IN THE SUPREME COURT OF THE STATE OF NEVADA

JEFFREY REED, Appellant, v. ALECIA DRAPER (IND./CONSERV.), Respondent.	)	Supreme Court Case No: 82575 District Court Case No.: 05D338668

APPELLANT'S APPENDIX
VOLUME VIII OF XVII

ROBERTS STOFFEL FAMILY LAW GROUP

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ELECTRONICALLY SERVED
8/1/2020 9:04 AM

EXHIBIT 5

EXHIBIT 5

EXHIBIT 5

[redacted]
REED, EMILY
AKA:

DOB: [redacted] F

UC Irvine Health

Neuropsychiatric Center
DISCHARGE/RELAPSE PREVENTION
Part II

Patient's Name: _____

V. My follow-up plan is: _____

_____

VI. After Discharge, the doctor prescribing my medication is:

MD _____ Phone: _____

If I have problems with my medications, or my symptoms get worse, I will call my doctor.

VII. My next appointment is: _____

VIII. Medications I currently take:

Name	Dose	Frequency
Olanzapine	1.5 mg	2x a day
Prozac	40mg	daily
Melatonin	3mg	@ bedtime
Xanax	1.5 mg	@ bedtime
Trazodone	1mg	@ bedtime
Multivitamin	1 tab	daily

To help me remember, I will take them: ☐ AM, when waking ☑ with meal ☑ at bedtime

IX. If my symptoms become severe, I will call the crisis line 714-456-7000

UCI Medical Center Emergency Room
101 The City Drive
Orange, California 92868-3298
or nearest Emergency Room

Other Resources:

UCI Outpatient Department: (714) 456-5902
Mental Health Association: (714) 547-7559
Alliance for the Mentally Ill (714) 544-8488

Other: _____

_____

_____

_____

Patient's Signature: _____ Date: _____ Time: _____

Staff Signature: *(if assisted)* _____ Date: 4/7/14 Time: 0714

Interpreter's Signature: _____ Date: _____ Time: _____

Part II to be completed day of discharge.

☐ Completed Independently ☐ Completed With Assistance ☐ Incomplete Because: ☐ Pt. Refused ☐ EHA Pt. ☐ Other _____

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.

[redacted] [redacted]
REED, EMILY DOB: [redacted] F
AKA:

UNIVERSITY of CALIFORNIA • IRVINE HEALTHCARE

PATIENT BELONGINGS LIST

PATIENT VALUABLES #:	PATIENT MEDICATIONS #:

Qty.	Items	Condition	Admitting Unit/Codes WP - With Patient SH - Sent Home w/ PP - Patient Property C - Controlled Access E - Evidence D - Destroyed/Approved by:	1st Transfer CODES		2nd Transfer CODES		D/C CODES	
				S	R	S	R	S	R
	Dress/Skirt	☐ Intact ☐ Torn/Cut							
	Hat/Belt/Gloves	☐ Intact ☐ Torn/Cut							
	Housecoat/Robe	☐ Intact ☐ Torn/Cut							
	Nightgown/Pajamas	☐ Intact ☐ Torn/Cut							
1	Pants/Shorts	☑ Intact ☐ Torn/Cut	WP						
	Shirt/Blouse	☐ Intact ☐ Torn/Cut							
	Shoes/Slippers	☐ Intact ☐ Torn/Cut							
	Socks/Hosiery	☐ Intact ☐ Torn/Cut							
1	Sweater/Jacket	☑ Intact ☐ Torn/Cut	WP						
	Undergarments	☐ Intact ☐ Torn/Cut							
	Other:	☐ Intact ☐ Torn/Cut							
	Other:	☐ Intact ☐ Torn/Cut							
5	Other: T-Shirts	☑ Intact ☐ Torn/Cut	WP						
	PROSTHETIC DEVICES								
	Dentures: ☐ Upper ☐ Lower								
	Partial: ☐ Upper ☐ Lower								
	Eyeglasses/Contact(s)								
	Hearing Aid(s): ☐ R ☐ L								
	Cane / Walker / W/C								
	Other:								

TRANSFERS

No.	To Unit/Room #	Date	Time	Staff Sending Patient	Staff Receiving Patient	Patient Sign
1st						
2nd						
D/C						

UC Irvine Medical Center is **not responsible** for belonging/valuables brought into the hospital unless such items are placed in the hospital safe. I fully understand **I am responsible for the items I keep with me and release the hospital from any responsibility for items in my possession. eg. Laptop computers, cell phones, audio equipment, etc.**

Patient/Responsible Party Signature: [signature] Date: 3/24/14 Time: 1857

Hospital Staff Print Name: SAMIR DRIDI RN Date: 3/24/14 Time: 18:05

Second witness if patient unable to sign: _____ Date: _____ Time: _____

If items are sent home, person's signature: _____ Date: _____ Time: _____

*Legend: S = Send R = Receive

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.

81664 (Rev 10-15-12)

PL 000002

ROA1267

[redacted] [redacted]
REED, EMILY
AKA:

DOB: [redacted] F

UNIVERSITY of CALIFORNIA · IRVINE HEALTHCARE

PATIENT BELONGINGS LIST

PATIENT VALUABLES #:	PATIENT MEDICATIONS #:

Qty.	Items	Condition	Admitting Unit/Codes WP - With Patient SH - Sent Home w/ PP - Patient Property C - Controlled Access E - Evidence D - Destroyed/Approved by:	1st Transfer CODES S	1st Transfer CODES R	2nd Transfer CODES S	2nd Transfer CODES R	D/C S	D/C R
	Dress/Skirt	☐ Intact ☐ Torn/Cut							
	Hat/Belt/Gloves	☐ Intact ☐ Torn/Cut							
	Housecoat/Robe	☐ Intact ☐ Torn/Cut							
	Nightgown/Pajamas	☐ Intact ☐ Torn/Cut							
1	Pants/Shorts	☑ Intact ☐ Torn/Cut	WP						
1	Shirt/Blouse	☑ Intact ☐ Torn/Cut	WP						
2	Shoes/Slippers	☑ Intact ☐ Torn/Cut	C						
2	Socks/Hosiery	☑ Intact ☐ Torn/Cut	C						
1	Sweater/Jacket	☑ Intact ☐ Torn/Cut	WP						
1	Undergarments	☑ Intact ☐ Torn/Cut	WP						
1	Other: bra	☑ Intact ☐ Torn/Cut	WP						
1	Other: [illegible]	☑ Intact ☐ Torn/Cut	C						
1	Other: [illegible]	☑ Intact ☐ Torn/Cut	C						
	PROSTHETIC DEVICES								
1	Dentures: ☐ Upper ☐ Lower	watch	WP						
	Partial: ☐ Upper ☐ Lower								
	Eyeglasses/Contact(s)								
	Hearing Aid(s): ☐ R ☐ L								
	Cane / Walker / W/C								
	Other:								

Perfume 3/18/14

TRANSFERS

No.	To Unit/Room #	Date	Time	Staff Sending Patient	Staff Receiving Patient	Patient Sign
1st						
2nd						
D/C						

81664

UC Irvine Medical Center is **not responsible** for belonging/valuables brought into the hospital unless such items are placed in the hospital safe. I fully understand **I am responsible for the items I keep with me and release the hospital from any responsibility for items in my possession. eg. Laptop computers, cell phones, audio equipment, etc.**

Patient/Responsible Party Signature: X [signature] Date: _____ Time: _____

Hospital Staff Print Name: [signature] Date: 3/18/14 Time: 1106

Second witness if patient unable to sign: _____ Date: _____ Time: _____

If items are sent home, person's signature: _____ Date: _____ Time: _____

*Legend: S = Send R = Receive

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.

81664 (Rev 10-15-12)

PL 000003

ROA1268

[redacted] [redacted]
REED, EMILY DOB: [redacted] F
AKA:

UNIVERSITY of CALIFORNIA • IRVINE HEALTHCARE

PATIENT BELONGINGS LIST

PATIENT VALUABLES #:	PATIENT MEDICATIONS #:

Qty.	Items	Condition	Admitting Unit/Codes WP - With Patient SH - Sent Home w/ PP - Patient Property C - Controlled Access E - Evidence D - Destroyed/Approved by:	1st Transfer CODES S	1st Transfer CODES R	2nd Transfer CODES S	2nd Transfer CODES R	D/C S	D/C R
	Dress/Skirt	☐ Intact ☐ Torn/Cut							
	Hat/Belt/Gloves	☐ Intact ☐ Torn/Cut							
	Housecoat/Robe	☐ Intact ☐ Torn/Cut							
	Nightgown/Pajamas	☐ Intact ☐ Torn/Cut							
1	Pants/Shorts	☑ Intact ☐ Torn/Cut	WP						
1	Shirt/Blouse	☑ Intact ☐ Torn/Cut	WP						
1	Shoes/Slippers	☑ Intact ☐ Torn/Cut	WP						
1	Socks/Hosiery	☑ Intact ☐ Torn/Cut	WP						
1	Sweater/Jacket	☑ Intact ☐ Torn/Cut	WP						
1	Undergarments	☑ Intact ☐ Torn/Cut	WP						
	Other:	☑ Intact ☐ Torn/Cut							
	Other:	☑ Intact ☐ Torn/Cut							
	Other:	☑ Intact ☐ Torn/Cut							
	PROSTHETIC DEVICES								
1	Dentures: ☐ Upper ☐ Lower		WP						
	Partial: ☐ Upper ☐ Lower								
	Eyeglasses/Contact(s)								
	Hearing Aid(s): ☐ R ☐ L								
	Cane / Walker / W/C								
	Other:								

TRANSFERS

No.	To Unit/Room #	Date	Time	Staff Sending Patient	Staff Receiving Patient	Patient Sign
1st						
2nd						
D/C						

UC Irvine Medical Center is **not responsible** for belonging/valuables brought into the hospital unless such items are placed in the hospital safe. I fully understand **I am responsible for the items I keep with me and release the hospital from any responsibility for items in my possession. eg. Laptop computers, cell phones, audio equipment, etc.**

Patient/Responsible Party Signature: X _____ Date: _____ Time: _____

Hospital Staff Print Name: _____ Date: 2/18/14 Time: _____

Second witness if patient unable to sign: _____ Date: _____ Time: _____

If items are sent home, person's signature: _____ Date: _____ Time: _____

*Legend: S = Send R = Receive

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.

81664 (Rev 10-15-12)

PL 000004

ROA1269

[redacted] [redacted] DOB: [redacted] F
REED, EMILY
AKA:

UC Irvine Health

Neuropsychiatric Center
DISCHARGE/RELAPSE PREVENTION
Part I

Patient's Name: Emily Reed

I. My illness is: Bipolar
My illness is characterized by periods of stabilization and periods of relapse (decline in function).
Relapse is often preventable if I am aware of my symptom/warning signs, make the changes indicated and seek help from support people and my physician when the warning signs occur.

II. My symptoms/Warning signs of relapse are:

Appetite
- binging, obsessive eating
- Anorexia
- rapid weight loss or gain

Appearance
- poor personal hygiene
- poor self care
- dramatic makeup & dress

Hostility
- verbal or physical threats
- desire to hurt others
- angry outbursts
- destruction of property
- impulsive behavior

Medication
- refusing medications
- cheeking medication
- self medicating
- constantly seeking medications

Mood
- loss of interest in everything
- increased isolation ✓
- tearfulness
- sleep all the time
- unable to sleep
- irritable
- agitated
- anxious
- talkative

Social Interaction
- withdrawn
- intrusive
- controlling

Suicide
- preoccupation with death
- thoughts of suicide
- self-destructive behavior
- suicide or self harm plan

Substance Abuse
- alcohol or substance use
- slurred speech
- pupils constricted or dilated

Thought Processes
- poor concentration
- distractible
- confused
- hear voices
- delusional
- obsessive
- racing thoughts
- suspicious

III. My symptoms can be reduced by:
- taking my medicine as ordered
- avoiding street drugs
- avoiding alcohol
- talking to family and friends
- identifying risky situations
- diversional activity, TV, Reading
- daily routine
- safe stable living
- walking, exercising
- keeping busy
- reducing stress
- seeing my doctor regularly
- attending groups - AA., NA., PHP, other.
- other _____

IV. My supports are: *(list friends, family, self-help groups' etc.)*

Name: Alecia Draper (mom) Address: [redacted] Phone: [redacted]
Name: Jeff Reed (Dad) Address: _____ Phone: [redacted]
Name: Lisa (Aunt) Address: _____ Phone: _____

Patient's Signature: Emily Reed Date: 4-7-14 Time: 9:21 am
Staff Signature: *(if assisted)* ~~Jiffon~~ Jiffon Date: 4/7/14 Time: 1004 am

Interpreter's Signature: _____ Date: _____ Time: _____

Part II to be completed day of discharge.
☐ Completed Independently ☐ Completed With Assistance ☐ Incomplete Because: ☐ Pt. Refused ☐ EHA Pt. ☐ Other _____

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.

[redacted] [redacted] [redacted]
REED, EMILY
AKA:

DOB: [redacted] F

Patient Identification

UCIMC NEUROPSYCHIATRIC CENTER
Adult Inpatient Services
SECLUSION / RESTRAINT ADVISEMENT

UCI Medical Center has a "Zero Tolerance for Violence" policy.

We want to inform you about the use of seclusion and restraint in our hospital. California State Law and UCI Hospital Policy state that **seclusion or restraint is only used when alternative methods are not sufficient to protect the patient or others from injury.**

Seclusion is the involuntary confinement of a person alone in a room where the person is physically prevented from leaving. A restraint is defined as any method of physically restricting a person's freedom of movement, physical activity or normal access to his/her body.

It is the goal of our hospital to provide a safe environment for all of our patients, families and staff.
In an emergency, a patient may be placed in seclusion or restraints. This is done only when other interventions fail to maintain a safe environment. While in seclusion or restraints, a patient is under continuous observation, with frequent assessments and is released as soon as criteria for safety are met.

In the event of an episode of seclusion or restraint, you have the right to decide whether you wish your family/significant other to be notified.

☒ Yes, I wish the following to be notified: Name: Alecia Kremidas Relationship: MOM
☐ I do not wish anyone to be notified. Telephone number: _____

Please help us by completing the following:

Do you have problems with managing your anger or controlling your behavior? ☐ Yes ☒ No
Do you have a history of being sexually or physically abused? ☐ Yes ☒ No
Do you have any pre-existing medical conditions / physical disabilities / limitations? ☐ Yes ☒ No

Please explain any yes answers: _____

It is important that we know any methods or tools that help you control your behavior.

What **makes it difficult for you to manage** your feelings and control your behavior?

☐ involuntary admission	☐ someone cursing	☐ people in uniforms	☐ yelling
☐ someone calling you names	☐ someone standing too close	☐ authority figure saying "No"	☐ loud noises
☐ waiting for medication	☐ redirection from staff	☐ people ignoring you	☐ television
☐ having to wait when asking for something		☐ a roommate that snores	☒ being isolated
☐ no access to money, cigarettes, clothes or _____			☒ being touched
☐ _____		☐ _____	

What **helps you to manage** your feelings and control your behavior?

☒ a change of scenery	☐ thinking of something pleasant	☐ talking to someone	☐ having a snack
☒ physical exercise	☐ being alone in a quiet place	☐ looking at books	☐ soft music
☐ doing crafts / activities	☐ relaxation exercises	☒ going for a walk	☒ counting
☐ thinking of consequences	☐ talking positive to yourself ("stay cool…I can handle it…take it easy")		
☐ watching TV	☐ medications (*specify*): _____		
☐ other:			

☐ Patient was unable to process, at time of admission. ***Attempted by***: _____ *Staff / date & time*

X Emily Reed — *Signature of patient* — 3/18/14 11:40 — date/time

Djkamm T11 — *Staff signature* — 3/18/14 @ 1140 — date/time

FORM #87185 *8/24/04 L.S.*

PL 000006

ROA1271

[redacted]

Patient Name: (Emily C. Reed) Pt
Date of Birth: [redacted]
Patient Address: [redacted]
City **State** **Zip Code**
Phone Number: [redacted]

UC Irvine Health

Authorization for Release of Health Information

Medical Record Number: [redacted]

I authorize UC Irvine Healthcare to release health information to:

Emily C. Reed
Name of person or facility to receive health information

Specify name/title of person to receive health information, if known

SAME AS ABOVE
Street Address, City, State, Zip Code

SAME AS ABOVE
Phone number

RECEIVED
MAY 04 2015
UCIMC-HIM
MEDICAL CORRESPONDENCE

INFORMATION TO BE RELEASED

☒ Discharge Summary	☒ Laboratory Reports	☒ Emergency Medicine Reports
☐ Billing Statements	☐ Dental Records	☒ History & Physical Exams
☒ Pathology Reports	☒ Operative Reports	☒ Diagnostic Imaging Reports
☒ EKG ☒ Progress Notes ☐ Vaccinations/Immunizations	☒ Radiology Reports	☒ Consultations ☒ Outpatient Clinic Records
☐ Other _____		

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE

3-2014 - Present.

SPECIFIC AUTHORIZATIONS

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

- ☐ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).
- ☒ I specifically authorize the release of information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, *et. seq.*)
- ☐ I specifically authorize the release of HIV/AIDS testing information (Health and Safety Code §120980(g)).
- ☐ I specifically authorize the release of genetic testing information (Health and Safety Code 124980(j)).

81610

5415 ROA

81610 (Rev 7-21-10)

COPIED BY HEALTHPORT 05/14/2015

PL 000007
Psyche auth letter.

THE PURPOSE OF THIS RELEASE IS *(check one or more)*

- ☐ Continuity of care or discharge planning
- ☐ Billing and payment of bill
- ☒ At the request of the patient/patient representative
- ☐ Other (state reason) _____

NOTICE

UCIMC and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

- ☑ I understand this authorization is voluntary. Treatment, payment enrollment or eligibility benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) obtaining information in connection with eligibility or enrollment in a health plan for 3) determining an entity's obligation to pay a claim, or 4) creating health information to provide a third party. Under no circumstances, however, am I required to authorize the release of mental health records.
- ☑ I may revoke this authorization at any time, provided that I do so in writing and submit it to UCIMC c/o Health Information Management, Rt. 118, Bldg. 25, Orange, CA 92868. The revocation will take effect when UCIMC receives it, except to the extent that UCIMC or others have already relied on it.
- ☑ I am entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization expires_____ (insert applicable date or event). If no date is indicated, this authorization will expire 12 months after the date of signing this form.

PERSONAL USE

I understand I will be charged a per page fee for copies produced for my personal use.

ER
Initial

SIGNATURE

Emily Reed ✓
(Signature of Patient or Patient's Legal Representative)

Date: May 4, 2015

Time: 2:10 AM/PM

Emily Reed
Printed Name

_____
(If signed by someone other than the patient, state your legal Relationship to the patient/authority)

_____
Witness or Translator

Mail form with original signature to:
UC Irvine Healthcare
Health Information Management
Building 25, Route 118
101 The City Drive South
Orange, California 92868
(714) 456-5670

81610 (Rev 7-21-10)

UC Irvine Medical Center

PSYCH RECORD AUTHORIZATION

Wednesday May 6, 2015 02:23 PM

Robert Bota
200 S. Manchester Ave., Suite 206

Last visit date:
Department: NEUR
Number: 110882
Telephone:

Dear Physician:

REGARDING: MR#: [redacted]

NAME: Reed, Emily

DOB: [redacted]

We have received an authorization from the above referenced patient requesting that copies of his/her psychiatric care records be released directly to him/her. Before we can release such records to the patient, we need to ensure that the patient's well-being will not be compromised by doing so.

Please indicate below whether or not you approve the release of the records to the patient. Please return the record (if provided) and this form to the Correspondence Secretary in the HIM Dept., Bldg. 25, Rt 118, once completed.

Thank you,

Correspondence Secretary
UCI Medical Center - Orange
(714) 456-5670

****

✓ I, Dr. [signature], **DO** approve the release of this patient's medical records directly to the patient.

____ I, Dr._____, **DO NOT** approve the release of this patient's medical records directly to the patient as I feel it may be detrimental to the patient's well-being.

