visiting while you are in the hospital? Yes No

ETHNIC CONCERNS

Do you have any social, religious, or cultural rituals, habits, or customs that will be affected by your hospitalization? Yes No

Explain: _____

None Identified @ Time of Admission

CODES: A - Non-applicable
B - Patient Unable to State

C - Patient Refused to Respond
D - Question Not Appropriate for the Patient

000024

20 ♂

CONSULTATION FORM

ROUTINE: URGENT:

Ordered by: Dr [Redacted]

REASON FOR CONSULT:

Please evaluate ↑ BP & [Redacted] grade fever

Signature: [Redacted]

Date / Time: 7-5-98 0900

CONSULTATION FINDINGS:

20 yo man ↑ elevated BP ↑ low grade fever. No subjective fever. ♀ cough or sputum ♀ N/V/D. ♀ RASH. ♀ ALKES. ♀ 130 per count ~~appetite~~ ♀ HA ♀ visual Δ. ♀ ~~ETM~~ ♀ Fit ITW ♀ Pmt ITW

RECOMMENDATIONS:

160/100 - 78 - 97.7 Nars nl
♀ Aderopathy. TM's clear. Oropharynx clear.
chest clear. ♀ ~~of~~ clear. CVS 2, 5. ♀ ~~6~~ 6
[Redacted]

Signature: [Redacted]

ATTENDING PHYSICIAN REVIEW / COMMENTS:

A/P [Redacted] ITW
P2 in [Redacted]
SR 180 [Redacted]
② NO sign Active
Infection 99° C
within RMSE of
Normal.
Date / Time: [Redacted]

Signature: [Redacted]

7/6/98
0530

00025

MedWatch #13099 Investigation
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GM

PSYCHOSOCIAL HISTORY - PART V

PAGE 1 of 4

INFORMANT: Chart pt

PATIENT'S CURRENT LIVING SITUATION: home & no house

ATMOSPHERE OF HOME: LOVING COMFORTABLE ABUSIVE SUPPORTIVE OTHER:

1. PRESENTING PROBLEM:

Depressed, deteriorated to time & place
apart of getting disoriented 2° to @ having same - quit job
walks - caffeine & epinephrine - unable to eat. Delusional

2. FAMILY OF ORIGIN

PATIENT WAS RAISED BY: NATURAL PARENTS ADOPTIVE PARENTS GRANDPARENTS OTHER: PT - threatening bodily harm to [redacted]

DESCRIBE RELATIONSHIP WITH CAREGIVERS father - carpenter - pt very unclear about where he is

LIST THE NAMES AND AGES OF SIBLINGS AND WHETHER THEY ARE LIVING OR DECEASED:
[redacted] walk at restaurant - 15 y/o old.

DESCRIBE RELATIONSHIP WITH SIBLINGS:

ATMOSPHERE OF CHILDHOOD HOME: LOVING COMFORTABLE CHAOTIC ABUSIVE SUPPORTIVE OTHER:

DISCIPLINE USED WITH PATIENT: whipped by fa, mother didn't discipline

SIGNIFICANT ISSUES FROM CHILDHOOD IMPACTING CURRENT ILLNESS:

Parents separated, divorced - pt unable to say when -
age 5 to 6 saw notes.

3. FAMILY HISTORY OF PHYSICAL AND PSYCHIATRIC DISORDERS

FAMILY HISTORY INCLUDES SIGNIFICANT PHYSICAL ILLNESS. Describe:

Diabetes fa

FAMILY HISTORY INCLUDES SIGNIFICANT PSYCHIATRIC ILLNESS. Describe:

Unknown

FAMILY HISTORY INCLUDES SUBSTANCE ABUSE. Describe:

@ eddie

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4. MARITAL AND FAMILY RELATIONSHIPS

PATIENT IS: SINGLE MARRIED DIVORCED WIDOWED Describe:

Current girlfriend - ok - 3yr relationship

DOES PATIENT HAVE CHILDREN? YES NO If So, Name and Age:

(If Female Patient) DOES PATIENT HAVE A HISTORY OF ABORTION / MISCARRIAGE? YES NO

If So, Describe:

HOW HAS CURRENT ILLNESS AFFECTED FAMILY RELATIONSHIPS?

Mother doesn't think pt needs to be here

PSYCHOSOCIAL HISTORY - PART V

PAGE 2 of 4 (Continued)

5. HISTORY OF ALCOHOL AND DRUG USE

PATIENT HAS A HISTORY OF ALCOHOL USE. Describe:

drinks socially

PATIENT HAS A HISTORY OF DRUG USE. Describe:

smoke marijuana

PATIENT HAS EXPERIENCED SYMPTOMS OF WITHDRAWAL WHEN ATTEMPTING TO DISCONTINUE USE.

Describe:

PATIENT HAS A HISTORY OF INTRAVENOUS DRUG USE. Has Patient Ever Shared Needles? YES NO

PATIENT HAS A HISTORY OF DRINKING / USING TO FEEL "NORMAL".

6. HISTORY OF PHYSICAL / EMOTIONAL / SEXUAL ABUSE

PATIENT HAS A HISTORY OF BEING PHYSICALLY ABUSED. *ja* OR ABUSING OTHERS.

PATIENT HAS A HISTORY OF BEING SEXUALLY ABUSED. *ja* OR ABUSING OTHERS.

PATIENT HAS A HISTORY OF BEING EMOTIONALLY ABUSED. *ja* OR ABUSING OTHERS.

7. EDUCATION (Highest Level of Education Completed)

ELEMENTARY JR. HIGH HIGH SCHOOL COLLEGE GRADUATE SCHOOL

OTHER: LEARNING DISABILITIES Explain:

IS PATIENT CURRENTLY IN SCHOOL? YES NO

If Yes, How Has Current Illness Impacted Academic Performance:

If Yes, Name of School:

CONTACT PERSON:

8. EMPLOYMENT / VOCATIONAL

PATIENT IS WORKING. Where and How Long: - *short metal a wheel*

PATIENT'S JOB HAS BEEN IMPACTED BY CURRENT ILLNESS How: *dump weeks -*

PATIENT'S EAP IS INVOLVED IN HIS / HER TREATMENT. Who is the EAP Representative: *friend for that job*

PATIENT HAS A HISTORY OF JOB INSTABILITY. Why:

PATIENT REQUIRES ASSISTANCE FROM VOCATIONAL REHABILITATION AGENCY. Why:

9. MILITARY

PATIENT SERVED IN THE MILITARY. Which Branch, When, and Type of Discharge:

10. LEGAL HISTORY (Arrests / DWI's / Probations / Pending Charges)

PATIENT HAS NEVER BEEN ARRESTED.

PATIENT HAS BEEN ARRESTED. What Charge and When: *@ [redacted] - had been drunk -*

PATIENT IS CURRENTLY ON PROBATION / PAROLE. Who is the Probation Officer: *car accident - he had*

CURRENT ILLNESS HAS AFFECTED LEGAL HISTORY. How: *to take classes at REX*

11. SOCIAL SUPPORT SYSTEM

PATIENT HAS A SUPPORT SYSTEM. Describe Patient's Peer Group and Current Living Environment: *girlfriend [redacted]*

12. CULTURAL INFLUENCES / RELIGIOUS BACKGROUND AND CURRENT ACTIVITY

PATIENT HAS A RELIGIOUS AFFILIATION. Name of Religion: *Baptist*

PATIENT IS / IS NOT CURRENTLY ATTENDING A CHURCH Which Church: *attended a church*

PATIENT'S AFFILIATION WITH A CHURCH IS PART OF HIS / HER SUPPORT SYSTEM. *three ago*

CURRENT ILLNESS HAS AFFECTED SPIRITUAL LIFE How:

ETHNIC, CULTURAL FACTORS Describe: *white, working class, single male*

currently psychotic

000027

PSYCHOSOCIAL HISTORY - PART V

PAGE 3 of 4 (Continued)

13. FAMILY ASSESSMENT

SIGNIFICANT OTHER INTERVIEWED? YES

Mother seen by Dr. [redacted] as part of hearing

FAMILY / S.O. IS SUPPORTIVE OF PATIENT AND WILLING TO BE INVOLVED IN TREATMENT.

FAMILY / S.O. IS UNWILLING TO BE INVOLVED IN TREATMENT. Why:

FAMILY / S.O. EXPRESSES CONCERN ABOUT PATIENT. Describe:

obtained attorney to prevent hospitalization

FAMILY / S.O. PERCEPTION OF ILLNESS.

does not believe [redacted] or in need of hospitalization

14. GOALS FOR TX

AS IDENTIFIED BY PATIENT:

1. pt has no goals
does not want to be here
- 2.

AS IDENTIFIED BY SIGNIFICANT OTHER:

1. girlfriend thinks he needs hospitalization
& 5-7 day stay
2. mother thinks he should not be here.