[signature]
Physician Name

5 V 15
Date

PL 000009

ROA1274

[redacted] DOB: [redacted] F
REED, EMILY
AKA:

UNIVERSITY of CALIFORNIA · IRVINE HEALTHCARE

PATIENT BELONGINGS LIST

REED EMILY

PATIENT VALUABLES #: /	PATIENT MEDICATIONS #:

Qty.	Items	Condition	Admitting Unit/Codes WP - With Patient SH - Sent Home w/ PP - Patient Property C - Controlled Access E - Evidence D - Destroyed/Approved by:	1st Transfer CODES		2nd Transfer CODES		D/C CODES	
				S	R	S	R	S	R
	Dress/Skirt	☐ Intact ☐ Torn/Cut							
	Hat/Belt/Gloves	☐ Intact ☐ Torn/Cut							
	Housecoat/Robe	☐ Intact ☐ Torn/Cut							
	Nightgown/Pajamas	☐ Intact ☐ Torn/Cut							
2	Pants/Shorts	☑ Intact ☐ Torn/Cut							
3	Shirt/Blouse	☐ Intact ☐ Torn/Cut							
	Shoes/Slippers	☐ Intact ☐ Torn/Cut							
	Socks/Hosiery	☐ Intact ☐ Torn/Cut							
	Sweater/Jacket	☐ Intact ☐ Torn/Cut							
2	Undergarments	☐ Intact ☐ Torn/Cut	WP						
	Other:	☐ Intact ☐ Torn/Cut	WP						
1	Other:	☐ Intact ☐ Torn/Cut	PP						
1	Other:	☐ Intact ☐ Torn/Cut	PP						
	PROSTHETIC DEVICES								
	Dentures: ☐ Upper ☐ Lower								
	Partial: ☐ Upper ☐ Lower								
	Eyeglasses/Contact(s)								
	Hearing Aid(s): ☐ R ☐ L								
	Cane / Walker / W/C								
	Other:	✓	WP						

TRANSFERS

No.	To Unit/Room #	Date	Time	Staff Sending Patient	Staff Receiving Patient	Patient Sign
1st						
2nd						
D/C						

UC Irvine Medical Center is **not responsible** for belonging/valuables brought into the hospital unless such items are placed in the hospital safe. I fully understand **I am responsible for the items I keep with me and release the hospital from any responsibility for items in my possession. eg. Laptop computers, cell phones, audio equipment, etc.**

Patient/Responsible Party Signature: _____ Date: 4/18/15 Time: 1405

Hospital Staff Print Name: _____ Date: 4/18/15 Time: 1405

Second witness if patient unable to sign: _____ Date: _____ Time: _____

If items are sent home, person's signature: _____ Date: _____ Time: _____

*Legend: S = Send R = Receive

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.

81664 (Rev 10-15-12)

81664

PL 000010

[redacted] DOB: [redacted] F

REED, EMILY

AKA:

Reed Emily

UNIVERSITY of CALIFORNIA · IRVINE HEALTHCARE

PATIENT BELONGINGS LIST

PATIENT VALUABLES #:	PATIENT MEDICATIONS #:

Qty.	Items	Condition	Admitting Unit/Codes WP - With Patient SH - Sent Home w/ PP - Patient Property C - Controlled Access E - Evidence D - Destroyed/Approved by:	1st Transfer CODES S	1st Transfer CODES R	2nd Transfer CODES S	2nd Transfer CODES R	D/C CODES S	D/C CODES R
	Dress/Skirt	☐ Intact ☐ Torn/Cut							
	Hat/Belt/Gloves	☐ Intact ☐ Torn/Cut							
	Housecoat/Robe	☐ Intact ☐ Torn/Cut							
	Nightgown/Pajamas	☐ Intact ☐ Torn/Cut							
1	Pants/Shorts	☐ Intact ☐ Torn/Cut							
	Shirt/Blouse	☐ Intact ☐ Torn/Cut							
1	Shoes/Slippers	☐ Intact ☐ Torn/Cut							
1	Socks/Hosiery	☐ Intact ☐ Torn/Cut							
1	Sweater/Jacket	☐ Intact ☐ Torn/Cut							
1	Undergarments	☐ Intact ☐ Torn/Cut							
1	Other: wrist watch	☐ Intact ☐ Torn/Cut		1					
1	Other: Rock	☐ Intact ☐ Torn/Cut							
	Other:	☐ Intact ☐ Torn/Cut							
	PROSTHETIC DEVICES								
	Dentures: ☐ Upper ☐ Lower								
	Partial: ☐ Upper ☐ Lower								
	Eyeglasses/Contact(s)								
	Hearing Aid(s): ☐ R ☐ L								
	Cane / Walker / W/C								
	Other:								

TRANSFERS

No.	To Unit/Room #	Date	Time	Staff Sending Patient	Staff Receiving Patient	Patient Sign
1st						
2nd						
D/C						

81664

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Patient/Responsible Party Signature: X Emily Reed Date: 4/11/15 Time: [redacted]

Hospital Staff Print Name: Peace Michaels Date: 4/11/15 Time: [redacted]

Second witness if patient unable to sign: _____ Date: _____ Time: _____

If items are sent home, person's signature: _____ Date: _____ Time: _____

*Legend: S = Send R = Receive

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.

81664 (Rev 10-15-12)

PL 000011

UC Irvine Health

CONFIDENTIAL PATIENT INFORMATION

Discharge Instructions - Inpatient

REED, EMILY	18y	F	[redacted]	BOTA, ROBERT
MHMP 222E-01 Med Psych MH 2-S				[redacted]

Admission/Discharge Dates

Admission Date: 04-18-2015

Discharge Date: 04-20-2015

Discharge Attending

Attending, BOTA, ROBERT, MD (A), Psychiatry

Discharge Information/Instructions

- Discharge Disposition: home
- Condition at Discharge: stable, improved
- Diet at discharge: regular
- Activity on discharge: activity as tolerated
- Equipment: none

Questions Regarding Prescriptions

Consumer Med Safety web address For more information about safe medication practices, please visit: http://www.consumermedsafety.org/

Follow Up Appointments

Follow Up Appointments: Follow up with your primary care provider

Referrals: Adult:

- Private Physician: An appointment has been made for you with Dr Nayana Shah on Thursday 04/23/2015 at 2:00pm. The office is located at 16152 Beach Blvd Suite 200 Huntington Beach, CA. If unable to keep this appointment please make sure to reschedule 714-841-6772.

Special Instructions/Safety Measures

For patients with Heart Failure, please weigh yourself as soon as you get home and every morning. Call your regular doctor or cardiologist with a weight gain of 3 pounds in a day or 5 pounds in a week. This may signal too much fluid and worsening of your Heart Failure.

Per Section 5331, Welfare and Institutional Code, State of California;
No person may be presumed incompetent because he or she has been evaluated or treated for mental disorder or chronic alcoholism, regardless of whether voluntary or involuntary received.

UC Irvine Health

CONFIDENTIAL PATIENT INFORMATION

Discharge Instructions - Inpatient

REED, EMILY	18y	F	[redacted]	BOTA, ROBERT
MHMP 222E-01 Med Psych MH 2-S				[redacted]

If your insurance company requires authorization for follow up care, please call them before making an appointment.

For information regarding advanced directive, call the California Health Decisions in Orange.

For information regarding health education classes, call toll free 877-UCI-DOCS.

To request an appointment or prescription renewal, view your health records, and contact your physician through myHealthcare, visit https://myhealthcare.healthcare.uci.edu/PPUI/Anonymous/Login.aspx.

Return to nearest emergency room right away for chest pain, worsening stomach pain, trouble breathing, dizziness when standing, trouble walking or thinking. For other symptoms, if you are unable to reach your doctor, see the doctor in the UCI Medical Center Emergency Room.

Please notify your physician or emergency department nurse of persistent redness, swelling, pain or numbness at the site of a previous IV.

If you smoke, now is the time to quit. Call 1-877-UCI-DOCS for free stop smoking classes.

Physician Signature: _____, MD

Instructions given by: _____, RN Interpreter: _____

PATIENT: I have received a copy of these instructions and I understand the information and my responsibility for on-going care needs.

Patient - _____

OTHER RESPONSIBLE PERSON _____

After you leave the hospital you will receive a survey. Your feedback is the most important way for us to judge how we are doing. If your health care and service needs were met we encourage you to reward us with a score of 5 on the survey questions. You may also provide specific written comments if you wish to do so.

[redacted]
REED, EMILY
AKA:

DOB: [redacted] F

UC Irvine Health

Neuropsychiatric Center
DISCHARGE/RELAPSE PREVENTION
Part II

Patient's Name: Emily Reed

V. My follow-up plan is: See therapist, go to an outpatient program

VI. After Discharge, the doctor prescribing my medication is:

MD Dr. Shah Phone: 714 841-6772

If I have problems with my medications, or my symptoms get worse, I will call my doctor.

VII. My next appointment is: 4-23-15 2:00pm

VIII. Medications I currently take:

Name	Dose	Frequency
Prozac	40mg	daily
Lorazepam	1mg	as needed 6 hours

To help me remember, I will take them: ☐ AM, when waking ☐ with meal ☐ at bedtime

IX. If my symptoms become severe, I will call the crisis line 714-456-7000

UCI Medical Center Emergency Room
101 The City Drive
Orange, California 92868-3298
or nearest Emergency Room

Other Resources:

UCI Outpatient Department: (714) 456-5902
Mental Health Association: (714) 547-7559
Alliance for the Mentally Ill (714) 544-8488

Other: _____

Patient's Signature: Emily Reed Date: 4-24-15 Time: 1600

Staff Signature: *(if assisted)* _____ Date: _____ Time: _____

Interpreter's Signature: _____ Date: _____ Time: _____

Part II to be completed day of discharge.

☐ Completed Independently ☐ Completed With Assistance ☐ Incomplete Because: ☐ Pt. Refused ☐ EHA Pt. ☐ Other _____

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.

[redacted]
REED, EMILY DOB: [redacted] F
AKA:

UNIVERSITY of CALIFORNIA • IRVINE HEALTHCARE

PATIENT BELONGINGS LIST

PATIENT VALUABLES #:	PATIENT MEDICATIONS #:

Qty.	Items	Condition	Admitting Unit/Codes WP - With Patient SH - Sent Home w/ PP - Patient Property C - Controlled Access E - Evidence D - Destroyed/Approved by:	1st Transfer CODES		2nd Transfer CODES		D/C CODES	
				S	R	S	R	S	R
	Dress/Skirt	☐ Intact ☐ Torn/Cut							
	Hat/Belt/Gloves	☐ Intact ☐ Torn/Cut							
	Housecoat/Robe	☐ Intact ☐ Torn/Cut							
	Nightgown/Pajamas	☐ Intact ☐ Torn/Cut							
(1)	Pants/Shorts	☑ Intact ☐ Torn/Cut	WP						
(1)	Shirt/Blouse	☑ Intact ☐ Torn/Cut	WP						
	Shoes/Slippers	☐ Intact ☐ Torn/Cut							
	Socks/Hosiery	☐ Intact ☐ Torn/Cut							
	Sweater/Jacket	☐ Intact ☐ Torn/Cut							
	Undergarments	☐ Intact ☐ Torn/Cut							
(1)	Other: Pajama top/bottom	☑ Intact ☐ Torn/Cut	WP						
+-	Other:	☐ Intact ☐ Torn/Cut							
(1)	Other: bra	☑ Intact ☐ Torn/Cut	WP						
	PROSTHETIC DEVICES								
	Dentures: ☐ Upper ☐ Lower								
	Partial: ☐ Upper ☐ Lower								
	Eyeglasses/Contact(s)								
	Hearing Aid(s): ☐ R ☐ L								
	Cane / Walker / W/C								
	Other:								

TRANSFERS

No.	To Unit/Room #	Date	Time	Staff Sending Patient	Staff Receiving Patient	Patient Sign
1st						
2nd						
D/C						

81664

UC Irvine Medical Center is **not responsible** for belonging/valuables brought into the hospital unless such items are placed in the hospital safe. I fully understand **I am responsible for the items I keep with me and release the hospital from any responsibility for items in my possession. eg. Laptop computers, cell phones, audio equipment, etc.**

Patient/Responsible Party Signature: _____ Date: _____ Time: _____

Hospital Staff Print Name: Arnold Bran [signature] Date: 4-18-15 Time: 2000

Second witness if patient unable to sign: _____ Date: 4-18-15 Time: _____

If items are sent home, person's signature: X Emily Reed Date: 4/20/15 Time: 1100

*Legend: S = Send R = Receive

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.

81664 (Rev 10-15-12)

PL 000015

[redacted]
REED, EMILY
AKA:

[redacted]
DOB: [redacted] F

UNIVERSITY of CALIFORNIA • IRVINE HEALTHCARE

PATIENT BELONGINGS LIST

REED EMILY

PATIENT VALUABLES #: /

PATIENT MEDICATIONS #:

Qty.	Items	Condition	Admitting Unit/Codes WP - With Patient SH - Sent Home w/ PP - Patient Property C - Controlled Access E - Evidence D - Destroyed/Approved by:	1st Transfer CODES S	1st Transfer CODES R	2nd Transfer CODES S	2nd Transfer CODES R	D/C CODES S	D/C CODES R
	Dress/Skirt	☐ Intact ☐ Torn/Cut							
	Hat/Belt/Gloves	☐ Intact ☐ Torn/Cut							
	Housecoat/Robe	☐ Intact ☐ Torn/Cut							
	Nightgown/Pajamas	☐ Intact ☐ Torn/Cut							
2	Pants/Shorts	☑ Intact ☐ Torn/Cut	WP						
3	Shirt/Blouse	☑ Intact ☐ Torn/Cut	WP						
	Shoes/Slippers	☐ Intact ☐ Torn/Cut							
	Socks/Hosiery	☐ Intact ☐ Torn/Cut							
	Sweater/Jacket	☐ Intact ☐ Torn/Cut							
2	Undergarments underwear	☑ Intact ☐ Torn/Cut	WP						
	Other: 1 shampoo 1 Cond	☑ Intact ☐ Torn/Cut	WP						
1	Other: Packet of Gum	☑ Intact ☐ Torn/Cut	PP						
1	Other: Black Rock	☑ Intact ☐ Torn/Cut	PP						
	PROSTHETIC DEVICES								
	Dentures: ☐ Upper ☐ Lower								
	Partial: ☐ Upper ☐ Lower								
	Eyeglasses/Contact(s)								
	Hearing Aid(s): ☐ R ☐ L								
	Cane / Walker / W/C								
	Other: (1) Watch (1) Ring ✓ Intact		WP						

TRANSFERS

No.	To Unit/Room #	Date	Time	Staff Sending Patient	Staff Receiving Patient	Patient Sign
1st						
2nd						
D/C						

UC Irvine Medical Center is **not responsible** for belonging/valuables brought into the hospital unless such items are placed in the hospital safe. I fully understand **I am responsible for the items I keep with me and release the hospital from any responsibility for items in my possession. eg. Laptop computers, cell phones, audio equipment, etc.**

Patient/Responsible Party Signature: X [signature] Date: 4/18/15 Time: 14:05

Hospital Staff Print Name: [signature] Date: 4/18/15 Time: 1405

Second witness if patient unable to sign: Emily Reed Date: _____ Time: _____

If items are sent home, person's signature: Emily Reed Date: 4/20/15 Time: 1100

*Legend: S = Send R = Receive

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.

81664 (Rev 10-15-12)

81664

PL 000016

UC Irvine Health

CONFIDENTIAL PATIENT INFORMATION

Discharge Instructions - Inpatient

REED, EMILY	18y	F	[redacted]	COX AHERN, SUSAN
T5BD-08 Medical Telemetry				[redacted]

Admission/Discharge Dates

Admission Date: 04-17-2015

Discharge Date: 04-18-2015

Discharge Attending

Attending, COX AHERN, SUSAN, DO (A), Hospital Medicine

Primary Care Provider/Other Providers

Admitting, NGUYEN, KELVIN TRONG, MD (A), Hospital Medicine

PCP, DEBOLD, LORI ANN, MD, Peds: General

Referring, BOTA, ROBERT, MD (A), Psychiatry

Discharge Diagnoses

1. Drug-induced dystonia , Code: 333.72
2. TACHYCARDIA
3. History of schizophrenia , Description: History of schizophrenia , Code: V11.0

Discharge Information/Instructions

- Discharge Disposition: transfer to inpatient psychiatric facility...
- Condition at Discharge: stable
- Rehab Potential full self care
- Discharge Order/Treatment Plan see above summary

Questions Regarding Prescriptions

Consumer Med Safety web address For more information about safe medication practices, please visit: http://www.consumermedsafety.org/

Follow Up Appointments

Follow Up Appointments: Follow up with your primary care provider

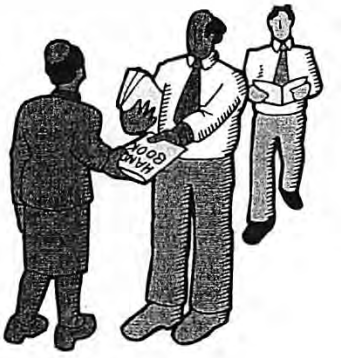
Special Instructions/Safety Measures

For patients with Heart Failure, please weigh yourself as soon as you get home and every morning. Call your regular doctor or cardiologist with a weight gain of 3 pounds in a day or 5 pounds in a week. This may signal too much fluid and worsening of your Heart Failure.

PL 000017

ROA1282

Adult Med-Psych
Unit 2 South
Orientation Guide and Handbook



For Patients and Families

ORGANIZATIONAL POLICY REGARDING THE USE OF SECLUSION AND RESTRAINTS

It is the goal of UCI Medical Center to provide a safe environment for our patients, visitors and staff. Education to patients and families regarding alternatives to seclusion and restraints will be provided as needed. Seclusion and restraints will only be utilized as a last resort for safety purposes. Patients will be monitored closely by our staff during any restraint or seclusion episode and staff will attend to their needs.

ALWAYS REMEMBER TO TREAT PEERS, STAFF AND YOURSELF WITH DIGNITY AND RESPECT

CONFIDENTIAL PATIENT INFORMATION
See: Cal. W & I Code, Section 5328

[redacted]
REED, EMILY DOB: [redacted] F
AKA:

COUNTY OF ORANGE, CALIFORNIA
HEALTH CARE AGENCY/BEHAVIORAL HEALTH CARE PATIENTS RIGHTS

Sections 5325 and 5325.1 of the Welfare and Institutions Code and Section 862, Title IX of the California Code of Regulations require that all persons prior to or at the time of their admission to the facility and during their stay, be advised of their rights as patients. There must also be written verification that they have been informed of these rights. This form has been designed to meet the requirements of these regulations. This side of the form will verify that the patient has been advised of his/her rights and provided with a copy of the Patients Rights Handbook. A completed copy shall be given to the person signing the acknowledgment. A completed copy shall be retained in the patient's personal file maintained by the facility. The original shall be filed in the chart.

ACKNOWLEDGMENT I have been personally advised and have received a copy of these rights at the time of my admission to YOIMC (NAME OF FACILITY)

X Emily Reed (SIGNATURE OF PATIENT) 3/18/14 (DATE) AND/OR

as the designated representative of _____ (NAME OF PATIENT)

have been personally advised and have received a copy of these rights at the time of his/her admission to UCIMC (NAME OF FACILITY)

X [signature] (SIGNATURE OF DESIGNEE) (TITLE: PARENT, GUARDIAN, ETC.) 3-18-14 (DATE)

RECONOCIMIENTO Yo he sido personalmente informado y haber recibido una copia de estos derechos en el momento de mi admisión a

_____ (NOMBRE DE FACILIDAD)

_____ (FIRMA DEL PACIENTE) (FECHA) Y/O

Yo, como el representante designado de _____ (NOMBRE DEL PACIENTE)

He sido personalmente informado y haber recibido una copia de estos derechos en el momento de su admisión

_____ (NOMBRE DE FACILIDAD)

_____ (NOMBRE DEL DESIGNADOR) (TITULO: PADRES, GUARDIAN, ETC.)

F0346-402 **PL 000020** [illegible] reverse side

CLIENT COPY DTP1018

ROA1285

UC Irvine Health

CONFIDENTIAL PATIENT INFORMATION

Discharge Instructions - Inpatient

REED, EMILY	18y	F	BOTA, ROBERT
MHMP 222E-01 Med Psych MH 2-S			[redacted]

Medication List

Discharge Medications

- LORazepam 1 mg oral tablet
  Instructions: 1 tab(s) orally every 6 hours, As Needed, anxiety
  (written prescription)

  Last dose taken: 4/20/15 at 8:30 Am and Next dose due at: As needed every 6 Hours

- FLUoxetine 20 mg oral tablet
  Instructions: 2 tab(s) orally once a day
  Indication: for depression
  (written prescription

  Last dose taken: 4/20/15 at 9Am and Next dose due at: 4/21/15 at 9Am

For more information about safe medication practices, please visit: http://www.consumermedsafety.org/

For Your Safety
Please check with your primary physician if you should take any medications(s) not on this list.
Keep a complete list of the medications you take with you at all times.
Provide a copy to your primary care provider and at each care visit.
Update your medication list with every change.

State of California - Health and Human Services Agency | Department of Health Care Services

INVOLUNTARY PATIENT ADVISEMENT (TO BE READ AND GIVEN TO THE PATIENT AT TIME OF ADMISSION)

Confidential Patient Information
See W&I Code Section 5328 and
HIPAA Privacy Rule 45 C.F.R. Section 164.508

Name of Facility: UCI MEDICAL CENTER

Patient's Name: EMILY REED | Admission Date: 4/16/15

Section 5150(h) of the Welfare and Institutions Code requires that each person admitted to a facility designated by the county for evaluation and treatment be given specific information orally and in writing, and in a language or modality accessible to the person and a record of the advisement be kept in the person's medical record.

My name is TONY My position here is RN

You are being placed in this psychiatric facility because it is our professional opinion, that as a result of a mental health disorder, you are likely to: (check applicable)

☒ Harm yourself ☐ Harm someone else ☒ Be unable to take care of your own food clothing or shelter

(List specific facts upon which the allegation of dangerous or gravely disabled due to mental health disorder is based, including pertinent facts arising from the admission interview):

We believe this is true because PT REPORTED HEARING VOICES, RAN INTO PARKING LOT, ROLLED AROUND ON GROUND AND SCREAMED FOR 35 MINUTES, IN DANGER OF HARMING SELF

You will be held for a period of up to 72 hours. This (does not) (does) include weekends or holidays.

Your 72-hour period begins: 4/16/15 @ 19:00 (Time and Date)

Your 72-hour evaluation and treatment period will end at: 4/19/15 @ 19:00 (Time and Date)

You will be held for a period up to 72 hours. During the 72 hours you may also be transferred to another facility. You may request to be evaluated or treated at a facility of your choice. You may request to be evaluated or treated by a mental health professional of your choice. We cannot guarantee the facility or mental health professional you choose will be available, but we will honor your choice if we can.

During these 72 hours you will be evaluated by the facility staff, and you may be given treatment, including medications. It is possible for you to be released before the end of the 72 hours. But if the staff decides that you need continued treatment you can be held for a longer period of time. If you are held longer than 72 hours, you have the right to a lawyer and a qualified interpreter and a hearing before a judge. If you are unable to pay for the lawyer, then one will be provided to you free of charge.

If you have questions about your legal rights, you may contact the county Patients' Rights Advocate at _____ (714) 834-5647 _____ (phone number of county Patients' Rights Advocacy Office).

Good cause for Incomplete Advisement			Date
Advisement Completed by	**Position**	**Language or Modality Used**	**Date**
[signature]	RN	ENGLISH	4/16/15

CC: Original to the Patient
Carbon to the Patient's Record

DHCS 1802 (01/2014)

REED, EMILY

MR#:	[redacted]	Gender:	Female	Admit Date:	04/16/2015 14:11
Visit#:	[redacted]	DOB:	[redacted]	Discharge Date:	04/17/2015 12:01
DR:	NGUYEN, KELVIN TRONG	Age:	18y	Service:	IP Medicine C

Consultation, Initial-Psychiatry

04/16/2015 11:26 HOWARD, PAMELA (MD (R))

- **Evaluation Date and Time:** 04-16-2015 11:26
- **Admission Date:** 04-16-2015

- **Referring Attending Physician:** CHAKRAVARTHY, BHARATH [MD (A)]
- **Reason for Referral:** +AH, confusion w/h/o MDD w/psychosis

Chief Complaint and History of Present Illness:

- **History of Present Illness:** Ms Reed is an 18 year old female with a history of PTSD, Depression w/psychotic features who was BIBA today after she became agitated at school and was rolling around on the asphalt at her high school (Marina HS).

School psychologist said that she was shaking in the bus on the way to school. She told her school counselor, "it is loud in my head, I don't want to go back, I don't understand, I don't want to go to the hospital." Then she took off running in the parking lot at the school then dropped down in the middle of the street rolling around on the ground in the fetal position for 35 minutes. Per psychologist report, She continued to scream in the middle of the street for the entire 35 minutes she was rolling around on the ground. The school counselor was concerned she was going to hurt herself.
Parametrics transported the patient to UCIMC.
She was given IM Versed 5mg during transport. On arrival to UCIMC she required restraints and IM Haldol and Benadryl for agitation. She was placed on 5150 for DTS 4/16/15 @ 1400.

Patient is asleep at time of interview with restraints removed.

The following information was provided by pts mother and step father who were bedside:
She went back to school after changing pathway program IEP on Monday. She has 2 classes to graduate. Over spring break she was functioning fine and had no escalation. School triggers her to feel more anxiety but she wanted to try. She would call and check in with mother and her anxiety was 7-8/10. She also told mother it was because this class was smaller 3-4 kids and so she feels everyone is watching her. She met with new therapist this week Therapist Elisse Collier (562-335-9552); seen her twice last Mon and Wed before but she isn't opening up to therapist. Her psychiatrist is also new and mother could not provide name of that person. They have seen her new psychiatrist once. Mother said since starting back Monday, she was anxious everyday after school. Monday was difficult for her and she talked to psychologist outside the classroom for most of the 2 hour session. Yesterday she did well (per step father.) Today she ran into parking lot and the parents don't know the details. They called paramedics to come and she was given Ativan IM (versed per EMS) at the scene. Recently she has been doing trauma processing work and has been dissociating. Her therapist is using a rock to help her stay in the moment. She talked to mother earlier and repeated the affirmations, "I'm loved" and "I can get through it" She told mother she had suicidal ideation with plan but wouldn't act on it. Per mother: "She doesn't want to die". Mother and daughter have safety contract and she also has one with the counselor and psychiatrist. When asked about AH, mother said "She said her 'head was really loud' but she wasn't able to explain it". She puts in earplugs because the outside voices are loud (she currently has earplugs in and is holding rock in plastic bag). She told mother there were two voices and she said "I knew it" _repeating that sentence numerous times.
Another significant stressor is the upcoming case against the man who is accused of sexually abused her. She is scheduled to testify in court which includes see the alleged man again. Per the patients mother - The man's mother lives 20 minutes from them and the man has made threats against the family and has shown them a gun. The patient mother reports that the police are unable to file a restraining order against the alleged

Consultation, Initial-Psychiatry

04/16/2015 11:26 HOWARD, PAMELA (MD (R))

perpetrator. She said "she won't feel safe until he is prison and he won't go to prison until she testifies. Until then, he is on home arrest.

Her last hospitalization was DelAmo hospital (Feb/March 2015) where she was admitted on a 5150 for suicidal ideation. It is believed that attempting to return to school was the inciting stressor. She was there for almost a month and was discharged 3 weeks ago. Since that time, she has seemed to do well but was complaining to mother she didn't like the Abilify because it was making her have tremors and she was agitated and didn't feel safe driving the car so that was recently stopped. She is currently on Prozac 40mg but mother isn't sure about other medications or even name of new psychiatrist. Her first hospitalization was at UCI in 3/2014 when she first told staff about her sexual abuse at the hands of a friend of her father's and was beginning to talk about the events. She was given dx of PTSD, MDD and SAD and started on Prozac 40mg daily, Clonazepam 1.5mg po BID, Prazosin 2mg po nightly, Melatonin 3mg po nightly and Lorazepam 1mg po q6H prn anxiety.

Mother said that she took those medication for 3 months then stopped them all complains of various side effects of which the step father seems unconvinced were real. She was also going to Center for Discovery for 4 weeks after getting out of UCI but mother said she was on so much medication she was falling down. She saw a new psychiatrist who stopped the Abilify recently. Mother thinks that her attempting to go back to school has been trigger for last two admission. She has been working with a therapist and mother said she is beginning to open up but it has also caused some flashbacks and panic attacks making her want to kill herself. Mother said "she is still holding a lot of anxiety". Of note: Mother was clearly anxious and speaking quickly during interview.

Robin Moses Case mgr 714-373-0517
Brain optimization assessment Mon Rick Tomey- Per collateral it showed that she is always in a state of trauma and unable to talk about her feelings.

Psychiatric ROS -
Depression ROS not completed at this time due to patient sedation
SUICIDE: suicidal ideation with plan (per mothers report)
HOMICIDE: no per mother

Mania: unknown at this time
HALLUCINATIONS: Told mother she had AH
ANXIETY: mother reports that patient gets agitated, heart papillations and very scared
PTSD: per mother: positive for Flashbacks. Hypervigilance and nightmares from sexual abuse.
Eating Disorders: no know hx, no parental observation consistent with ED behaviors

Access to firearms? no

Do you feel safe in hospital? patient sedated, unable to answer
Would you be willing to contract for safety? patient sedated, unable to answer

Collateral: Alicia Draper [redacted] mother;

Medical ROS: patient sedated, unable to answer

PL 000024

Consultation, Initial-Psychiatry

04/16/2015 11:26 HOWARD, PAMELA (MD (R))

PAST PSYCHIATRIC HISTORY:
-Diagnoses: PTSD, MDD w/psychotic features.
-Prior hospitalizations: # 2
-First hospitalization: UCI 4/2014 x 1 mo; Del Amo 5150 DTS 3/2015 x 1 mo
- Last hospitalization: 3 weeks ago Del Amo
-Suicide attempts: no
-Psych MD: Dr. Shah 714-841-6227; Therapist Elisse Collier (562-336-9552);
-Self Harm behaviors: no

MEDICATION HISTORY:

CURRENT: Prozac 40mg daily

PAST med trials: Abilify- akathisia,
Clonazepam 1.5mg po BID, (d/c'd)
Prazosin 2mg po nightly, (d/c'd)
Melatonin 3mg po nightly (d/c'd)
Lorazepam 1mg po q6H prn anxiety. (d/c'd)

PAST MEDICAL/SURGICAL HISTORY:
none

LMP: unknown

Allergies & Intolerances:
Allergies:
- No Known Allergies:

Medications:
- Medications: diphenhydrAMINE Injection 5 mg (given)
  haloperidol Injection 5 mg (given)
- Home Medications: Home Medications List is Complete.

. Prozac 40 mg oral capsule 1 cap(s) orally once a day

. Abilify - stopped per mother

Social History:
- Smoking Status: never smoker[1]
- Chewing Tobacco: no[2]
- Frequency of Alcohol Intake: never[1]
- Substance Use: Substance abuse hx Denies use of etoh, illicit, or tobacco[2]
- Patient Lives With: parent
- Relationship Status: single / never married
- Children: no

Consultation, Initial-Psychiatry

04/16/2015 11:26 HOWARD, PAMELA (MD (R))

- **Details:** Social:

Developmental: Patient met all developmental milestones as expected. She has always had A's in school, although mother reports that she tested at 1st grade reading level while in 4th grade. She had failed multiple hearing tests but her repeat tests were inconsistent indicating possible malingering and her brainstem testing in 2013 demonstrated no hearing loss.

She grew up in Las Vegas and moved to Huntington Beach with her mother 3 years previously. She lives with her mother, and 2 brothers age 13,15. Mother has remarried although (Jeff) new husband lives in Brea do to work. Parents divorced in 2006 and parents have joint legal custody and mother Alicia Draper (714 916 1524) has majority physical custody. Emily and her 2 brothers go to Vegas to stay with their father (Jeff) 702 241 2486, every other weekend and 7 weeks in the summer. Patient has an IEP through school started in 5th grade. Recently went back to school for a few hours a day to get 2 courses done to get GED.

Per mother sexual abuse at hands of friend of fathers and is going to have to testify soon.

Family History:

- **Details:** Family: 13 yo brother with MDD, unknown medication hx

Vital Signs:

- **Vitals:** -

First set of Vital Signs
HR (bpm): 81; Respirations (breaths/min): 16; SBP (mm Hg): 83; DBP (mm Hg): 43; SpO2 (%): 96;

Physical Exam:

- **Exam:** Appearance: stated age, fair grooming and hygiene, wearing hospital clothes, sleeping

Behavior: asleep
Speech: non-verbal, alseep
Mood: non-verbal
Affect: not obtained
Thought content: not obtained
Thought processes: not obtained
Insight: poor
Judgment: poor
Association: not able to evaluate
Neurologic: moving all 4 extremities to gravity

unable to do cognitive

Assessment and Plan:
Active Problem List:

1. **Major depressive disorder;**

- **Assessment and Plan:** Ms Reed is an 18 year old female with a history of PTSD, Depression w/psychotic features who was BIBA today after she became agitated at school. She has significant stressors and was too disorganized to protect her own safety at school. She required sedation and emergency medications, after which she is unable contribute addational information to interview. Without her narrative we are unable to determine if her disorganized behavior was due to dissociative episode related to PTSD, psychotic exacerbation related to recent discontinuation of Abilify, behavioral demonstration motivated by desire to escape from school, result of acute stress reaction.

PL 000026

REED, EMILY
MR#: [redacted] **Gender:** Female **Admit Date:** 04/16/2015 14:11
Visit#: 2043855341 **DOB:** [redacted] **Discharge Date:** 04/17/2015 12:01
DR: NGUYEN, KELVIN TRONG **Age:** 18y **Service:** IP Medicine C

Consultation, Initial-Psychiatry

04/16/2015 11:26 HOWARD, PAMELA (MD (R))

The patient has risk factors for suicide including loss of rational thought process, h/o depression, anxiety, organized plan/access (but won't tell mother what it is). Patient is at high immediate risk for suicide.

Axis I: PTSD. Major Depressive Disorder. Social Anxiety Disorder.
Axis II: Deferred
Axis III: Intermittent constipation.
Axis VI: Mod-severe: history of abuse, decline in social and academic functioning, complex family dynamics, repeated unsuccessful attempt to reintegrate into school environment.
Axis V: Global Assesement of Functioning 15

Recommendations:
ED: get UTOX, UPREG,

1. Patient requires inpatient psychiatric hospitalization on basis of DTS - 5150 for DTS 4/16/15 @ 1400. please attempt to find pt placement at Del Amo facility for continuity of care.
2. Please coordinate with case manager to facilitate transfer to accepting, contracted, designated inpatient psychiatric facility.

[redacted]

Recommendations if patient is admitted to UCI:
- Admit to 2S - need to ask her about CFS as she has been sedated in ED.
- Legal status:5150 for DTS 4/16/15 @ 1400.
- Recommend starting
  Prozac 40mg po daily
- mother says Risperidone recently started too- called Dr. Shah and have not gotten call back yet.

Plan to talk to psychiatrist Dr. Shah 714-841-6227 to confirm her medications.

Above case discussed with and supervised by on-call attending Dr. Allee who agrees with above assessment and plan.

- **Attending Attestation:** I did not see the patient on the day of this note, but I have reviewed the resident/fellow's note and agree with the findings and plan as documented.

Billing:
- **Consult Billing Service Level:** not applicable

Electronic Signatures:
ALLEE, TINA M (MD (A)) (Signed 04-16-2015 16:15)
Authored: Chief Complaint and History of Present Illness, Medications, Social History, Assessment and Plan, Note Completion, Billing
Co-Signer: Admission Date, Chief Complaint and History of Present Illness, Allergies & Intolerances, Medications, Social History, Family History, Vital Signs, Physical Exam, Data Review, Assessment and Plan, Note Completion
HOWARD, PAMELA (MD (R)) (Signed 04-16-2015 14:08)
Authored: Admission Date, Chief Complaint and History of Present Illness, Allergies & Intolerances,

PL 000027

REED, EMILY

MR#:	[redacted]	**Gender:**	Female	**Admit Date:**	04/16/2015 14:11
Visit#:	[redacted]	**DOB:**	[redacted]	**Discharge Date:**	04/17/2015 12:01
DR:	NGUYEN, KELVIN TRONG	**Age:**	18y	**Service:**	IP Medicine C

Consultation, Initial-Psychiatry

04/16/2015 11:26 HOWARD, PAMELA (MD (R))

Medications, Social History, Family History, Vital Signs, Physical Exam, Data Review, Assessment and Plan, Note Completion

Last Updated: 04-16-2015 16:15 by ALLEE, TINA M (MD (A))

References:
1. Data Referenced From "ED Primary Assessment" 4/16/2015 11:05 AM
2. Data Referenced From "H&P-Primary-Psychiatry" 3/18/2014 1:44 PM

PL 000028

UC Irvine Health
101 The City Drive | Orange, CA 92868
Results Report

REED, EMILY

MR#:	[redacted]	**Gender:**	F	**Admit Date:**	04/16/2015
Visit#:		**DOB:**	[redacted]	**Discharge Date:**	04/17/2015
Dr:	NGUYEN, KELVIN TRONG	**Age:**	19y		
Service:	IP Medicine C				

Diagnostic Radiology

Chest AP XR — **1 or more Final Results Received**
Ordered: 04/17/2015 12:42 — **Resulted: 04/17/2015 12:52**
Requested By: GLASSY, MATTHEW SCOTT (MD (R)) — **Org Performed: RADNET**

Chest AP XR — Final

Examination: 71010 CR Chest AP

Report

Procedure: CR Chest AP

Exam Date: 4/17/2015 12:26 PM

Comparison Study: None available at time of dictation.

History: 18 years old Female with mood disorder.

Findings/
Impression: The lungs are clear and there is no effusion. Normal cardiomediastinal silhouette. Scoliosis of thoracolumbar spine.
***** Final *****

Dictated by: Cyrlak, Dvora, M.D. 04/17/2015 12:47 pm
Electronically Signed by: Cyrlak, Dvora, M.D. 04/17/2015 12:47 pm

University of California - Irvine Healthcare

REED, EMILY

MR#:	[redacted]	**Gender:**	Female	**Admit Date:**	04/16/2015 14:11
Visit#:	[redacted]	**DOB:**	[redacted]	**Discharge Date:**	04/17/2015 12:01
DR:	NGUYEN, KELVIN TRONG	**Age:**	18y	**Service:**	IP Medicine C

Discharge Note.

04/17/2015 11:39 CHOI, BRIAN (MD (R))

Admission/Discharge Dates:

- **Admission Date** 04-16-2015
- **Discharge Date:** 04-17-2015

Discharge Attending:

Provider Role	Provider Name	Occupation	Specialty
Attending	BOTA, ROBERT	MD (A)	Psychiatry

Significant Events:

- **Event Description:** Patient was becoming anxious during the morning, stating that the voices were getting louder and louder. Patient then started to posture with arms flexed at elbows, neck extension, with eyes rolled back and intermittent choking sounds with increased time between breaths. Rapid response called. Vital signs were checked which showed elevated heart rate to approximately 170s, blood pressure up to 160/90s, oxygen saturation was maintained above 90% without episodes of apnea. Patient was taken back to her room and laid down in bed. Medication administration reviewed and no new meds given. Only fluoxetine 40mg given earlier at approximately 830am. Chart reviewed which reveals similar episode at school prior to admission to hospital. Rapid response team arrived and evaluated patient prior to transfer to medicine.

Discharge Type and Core Measures:

- **Discharge Type** Standard
- **Smoking Status** never smoker

Discharge Instructions:

- **Discharge Disposition:** transfer to other acute care facility...
- **Location:** inpatient medicine
- **Condition at Discharge:** fair
- **Discharge Order/Treatment Plan:** Activity
  Activity - Per Unit Standard of Care
- **Medication List:**

Discharge Medications

- FLUoxetine 20 mg oral tablet
  Instructions: 2 tab(s) orally once a day

Blood Thinners:
no.

Questions Regarding Prescriptions:
For more information about safe medication practices, please visit: http://www.consumermedsafety.org/.

Follow Up Appointments:
No follow up needed.

REED, EMILY
MR#: [redacted] Gender: Female Admit Date: 04/16/2015 14:11
Visit#: [redacted] DOB: [redacted] Discharge Date: 04/17/2015 12:01
DR: NGUYEN, KELVIN TRONG Age: 18y Service: IP Medicine C

Discharge Note.

04/17/2015 11:39 CHOI, BRIAN (MD (R))

Note Completion:

- **Attending Attestation:** I was present with the resident/fellow during the history and exam. I discussed the case with the resident/fellow and agree with the findings and plan as documented by the resident/fellow. My additions or revision are included in the record.
- **Attending Comments/Additional Findings/Exceptions:** transferred to medicine for medical stabilization. no allergic reaction.

Billing:
Billing Level:

- **Billing Level:** Less than 30mins of discharge planning, education and care coordination by Attending

Other Instructions-UCI Health Care Team:
Nursing:

The patient left the hospital:	by stracher
The patient left the hospital with	other, staff, Response team
Medication information sheets were provided	for all discharge medications
Discharge instructions	patient and/or family given a copy of the Discharge Note

Authors:
ELECTRONIC SIGNATURES MAY BE ATTRIBUTED TO INDIVIDUALS THAT REVIEWED DOCUMENTATION IN THE LISTED SECTIONS WITHOUT AUTHORING CHANGES.