15. HISTORY OF PREVIOUS TREATMENT OR COMMUNITY MENTAL HEALTH RESOURCES USED (if different from Needs Assessment)

OUTPATIENT THERAPY With Whom and When: *per family*

INPATIENT TREATMENT Where and When: *per family*

SELF HELP GROUP Which Groups and When:

MEDICATION MANAGEMENT Which Medications and When:

OUTCOME OF ANY PREVIOUS TREATMENT:

16. DISCHARGE PLANS AND IDENTIFIED PROBLEMS

WHERE WILL THE PATIENT LIVE? HOME WITH FAMILY NEEDS PLACEMENT

PARTIAL HOSPITAL PROGRAM: ATTEND AFTERCARE FOLLOW UP WITH INDIVIDUAL THERAPIST:

FAMILY THERAPY:

needs out pt referral

OTHER:

PSYCHOSOCIAL HISTORY - PART V

PAGE 4 of 4 (Continued)

17. FINANCIAL RESOURCES

- PATIENT IS ABLE TO SUPPORT SELF WITHOUT ASSISTANCE. *Walter covers own expenses.*
- PATIENT REQUIRES REFERRAL FOR FINANCIAL AID. *does not have to*
- PATIENT REQUIRES REFERRAL FOR CREDIT COUNSELING. *pay rent*
- CURRENT ILLNESS HAS AFFECTED FINANCIAL SITUATION. How:

18. PATIENT STRENGTHS

*Supportive family
physical health.*

PATIENT DEFICITS

*uses m.j. epinephrine to
manage mood & crisis problems*

19. DEVELOPMENTAL MILESTONES: At What Age Did Your Child First: (Child and Adolescent Only)

	YEARS	MONTHS	YEARS	MONTHS
SIT UP:				
CRAWL:				
STAND ALONE:				
WALK BY SELF:				
FEED SELF:				
DRESS SELF:				
SPEAK FIRST REAL WORDS:				
PREGNANCY: <input type="checkbox"/> PLANNED <input type="checkbox"/> UNPLANNED			DELIVERY: <input type="checkbox"/> COMPLICATED <input type="checkbox"/> UNCOMPLICATED	
OTHER DEVELOPMENTAL INFORMATION ABOUT YOUR CHILD:				

20. HIGH RISK PSYCHOSOCIAL ISSUES REQUIRING EARLY TREATMENT PLANNING AND INTERVENTION(S)

i.e., UNATTENDED CHILDREN IN HOME, PRIOR NON COMPLIANCE TO SPECIFIC TREATMENT AND/OR DISCHARGE INTERVENTIONS, AND POTENTIAL OBSTACLES TO PRESENT TREATMENT AND DISCHARGE PLANNING:

21. INTEGRATED SUMMARY AND RECOMMENDATIONS

INCLUDE SUGGESTED PROBLEMS TO BE ADDRESSED DURING THIS EPISODE OF TREATMENT ANTICIPATED OUTCOMES, TREATMENT, INTERVENTIONS:

*SWM - admitted psychosis, unable to eat,
quit job, disoriented to the place, here
involuntarily as mother doesn't think he needs
hospitalization, girlfriend does think he needs this.
No plan out-pt to hospitalization.*

- 1) stabilize mood, ↑ orientation*
- 2) family meeting to determine baseline & conflict areas*
- 3) return home out-pt to be set up*

& [redacted] causes arranged for fall

7/6/08
Date / Time

000029

**INTERDISCIPLINARY TREATMENT PLAN /
UPDATE - INPATIENT**

initial

DATE REVISED: _____ DX CHANGED? Yes No
If Yes: Axis I _____ Axis II _____ Axis III _____

INDICATE REASON(S) PATIENT CONTINUES TO NEED HOSPITALIZATION:

- Suicidal Ideation Danger to Self or Others Severely Impaired Disorder of Thoughts or Perception
 Severe Impairment of Level of Functioning Severe Depression / Anxiety Medication Stabilization
 Discharge May Exacerbate Illness Post Acute Detox Symptoms Conduct Requires 24 Hour Supervision
 Other: _____

PROGRESS IN TREATMENT	PROBLEM NUMBER									
	1	2	3	4	5	6	7	8	9	10
A. Progress as Expected										
B. No Progress. Continue Objectives.										
C. Revise Objectives (Goals).										
D. Revise Interventions.										
E. Problem Resolved										

(If Problems are Coded as C, D or E, Refer to the Problem List)

DESCRIBE PATIENT'S PROGRESS TOWARD GOALS IN BEHAVIORAL TERMS:

ESTIMATED CONTINUED LENGTH OF STAY: _____

DISCHARGE PLAN: (Circle relevant aftercare plan)

- IOP Aftercare Group Outpatient Therapy 12-Step Recovery Group Medication Management Family Therapy

OTHER: _____

REFERRALS INDICATED: _____

PARTICIPATING TEAM MEMBERS:

_____ DATE / TIME: *7/7/98* _____ DATE / TIME: *7/7/98*

 _____ DATE / TIME: _____ _____ DATE / TIME: _____
 _____ DATE / TIME: *0900 7/7/98* _____ DATE / TIME: _____
 Recreation Therapy _____ DATE / TIME: _____ _____ DATE / TIME: *7/7/98*
 Education _____ DATE / TIME: _____ _____ DATE / TIME: _____