Electronic Signatures:
BOTA, ROBERT (MD (A)) (Signed 04-21-2015 15:05)
Authored: Admission/Discharge Dates, Note Completion, Billing
Co-Signer: Admission/Discharge Dates, Note Completion
CHOI, BRIAN (MD (R)) (Signed 04-21-2015 14:30)
Authored: Admission/Discharge Dates, Providers, Significant Events, Physical Exam on Day of Discharge, Discharge Information/Instructions/Core Measures, Note Completion, Authorship Disclaimer
PHUNG, QUYEN (Pharmacist) (Signed 04-17-2015 11:59)
Authored: Admission/Discharge Dates, Discharge Information/Instructions/Core Measures
SCHWEIGERT, EMMA (RN) (Signed 04-17-2015 12:07)
Authored: Admission/Discharge Dates, Other Instructions-UCI Health Care Team

Last Updated: 04-21-2015 15:05 by BOTA, ROBERT (MD (A))

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: NGUYEN, KELVIN TRONG

Gender: Female
DOB: [redacted]
Age: 18y

Admit Date: 04/16/2015 14:11
Discharge Date: 04/17/2015 12:01
Service: IP Medicine C

Emergency Physician Treatment Record

04/16/2015 10:41 BREED, WYNNE (MD (R))

Clinician Documentation:

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:
This patient is a 18 year old female pmh depression, SI, AVH, PTSD s/p sexual assault
Patient is set at school to be rolling around in thrashing and treatment of parking lots not responding to commands and not interacting with staff. Patient has a prior episodes were she has had anxiety worsening and then decompensated.
Patient endorses no fever, no vomiting, no shortness of breath, no rash

symptoms were severe upon arrival

PAST MEDICAL HISTORY:
depression, PTSD s/p sexual assault, anxiety

PAST SURGICAL HISTORY:
denies

ALLERGIES:
No Known Allergies

MEDICATIONS:
See Nursing Medication List

FAMILY HISTORY:
Reviewed and non-contributory.

SOCIAL HISTORY:
denies tobacco, alcohol, or substance use

REVIEW OF SYSTEMS:
Review of systems negative except for those elements noted above in HPI

NURSING NOTES: Reviewed

PHYSICAL EXAM:
VITALS (since 6 AM yesterday):
Tc: 36.9 (Tmax: 37.3 @ 04-16-15 11:49) HR: 87 (81 - 87) BP: 86/39 (83 - 86 / 39 - 43) RR: 15 (15 - 16)
SpO2: 99% (96% - 99%) Wt: 49.9kg

PL 000032

Emergency Physician Treatment Record

04/16/2015 10:41 BREED, WYNNE (MD (R))

Gen: age-appropriate, very agitated
Head: NCAT,
Neck: no nuchal rigidity, full range of motion of neck without tenderness, no C-spine tenderness
Eyes: EOMI, no scleral icterus, no conjunctival injection
CV: regular rate and regular rhythm
Pulm: clear to auscultation bilaterally, breathing comfortably
Abd: soft, non-tender, non-distended, no guarding, no rebound
GU: no costovertebral angle tenderness
Musculoskeletal: no T-spine tenderness, no L-spine tenderness
Extremities: no peripheral edema, no extremity tenderness
Neuro: awake, alert, moving all extremities
Psych: non-verbal, thrashing when not in contact w/ pet rock or ice pack

Assessment:
Assessment: 18F pmh PTSD s/p sexual assault BIBA for severe agitaiton, requiring sedatives en route, and in ED. Pt is accompanied by mothe who is good historian, confirms this is consistent w/ prior behavior when under stress or having exacerbation of previous PTSD symptoms, improved w/ pet rock and ice bags. Differential diagnosis PTSD, anxiety, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar affective disorder with manic or depressive phase, neurotic disorders including borderline, oppositional defiant, obsessive compulsive, and others. Patient is unable to cope with social situation and needs urgent evaluation by psychiatrist. If patient expresses suicidal or homicidal ideation and is here voluntarily, will maintain patient safety with Level II observation by security officer. If involuntary yet graveley disabled, or danger of self harm or to others, will place on 5150 legal hold. Will exclude acute medical illness such as electrolyte disorder, dehydration, intoxication, delirium, withdrawal and overdose.
PLan: IM benadryl and haldol, psych evaluation, UA, UTox, consider additional benzo (pt received benzo en route)

MDM/ED Course:
No evidence of acute organic disease to rule out psychiatric evaluation at this time. Medically cleared. - Breed.
12:03 when the patient initially came to the ED she was severely agitated, in restraints (by EMS) and would not let go of a rock in her hand and she would not transfer from the EMS gurney to the ED gurney. Due to her severe agitation we decided to medicate the patient with haloperidol and benadryl for patient safety and for staff safety. Dr. Chakravarthy.
pt to be admitted for inpt stabilization by psych team. - WB.

Diagnosis:
Diagnosis: mental health crisis
PTSD
anxiety
depression

PL 000033

REED, EMILY
MR#: [redacted] Gender: Female Admit Date: 04/16/2015 14:11
Visit#: [redacted] DOB: [redacted] Discharge Date: 04/17/2015 12:01
DR: NGUYEN, KELVIN TRONG Age: 18y Service: IP Medicine C

Emergency Physician Treatment Record

04/16/2015 10:41 - BREED, WYNNE (MD (R))

Attending Attestation:

Attending Attestation: I was present with the resident/fellow during the history and exam. I discussed the case with the resident/fellow and agree with the findings and plan as documented by the resident/fellow. My additions or revision are included in the record.

NOTE IS READY TO BE COMPLETED Chart is complete and signed

Electronic Signatures:

BREED, WYNNE (MD (R)) (Signed 04-17-2015 16:13)
Authored: HPI, ED COURSE/DISPOSITION, TREATMENT NOTE FINALIZATION
CHAKRAVARTHY, BHARATH (MD (A)) (Signed 04-19-2015 17:54)
Authored: HPI, ED COURSE/DISPOSITION, TREATMENT NOTE FINALIZATION

Last Updated: 04-19-2015 17:54 by CHAKRAVARTHY, BHARATH (MD (A))

UC Irvine Health
Department of Pathology & Laboratory Medicine | Edwin S. Monuki, M.D., Ph.D. and Associates
101 The City Drive, Orange, CA 92868
Laboratory Result Report

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
Dr: NGUYEN, KELVIN TRONG
Service: IP Medicine C

Gender: F
DOB: [redacted]
Age: - 19y

Admit Date: 04/16/2015
Discharge Date: 04/17/2015

Chemistry

Comprehensive Metabolic Panel — **Anc ID:** F84242 — **Order ID:** 001DKPVJR
Ordered: 04/17/2015 06:00 — **Collected:** 04/17/2015 06:00 — **Resulted:** 04/17/2015 07:44
Requested By: ROCHA, EVITA (MD (R)) — 1 or more Final Results Received

			Reference Range	
Sodium	142		[135-145 MEQ/L]	Final
Potassium	3.7		[3.3-4.8 MEQ/L]	Final
Chloride	111		[101-111 MEQ/L]	Final
CO2	22	L	[25-34 MEQ/L]	Final
Electrolyte Balance	9		[2-12 MEQ/L]	Final
Glucose	78		[70-115 mg/dL]	Final
	Normal Fasting Glucose: <100 mg/dl Impaired Fasting Glucose: 100-125 mg/dl Provisional DX of diabetes(must be confirmed) >125 mg/dl.			
BUN	9		[8-26 mg/dL]	Final
Creatinine	0.6		[0.5-1.3 mg/dL]	Final
Calcium	8.9		[8.4-10.2 mg/dL]	Final
Protein, Total	6.6		[6.1-8.2 G/DL]	Final
Albumin	3.8		[3.2-5.5 G/DL]	Final
Alkaline Phosphatase	60		[26-110 IU/L]	Final
AST	55	H	[8-40 IU/L]	Final
ALT	21		[0-60 IU/L]	Final
Bilirubin, Total	1.6	H	[0.0-1.4 MG/DL]	Final

Lipid Screen — **Anc ID:** F84242 — **Order ID:** 001DKPVJS
Ordered: 04/17/2015 06:00 — **Collected:** 04/17/2015 06:00 — **Resulted:** 04/17/2015 07:59
Requested By: ROCHA, EVITA (MD (R)) — 1 or more Final Results Received

			Reference Range	
Cholesterol	133		[<200 MG/DL]	Final
	<200mg/dL desirable by NCEP guidelines.			
Triglycerides	23		[<150 MG/DL]	Final
	<150mg/dL desirable by NCEP guidelines.			
HDL Cholesterol	47		[>40 MG/DL]	Final
	>40mg/dL desirable by NCEP guidelines.			
Lp(A) Cholesterol	0.9		[0-5 MG/DL]	Final

Result Indicator: L = Low, H = High, A = Abnormal

PL 000035

REED, EMILY
MR#: [redacted] **Gender:** F **Admit Date:** 04/16/2015
Visit#: [redacted] **DOB:** [redacted] **Discharge Date:** 04/17/2015
Dr: NGUYEN, KELVIN TRONG **Age:** 19y
Service: IP Medicine C

Reference Range:
0-5 mg/dL = No increased risk for CHD
6-10 mg/dL = Slight increased risk for CHD
11-15 mg/dL = Moderately increased risk for CHD
>15 mg/dL = Significantly increased risk for CHD

VLDL Cholesterol	1		[MG/DL]	Final

No target levels have been established by NCEP guidelines.

LDL Cholesterol	84		[<160 MG/DL]	Final

Target levels for LDL cholesterol by NCEP guidelines depend on the number of major risk factors:
<100mg/dL for patients with diabetes or CHD.
<130mg/dL for patients with 2 or more risk factors excluding diabetes and CHD.
<160mg/dL for patients with <2 major risk factors.

Non HDL Cholesterol	86		[<130 MG/DL]	Final

Target levels for non HDL cholesterol by NCEP guidelines depend on the number of major risk factors.
<130 mg/dl for patients with diabetes or CHD.
<160 mg/dl for patients with 2 or more risk factors excluding diabetes and CHD.
<190 mg/dl for patients with <2 major risk factors.

Vitamin B12 Level — **Anc ID: F84242** — **Order ID: 001DKPVJV**
Ordered: 04/17/2015 06:00 — **Collected: 04/17/2015 06:00** — **Resulted: 04/17/2015 08:15**
Requested By: ROCHA, EVITA (MD (R)) — **1 or more Final Results Received**

			Reference Range	
Vitamin B12 Level	386		[180-1241 PG/ML]	Final

Folate, Serum — **Anc ID: F84242** — **Order ID: 001DKPVJX**
Ordered: 04/17/2015 06:00 — **Collected: 04/17/2015 06:00** — **Resulted: 04/17/2015 08:48**
Requested By: ROCHA, EVITA (MD (R)) — **1 or more Final Results Received**

			Reference Range	
Folate, Serum	29.0		[>5.9 NG/ML]	Final

Thyroid Cascade — **Anc ID: F84242** — **Order ID: 001DKPVJY**
Ordered: 04/17/2015 06:00 — **Collected: 04/17/2015 06:00** — **Resulted: 04/17/2015 08:14**
Requested By: ROCHA, EVITA (MD (R)) — **1 or more Final Results Received**

			Reference Range	
TSH	1.40		[0.50-5.00 uIU/mL]	Final

CK — **Anc ID: F84242** — **Order ID: 001DKRGNY**
Ordered: 04/17/2015 06:00 — **Collected: 04/17/2015 06:00** — **Resulted: 04/17/2015 13:44**
Requested By: ROCHA, EVITA (MD (R)) — **1 or more Final Results Received**

			Reference Range	
CK	1320	H	[22-269 U/L]	Final
	ADD ON 1240			

Result Indicator: L = Low, H = High, A = Abnormal

PL 000036

UC Irvine Health
Department of Pathology & Laboratory Medicine | Edwin S. Monuki, M.D., Ph.D. and Associates
101 The City Drive, Orange, CA 92868
Laboratory Result Report

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
Dr: NGUYEN, KELVIN TRONG
Service: IP Medicine C
Gender: F
DOB: [redacted]
Age: 19y
Admit Date: 04/16/2015
Discharge Date: 04/17/2015

C Reactive Protein — Anc ID: F84242 — Order ID: 001DKRPBQ
Ordered: 04/17/2015 06:00 — Collected: 04/17/2015 06:00 — Resulted: 04/17/2015 14:06
Requested By: ROCHA, EVITA (MD (R)) — 1 or more Final Results Received

		Reference Range	
C Reactive Protein	<0.5 ADDED ON AT 1319	[0-0.7 MG/DL]	Final

Updated

Miscellaneous Test (Chemistry)(LIO) — Anc ID: F84242 — Order ID: 001DLFLHP
Ordered: 04/17/2015 06:00 — Collected: 04/17/2015 06:00 — Resulted: 04/28/2015 10:14
Requested By: ROCHA, EVITA (MD (R)) — 1 or more Final Results Received

		Reference Range	
Misc Test Name (Chem)	VIT D		Final
Misc Test (Chem) Reference Lab	(NOTE) UCLA MEDICAL CENTER CLINICAL LABORATORY 10833 LECONTE AVENUE; LOS ANGELES, CA 90095-1713		Final
Misc Test (Chem) Results	20 NG/ML		Final
Misc Test (Chem) Normal Values:	(NOTE) Reference Range : 30 - 80 ng/mL Deficiency : Less than 20ng/mL Insufficiency : 20 - 29 ng/mL Optimum Level : 30 - 80 ng/mL This test measures both 25-hydroxy vitamin D2 and D3		Final

Beta hCG — Anc ID: H43000 — Order ID: 001DKPMXL
Ordered: 04/16/2015 18:20 — Collected: 04/16/2015 18:20 — Resulted: 04/16/2015 20:01
Requested By: BREED, WYNNE (MD (R)) — 1 or more Final Results Received

		Reference Range	
Beta hCG	<1 REFERENCE RANGES FOR BETA HCG (MIU/ML): Healthy, non-pregnant individuals typically have low (<5 mIU/mL [IU/L] to undetectable HCG levels, however, hCG can rise to detectable levels in peri- and post-menopausal women. (Gronowski, 2008) HCG results between 5 mIU/mL and 25 mIU/mL may be indicative of early pregnancy but should be interpreted in light of the total clinical presentation of the patient. (Tietz, 2006) PREGNANCY:	[MIU/ML]	Final

Result Indicator: L = Low, H = High, A = Abnormal

UC Irvine Health
Department of Pathology & Laboratory Medicine | Edwin S. Monuki, M.D., Ph.D. and Associates
101 The City Drive, Orange, CA 92868
Laboratory Result Report

REED, EMILY
MR#: [redacted]
Visit#:
Dr: NGUYEN, KELVIN TRONG
Service: IP Medicine C

Gender: F
DOB: [redacted]
Age: 19y

Admit Date: 04/16/2015
Discharge Date: 04/17/2015

0-2 WEEKS	0-500
2-3 WEEKS	100-1000
3-4 WEEKS	500-6000
1ST TRIMESTER	5000-200000
2ND TRIMESTER	5000-50000
3RD TRIMESTER	5000-50000

Comprehensive Metabolic Panel — Anc ID: H43000 — Order ID: 001DKPMXM
Ordered: 04/16/2015 18:20 — Collected: 04/16/2015 18:20 — Resulted: 04/16/2015 19:52
Requested By: BREED, WYNNE (MD (R)) — 1 or more Final Results Received

			Reference Range	
Sodium	142		[135-145 MEQ/L]	Final
Potassium	3.7		[3.3-4.8 MEQ/L]	Final
Chloride	111		[101-111 MEQ/L]	Final
CO2	25		[25-34 MEQ/L]	Final
Electrolyte Balance	6		[2-12 MEQ/L]	Final
Glucose	87		[70-115 mg/dL]	Final

Normal Fasting Glucose: <100 mg/dl
Impaired Fasting Glucose: 100-125 mg/dl
Provisional DX of diabetes(must be confirmed) >125 mg/dl.

BUN	9		[8-26 mg/dL]	Final
Creatinine	0.7		[0.5-1.3 mg/dL]	Final
Calcium	9.2		[8.4-10.2 mg/dL]	Final
Protein, Total	6.4		[6.1-8.2 G/DL]	Final
Albumin	3.7		[3.2-5.5 G/DL]	Final
Alkaline Phosphatase	58		[26-110 IU/L]	Final
AST	47	H	[8-40 IU/L]	Final
ALT	19		[0-60 IU/L]	Final
Bilirubin, Total	1.4		[0.0-1.4 MG/DL]	Final

Thyroid Cascade — Anc ID: H43000 — Order ID: 001DKPMXQ
Ordered: 04/16/2015 18:20 — Collected: 04/16/2015 18:20 — Resulted: 04/16/2015 20:01
Requested By: BREED, WYNNE (MD (R)) — 1 or more Final Results Received

		Reference Range	
TSH	2.10	[0.50-5.00 uIU/mL]	Final

Hematology

CBC With Diff — Anc ID: F84242 — Order ID: 001DKPVJQ
Ordered: 04/17/2015 06:00 — Collected: 04/17/2015 06:00 — Resulted: 04/17/2015 07:24
Requested By: ROCHA, EVITA (MD (R)) — 1 or more Final Results Received

Reference Range

Result Indicator: L = Low, H = High, A = Abnormal

PL 000038

ROA1303

UC Irvine Health
Department of Pathology & Laboratory Medicine | Edwin S. Monuki, M.D., Ph.D. and Associates
101 The City Drive, Orange, CA 92868
Laboratory Result Report

REED, EMILY
MR#: [redacted] **Gender:** F **Admit Date:** 04/16/2015
Visit#: [redacted] **DOB:** [redacted] **Discharge Date:** 04/17/2015
Dr: NGUYEN, KELVIN TRONG **Age:** 19y
Service: IP Medicine C

White Blood Cell Count	6.7	[4.0-10.5 THOUS/MCL]	Final
RBC	4.71	[3.70-5.00 MILL/MCL]	Final
Hemoglobin	14.7	[11.5-15.0 G/DL]	Final
Hematocrit	42.4	[34.0-44.0 %]	Final
MCV	90.1	[81.5-97.0 FL]	Final
MCH	31.2	[27.0-33.5 PG]	Final
MCHC	34.7	[32.0-35.5 G/DL]	Final
RDW-CV	13.2	[11.6-14.4 %]	Final
Platelet Count	246	[150-400 THOUS/MCL]	Final
Neutrophils	4.5 67%	[2.0-8.1 THOUS/MCL]	Final
Lymphocyte	1.7 25%	[0.9-3.3 THOUS/MCL]	Final
Monocyte	0.5 7%	[0-0.8 THOUS/MCL]	Final
Eosinophil	0.0 1%	[0-0.5 THOUS/MCL]	Final
Basophil	0.0 0%	[0-0.2 THOUS/MCL]	Final
RBC Morphology	NO RBC ABNORMALITIES DETECTED BY AUTOMATED ANALYSIS.		Final
Plt Morph/Comm	DIFFERENTIAL PERFORMED BY AUTOMATED ANALYSIS. NO PLATELET ABNORMALITIES DETECTED BY AUTOMATED ANALYSIS.		Final

Glycated Hgb, A1C **Anc ID: F84242** **Order ID: 001DKPVJT**
Ordered: 04/17/2015 06:00 **Collected: 04/17/2015 06:00** **Resulted: 04/17/2015 09:37**
Requested By: ROCHA, EVITA (MD (R)) **1 or more Final Results Received**

		Reference Range	
Glycated Hgb, A1C	4.7	[4.6-6.0 %]	Final

Reference values for HgA1C:
High risk for future diabetes ("prediabetes"): 5.7 - 6.4%
Diabetes mellitus: = or >6.5%
Target goal for most diabetics: <7.0%
per ADA guidelines and recommendations, 2010

Sedimentation Rate **Anc ID: F84242** **Order ID: 001DKRPBR**
Ordered: 04/17/2015 06:00 **Collected: 04/17/2015 06:00** **Resulted: 04/17/2015 14:41**
Requested By: ROCHA, EVITA (MD (R)) **1 or more Final Results Received**

		Reference Range	
Sedimentation Rate	10	[0-20 MM/HR]	Final

CBC With Diff **Anc ID: H43000** **Order ID: 001DKPMXK**

Result Indicator: L = Low, H = High, A = Abnormal

PL 000039

ROA1304

UC Irvine Health
Department of Pathology & Laboratory Medicine | Edwin S. Monuki, M.D., Ph.D. and Associates
101 The City Drive, Orange, CA 92868
Laboratory Result Report

REED, EMILY
MR#: [redacted]
Visit#:
Dr: NGUYEN, KELVIN TRONG
Service: IP Medicine C

Gender: F
DOB: [redacted]
Age: 19y

Admit Date: 04/16/2015
Discharge Date: 04/17/2015

Ordered: 04/16/2015 18:20
Requested By: BREED, WYNNE (MD (R))

Collected: 04/16/2015 18:20

Resulted: 04/16/2015 19:13
1 or more Final Results Received

		Reference Range	
White Blood Cell Count	8.4	[4.0-10.5 THOUS/MCL]	Final
RBC	4.61	[3.70-5.00 MILL/MCL]	Final
Hemoglobin	14.4	[11.5-15.0 G/DL]	Final
Hematocrit	41.9	[34.0-44.0 %]	Final
MCV	91.0	[81.5-97.0 FL]	Final
MCH	31.2	[27.0-33.5 PG]	Final
MCHC	34.3	[32.0-35.5 G/DL]	Final
RDW-CV	13.5	[11.6-14.4 %]	Final
Platelet Count	236	[150-400 THOUS/MCL]	Final
Neutrophils	5.4 65%	[2.0-8.1 THOUS/MCL]	Final
Lymphocyte	2.1 25%	[0.9-3.3 THOUS/MCL]	Final
Monocyte	0.8 9%	[0-0.8 THOUS/MCL]	Final
Eosinophil	0.0 1%	[0-0.5 THOUS/MCL]	Final
Basophil	0.0 0%	[0-0.2 THOUS/MCL]	Final
RBC Morphology	NO RBC ABNORMALITIES DETECTED BY AUTOMATED ANALYSIS.		Final
Plt Morph/Comm	DIFFERENTIAL PERFORMED BY AUTOMATED ANALYSIS. NO PLATELET ABNORMALITIES DETECTED BY AUTOMATED ANALYSIS.		Final

Microbiology

MRSA Screen
Ordered: 04/16/2015 22:10
Requested By: BOTA, ROBERT (MD (A))

Anc ID: H43401
Collected: 04/16/2015 22:10

Order ID: 001DKPTWN
Resulted: 04/18/2015 11:09
1 or more Final Results Received

		Reference Range	
Specimen Description	NARES		Final
Special Information	NONE		Final
Culture Results	NEGATIVE for METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS NEGATIVE for Methicillin susceptible STAPHYLOCOCCUS AUREUS		Final
Report Status	FINAL 04/18/2015		Final

Result Indicator: L = Low, H = High, A = Abnormal

UC Irvine Health
Department of Pathology & Laboratory Medicine | Edwin S. Monuki, M.D., Ph.D. and Associates
101 The City Drive, Orange, CA 92868
Laboratory Result Report

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
Dr: NGUYEN, KELVIN TRONG
Service: IP Medicine C

Gender: F
DOB: [redacted]
Age: 19y

Admit Date: 04/16/2015
Discharge Date: 04/17/2015

Serology

Syphilis Antibody Screen — Anc ID: F84242 — Order ID: 001DKPVJZ
Ordered: 04/17/2015 06:00 — Collected: 04/17/2015 06:00 — Resulted: 04/18/2015 13:53
Requested By: ROCHA, EVITA (MD (R)) — 1 or more Final Results Received

	Reference Range	
Treponema pallidum Antibody		Final
NONREACTIVE		
NO TREPONEMA PALLIDUM ANTIBODIES DETECTED		

(NOTE)
A reactive result indicates that antibody is present in the sample as a result of previous or present infection with T. pallidum. All reactive ELISA results will be tested by the Rapid Plasma Reagin test (RPR). Those with a reactive RPR will be titrated to determine the level of anti-cardiolipin antibodies, a result that subsequently can be used to assess the response to therapy. Patients with a reactive ELISA and nonreactive RPR results will be tested with the T. pallidum particle agglutination (TP-PA) assay. If the TP-PA is nonreactive the most likely explanation is that the ELISA was a false positive. A new specimen can be submitted in 2-4 weeks for testing. If the TP-PA is reactive the patient most likely has been treated in the past for syphilis. However, treatment is indicated unless a history of treatment exists.

A nonreactive result indicates that no, or undetectable antibody levels are present in the sample, but does not rule out a recent or current infection. In case of suspicious primary syphilis recollect and retest 2-4 weeks later.

An equivocal result indicates that a low level of antibody is detected, and the patient should be monitored for antibody status. A second sample should be collected 2-4 weeks later and tested for any change in antibody response.

Result Indicator: L = Low, H = High, A = Abnormal

UC Irvine Health
Department of Pathology & Laboratory Medicine | Edwin S. Monuki, M.D., Ph.D. and Associates
101 The City Drive, Orange, CA 92868
Laboratory Result Report

REED, EMILY

MR#:	[redacted]	**Gender:**	F	**Admit Date:**	04/16/2015
Visit#:		**DOB:**	[redacted]	**Discharge Date:**	04/17/2015
Dr:	NGUYEN, KELVIN TRONG	**Age:**	19y		
Service:	IP Medicine C				

Result Indicator: L = Low, H = High, A = Abnormal

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
Dr: NGUYEN, KELVIN TRONG
Service: IP Medicine C
Gender: F
DOB: [redacted]
Age: 19y
Admit Date: 04/16/2015
Discharge Date: 04/17/2015

Cocaine (300 ng/mL), Methadone (300 ng/mL),
MDMA (500 ng/mL), Opiates (300 ng/mL),
PCP (25 ng/mL), Propoxyphene (300 ng/mL),
THC (100 ng/mL).

UA, Unres

Urinalysis with Microscopic, Random Urine — Anc ID: H42641 — Order ID: 001DKNPCZ
Ordered: 04/16/2015 15:44 — Collected: 04/16/2015 15:44 — Resulted: 04/16/2015 16:14
Requested By: BREED, WYNNE (MD (R)) — 1 or more Final Results Received

			Reference Range	
Urine Sample Site, UA	URINE, CLEAN CATCH			Final
Color, UA	YELLOW			Final
Clarity, UA	CLOUDY			Final
Urine Specific Grav, UA	1.018		[1.003-1.030]	Final
pH, UA	5		[5.0-8.0]	Final
Protein, UA	30	A	[NEG MG/DL]	Final
Glucose, UA	NEGATIVE		[NEG MG/DL]	Final
Ketones, UA	20	A	[NEG MG/DL]	Final
Bilirubin, UA	NEGATIVE		[NEG]	Final
Hemoglobin, UA	SMALL	A	[NEG]	Final
Leukocyte Esterase, UA	NEGATIVE		[NEG]	Final
Nitrite, UA	NEGATIVE		[NEG]	Final
Urobilinogen, UA	<2		[<2.0 MG/DL]	Final
RBC, UA	4	H	[0-3 #/HPF]	Final
WBC, UA	<1		[0-5 #/HPF]	Final
WBC Clumps, UA	NONE		[NONE #/HPF]	Final
Bacteria, UA	FEW	A	[NONE]	Final
Amorphous Crystal, UA	MODERATE		[/HPF]	Final
Squamous Epithelial, UA	1		[0-10 /HPF]	Final
Mucous, UA	MODERATE	A	[NONE /LPF]	Final

Result Indicator: L = Low, H = High, A = Abnormal

UC Irvine Health
101 The City Drive | Orange, CA 92868
Results Report

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
Dr: COX AHERN, SUSAN
Service: IP Medicine C

Gender: F
DOB: [redacted]
Age: 19y

Admit Date: 04/17/2015
Discharge Date: 04/18/2015

CT Scans

Head w/o Contrast CT
Ordered: 04/17/2015 19:14
Requested By: GLASSY, MATTHEW SCOTT (MD (R))

1 or more Final Results Received
Resulted: 04/17/2015 19:44
Org Performed: RADNET

Head w/o Contrast CT — Final — Updated

Examination: 70450 CT Head or Brain without Contrast

Report

EXAM: CT Head or Brain without Contrast

INDICATION: Altered mental status

EXAM DATE: 4/17/2015 7:08 PM

COMPARISON: None

TECHNIQUE: CT of the head without intravenous contrast.

Radiation Dose Information:

This patient received a total of 1 exposure event(s) during this CT examination. The CTDIvol and DLP radiation dose values for each exposure are:

Exposure: 1; Series: 2; Anatomy: Head; Phantom: 16 cm; CTDIvol: 55; DLP: 1133

The dose indicators for CT are the volume Computed Tomography (CT) Dose Index (CTDIvol) and the Dose Length Product (DLP), and are measured in units of mGy and mGy-cm, respectively. These indicators are not patient dose, but values generated from the CT scanner acquisition factors. The report includes radiation exposure data for exposures received during this examination. If multiple reports are produced from this examination, the exposure data is duplicated in each report. The exposure data reported is indicative, but not determinative, of the radiation dose received by this patient.

FINDINGS:

There is no evidence of acute intracranial hemorrhage, extra-axial collection, mass effect, midline shift, herniation or hydrocephalus. The ventricles, sulci and cisterns are age appropriate. The gray-white differentiation is intact. The visualized paranasal sinuses and mastoid air cells are clear. The surrounding soft tissues and osseous structures are unremarkable.

IMPRESSION:

1. No evidence of acute intracranial hemorrhage, mass effect or

PL 000044

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
Dr: COX AHERN, SUSAN
Service: IP Medicine C

Gender: F
DOB: [redacted]
Age: 19y

Admit Date: 04/17/2015
Discharge Date: 04/18/2015

hydrocephalus.

END IMPRESSION:
***** Final *****

Dictated by: Nguyen, Huan, M.D. 04/17/2015 7:28 pm
Electronically Signed by: Goyenechea, Martin , M.D. 04/17/2015 7:38 pm

PL 000045

UC Irvine Health

CONFIDENTIAL PATIENT INFORMATION

Discharge Instructions - Inpatient

REED, EMILY	18y	F	[redacted]	COX AHERN, SUSAN
T5BD-08 Medical Telemetry				[redacted]

Admission/Discharge Dates

Admission Date: 04-17-2015

Discharge Date: 04-18-2015

Discharge Attending

Attending, COX AHERN, SUSAN, DO (A), Hospital Medicine

Primary Care Provider/Other Providers

Admitting, NGUYEN, KELVIN TRONG, MD (A), Hospital Medicine

PCP, DEBOLD, LORI ANN, MD, Peds: General

Referring, BOTA, ROBERT, MD (A), Psychiatry

Discharge Diagnoses

1. Drug-induced dystonia , Code: 333.72
2. TACHYCARDIA
3. History of schizophrenia , Description: History of schizophrenia , Code: V11.0

Discharge Information/Instructions

- Discharge Disposition: transfer to inpatient psychiatric facility...
- Condition at Discharge: stable
- Rehab Potential full self care
- Discharge Order/Treatment Plan see above summary

Questions Regarding Prescriptions

Consumer Med Safety web address For more information about safe medication practices, please visit: http://www.consumermedsafety.org/

Follow Up Appointments

Follow Up Appointments: Follow up with your primary care provider

Special Instructions/Safety Measures

For patients with Heart Failure, please weigh yourself as soon as you get home and every morning. Call your regular doctor or cardiologist with a weight gain of 3 pounds in a day or 5 pounds in a week. This may signal too much fluid and worsening of your Heart Failure.

UC Irvine Health

CONFIDENTIAL PATIENT INFORMATION

Discharge Instructions - Inpatient

REED, EMILY	18y F	COX AHERN, SUSAN
T5BD-08 Medical Telemetry		[redacted]

Medication List

Discharge Medications

- FLUoxetine 20 mg oral tablet
  Instructions: 2 tab(s) orally once a day

  Last dose taken: Unknown and Next dose due at: _____

- diphenhydrAMINE 25 mg oral tablet
  Instructions: 1 tab(s) orally every 8 hour

  Last dose taken: 4/18/2015 0616 and Next dose due at: 4/18/2015 1400

For more information about safe medication practices, please visit: http://www.consumermedsafety.org/.

For Your Safety

Please check with your primary physician if you should take any medications(s) not on this list.
Keep a complete list of the medications you take with you at all times.
Provide a copy to your primary care provider and at each care visit.
Update your medication list with every change.

UC Irvine Health

CONFIDENTIAL PATIENT INFORMATION

Discharge Instructions - Inpatient

REED, EMILY	18y	F	[redacted]	COX AHERN, SUSAN
T5BD-08 Medical Telemetry				[redacted]

If your insurance company requires authorization for follow up care, please call them before making an appointment.

For information regarding advanced directive, call the California Health Decisions in Orange.

For information regarding health education classes, call toll free 877-UCI-DOCS.

To request an appointment or prescription renewal, view your health records, and contact your physician through myHealthcare, visit https://myhealthcare.healthcare.uci.edu/PPUI/Anonymous/Login.aspx.

Return to nearest emergency room right away for chest pain, worsening stomach pain, trouble breathing, dizziness when standing, trouble walking or thinking. For other symptoms, if you are unable to reach your doctor, see the doctor in the UCI Medical Center Emergency Room.

Please notify your physician or emergency department nurse of persistent redness, swelling, pain or numbness at the site of a previous IV.

If you smoke, now is the time to quit. Call 1-877-UCI-DOCS for free stop smoking classes.

Physician Signature: _____, MD

Instructions given by: Carlin Lewis RN, RN Interpreter: _____
4/18/2015 1130

PATIENT: I have received a copy of these instructions and I understand the information and my responsibility for on-going care needs.

Patient - Emily Reed

OTHER RESPONSIBLE PERSON _____

After you leave the hospital you will receive a survey. Your feedback is the most important way for us to judge how we are doing. If your health care and service needs were met we encourage you to reward us with a score of 5 on the survey questions. You may also provide specific written comments if you wish to do so.

EEG REPORT

DATE OF TEST: 04/17/2015

REFERRING PHYSICIAN: Kelvin Trong Nguyen, MD(R)

CLINICAL HISTORY: This is an 18-year-old young lady with a history of PTSD presenting after an episode of tachycardia and agitation. She was rolling around at school, hearing voices and apparently shaking on the bus. The patient has major depression and psychotic features.

MEDICATIONS: Haldol.

TECHNIQUE: This is a routine inpatient 22-channel digital EEG recording using the Nihon-Kohden system with disk electrodes placed according to the 10/20 international system with a single EKG, 2 additional T1-T2 scalp electrodes, and 2 EOG channels. Activation procedures included mental activation and noxious stimulation, hyperventilation and photic stimulation as needed.

STATE: Awake.

RESULTS: Normal study.

1. During awake state with eyes closed, well-developed 11-12 hertz alpha rhythm was seen in the posterior head regions, waxing and waning, and reactive to eye opening. Drowsiness and stage II sleep were not achieved.
2. No epileptiform abnormality was identified.
3. Activation procedures were not performed.
4. The single lead EKG tracing showed regular rhythm at about 108 beats per minute.

IMPRESSION: Normal awake study. No potentially epileptogenic abnormality was identified. The diagnosis of epilepsy remains a clinical one.

Electronically Signed by
Mona Sazgar 04/20/2015 02:20 P

Mona Sazgar MD(A)
Dept. of Neurology
Associate Clinical Professor
Comprehensive Epilepsy Program

cc: Kelvin Trong Nguyen
Mona Sazgar

2002319 -- 651885185 / DD: 04/17/2015 04:41 P / DT: 04/17/2015 05:12 P

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: COX AHERN, SUSAN

Gender: Female
DOB: [redacted]
Age: 18y

Admit Date: 04/17/2015 12:10
Discharge Date: 04/18/2015 12:30
Service: IP Medicine C

H&P-Primary-Med: General

04/17/2015 12:41 GLASSY, MATTHEW SCOTT (MD (R))

Evaluation and Admission Date:

- **Evaluation Date and Time:** 04-17-2015 12:41
- **Admission Date:** 04-17-2015

Chief Complaint and History of Present Illness:

- **History of Present Illness:** This is an 18 year old female history of depression with psychotic features and previous SI, PTSD who presents from inpatient psychiatry after a rapid response call for tachycardia. Patient was initially BIBA to psychiatry after she was found agitated at school and rolling around on the asphalt at her high school (Marina at bedtime. Please see psych H&P for details but she was apparently "shaking" on the bus on way to school, stating that she heard voices and she wanted to go to the hospital. She then laid in the fetal position for 35 min on the ground screaming and stating that she wanted to hurt herself. She was given haldol IM and versed in ambulance on the way to the hospital. She was given haldol again at 1050 am this am. These may have been her first haldol doses for her.

Per chart she has been feeling increasing anxiety at school recently. There is also apparently a case against a man who has been sexually abusing her. In psychiatry today she was noted to become dystonic with L side flexure and tachycardic to 160s. A rapid response was called and she is transferred to inpatient telemetry. On my evaluation patient is non verbal but eyes open, able to follow commands and write her subjective. Currently she reports L side occiput pain. Also reports bilateral leg pain. Denies any neck pain, visual disturbances, hearing changes. No other pain elsewhere.

Past History:

Past Medical History:

- **History of depression:** Description: History of depression
- **History of anxiety:** Description: History of anxiety
- **History of schizophrenia:** Description: History of schizophrenia
- **Social anxiety disorder:**
- **Chronic post-traumatic stress disorder:**
- **Major depressive disorder:**

- **Psychiatric:** anxiety; depression; schizophrenia

Allergies & Intolerances:

Allergies:

- **No Known Allergies:**

Home Medications:

- **FLUoxetine 20 mg oral tablet:** 2 tab(s) orally once a day

Social History:

- **Smoking Status:** never smoker
- **Frequency of Alcohol Intake:** never
- **Substance Use:** none
- **Other:** 13 yo brother with MDD,

Review of Systems:

- **Unable to Obtain Due To:** acute delirium or psychosis

PL 000050

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: COX AHERN, SUSAN

Gender: Female
DOB: [redacted]
Age: 18y

Admit Date: 04/17/2015 12:10
Discharge Date: 04/18/2015 12:30
Service: IP Medicine C

H&P-Primary-Med: General

04/17/2015 12:41 GLASSY, MATTHEW SCOTT (MD (R))

Vital Signs:

- **Vitals:** Temp 37.1, BP 133/77, sating 98%, 16 respiratory rate

Physical Exam:

- **Exam:** GEN: non verbal with eyes open, follows commands, No respiratory distress
HEENT: Normocephalic/atraumatic, Pupils equal and reactive to light and accomodation bilaterally, extraoccular movements are intact, no scleral icterus. MMM.
NECK: Dystonic with contracture to L, Supple, Range of motion limited to L due to pain, no lymphadenopathy. No Jugular Venous Distention. No thyromegaly
HEART: tachycardic, noraml S1S2
LUNGS: Clear to auscultation bilaterally, No wheezes, Rales, or ronchi
ABD: Soft, nontender, nondistended, +bowel sounds x 4, no organomegaly appreciated. No masses. No rebound. No CVA Tenderness.
EXT: No edema. PPP 2+ distally throughout.
SKIN: Clean/dry/intact
NEURO: CN II-XII intact but poor participation, L side increased tone. She does have discordant free extremity movement such as scratching her head and rubbing her nose but only with her right hand. Sensation intact throughout. Increased tone in bilateral lower extremities.

Assessment and Plan:

- **Assessment and Plan:** # Acute dystonia with L side predominant contracture. She did receive a couple of doses of haldol with last one this am prior to her dystonia. It is unclear if she has received haldol previously. She is awake and participatory in exam, doubt meningitis or other intracranial event. Doubt seizure but possible. Possibly psychosis as well on the differential.

- benadryl IV now
- obtain lactate, prolactin (for seizure)
- CPK, ESR, CRP
- basic labs
- CT head/neck if doesn't respond to benadryl
- hold anti dopaminergic medications for now

Depression with psychotic features
- will discuss with psychiatry
- continue 5150 hold

FEN
- reg diet

prophylaxis
- ambulate

FULL CODE

- **Attending Attestation:** I was present with the resident/fellow during the history and exam. I discussed the case with the resident/fellow and agree with the findings and plan as documented by the resident/fellow. My additions or revision are included in the record.

PL 000051

REED, EMILY
MR#: [redacted] **Gender:** Female **Admit Date:** 04/17/2015 12:10
Visit#: [redacted] **DOB:** [redacted] **Discharge Date:** 04/18/2015 12:30
DR: COX AHERN, SUSAN **Age:** 18y **Service:** IP Medicine C

H&P-Primary-Med: General

04/17/2015 12:41 GLASSY, MATTHEW SCOTT (MD (R))

- **Attending Comments/Additional Findings/Exceptions:** EPS due to haldol versus psychogenic dystonia. No seizures, normal EEG, exam minimal cogwheeling and felt the patient was resisting my passive movement of her left upper extremity. Symptoms responded to benadryl. Had similar episode to abilify. Stable for transfer to psychiatry for further care.