**INTERDISCIPLINARY TREATMENT PLAN /
UPDATE - INPATIENT**

DATE REVISED: 7/14/98 DX CHANGED? Yes
 If Yes: Axis I _____ Axis II _____ Axis III _____

INDICATE REASON(S) PATIENT CONTINUES TO NEED HOSPITALIZATION:

- Suicidal Ideation
 Severe Impairment of Level of Functioning
 Discharge May Exacerbate Illness
 Other: _____
- Danger to Self or Others
 Severe Depression / Anxiety
 Post Acute Detox Symptoms
- Severely Impaired Disorder of Thoughts or Perception
 Medication Stabilization
 Conduct Requires 24 Hour Supervision

PROGRESS IN TREATMENT	PROBLEM NUMBER									
	1	2	3	4	5	6	7	8	9	10
A. Progress as Expected	<input checked="" type="checkbox"/>									
B. No Progress. Continue Objectives.										
C. Revise Objectives (Goals).										
D. Revise Interventions.										
E. Problem Resolved										

(If Problems are Coded as C, D or E, Refer to the Problem List)

DESCRIBE PATIENT'S PROGRESS TOWARD GOALS IN BEHAVIORAL TERMS:

*Continues to demonstrate very loose associations.
 is medication compliant though he does require an ITU
 environment. Taking anti psychotic medication well.
 Plan for additional family therapy*

ESTIMATED CONTINUED LENGTH OF STAY: ONE WEEK

DISCHARGE PLAN: (Circle relevant aftercare plan)

- IOP. Aftercare Group Outpatient Therapy 12-Step Recovery Group Medication Management Family Therapy

OTHER: _____

REFERRALS INDICATED: _____

PARTICIPATING TEAM MEMBERS:

_____ DATE / TIME: 7/14/98 (0930)
 _____ DATE / TIME: 7/14/98
 _____ DATE / TIME: 7/14/98 (0920)
 _____ DATE / TIME: 7/14/98 (0920)
 Recreation Therapy _____ DATE / TIME: _____
 Education _____ DATE / TIME: _____

**INTERDISCIPLINARY TREATMENT PLAN /
UPDATE - INPATIENT**

Patient Identification

DATE REVISED: 7/21/98 DX CHANGED? Yes No
If Yes: Axis I _____ Axis II _____ Axis III _____

INDICATE REASON(S) PATIENT CONTINUES TO NEED HOSPITALIZATION:

- Suicidal Ideation Danger to Self or Others Severely Impaired Disorder of Thoughts or Perception
 Severe Impairment of Level of Functioning Severe Depression / Anxiety Medication Stabilization
 Discharge May Exacerbate Illness Post Acute Detox Symptoms Conduct Requires 24 Hour Supervision
 Other: _____

PROGRESS IN TREATMENT	PROBLEM NUMBER									
	1	2	3	4	5	6	7	8	9	10
A. Progress as Expected	X									
B. No Progress. Continue Objectives.										
C. Revise Objectives (Goals).										
D. Revise Interventions.										
E. Problem Resolved										

(If Problems are Coded as C, D or E, Refer to the Problem List)

DESCRIBE PATIENT'S PROGRESS TOWARD GOALS IN BEHAVIORAL TERMS:

Pt. continues in psychotic behavior, altered perception of reality. Still requiring ITU environment, remains compliant in meds.

ESTIMATED CONTINUED LENGTH OF STAY: _____

DISCHARGE PLAN: (Circle relevant aftercare plan)

- IOP Aftercare Group Outpatient Therapy 12-Step Recovery Group Medication Management Family Therapy

OTHER: _____

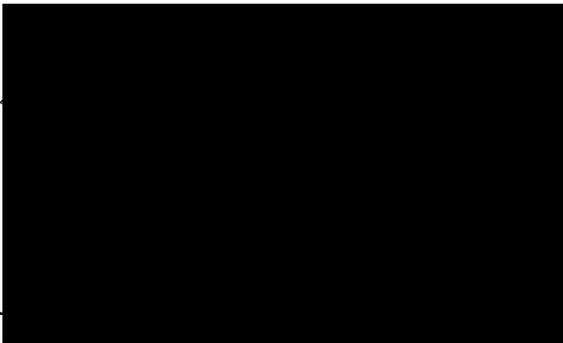
REFERRALS INDICATED: _____

PARTICIPATING TEAM MEMBERS:

_____ (1000) DATE / TIME: 7/21/98 _____ DATE / TIME: _____
 _____ Social Work DATE / TIME: _____
 _____ (1000) DATE / TIME: 7/21/98 _____ DATE / TIME: _____
 _____ Nursing _____ DATE / TIME: _____
 _____ (1000) DATE / TIME: 7/21/98 _____ DATE / TIME: _____
 _____ Recreation Therapy _____ DATE / TIME: _____
 _____ Education _____ DATE / TIME: _____



**INTERDISCIPLINARY TREATMENT PLAN /
UPDATE - INPATIENT**



DATE REVISED: _____ DX CHANGED? Yes No
If Yes: Axis I _____ Axis II _____ Axis III _____

INDICATE REASON(S) PATIENT CONTINUES TO NEED HOSPITALIZATION:

- Suicidal Ideation Danger to Self or Others Severely Impaired Disorder of Thoughts or Perception
 Severe Impairment of Level of Functioning Severe Depression / Anxiety Medication Stabilization
 Discharge May Exacerbate Illness Post Acute Detox Symptoms Conduct Requires 24 Hour Supervision
 Other: _____

PROGRESS IN TREATMENT	PROBLEM NUMBER									
	1	2	3	4	5	6	7	8	9	10
A. Progress as Expected										
B. No Progress. Continue Objectives.										
C. Revise Objectives (Goals).										
D. Revise Interventions.										
E. Problem Resolved										

(If Problems are Coded as C, D or E, Refer to the Problem List)

DESCRIBE PATIENT'S PROGRESS TOWARD GOALS IN BEHAVIORAL TERMS:

ESTIMATED CONTINUED LENGTH OF STAY: _____

DISCHARGE PLAN: (Circle relevant aftercare plan)

- IOP Aftercare Group Outpatient Therapy 12-Step Recovery Group Medication Management Family Therapy

OTHER: _____

REFERRALS INDICATED: _____

PARTICIPATING TEAM MEMBERS:



(1000)
 TIME: 7/21/98
 (1000)
 TIME: 7/21/98
 (0000)
 TIME: 7/21/98



7/21/98

Nursing

DATE / TIME:

DATE / TIME:



ME: 7/21/98

Education

DATE / TIME:



**INTERDISCIPLINARY TREATMENT PLAN /
UPDATE - INPATIENT**

Patient Identification

DATE REVISED: 7/28/98 DX CHANGED? Yes No
 If Yes: Axis I _____ Axis II _____ Axis III _____

INDICATE REASON(S) PATIENT CONTINUES TO NEED HOSPITALIZATION:

- Suicidal Ideation Danger to Self or Others Severely Impaired Disorder of Thoughts or Perception
 Severe Impairment of Level of Functioning Severe Depression / Anxiety Medication Stabilization
 Discharge May Exacerbate Illness Post Acute Detox Symptoms Conduct Requires 24 Hour Supervision
 Other: _____

PROGRESS IN TREATMENT	PROBLEM NUMBER									
	1	2	3	4	5	6	7	8	9	10
A. Progress as Expected	<input checked="" type="checkbox"/>									
B. No Progress. Continue Objectives.										
C. Revise Objectives (Goals).										
D. Revise Interventions.										
E. Problem Resolved										

(If Problems are Coded as C, D or E, Refer to the Problem List)

DESCRIBE PATIENT'S PROGRESS TOWARD GOALS IN BEHAVIORAL TERMS:

Patient remains intermittently non-compliant with his medications. He remains unable to tolerate the T stimulation when attempting to transition to adult unit and groups. Continues to verbalize distortion of thought processes; appears to be responding to internal stimuli.

ESTIMATED CONTINUED LENGTH OF STAY: 1 additional week

DISCHARGE PLAN: (Circle relevant aftercare plan)

- IOP Aftercare Group Outpatient Therapy 12-Step Recovery Group Medication Management Family Therapy

OTHER: _____

REFERRALS INDICATED: _____

PARTICIPATING TEAM MEMBERS:

 DATE / TIME: 7/28/98 ¹⁰⁰⁰

 DATE / TIME: _____

 DATE / TIME: 7/28/98 ⁽⁰⁹²⁵⁾

 DATE / TIME: _____

 DATE / TIME: 7/28/98
 Education

**INTERDISCIPLINARY TREATMENT PLAN /
UPDATE - INPATIENT**

Patient Identification

DATE REVISED: 8-4-98 DX CHANGED? Yes No
If Yes: Axis I _____ Axis II _____ Axis III _____

INDICATE REASON(S) PATIENT CONTINUES TO NEED HOSPITALIZATION:

- Suicidal Ideation Danger to Self or Others Severely Impaired Disorder of Thoughts or Perception
 Severe Impairment of Level of Functioning Severe Depression / Anxiety Medication Stabilization
 Discharge May Exacerbate Illness Post Acute Detox Symptoms Conduct Requires 24 Hour Supervision
 Other: _____

PROGRESS IN TREATMENT	PROBLEM NUMBER									
	1	2	3	4	5	6	7	8	9	10
A. Progress as Expected	✓									
B. No Progress. Continue Objectives.										
C. Revise Objectives (Goals).										
D. Revise Interventions.										
E. Problem Resolved										

(If Problems are Coded as C, D or E, Refer to the Problem List)

DESCRIBE PATIENT'S PROGRESS TOWARD GOALS IN BEHAVIORAL TERMS:

Pt is taking medications as ordered and is functioning better with peers. Pt will need outpt therapy & continuous medication.