Attending Attestation:
- **Attending Evaluation Date and Time:** 04-18-2015 11:00

Billing:
- **Billing Service Level:** not applicable

Electronic Signatures:
COX AHERN, SUSAN (DO (A)) (Signed 04-19-2015 13:01)
Authored: Note Completion, Attending Attestation, Billing
GLASSY, MATTHEW SCOTT (MD (R)) (Signed 04-17-2015 13:10)
Authored: Evaluation and Admission Date, Chief Complaint and History of Present Illness, Past History, Allergies & Intolerances, Home Medications (Outpatient Medication Review), Social History, Review of Systems, Vital Signs, Physical Exam, Data Review, Assessment and Plan

Last Updated: 04-19-2015 13:01 by COX AHERN, SUSAN (DO (A))

UC Irvine Health
Department of Pathology & Laboratory Medicine | Edwin S. Monuki, M.D., Ph.D. and Associates
101 The City Drive, Orange, CA 92868.
Laboratory Result Report

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
Dr: COX AHERN, SUSAN
Service: IP Medicine C
Gender: F
DOB: [redacted]
Age: 19y
Admit Date: 04/17/2015
Discharge Date: 04/18/2015

Chemistry

Magnesium — **Anc ID: S60623** — **Order ID: 001DKSHCY**
Ordered: 04/18/2015 06:10 — **Collected: 04/18/2015 06:10** — **Resulted: 04/18/2015 07:56**
Requested By: TIEN, CONNIE (MD (R)) — **1 or more Final Results Received**

			Reference Range	
Magnesium	1.7	L	[1.8-2.5 mg/dL]	Final

Phosphorus — **Anc ID: S60623** — **Order ID: 001DKSHDF**
Ordered: 04/18/2015 06:10 — **Collected: 04/18/2015 06:10** — **Resulted: 04/18/2015 07:56**
Requested By: TIEN, CONNIE (MD (R)) — **1 or more Final Results Received**

			Reference Range	
Phosphorus	3.2		[2.5-4.6 MG/DL]	Final

Comprehensive Metabolic Panel — **Anc ID: S60623** — **Order ID: 001DKSHDW**
Ordered: 04/18/2015 06:10 — **Collected: 04/18/2015 06:10** — **Resulted: 04/18/2015 07:56**
Requested By: TIEN, CONNIE (MD (R)) — **1 or more Final Results Received**

			Reference Range	
Sodium	142		[135-145 MEQ/L]	Final
Potassium	3.5		[3.3-4.8 MEQ/L]	Final
Chloride	110		[101-111 MEQ/L]	Final
CO2	24	L	[25-34 MEQ/L]	Final
Electrolyte Balance	8		[2-12 MEQ/L]	Final
Glucose	77		[70-115 mg/dL]	Final
	Normal Fasting Glucose: <100 mg/dl Impaired Fasting Glucose: 100-125 mg/dl Provisional DX of diabetes(must be confirmed) >125 mg/dl.			
BUN	8		[8-26 mg/dL]	Final
Creatinine	0.5		[0.5-1.3 mg/dL]	Final
Calcium	8.5		[8.4-10.2 mg/dL]	Final
Protein, Total	5.8	L	[6.1-8.2 G/DL]	Final
Albumin	3.3		[3.2-5.5 G/DL]	Final
Alkaline Phosphatase	53		[26-110 IU/L]	Final
AST	45	H	[8-40 IU/L]	Final
ALT	22		[0-60 IU/L]	Final
Bilirubin, Total	1.1		[0.0-1.4 MG/DL]	Final

CK — **Anc ID: S60623** — **Order ID: 001DKSHFH**
Ordered: 04/18/2015 06:10 — **Collected: 04/18/2015 06:10** — **Resulted: 04/18/2015 07:56**
Requested By: TIEN, CONNIE (MD (R)) — **1 or more Final Results Received**

Result Indicator: L = Low, H = High, A = Abnormal

PL 000053

UC Irvine Health
Department of Pathology & Laboratory Medicine | Edwin S. Monuki, M.D., Ph.D. and Associates
101 The City Drive, Orange, CA 92868
Laboratory Result Report

REED, EMILY
MR#: [redacted]
Visit#:
Dr: COX AHERN, SUSAN
Service: IP Medicine C
Gender: F
DOB: [redacted]
Age: 19y
Admit Date: 04/17/2015
Discharge Date: 04/18/2015

Chemistry

			Reference Range	
CK	823	H	[22-269 U/L]	Final

Lactic Acid — Anc ID: F85762 — Order ID: 001DKRGKR
Ordered: 04/17/2015 13:42 — Collected: 04/17/2015 13:42 — Resulted: 04/17/2015 14:29
Requested By: GLASSY, MATTHEW SCOTT (MD (R)) — 1 or more Final Results Received

			Reference Range	
Lactic Acid	0.9		[0.7-2.1 mmol/L]	Final

Prolactin — Anc ID: F85762 — Order ID: 001DKRGKY
Ordered: 04/17/2015 13:42 — Collected: 04/17/2015 13:42 — Resulted: 04/18/2015 10:40
Requested By: GLASSY, MATTHEW SCOTT (MD (R)) — 1 or more Final Results Received

			Reference Range	
Prolactin	26	H	[0-24 NG/ML]	Final

C Reactive Protein — Anc ID: F85762 — Order ID: 001DKRNMN
Ordered: 04/17/2015 13:42 — Collected: 04/17/2015 13:42 — Resulted: 04/17/2015 14:33
Requested By: GLASSY, MATTHEW SCOTT (MD (R)) — 1 or more Final Results Received

			Reference Range	
C Reactive Protein	<0.5		[0-0.7 MG/DL]	Final

CK — Anc ID: F85762 — Order ID: 001DKRNMS
Ordered: 04/17/2015 13:42 — Collected: 04/17/2015 13:42 — Resulted: 04/17/2015 14:33
Requested By: GLASSY, MATTHEW SCOTT (MD (R)) — 1 or more Final Results Received

			Reference Range	
CK	1378	H	[22-269 U/L]	Final

Hematology

Sedimentation Rate — Anc ID: F85762 — Order ID: 001DKRNMQ
Ordered: 04/17/2015 13:42 — Collected: 04/17/2015 13:42 — Resulted: 04/17/2015 14:41
Requested By: GLASSY, MATTHEW SCOTT (MD (R)) — 1 or more Final Results Received

			Reference Range	
Sedimentation Rate	14		[0-20 MM/HR]	Final

Microbiology

Result Indicator: L = Low, H = High, A = Abnormal

PL 000054

UC Irvine Health
Department of Pathology & Laboratory Medicine | Edwin S. Monuki, M.D., Ph.D. and Associates
101 The City Drive, Orange, CA 92868
Laboratory Result Report

REED, EMILY
MR#: [redacted] **Gender:** F **Admit Date:** 04/17/2015
Visit#: [redacted] **DOB:** [redacted] **Discharge Date:** 04/18/2015
Dr: COX AHERN, SUSAN **Age:** 19y
Service: IP Medicine C

Microbiology

Bacterial Culture Urine Quantitative **Anc ID: S60994** **Order ID: 001DKTFLV**
Ordered: 04/18/2015 06:13 **Collected: 04/18/2015 06:13** **Resulted: 04/19/2015 10:50**
Requested By: GLASSY, MATTHEW SCOTT (MD (R)) **1 or more Final Results Received**

		Reference Range	
Specimen Description	URINE, CLEAN CATCH		Final
Special Information	NONE		Final
Culture Results	> 100,000 COLONIES/ML GRAM POSITIVE ROD resembling Lactobacillus species > 100,000 COLONIES/ML DIPHTHEROIDS (2 MORPHOTYPES) Multiple organisms present in urine, possible contamination		Final
Report Status	FINAL 04/19/2015		Final

MRSA Screen **Anc ID: F86502** **Order ID: 001DKRDZN**
Ordered: 04/17/2015 17:47 **Collected: 04/17/2015 17:47** **Resulted: 04/18/2015 21:38**
Requested By: NGUYEN, KELVIN TRONG (MD (A)) **1 or more Final Results Received**

		Reference Range	
Specimen Description	NARES		Final
Special Information	NONE		Final
Culture Results	NEGATIVE for METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS NEGATIVE for Methicillin susceptible STAPHYLOCOCCUS AUREUS		Final
Report Status	FINAL 04/18/2015		Final

UA, Urines

Urinalysis with Reflex to Culture, Random Urine **Anc ID: S60915** **Order ID: 001DKRGLF**
Ordered: 04/18/2015 06:13 **Collected: 04/18/2015 06:13** **Resulted: 04/18/2015 06:34**
Requested By: GLASSY, MATTHEW SCOTT (MD (R)) **1 or more Final Results Received**

			Reference Range	
Urine Sample Site, UA	URINE, CLEAN CATCH			Final
Color, UA	YELLOW			Final
Clarity, UA	HAZY			Final
Urine Specific Grav, UA	1.020		[1.003-1.030]	Final
pH, UA	5		[5.0-8.0]	Final
Protein, UA	30	A	[NEG MG/DL]	Final
Glucose, UA	NEGATIVE		[NEG MG/DL]	Final
Ketones, UA	NEGATIVE		[NEG MG/DL]	Final

Result Indicator: L = Low, H = High, A = Abnormal

UC Irvine Health
Department of Pathology & Laboratory Medicine | Edwin S. Monuki, M.D., Ph.D. and Associates
101 The City Drive, Orange, CA 92868
Laboratory Result Report

REED, EMILY
MR#: [redacted]
Visit#:
Dr: COX AHERN, SUSAN
Service: IP Medicine C

Gender: F
DOB: [redacted]
Age: 19y

Admit Date: 04/17/2015
Discharge Date: 04/18/2015

Bilirubin, UA	NEGATIVE		[NEG]	Final
Hemoglobin, UA	LARGE	A	[NEG]	Final
Leukocyte Esterase, UA	TRACE	A	[NEG]	Final
Nitrite, UA	NEGATIVE		[NEG]	Final
Urobilinogen, UA	<2		[<2.0 MG/DL]	Final
RBC, UA	110	H	[0-3 #/HPF]	Final
WBC, UA	34	H	[0-5 #/HPF]	Final
WBC Clumps, UA	NONE		[NONE #/HPF]	Final
Bacteria, UA	FEW	A	[NONE]	Final
UA Culture	URINE SENT TO MICROBIOLOGY FOR CULTURE			Final
Squamous Epithelial, UA	3		[0-10 /HPF]	Final
Mucous, UA	MANY	A	[NONE /LPF]	Final

Result Indicator: L = Low, H = High, A = Abnormal

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: BOTA, ROBERT

Gender: Female
DOB: [redacted]
Age: 18y

Admit Date: 04/18/2015 12:31
Discharge Date: 04/20/2015 16:13
Service: IP Mental Health Adult Med

ATS Progress Note-PSYCH-recreational therapy

04/20/2015 11:32 LARSON, JAN (CTRS)

Group/Patient Attendance:

• Group type	recreational therapy
• Group topic	Leisure Education 'Uno Card Game'
• Patient attendance	attended

Group Assessment/Intervention(s):

• Cognition/Perception	impaired insight; impaired judgement
• Mood	anxious; depressed; pleasant; skeptical
• Affect	anxious; blunted; flat; guarded
• Thought Process	poverty of thought
• Speech	soft
• Barriers	anxiety; severity of illness
• Psychomotor Activity	slow
• Group Interventions	encourage participation; provide counseling and support; provide education; structured activity

Group Evaluation:

• Participation	active participation
• Offered for	45-60 minutes
• Patient response	active
• Interpersonal	responsive to interaction; appropriate self disclosure; appropriate social interaction; showed empathy

Plan of Care:
Problem/Goals/Intervention

Long Term Goals (04/20/2015 10:32):
Demonstrates absence of inappropriate behavior prior to discharge; Symptoms no longer interfere with daily functioning;

Problems:

Mood Disorder (04/20/2015 10:32):
Short term goals: Participates appropriately in milieu for 8 hr intervals; Patient identifies one positive coping skill to decrease suicide ideation;
Interventions: Provide positive reinforcement that patient is worthwhile; Assist patient with identifying positive aspects of life;

Thought Disorder (04/20/2015 10:32):
Short term goals: Able to hold topic conversation/remain engaged in activity; Patient states recognition of visual hallucinations, auditory hallucinations, olfactory hallucinations, or delusional thought;
Interventions: Redirect patient with reality testing when needed; Assess for perceived symptoms;

Electronic Signatures:
LARSON, JAN (CTRS) (Signed 04-20-2015 11:34)

REED, EMILY
MR#: [redacted]
Visit#:
DR: BOTA, ROBERT

Gender: Female
DOB: [redacted]
Age: 18y

Admit Date: 04/18/2015 12:31
Discharge Date: 04/20/2015 16:13
Service: IP Mental Health Adult Med

ATS Progress Note-PSYCH-recreational therapy

04/20/2015 11:32 LARSON, JAN (CTRS)

Authored: Accessing Provider, Plan of Care

Last Updated: 04-20-2015 11:34 by LARSON, JAN (CTRS)

PL 000058

[redacted] [redacted]
REED, EMILY DOB [redacted]
AKA:

UNIVERSITY of CALIFORNIA • IRVINE HEALTHCARE

Neuropsychiatric Center
INTERDISCIPLINARY TREATMENT PLAN
Initiate within 8 hours

DISCHARGE / AFTERCARE PLANNING

	Patient/Caretaker GOALS	MET	INTERVENTIONS
Strengths/Assets	Short term: ☑ Will be able to state # 5 pt. strengths and discuss their role in self care and symptom management. ☑ Identify self esteem qualities that benefit pt's health/well being Long term: ☑ Uses strengths to support symptom management		☑ MD/NSG to assess pt. strengths/assets during admission assessment. ☐ RT to assess patient needs and provide plan for use of strategies in daily activities ☑ NSG/CSW to explore pt. strengths and their role and best outcomes with pt. ☑ RT to assist in identifying strengths and reinforce self positives ☑ CSW to review patient strengths at discharge planning family meeting ☐ TEAM to prompt for participation in self care & symptoms management group education **Educational preferences:** Verbal, Written, Audio Via 1:1, milieu, Groups: O.T., Nursing, S.W., Music Therapy
Support System	Short term: ☑ Verbalizes understanding of illness depression ☑ Acknowledges need to comply with Tx plan ☑ Identifies support needs and states plan to meet needs ☑ Identifies strategies for developing support system Long term: ☑ Support system meeting with TEAM for aftercare plan		☐ MD to contact PCP for increased database ☑ CSW to coordinate family meeting(s) with support people _____ ☑ NSG to support visitation(s) and monitor for safe, appropriate interactions ☐ TEAM to evaluate pt.'s support system & involve as appropriate ☐ RT to educate in managing physical health issues & available supportive resources
Discharge Planning	Short term: ☑ Will verbalize the importance of obtaining and maintaining follow-up care ☑ Will have a list of community resources for aftercare ☑ Will identify appropriate discharge plan for self care ☑ Will identify safety plan communicate when having impulse of harming self and/or others Long term: ☐ Discharge to appropriate living situation *(highest level of self care potential and least restrictive environment)*		☑ CM/CSW to evaluate recent level of care; increase data base / research options for aftercare ☐ RT to determine level of function for placement needs ☐ TEAM to evaluate and discuss level of continuing care needed ☐ CSW/RT to provide/discuss referrals/recommendations for discharge with pt / _____ ☐ MD to provide discharge prescriptions orders, as applicable ☑ NSG/CSW to Educate pt. on follow-up care ☐ RT to provide feedback to family/caregiver for level of care needed

Plan reviewed with patient / caregiver: Plan Initiated by: [redacted] RN (date/time): 3/18/14 @ 1115
Staff: [redacted] 3-20-14 Patient / caretaker: X Emily Reed (Date) 3/18/14 11:50
Staff: [redacted] Patient / caretaker: _____ (Date) _____

All documentation must indicate the specific date and time of entry and a signature complete with identity credential, title or classification.

83052 (Rev 03/10) 3/20/14 3/26/14

PSYCHIATRIC / MENTAL

Patient/Caretaker GOALS	MET	INTERVENTIONS
High Risk Behavior Identify risk behavior(s): Suicide, self harm **Short term:** ☑ No harmful behavior directed towards self/others for 72 hours/days ☑ Will identify trigger(s) for high risk behaviors ☑ Demonstrates proper improved use of coping skills (specify skills to develop): deep breathing exercise, journaling, communicating needs appropriately **Long term:** ☐ Absence of inappropriate behavior _____ ☑ Will use non-violent & socially appropriate behaviors at all times		☐ MD & NSG to assess potential for harm toward self/others _____ ☐ MD to assess for appropriate Tx/medications & order precautions for: _____ ☐ CSW to contact family/B & C/ _____ to increase database ☐ NSG/CSW/RT to provide choices/set boundaries/explain unit rules and acceptable behavior ☐ NSG/CSW to assist pt. in identifying precipitating stressors/triggers ☐ RT/NSG to help pt. identify & develop alternative responses of negative behaviors ☐ TEAM to develop behavioral contract with pt. _____ ☐ CSW to coordinate *Family meeting* to _____ ☐ NSG/CSW to collaborate with MD for order to perform body checks for _____ **TEAM** to educate in: ☐ Medication management ☐ Symptom management ☐ Coping skills ☐ Anger management
Mood Disorder **Short term:** ☑ Will be able to behave appropriately in milieu for 15 minute intervals ☑ Will attend #all groups per day ☑ Sleeps 6h-7h hours every night ☑ Will identify personal triggers to mood changes ☑ Will verbalize #2 strategies to moderate mood change ☑ Will complete ADLs: _____ without prompts IMPROVED MOOD AEB ↓ S/I THOUGHTS ON PLANS & ↓ ANXIETY 2° PTSD R/T HX ABUSE C/IN 3-7 DAYS **Long term:** ☑ Symptoms no longer interfere with daily functioning ☑ Verbalizes understanding of illness, medication compliance and discharge follow up to reduce the risk of relapse		☑ TEAM to assess and evaluate mental status, thought content, ADLs & behaviors daily ☑ MD to evaluate medication needs, effectiveness, side affects & order precautions ☑ NSG to assess and document sleep pattern and hours of sleep ☑ NSG to discuss/evaluate potential for self harm with pt. able to contract safety ☐ TEAM to develop behavioral contract with pt. _____ ☐ RT to support medication awareness and management ☑ CSW to coordinate *Family meeting* to _____ CPS REPORT ☐ RT to provide education for symptom identification and management **TEAM** to educate in: ☐ Medication management ☐ Coping skills ☐ Relapse prevention

[redacted] [redacted]
REED, EMILY DOB: [redacted]
AKA:

UNIVERSITY of CALIFORNIA · IRVINE HEALTHCARE

Neuropsychiatric Center
INTERDISCIPLINARY TREATMENT PLAN
Initiate within 8 hours

	Patient/Caretaker GOALS	MET	INTERVENTIONS
Thought Disorder	**Short term:** ☐ Demonstrates decreased isolation: Attends ____hours in milieu ☐ Will attend # _____ groups/day for _____ ☐ Will demonstrate improved reality orientation by stating correct name, day, date, place _____ ☐ Will complete ADLs: _____ without prompts ☐ Will be able to hold topic conversation/remain engaged in an activity for ____minutes ☐ Will state recognition of V/H, A/H, _____ **Long term:** ☐ Symptoms no longer interfere with daily functioning ☐ Verbalizes understanding of illness, medication compliance and discharge follow up to reduce the risk of relapse		☐ TEAM to assess and evaluate mental status, thought content, ADLs & behaviors daily ☐ MD to rule out organic causes (PE, labs, drug screen, possible medications side effects) ☐ MD/CSW to Contact family/B & C/Primary MD/Therapist to assess for medication/Tx compliance and to identify possible stressors precipitating decompensation ☐ MD to evaluate for appropriate medication regimen & assess response/adverse reactions daily ☐ NSG to redirect pt. with reality testing when experiencing _____ _____ *(i.e. Delusions, PI or hallucinations)* ☐ TEAM to prompt pt. for participation in _____ ☐ NSG to provide areas for time-outs/safety/quiet ☐ NSG/CSW/RT to evaluate for existing coping skills and discuss needs with pt. ☐ NSG to assess patient for level of pt. perceived symptoms ☐ NSG/CSW to develop pt. distraction options with pt. ☐ RT to provide structured activity to increase thought organization _____ ☐ CSW to coordinate *Family meeting to* _____ **TEAM** to educate pt. in: ☐ Medication management ☐ Symptom management ☐ Coping skills ☐ Relapse prevention
Pt Stated Goals	**Patient Stated Short Term Goals:** "making sure I eat" **Long term:**		
Other			

83052 (Rev. 8/31/07) Page 3 of 6

PL 000061

LIFESTYLE/SPIRITUAL

	Patient/Caretaker GOALS	MET	INTERVENTIONS
Substance Abuse/Addictive Behaviors	**Short term:** ☐ Pt. will be free of withdrawal symptoms ☐ Will identify # ___ personal concerns of ETOH/Drug abuse ☐ Will verbalize benefits of healthy, drug free lifestyle ☐ Will verbalize understanding of consequences of substance abuse ☐ Will be able to state # ___ negative impact(s) of substance abuse on his/her Tx plan and physical & mental health ☐ Will be able to state # ___ community resources available to assist in sustaining sobriety ☐ Commitment to join/attend (i.e. AA) _____ # ___ meetings **Long term:** Maintains abstinence		☐ MD oversee medical and supportive management of withdrawals/toxicity ☐ NSG to assess for symptoms of withdrawal/toxicity & collaborate with MD for medication needs ☐ CM/CSW to explore needs and options for aftercare; provide referrals to _____ ☐ RT to provide education of substance abuse impact on mental illness symptoms & offer strategies to maintain sobriety and stabilize symptoms ☐ TEAM to assess role of abuse in psychiatric presentation and educate pt. **TEAM** to educate in: ☐ Medication management ☐ Symptom management ☐ Coping skills ☐ Relapse prevention ☐ Substance abuse ☐ Effects on health/life functioning
Cultural & Spiritual	**Short term:** ☐ Will identify # ___ resources to meet identified needs: _____ ☐ Will identify spiritual/cultural needs which impact their illness and ability to receive assistance _____ **Long term:** Will state that spiritual/cultural needs have been met		☐ NSG to provide access for spiritual counseling ☐ TEAM to assess for stressors and potential conflicts in spirituality ☐ NSG to prompt pt. for group participation ☐ TEAM to prompt pt. to share beliefs/traditions that impact healthcare ☐ TEAM to offer available resources for cultural and spiritual needs
Communication	**Short term:** ☐ Will identify communication strengths and deficits ☐ Will communicate with staff and peers in constructive manner ☐ Will communicate needs assertively ☐ Will independantly initiate interactions with others **Long term:** Will state the communication needs have been met		☐ TEAM will model and prompt for healthy communication skills ☐ CSW to educate in assertive/effective communication skills ☐ RT to provide opportunities to express thoughts/feelings using a variety of media ☐ NSG/RT to assess for alternative means of communication with patient ☐ Utilize interpreters/communication aides/strategies _____
Non-compliance w/Tx	**Short term:** ☐ Will identify beliefs that influence noncompliance ☐ Will participate in and make a commitment to the treatment plan ☐ Will participate in daily structured activities without prompts ☐ Will identify # ___ consequences of non-compliance **Long term:** ☐ Will verbalize understanding of disorder, rationale for compliance with Tx plan, commitment for follow-up care and need to continue medication/treatment after discharge		☐ MD/NSG to assess/discuss reasons for non-compliance, with patient ☐ NSG to assess readiness to learn on admit & as indicated ☐ TEAM to prompt pt. for participation in development of Tx plan ☐ TEAM to prompt pt. for participation in daily structured activities and groups. ☐ RT to reinforce benefits of compliance with treatment plan **TEAM** to educate in: ☐ Medication management ☐ Symptom management ☐ Coping skills ☐ Relapse prevention