ESTIMATED CONTINUED LENGTH OF STAY: 1 day

DISCHARGE PLAN: (Circle relevant aftercare plan)

IOP Aftercare Group Outpatient Therapy 12-Step Recovery Group Medication Management Family Therapy

OTHER: _____

REFERRALS INDICATED: _____

PARTICIPATING TEAM MEMBERS:

DATE / TIME: 5/9/98 So _____ ME: 8/4/98

DATE / TIME: 8-4-98 0950 Nursing DATE / TIME: (0930)

DATE / TIME: _____ DATE / TIME: _____
 Recreation Therapy _____

DATE / TIME: _____ DATE / TIME: 8/3/98
 Education _____ Utilization Review _____

INTERDISCIPLINARY TREATMENT PLAN

CARE PLAN FORMULATED BY: [REDACTED]

DATE: 7/3/98

DATE OF ADMISSION: 7/2/98

PROGRAM: ITU

<p>DIAGNOSES:</p> <p>AXIS I: <u>Psychotic d/o</u> <u>AD/5 / R/o drug induced</u></p> <p>AXIS II: <u>deferred</u> <u>W/O</u></p> <p>AXIS III: <u>hx of ↑BP</u> <u>insomnia</u></p> <p>AXIS IV: <u>moderate</u></p> <p>AXIS V: <u>20/65</u></p>	<p>PATIENT'S ASSETS:</p> <p><input checked="" type="checkbox"/> General Fund of Knowledge</p> <p><input checked="" type="checkbox"/> Average or Above Intelligence</p> <p><input checked="" type="checkbox"/> Supportive Family / Friends</p> <p><input type="checkbox"/> Motivation for Treatment / Growth</p> <p><input type="checkbox"/> Capable of Independent Living</p> <p><input checked="" type="checkbox"/> Work Skills</p> <p><input type="checkbox"/> Religious Affiliation</p> <p>PATIENT'S STRESSORS:</p> <p><input type="checkbox"/> Loss (of Whom or What)</p> <p><input type="checkbox"/> Legal Issue</p> <p><input checked="" type="checkbox"/> Marital or Family Conflict</p> <p><input type="checkbox"/> Financial Difficulties</p> <p><input type="checkbox"/> Traumatic Event</p> <p><input type="checkbox"/> Educational Concerns</p> <p><input checked="" type="checkbox"/> Physical Health</p> <p><input type="checkbox"/> Active Sense of Humor</p> <p><input type="checkbox"/> Ability for Insight</p> <p><input checked="" type="checkbox"/> Communication Skills</p> <p><input checked="" type="checkbox"/> Financial Means</p> <p><input type="checkbox"/> Special Hobby / Interest</p> <p><input type="checkbox"/> Other: _____</p> <p><input checked="" type="checkbox"/> Substance Abuse</p> <p><input type="checkbox"/> Medication Change or Non-Compliance</p> <p><input type="checkbox"/> Occupational Concerns</p> <p><input type="checkbox"/> Health Problems</p> <p><input type="checkbox"/> Other: <u>Psychotic features</u></p>
--	---

PROBLEM LIST	TO BE ADDRESSED	DEFERRED	PROBLEM LIST	TO BE ADDRESSED	DEFERRED
<u>Out of contact</u> <u>re reality</u>	<u>1</u>				

MedWatch #13099 Investigation
Exhibit# 1 Part 3 of 13
4-5 March 1999 GM

DISCHARGE CRITERIA:

- Reduction of life-threatening or endangering symptoms to within safe limits
- Ability to meet basic life and health needs
- Adequate post-discharge living arrangements
- Self-care adequate arrangements made
- Improved stabilization in mood, thinking and/or behavior
- Withdrawal symptoms are absent or sub-acute and managed without 24 hour nursing intervention
- Need for constant or close observation no longer present
- Medical problems require only outpatient monitoring
- Verbal commitment to aftercare and medication compliance
- Motivation to continue treatment in a less acute level of care
- Other: _____

PRELIMINARY DISCHARGE PLAN:

- Return to previous living arrangement
- Placement in alternative living arrangements
- Participate in Family Therapy
- Return to previous work or school arrangement
- Attend Aftercare / Continuing Care Group
- Attend PHP / IOP
- Attend 12-Step Recovery Group
- Outpatient Therapy with attending M.D. of [REDACTED] (Circle Applicable)
- Referrals Indicated: _____

ESTIMATED LENGTH OF STAY: 7-10 days
DATE / TIME: 7/7/98 (0900)

PHYSICIAN APPROVAL OF TREATMENT PLAN: [REDACTED]

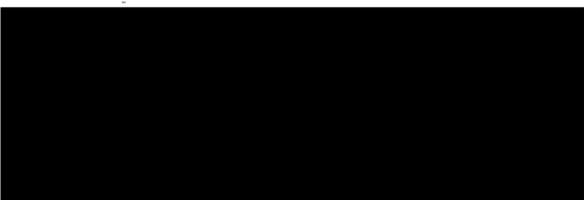
PATIENT / FAMILY INVOLVEMENT

This Treatment Plan has been presented to and reviewed by the patient and/or family member. The patient and family have been given the opportunity to ask questions and make suggestions.

PATIENT SIGNATURE: [REDACTED] DATE / TIME: _____

FAMILY SIGNATURE (as applicable): [REDACTED] DATE / TIME: _____

STAFF SIGNATURE: [REDACTED] DATE / TIME: 8-5-98 1030



**PRE-DISCHARGE EVALUATION
OF RISK TO SELF / OTHERS**

PAGE 1 of 1

Patient Identification

(Please check all that apply)

Informant was Patient Family Friends Hospital Health Professional
 Other Health Professional Other _____

SECTION I - CURRENT RISK TO SELF / OTHERS AT TIME OF DISCHARGE:

Does the patient or do others report:

the patient having suicidal ideation or making suicidal threats?

Yes

No

the patient having homicidal / assaultive ideation or making homicidal threats?

Yes

No

If the answers to the above questions are NO, then go to Section II;

Otherwise answer the following questions:

Is the ideation repetitive or persistent?

Yes

No

Does the patient have a specific plan?

Yes

No

Does the ideation involve serious / lethal intent?

Yes

No

Does the ideation have delusional or hallucinatory content?

Yes

No

If the answer to any of the above questions is YES, then describe the basis for such answer below, then complete Section II. (Describe the patient's plan, ideations, hallucinations, etc. and if they represent a risk to others at time of the discharge, describe considerations regarding "duty to protect" or "duty to warn".)

Comments: _____

SECTION II - ADDITIONAL RISK MANAGEMENT CONSIDERATIONS:

Does the patient have a history of suicidal attempts soon after a past discharge?

Yes

No

Does the patient have a history of concealing or denying past suicide / homicide / assaultive ideation / behaviors?

Yes

No

Were clinical indications for a second opinion concerning discharge risk present?

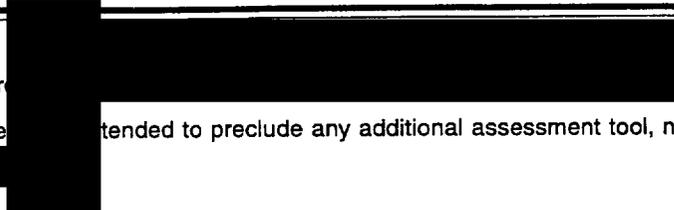
(If yes, please comment below)

Yes

No

Comments: _____
_____ *1st episode of illness* _____

Physician's Signature



Date / Time:

8/5/98 (0930)

This guideline is intended to preclude any additional assessment tool, nor is it a substitute for clinical judgement.

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CONTINUING CARE / DISCHARGE PLANNING

Facility Name

NAME: [REDACTED] ADDRESS: [REDACTED] PHONE: [REDACTED]
 HOSPITAL: [REDACTED] PHYSICIAN: [REDACTED]
 PHYSICIAN TELEPHONE #: [REDACTED]

DISCHARGE TO: home TRANSFERRED TO: _____ DATE OF NEXT ATTENDANCE: _____

ROUTINE
 AMA
 AT PATIENT'S OR FAMILY'S REQUEST
 OTHER (Explain): _____

TRANSPORTATION: PERSONAL CAR
 PARENT / RELATIVE
 PUBLIC
 SELF
 OTHER (Explain): _____

ACCOMPANIE BY: [REDACTED] RELATIONSHIP: mother

FOLLOW-UP APPOINTMENTS

NAME	ADDRESS	TELEPHONE #	DATE OF NEXT APPT.	TIME
Psychiatrist: [REDACTED]	[REDACTED] MD		8-7-98 Fri	0930
Individual Therapist:				
Marriage / Family:				
Primary Care Physician: [REDACTED]	[REDACTED] MD			
Continuing Care:				

Persons in Recovery from Chemical Dependency are expected to attend 90 NA or AA Meetings in the 90 days following discharge.