[redacted]
REED, EMILY
AKA:
DOB: [redacted] F

UNIVERSITY of CALIFORNIA · IRVINE HEALTHCARE

Neuropsychiatric Center

INTERDISCIPLINARY TREATMENT PLAN

Initiate within 8 hours

MEDICAL/PHYSICAL

	Patient/Caretaker GOALS	MET	INTERVENTIONS
MEDICAL	**Short term:** Medical Stability; achieve homeostasis Specify: ☐ Pain will not interfere with daily activities ☐ Verbalizes understanding of illness(s) and the need to comply with Tx and follow up ☐ Will have a plan for self care: _____ **Long term:** ☐ Symptoms no longer interfere with daily functioning ☐ Verbalizes understanding of illness(es) and the need to comply with Tx to maintain highest level of health		☐ TEAM to assess Hx & increase database regarding: ☐ MD to request Medicine/_____ consult for _____ ☐ MD to evaluate for appropriate medication regimen & Tx _____ _____ ☐ MD to order and monitor labs tests: ☐ NSG to monitor fluid intake & Output R/T _____ ☐ NSG to do physical assessments R/T _____ ☐ NSG to explore pain relief options with pt. ☐ SW to assess pt's comfort level ☐ NSG to provide/acquire _____ ☐ NSG to monitor/assess for S & S of _____ _____ ☐ Rehab therapy to follow medical/physical health precautions/recommendations ☐ RT to evaluate medical issues impact on level of function & need for assistive devices, provide input to TEAM re: ADLs, mobility & feeding **TEAM** to educate in: ☐ Medication management ☐ Symptom management ☐ Coping skills ☐ Relapse prevention ☐ Disease process(s):
Nutrition/Diet	**Short term:** ☐ Will attain initial target weight of ___# kg ☐ Will attain a target weight of ___ # kg for ___days prior to discharge ☐ Will attain/maintain adequate nutrition as evidenced by body weight ratio and lab values ☐ Will comply with diet order > 80% ☐ Will feed self safely ___with set-up ___with assist ___ WD assist **Long term:** ☐ Will verbalize understanding of importance of diet in maintaining a healthy living style		☐ NSG preferences & aversions with pt. ☐ NSG to review menu & diet plan with pt. ☐ NSG to initiate dietician referral ☐ NSG to monitor weight ___ in kg(s) ☐ NSG to monitor dietary intake ☐ MD to order and evaluate labs: _____ ☐ OT to evaluate & monitor ability to feed self and make recommendations for Tx strategies ☐ NSG to assess ability to swallow ☐ OT referral to evaluate and refer to Speech Therapy, as needed ☐ TEAM to follow eating disorder protocol ☐ 1:1 for meals ☐ Lock out of room ☐ minutes after meals **TEAM** to educate in and prompt pt. for participate in healthy living groups, _____ _____

83052 (Rev. 6/31/07)

	Patient GOALS	MET	INTERVENTIONS
Skin Integrity	☐ at risk ☐ actual breakdown present (describe): Short term: ☐ Skin integrity will be maintained ☐ No further skin breakdown ☐ Existing interruption will heal without infection ☐ Wound(s) will close and be free of infectious signs by _____ ☐ Opening will decrease in measure specify _____ ☐ Will eat ___% of meals provided: _____ Long term: ☐ Healthy skin integrity and will use strategies to maintain skin integrity		☐ MD to order labs, including albumin level ☐ MD to rule out possible causes of breakdown ☐ MD to evaluate medications to facilitate healing ☐ NSG to initiate referral for skin care nurse consult ☐ NSG to provide and document skin care and assessments NSG to ☐ prompt ☐ assist *Patient* to maintain adequate hygiene & nutrition NSG to ☐ prompt ☐ assist ☐ provide *Patient* position changes, ROM and postural supports every 2 hrs to prevent pressure areas ☐ NSG to evaluate effectiveness of skin/wound care Tx. Consult MD when changes are needed. ☐ NSG to provide/acquire _____ *(assistive positional device)* ☐ OT to evaluate physical needs causing skin breakdown ☐ TEAM to educate and prompt pt. participate in healthy living groups, including ☐ self care ☐ ROM ☐ skin care ☐ repositioning to relieve pressure areas
Self-Care Deficit	Short term: ☐ Will attend to ADLs with prompts by _____ ☐ Will attend to ADLs without prompts by _____ ☐ Will cooperate with assistance of ADLs by _____ ☐ Will attend to ADLs independent by _____ ☐ Will attend to ADLs with minimal assist by _____ ☐ Will attend to upper body ADLs independently by _____ Long term: ☐ Will have a plan for meeting self-care needs outside of hospital		☐ MD/NSG to assess for causes of self care deficit ☐ NSG/RT to evaluate ability to perform self-care activities ☐ NSG to assess reasons for neglect of self-care ☐ NSG to assist with self-care ☐ NSG to provide prompts for self-care ☐ NSG/RT to obtain or provide referral for acquiring assistive device(s) _____ ☐ RT to enter treatment plan regarding ADLs, mobility, feeding ☐ RT/NSG to assist pt. to meet ADLs needs, prompt for independence and educate for safety. ☐ NSG/RT to educate pt./caretaker on proper use of assistive device(s): _____ ☐ NSG/RT to educate pt./caretaker in self care needs: _____
Fall Risk	Short term: ☐ Will not fall during hospitalization ☐ Will ask for assistance prior to attempting ambulation ☐ Will be able to state/demonstrate ____ # of fall prevention strategies. Long term: ☐ Will provide a safe environment and applies preventive measures & strategies to reduce fall risks.		☐ NSG to provide ____ 1:1 ambulation ____ transfer assistance _____ ☐ NSG to assess pt.'s ability and willingness to ask for assistance daily ☐ NSG to prompt pt. to ask for assistance prior to ambulating/transferring ☐ OT to complete fall risk assessment & provide recommendations, including PT assessment as indicated ☐ RT/NSG to assist pt. to meet ADLs needs, prompt for independence and educate for safety. ☐ NSG/RT to develop plan to minimize risk of falls, educate pt. ☐ TEAM to provide assistive device(s) _____ ☐ NSG/RT to educate pt./caretaker on proper use of assistive device(s) _____ ☐ NSG/RT to educate pt./caretaker in Fall precautions; preventive strategies

[redacted] REED, EMILY
AKA:

[redacted] DOB: [redacted] F

UNIVERSITY of CALIFORNIA • IRVINE HEALTHCARE

Neuropsychiatric Center
INTERDISCIPLINARY TREATMENT PLAN
PROBLEM LIST

Date of Admission: 3/18/14 UNIT: MHAO

Admission Global Assessment of Functioning (GAF) Score: _____ Estimated highest GAF in last year: _____

TSR= 7-day Discharge Medication Required IMD= Institutions for Mental Diseases

DISCHARGE / AFTERCARE PLANNING *(initiate within 8 hours)*

Focus	Presenting signs / symptoms / needs	Date/Time & Initials
Patient Strengths & Assets	☐ Tx compliant ☑ Voluntary admission ☑ Motivated for Tx ☐ Insight into illness ☐ Independent living ☑ Intact cognition ☐ Group resources ☐ Financial resources ☐ Spiritual support ☑ Family/social support ☐ Employed ☐ Follows up with appointments ☐ Seeks education on Dx and Tx ☐ Seeks education in _____ ☐ Other:	3/18/14 1115 Dr
Support system	☑ Family ☐ Belongs to Group(s): _____ ☑ Friends ☐ Other: _____ 3/20/14 NP	3/18/14 1115 Dr
Discharge Plan	Legal status: ☑ Voluntary ☐ Vol. by conservator: _____ 3/20/14 ☐ WRIT filed ☐ 5150 ☐ 5250 ☐ 5585 *expires* __/__/__ @ __:__ ☐ Clinical Review __/__/__ ☐ T-CON filed ☐ TSR ☐ Research ☐ Pending transfer to another facility: _____ Current living arrangement: ☐ homeless Lives: ☐ alone ☑ with mom & 2 brothers (younger) ☐ B&C ☐ Room & Board ☐ IMD ☐ SNF NP 3/20/14 Name of facility and contact name/# as available	3/18/14 1115 Dr

PSYCHIATRIC / MENTAL HEALTH ISSUES

Focus	Presenting signs / symptoms / needs	Date/Time & Initials
High Risk	☐ Suicide ☐ Assault ☑ Self harm/mutilation ☐ Hypersexual ☐ Elopement ☐ Firesetting *Specify behaviors:* "purposefully not eating & purging then passing out"	3/18/14 1115 Dr
Mood disorder	**Suicidal:** ☐ without plan ☑ with plan to "purposefully not eating & purging then passout" **Eating:** ☐ increased ☑ decreased **Sleep:** ☐ increased ☐ decreased ☐ Hyper-verbal ☐ Mute ☑ Depressed affect ☐ Manic ☑ Anxious ☐ Labile ☐ Angry *Specify signs/behaviors:* Hx of sexual & physical abuse 3/27/14 ARNS E	3/18/14 1115 Dr
Thought disorder	☐ A/H ☐ V/H ☐ Tactile Hallucinations ☐ Command to _____ **Not Oriented to:** ☐ Person ☐ Place ☐ Time ☐ Situation **Ideation:** ☐ Paranoid ☐ Homicidal ☐ Delusional ☐ Loose ☐ Tangential ☐ Flight of ideas ☐ Racing thoughts ☐ Religiously preoccupied *Specify thoughts:*	
Patient Goals	Patient stated goals: "making sure I eat" 3/18/14 1115 Dr	Other

68034 (Rev. 11/18/09) I=Initiated Problem C=Completed Problem Page 1 of 2

[redacted] REED, EMILY
AKA:

DOB: [redacted] F

UNIVERSITY of CALIFORNIA • IRVINE HEALTHCARE

Neuropsychiatric Center

INTERDISCIPLINARY TREATMENT PLAN PROBLEM LIST

LIFESTYLE/SPIRITUAL HEALTH ISSUES *(Initiate within 8 hours)*

Focus	*Presenting signs / symptoms / needs*	Date/Time & Initials
Substance abuse dependence	*Specify:* Drug screen + _____ ETOH level _____ Abuse Hx: _____ ❑ daily ❑ weekly ❑ intermittently for _____ (length of time) ❑ Signs of withdrawal _____ ❑ Signs of toxicity _____	
Cultural & spiritual needs	*Specify needs:*	
Communication	❑ Does not speak/understand English ❑ Blind ❑ Deaf Primary Language _____ ❑ Needs translator services: _____ Communications aids/devices: _____	
Treatment Non-compliance	❑ Not taking medication(s) X _____ due to: *Specify non-compliance:*	

MEDICAL / PHYSICAL HEALTH ISSUES

Focus	*Presenting signs / symptoms / needs*	Date/Time & Initials
Medical Instability	❑ Diabetes ❑ UTI ❑ Dental Problems ❑ R/O Delirium ❑ HTN ❑ Initial Blood sugar _____ ❑ Infection _____ ❑ Hypotension ❑ Liver ❑ Renal ❑ Respiratory problems _____ ❑ Cardiac problems: _____ ❑ Pain management: ❑ GI problems: ❑ Seizure d/o [last seizure = _____] ❑ Other: *Specify instabilities:*	
Nutrition/ Diet	❑ Eating disorder ❑ Nausea ❑ Vomiting ❑ Difficulty swallowing ❑ Mechanical problems ❑ Food allergies ❑ Special diet: _____ *Specify needs:*	
Skin Integrity/ Wounds	❑ Incontinence (bowel, bladder) with poor self care Admit Braden score _____ Wound(s)/Skin break/down **Location and brief description:**	
Self-care deficit	*Appearance:* ❑ Dirty ❑ Dishevled ❑ Malodorous *Specify:* ❑ **Changes in functional ability:** ❑ **Assistive devices:** _____	
Fall risk	❑ Pt identified as at high risk per Fall Risk Predictor assessment *Specify:*	

STAFF:

Initial [redacted] Signature [redacted]
Initial [redacted] Signature [redacted]
Initial [redacted] Signature [redacted]

Initial [redacted] Signature [redacted]
Initial ___ Signature _____
Initial ___ Signature _____

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88034 (Rev. 11/18/09)

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REED, EMILY
AKA:

Reed Emily

UNIVERSITY of CALIFORNIA • IRVINE HEALTHCARE

Neuropsychiatric Center
INTERDISCIPLINARY TREATMENT PLAN- WEEKLY REVIEW

Unit: 2N Admit Date: 3/18/14

Diagnosis: MDE, Social anxiety Current GAF: 25 Review Date/Time: 3/20/14

Justification for continued hospitalization: DTS

DISCHARGE / AFTERCARE PLANNING

Focus — Current signs/symptoms	Progress / New Interventions / Medication changes / Education
Patient Strengths & Assets: ☐ Tx compliance/participation	participating with interviews attends groups; guarded
Support system: Mother involved in Tx plan	Family Meeting(s) 3/20/14 @ 9:15
Current Discharge Plan: To home after psychiatrically Estimated Discharge 3/25/14 base ☐ Own home/apartment Lives: ☐ alone ☐ with: mother & ☐ Room &Board ☐ Shelter ☐ B & C ☐ IMD ☐ Sober living after ☐ SNF ☐ Assisted Living	Legal status: ☐ Voluntary ☐ Vol. by conservator ☐ 5150 ☐ 5250 ☐ 5585 Expires: __/__/__ @ ____:____ ☐ A of A (5353) __/__/__ ☐ PCH __/__/__ ☐ upheld ☐ T-CON filed __/__/__ ☐ Riese filed __/__/__ ☐ Clinical Review __/__/__ ☐ upheld ☐ Writ filed __/__/__ ☐ TSR ☐ Research ☐ Pending transfer to: Referrals: Social services out-pt referrals for psych & therapist. Follow-up appointments: Rx needs:
Facility info:	PPD/CXR: ☐ not needed ☐ needed ☐ Done _____ (date) Pneumococcal vaccine: ☐ not needed ☐ needed ☐ Done _____ (date)

PSYCHIATRIC / MENTAL HEALTH ISSUES

Focus — Current signs/symptoms	Progress / New Interventions / Medication changes / Education
High risk: ☐ Suicide ☐ Assault ☐ Self harm/mutilation ☐ Hypersexual ☐ Elopement ☐ Fire setting *Describe behaviors/statements:*	Observation Level _____
Mood disorder: Suicidal: ☐ without plan ☐ with plan to: _____ **Sleep:** ☐ Increased ☐ Decreased ☐ Needs prompts for food intake ☐ Depressed ☐ Manic ☐ Anxious ☐ Labile ☐ Hyper verbal *Describe behaviors/statements:*	Observation Level 15 continues to endorse depressive SXS & anxiety isolative, selectively mute at times Prozac liquid 10mg PO Ativan 0.5mg PO TID before meals
Thought disorder: Hallucinations: ☐ Auditory ☐ Visual ☐ Tactile ☐ Command to _____ Ideation: ☐ Paranoid ☐ Homicidal ☐ Loose ☐ Delusional ☐ Tangential ☐ Flight of ideas ☐ Racing thoughts ☐ Religiously preoccupied Not oriented to: ☐ Person ☐ Place ☐ Time ☐ Situation *Describe behaviors/statements:*	Observation Level _____

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REED, EMILY
AKA:

DOB: [redacted] F

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Neuropsychiatric Center
INTERDISCIPLINARY TREATMENT PLAN
WEEKLY REVIEW

PSYCHIATRIC / MENTAL HEALTH ISSUES (Cont.)

Focus — Current signs/symptoms	Progress / New Interventions / Medication changes / Education
Patient Stated Goals:	"not feel this way"
Other:	

LIFESTYLE / SPIRITUAL HEALTH ISSUES

Focus — Current signs/symptoms	Progress / New Interventions / Medication changes / Education
Substance abuse/dependence: Specify: Ø	
Cultural/spiritual needs: Ø	Ethnic considerations ☐ Yes ☐ No_____
Communication needs: Language: English Aids: _____	
Non-compliance with treatment: ☐ Medication refusal Specify: Ø	☐ Riese filed _____ Labs done _____

MEDICAL / PHYSICAL HEALTH ISSUES

Focus — Current signs/symptoms	Progress / New Interventions / Medication changes / Education
Medical Issues: ☐ GI ☐ Sz ☐ Pain ☐ Cardiac ☐ Respiratory ☐ Tremors ☐ Delirium ☐ HTN ☐ IV therapy ☐ Diabetes ☐ Liver ☐ Renal ☐ Dehydration ☐ Infection ☐ Hypotension Abnormal: ☐ VS ☐ EKG ☐ Labs Specify:	Labs:_____ Blood sugar range:_____ Tests:_____ VS:_____ Pain Level range_____ Consults/Referrals:_____ Medication changes:_____ Daily weights 48 kgs on admission Wt. 47.8 kgs +/- Kg)
Nutrition/Diet: ☐ Eating disorder ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Mechanical d/o ☐ Dysphagia ☐ Intolerance ☐ Tube feeds Deficit:	Diet Regular I&O_____ ↓ Po intake, emesis & meal likely due to anxiety increase Ativan to increase compliance & meals
Skin Integrity/Wound: Braden score _____ ☐ Incontinence (bowel, bladder) ☐ Poor ADLs Specify: Ø	
Self-care deficit: ☐ Poor ADLs ☐ Changes in functional ability: Ø	
Fall risk: Specify: Ø	

Attending [redacted] Resident [redacted] Patient [redacted]
R.N. [redacted] R.T. [redacted] C.S.W. [redacted]
Other _____

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[redacted] [redacted]

REED, EMILY

AKA:

DOB: [redacted] F

UNIVERSITY of CALIFORNIA · IRVINE HEALTHCARE

Neuropsychiatric Center
INTERDISCIPLINARY TREATMENT PLAN
WEEKLY REVIEW

Diagnosis: ~~R~~ DN MDE; social anxiety consider PTSD Unit: 2N Admit Date: 3/18/14

Current GAF: 20 Review Date/Time: 3/27/14 - [illegible]

Justification for continued hospitalization: DTS

DISCHARGE / AFTERCARE PLANNING	
Focus *Current signs/symptoms*	*Progress / New Interventions / Medication changes / Education*
Patient Strengths & Assets: ☐ Tx compliance/participation	Compliant c medications attends groups; mood + affect slowly improving
Support system: mother involved in Tx plan father	Family Meeting(s) __/__/__ @ __:__
Current Discharge Plan: Partial program Estimated Discharge 4/2/14 ☐ Own home/apartment Lives: ☐ alone ☐ with: ☐ Room & Board ☐ Shelter ☐ B & C ☐ IMD ☐ Sober living ☐ SNF ☐ Assisted Living Facility info: out-patient	Legal status: ☑ Voluntary ☐ Vol. by conservator ☐ 5150 ☐ 5250 ☐ 5585 Expires: __/__/__ @ __:__ ☐ A of A (5353) __/__/__ ☐ PCH __/__/__ ☐ upheld ☐ T-CON filed __/__/__ ☐ Riese filed __/__/__ ☐ Clinical Review __/__/__ ☐ upheld ☐ Writ filed __/__/__ ☐ TSR ☐ Research ☐ Pending transfer to: Referrals: Follow-up appointments: Rx needs: on PHP list # 2. out-pt providers p PHP. v. FOCUS. PPD/CXR: ☐ not needed ☐ needed ☐ Done ____ (date) Pneumococcal vaccine: ☐ not needed ☐ needed ☐ Done ____ (date)

PSYCHIATRIC / MENTAL HEALTH ISSUES	
Focus *Current signs/symptoms*	*Progress / New Interventions / Medication changes / Education*
High risk: ☑ Suicide ☐ Assault ☑ Self harm/mutilation ☐ Hypersexual ☐ Elopement ☐ Fire setting *Describe behaviors/statements:*	Observation Level q 15 Patient has bitten her arm on 2 occasions No evidence of laceration, abrasion, bleeding
Mood disorder: Suicidal: ☐ without plan ☐ with plan to: Sleep: ☐ Increased ☐ Decreased ☐ Needs prompts for food intake ☐ Depressed ☐ Manic ☐ Anxious ☐ Labile ☐ Hyper verbal *Describe behaviors/statements:*	Observation Level 15 Pt continues to endorse SI Hypoverbal often replies "I don't know" Disclosed 3/26/14 hx of sexual abuse and sxs consistent c PTSD Prozac 30mg plan to titrate to 40mg Klonopin 1mg PO BID Zyprexa 5mg PO qhs
Thought disorder: Hallucinations: ☐ Auditory ☐ Visual ☐ Tactile ☐ Command to Ideation: ☐ Paranoid ☐ Homicidal ☐ Loose ☐ Delusional ☐ Tangential ☐ Flight of ideas ☐ Racing thoughts ☐ Religiously preoccupied Not oriented to: ☐ Person ☐ Place ☐ Time ☐ Situation *Describe behaviors/statements:*	Observation Level ____

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83053 (Rev. 2/16/10)

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REED, EMILY
AKA:

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UNIVERSITY of CALIFORNIA • IRVINE HEALTHCARE

Neuropsychiatric Center
INTERDISCIPLINARY TREATMENT PLAN
WEEKLY REVIEW

PSYCHIATRIC / MENTAL HEALTH ISSUES (Cont.)