A Weekly Schedule Follows: Dr [REDACTED] has been started to release

NA / AA SPONSOR AND TELEPHONE # [REDACTED]

DISCHARGE MEDICATION	DOSAGE	FREQUENCY	ROUTE
Verapamil SR	180mg	qam	po
Olanzapine	5 mg (3 tabs qhs)	qhs	po
Cogentin	2 mg	bid	po
Haldol	5mg	qhs	po

PRESCRIPTIONS HAVE BEEN GIVEN TO THE PATIENT.
 Yes
 No
 N/A (If No) Explain Why _____

PRESCRIBED MEDICATIONS ARE INDEED AVAILABLE THROUGH INSURANCE, SELF PAY, ETC.: Yes
 No
 N/A

DISCHARGE DIAGNOSIS:

AXIS I: Schizophrenia d/o AXIS III: HTN
Steroid abuse, mJ abuse Insomnia
R/o sub induced & d/o
 AXIS II: depressed AXIS IV: moderate
 AXIS V: 20/65

CONTINUING CARE / DISPOSITION (Home, Outpatient, IOP, PHP, RTC, Home Health, Etc.): home with mother

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**CONTINUING CARE /
DISCHARGE PLANNING**

Patient Identification

PROBLEM AREAS TO BE ADDRESSED
IN CONTINUING CARE:

Continue medication as prescribed

Keep out of appointments

THREE MONTH GOALS FOR
CONTINUING CARE:

Stable

FINANCIAL SUPPORT
EDUCATION /
VOCATIONAL PLANS

SCHOOL PART-TIME FULL-TIME
WORK PART-TIME FULL-TIME
 OTHER (Please Explain)

SPECIAL CONDITIONS

Student & working parents admit

Other Treatment Recommendations Such as Support Groups, Specific Exercise Programs, Etc. Also Address Social Services Components Such as Appointment with State Disability, the Department of Social Security, Welfare, Foodstamps, Etc.

FAMILY / SIGNIFICANT OTHERS
PARTICIPATE AS FOLLOWS:

INDIVIDUAL Mother met several times GROUP Father DA [redacted]

OTHER (Identify):

to discuss diagnosis and make life plans

TREATMENT SUMMARY:

Pt entered hospital in psychotic state to provide for safe environment and med management. He remained psychotic most of the hospitalization.

DURING TREATMENT PHYSICAL PROBLEMS
THAT WERE IDENTIFIED / TREATED:

HTN / Insomnia

SPECIAL INSTRUCTIONS:

Reg diet, activities ad lib

PATIENT DEMONSTRATES UNDERSTANDING OR KNOWLEDGE OF:

REFERRALS OR PLACEMENT

Yes No N/A

MEDICATIONS HAVE BEEN EXPLAINED
TO MY SATISFACTION: (Patient's Initials)

POTENTIAL DRUG - FOOD INTERACTION

Yes No N/A

WHEN AND HOW TO SEEK
FURTHER TREATMENT:

Yes No N/A

MEDICATIONS AND HOW TO ADMINISTER

Yes No N/A

FAMILY DEMONSTRATES ABILITY
TO CARE FOR PATIENT:

Yes No N/A

(If Patient is Unable, Family is Knowledgeable):

Yes No N/A

NUTRITION INTERVENTION
AND / OR MODIFIED DIET:

Yes No N/A

IMPORTANCE OF GETTING MEDS FILLED PRIOR TO NEXT SCHEDULED DOSAGE:

Yes No N/A

IMPORTANCE OF COMMUNICATING WITH ATTENDING PHYSICIAN IF EXPERIENCING SIDE EFFECTS:

Yes No N/A Patient's Initials [redacted]

MEDICAL CONDITION:

Yes No N/A

PERTINENT LAB FINDINGS:

Yes No N/A

OTHER FOLLOW-UP ISSUES:

Yes No N/A

NURSING SUMMARY OF PATIENT'S
CONDITION UPON DISCHARGE:

Pt. eagerly anticipating Dc home today, admitted to [redacted] was able to transition to adult unit to stabilization of mood & behavior. Pt is able to state importance of [redacted] TIME PATIENT MET HOSPITAL: 1300 AM

I UNDERSTAND AND AGREE WITH
THE PRECEDING INSTRUCTIONS:

PATIENT SIGNATURE

PERSONAL ITEMS & VALUABLES
RECEIVED (Patient Initials):

FAMILY OR SIGNIFICANT
OTHER SIGNATURE:

DATE:

MSW / THE
SIGNATURE

PHYSICIAN
SIGNATURE

2/5/98

98

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