Focus — *Current signs/symptoms*	*Progress / New Interventions / Medication changes / Education*
Patient Stated Goals:	
Other:	

LIFESTYLE / SPIRITUAL HEALTH ISSUES

Focus — *Current signs/symptoms*	*Progress / New Interventions / Medication changes / Education*
Substance abuse/dependence: *Specify:* Ø	
Cultural/spiritual needs: Ø	Ethnic considerations ☐ Yes ☐ No_____
Communication needs: Language: English Aids: _____	
Non-compliance with treatment: ☐ Medication refusal *Specify:* Ø	☐ Riese filed _____ Labs done _____

MEDICAL / PHYSICAL HEALTH ISSUES

Focus — *Current signs/symptoms*	*Progress / New Interventions / Medication changes / Education*
Medical Issues: ☐ GI ☐ Sz ☐ Pain ☐ Cardiac ☐ Respiratory ☐ Tremors ☐ Delirium ☐ HTN ☐ IV therapy ☐ Diabetes ☐ Liver ☐ Renal ☐ Dehydration ☐ Infection ☐ Hypotension Abnormal: ☐ VS ☐ EKG ☐ Labs *Specify:*	Labs: _____ Blood sugar range: _____ Tests: _____ VS: _____ Pain Level range_____ Consults/Referrals: _____ Medication changes: _____ occasional decreased Po intake, and emesis 30min-1hr post meals. Day Room Support Daily weights, weight has been stable Wt. 48.164 +/- Kg)
Nutrition/Diet: ☐ Eating disorder ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Mechanical d/o ☐ Dysphagia ☐ Intolerance ☐ Tube feeds *Deficit:*	Diet ~~Regular~~ I & O _____ Dietician consult, following recs, multiple small meals throughout day. Ensure Plus TID for < 100% consumption of meal
Skin Integrity/Wound: Braden score _____ ☐ Incontinence (bowel, bladder) ☐ Poor ADLs *Specify:* Ø	
Self-care deficit: ☐ Poor ADLs ☐ Changes in functional ability: Ø	
Fall risk: *Specify:* Ø	

Attending _____ Resident _____ Patient Emily Reed
R.N. _____ R.T. _____ C.S.W. _____
Other _____ Danette Pagini RN CCM.

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.

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REED, EMILY
AKA:

[redacted]
DOB: 11/16/1996 F

UNIVERSITY of CALIFORNIA • IRVINE HEALTHCARE

Neuropsychiatric Center
INTERDISCIPLINARY TREATMENT PLAN WEEKLY REVIEW

Diagnosis: MDD, PTSD, Social Anxiety d/o Current GAF: 25 Unit: HHAO Admit Date: 3/18/14
Review Date/Time: 4/3/14
Justification for continued hospitalization: DTS

DISCHARGE / AFTERCARE PLANNING

Focus — Current signs/symptoms	Progress / New Interventions / Medication changes / Education
Patient Strengths & Assets: ☒ Tx compliance/participation	Speaking more, taking meds. Improved participation in group. More socially interested. ↑ Clonazepam to 1.25 mg BID. ↑ Prazosin to 2 mg QHS. DC Zyprexa.
Support system: mom involved in Tx plan	Family Meeting(s) 3/20/14 @ 9:15
Current Discharge Plan: To Center For Discovery Estimated Discharge 9/4/15 ☐ Own home/apartment Lives: ☐ alone ☐ with: _____ ☐ Room &Board ☐ Shelter ☐ B & C ☐ IMD ☐ Sober living ☐ SNF ☐ Assisted Living **Facility info:** _____	**Legal status:** ☒ Voluntary ☐ Vol. by conservator _____ ☐ 5150 ☐ 5250 ☐ 5585 *Expires:* __/__/__ @ ____:____ ☐ A of A (5353) __/__/__ ☐ PCH __/__/__ ☐ upheld ☐ T-CON filed __/__/__ ☐ Riese filed __/__/__ ☐ Clinical Review __/__/__ ☐ upheld ☐ Writ filed __/__/__ ☐ TSR ☐ Research ☐ Pending transfer to: _____ Referrals: _____ Follow-up appointments: residential. Rx needs: _____ **PPD/CXR:** ☐ not needed ☐ needed ☐ Done _____ (date) **Pneumococcal vaccine:** ☐ not needed ☐ needed ☐ Done _____ (date)

PSYCHIATRIC / MENTAL HEALTH ISSUES

Focus — Current signs/symptoms	Progress / New Interventions / Medication changes / Education
High risk: ☐ Suicide ☐ Assault ☐ Self harm/mutilation ☐ Hypersexual ☐ Elopement ☐ Fire setting ***Describe behaviors/statements:***	Continued SI, urges to self-harm. Observation Level Q15 Last episode self-harm on 3/29.
Mood disorder: **Suicidal:** ☒ without plan ☐ with plan to: _____ **Sleep:** ☐ Increased ☐ Decreased ☐ Needs prompts for food intake ☐ Depressed ☐ Manic ☐ Anxious ☐ Labile ☐ Hyper verbal ***Describe behaviors/statements:***	Observation Level Q15 Depressed, tearful, anxious. Having flashbacks
Thought disorder: **Hallucinations:** ☐ Auditory ☐ Visual ☐ Tactile ☐ Command to _____ **Ideation:** ☐ Paranoid ☐ Homicidal ☐ Loose ☐ Delusional ☐ Tangential ☐ Flight of ideas ☐ Racing thoughts ☐ Religiously preoccupied **Not oriented to:** ☐ Person ☐ Place ☐ Time ☐ Situation ***Describe behaviors/statements:***	Observation Level Q15 Ø

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UNIVERSITY of CALIFORNIA • IRVINE HEALTHCARE

Neuropsychiatric Center
INTERDISCIPLINARY TREATMENT PLAN
WEEKLY REVIEW

PSYCHIATRIC / MENTAL HEALTH ISSUES (Cont.)

Focus — *Current signs/symptoms*	*Progress / New Interventions / Medication changes / Education*
Patient Stated Goals:	To feel better
Other: -	

LIFESTYLE / SPIRITUAL HEALTH ISSUES

Focus — *Current signs/symptoms*	*Progress / New Interventions / Medication changes / Education*
Substance abuse/dependence: *Specify:*	Ø
Cultural/spiritual needs:	Ø Ethnic considerations ☐ Yes ☐ No_____
Communication needs: Language:_____ Aids:_____	Ø
Non-compliance with treatment: ☐ Medication refusal *Specify:*	Ø ☐ Riese filed_____ Labs done_____

MEDICAL / PHYSICAL HEALTH ISSUES

Focus — *Current signs/symptoms*	*Progress / New Interventions / Medication changes / Education*
Medical issues: ☐ GI ☐ Sz ☐ Pain ☐ Cardiac ☐ Respiratory ☐ Tremors ☐ Delirium ☐ HTN ☐ IV therapy ☐ Diabetes ☐ Liver ☐ Renal ☐ Dehydration ☐ Infection ☐ Hypotension Abnormal: ☐ VS ☐ EKG ☐ Labs *Specify:*	Labs:_____ Blood sugar range:_____ Tests:_____ VS:_____ Pain Level range_____ Consults/Referrals:_____ Medication changes:_____ Ø Wt._____ (+/- Kg)
Nutrition/Diet: ☐ Eating disorder ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Mechanical d/o ☐ Dysphagia ☐ Intolerance ☐ Tube feeds *Deficit:*	Diet 6 small meals/day I&O_____ Poor PO intake
Skin Integrity/Wound: Braden score_____ ☐ Incontinence (bowel, bladder) ☐ Poor ADLs *Specify:*	Ø
Self-care deficit: ☐ Poor ADLs ☐ Changes in functional ability:	Ø
Fall risk: *Specify:*	Ø

Attending [signature] Resident [signature] R2 Patient [signature]
R.N. [signature] R.N. [signature] C.S.W. [signature]
Other _____ [signature]

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83053 (Rev. 2/16/10)

REED, EMILY

MR#:	[redacted]	Gender:	Female	Admit Date:	03/18/2014 11:06
Visit#:	[redacted]	DOB:	[redacted]	Discharge Date:	04/07/2014 13:27
DR:	TURAKHIA, ATUR V	Age:	17y	Service:	IP Mental Health Adolescent

Progress Note-Primary: Psychiatry

03/25/2014 10:27 NISENBAUM, DAVID (MD (R))

- **Evaluation Date and Time:** 03-25-2014 10:27

Role:

- **Role:** Primary Service

Hospital Days:

- **Hospital Days:** 8

Subjective Findings:

- **Active Problems:** Patient interviewed and discussed with treatment team. No acute events overnight. She slept 7.5 hours but reports intermittent sleep disruptions. She consumed 50/50/100 percent of meals. Also reported episode of emesis one hour after dinner last night. Denies abdominal pain. She is unsure of when her last BM occurred, and was asked by nursing staff to complete a log so that she could mark when she has her next BM. She has had visits from her father over the weekend and he had to return to Las Vegas today. She reported with excitement that "I have good news, my father is going to move back to be closer to us". She continues to endorse anxiety although appears less anxious than previous interview. Following interview, patient quickly walked to resident and said "I do want to die" and became tearful.

Medications:

- **Medications:** Scheduled Med(s):
  clonazePAM Tablet 0.5 mg 2 times a day
  FLUoxetine Oral Soln 30 mg daily
  multivitamin peds chewable Tablet 1 tablet(s) daily
  OLANZapine Tablet 2.5 mg nightly at bedtime

Objective Findings:

Vital Signs:

- **Vital Signs:** Weight (03/25/14) = 47.3 kg
  Temp (degrees C): 36.5 (36.3 - 37), Respiration (breaths/min): 16 (16 - 16),

Psychiatric: MSE

Appearance: Caucasian thin female, avg height, appears their stated age, good grooming and hygiene with hair in pigtails, and is wearing sweatshirt appropriate to weather and circumstance.
Behavior: Cooperative with interview, intermittently tearful, poor eye contact with her neck flexed looking at the ground, No PMR or PMA, sitting upright in chair
Speech: Hypoverbal with decreased volume, soft tone, decreased volume
Mood: "nervous"
Affect: blunted, guarded
Thought content: +SI, denies current HI, AH, VH
Thought processes: grossly linear, although paucity of thought
Insight: poor
Judgment: poor

Review of Medical Necessity:

- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.
- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

PL 000073

Progress Note-Primary: Psychiatry

03/25/2014 10:27 NISENBAUM, DAVID (MD (R))

Assessment and Plan:
Global Assessment & Plan:

- **Assessment and Plan:** 17 yo F with depressive symptoms and anxiety that has resulted in decreased functioning over the past 3 weeks BIB mother after endorsing SI with plan to not eat so she'll pass out. She has had decreased PO intake, loss of appetite and emesis possibly due to recent exacerbation in anxiety and depression likely related to unresolved emotional conflict involving her brother. Although, this will require further assessment. She has had minimal consumption of meals on the unit and observed episode of emesis likely due to anxiety and not meeting current criteria for eating disorder. Patient reports one episode of hearing a voice possibly consistent with non command type AH. Patient has also had decreased communication with possible occasional selective mutism, per mother she has had frequent crying spells and has been unable to attend school recently. She continues to endorse SI and patient is at increased risk of dangerousness to self and has had severe declines in functioning and requires inpatient hospitalization for medication initiation and stabilization.

Patient states she will tell nursing staff if she is having thoughts of self harm and therefore does not require current 1:1 and we will continue to assess for this need

Diagnosis
Axis I: MDE, consider MDE with psychotic features; social anxiety do; rule out autism spectrum
Axis II: Deferred
Axis III: No acute issues.
Axis VI: Moderate- poor coping skills, poor social functioning
Axis V: Global assessment of functioning on admission of 25

Plan:
1. Psychiatric Medication Management:
-Continue Prozac PO liquid formulation to 30mg PO QD with goal of titration to 40mg PO QD
-Increase Klonopin to 1mg PO BID with goals of controlling anxiety and compliance with meals
-Continue Zyprexa 2.5mg PO qhs as patient had endorsed AH and goal of stimulating appetite
-Both mother and father of patient have been consented, and understand risks, benefits, and alternatives to treatment with above medications and are in agreement with treatment plan
-Appreciate Dietician recs, will continue MVI, check daily weights, and encourage Ensure Plus TID PRN for less than 100 percent consumption
Weight has been stable during hospital course
2. Medical Issues:
Patient has been unable to remember date of last BM, we will start Colace 100mg PO QD and Senna and request patient to complete log for dates of BM
3. Continue individual, group, milieu, and allied services therapy
4. Legal: vol by parent
Writer called Orange County CPS regarding mother of patient's report of potential physical abuse of patient's brother Adam in Las Vegas NV by family friend (AI), they stated that statute of limitation had passed as incident had occurred in 2007, therefore filed report with Clark County (las vegas) CPS Lorea Arostegui referral # 1600635
5.. Disposition: Appreciate CM assistance with placement following discharge

REED, EMILY
MR#: [redacted] **Visit#:** [redacted]
DR: TURAKHIA, ATUR V

Gender: Female **DOB:** [redacted] **Age:** 17y

Admit Date: 03/18/2014 11:06
Discharge Date: 04/07/2014 13:27
Service: IP Mental Health Adolescent

Progress Note-Primary: Psychiatry

03/25/2014 10:27 NISENBAUM, DAVID (MD (R))

Above case was discussed with and supervised by attending psychiatrist Dr. Turakhia who agrees with above assessment and plan.

Billing Service Level:

- **Billing Service Level:** Level 2 - inpatient follow-up
- **Billing Modifiers:** GC

Attending Attestation:

- I personally coordinated care with: nurse; case manager; social worker.
- **Attending Attestation Statement:** I was present with the resident/fellow during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented by the resident. Any additions or revisions are included in the record.
- **Attestation Comments:** Still urges to bite self. Expressed desire to die. Emesis yesterday after dinner. Increase Clonazepam to 1mg BID. Will change meals to 6 small meals per dietician recs.

Electronic Signatures:

NISENBAUM, DAVID (MD (R)) (Signed 03-25-2014 15:00)
Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan

TURAKHIA, ATUR V (MD (A)) (Signed 04-27-2014 18:17)
Authored: Assessment and Plan, Billing Service Level, Attending Attestation, Note Finalization
Co-Signer: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan

Last Updated: 04-27-2014 18:17 by TURAKHIA, ATUR V (MD (A))

Progress Note-Primary: Psychiatry

03/27/2014 10:55 NISENBAUM, DAVID (MD (R))

- **Evaluation Date and Time:** 03-27-2014 10:55

Role:
- **Role:** Primary Service

Hospital Days:
- **Hospital Days:** 10

Subjective Findings:
- **Active Problems:** Patient interviewed and discussed with treatment team. She slept 7 hours with intermittent sleep disturbances. Patient disclosed a long hx of sexual abuse from family friend AJ, for multiple years with the last incident possibly in the past few months. This is more extensively documented in event note by Dr. Seegan 3/26/14, which was reviewed by treatment team this AM. Patient states that she was able to talk about the abuse now because her aunt had shared a story with her that made her feel more comfortable sharing what happened to her. She reports feeling "scared" but feels safe here in the hospital. She also is now endorsing sxs including flashbacks and "memories of being touched" and that this has been what is occurring when she takes showers here in the hospital and has occasionally bitten her arm as she is "having a panic". She also endorsed avoidance behavior, as she does not like taking baths reporting that this reminded her of abuse in the past. Also, has occasional nightmares multiple times during the week, although unsure of how frequent.

  She consumed 20 percent of dinner with Ensure supplementation and 100 percent of breakfast without episodes of emesis x 24 hours. She denies daytime sedation or dizziness and orthostatics were negative.
  This AM she reports SI without plan and when asked about details of this replied "I don't know". She reports her anxiety has had mild improvements from earlier in the week, although she "feels scared".

Medications:
- **Medications:** Scheduled Med(s):
  clonazePAM Tablet 1 mg 2 times a day
  FLUoxetine Oral Soln 30 mg daily
  multivitamin peds chewable Tablet 1 tablet(s) daily
  OLANZapine Tablet 5 mg nightly at bedtime
  senna Tablet 8.6 mg nightly at bedtime

Objective Findings:
Vital Signs:
- **Vital Signs:** Weight (03/27/14) = 48 kg
  Temp (degrees C): 36 (36 - 37), Respiration (breaths/min): 14 (14 - 16),

Psychiatric: MSE
Appearance: Caucasian thin female, avg height, appears their stated age, good grooming and hygiene, and is wearing sweatshirt appropriate to weather and circumstance.
Behavior: Cooperative with interview, calm, intermittent eye contact, No PMR or PMA, sitting upright in chair
Speech: Hypoverbal with decreased volume, soft tone
Mood: "scared"
Affect: blunted, guarded

Progress Note-Primary: Psychiatry

03/27/2014 10:55 NISENBAUM, DAVID (MD (R))

Thought content: +SI, denies current HI, AH, VH
Thought processes: grossly linear
Insight: poor
Judgment: poor

Review of Medical Necessity:

- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.
- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

Assessment and Plan:
Global Assessment & Plan:

- **Assessment and Plan:** 19 yo F with depressive symptoms and anxiety that has resulted in decreased functioning over the past 3 weeks BIB mother after endorsing SI. She has had minimal consumption of meals on the unit and observed episode of emesis likely due to anxiety and not meeting current criteria for eating disorder. Patient disclosed extensive hx of sexual abuse by family friend AI, she previously denied his to treatment team and mother, although felt more comfortable reporting the abuse following discussion with her aunt. She is also endorsing sxs consistent with PTSD including reexperiencing and avoidance cluster of sxs.
  Patient has also had decreased communication with possible occasional selective mutism, per mother she has had frequent crying spells and has been unable to attend school recently. During hospital course she has had self injurious behavior of biting her arm. She continues to endorse SI and patient is at increased risk of dangerousness to self and has had severe declines in functioning and requires inpatient hospitalization for medication initiation and stabilization.

  Patient states she will tell nursing staff if she is having thoughts of self harm and therefore does not require current 1:1 and we will continue to assess for this need

  Diagnosis
  Axis I: MDE; social anxiety do; consider PTSD
  Axis II: Deferred
  Axis III: No acute issues.
  Axis VI: Moderate- poor coping skills, poor social functioning
  Axis V: Global assessment of functioning on admission of 25

  Plan:
  1. Psychiatric Medication Management:
  -Continue Prozac 30 PO QD liquid formulation with goal of titration to 40mg PO QDay
  -Continue Klonopin to 1 mg PO BID with goals of controlling anxiety and compliance with meals, consider titration as tolerated if anxiety is not controlled with current dosage.
  -Continue Zyprexa 5mg PO qhs as patient had endorsed AH and goal of stimulating appetite
  -Start Prazosin 1mg PO QHS for nightmares associated with PTSD
  -Both mother and father of patient have been consented and understand risks, benefits, and alternatives to treatment with above medications and are in agreement with treatment plan
  -Appreciate Dietician recs, will continue MVI, check daily weights, and encourage Ensure Plus TID PRN for less than 100 percent consumption

Progress Note-Primary: Psychiatry

03/27/2014 10:55 NISENBAUM, DAVID (MD (R))

Weight has been stable during hospital course

2. Medical Issues:
Patient reports +BM 2 days previously, although does not recall previous BM therefore we will continue Senna and request patient to complete log for dates of BM

3. Continue individual, group, milieu, and allied services therapy

4. Legal: vol by parent
Writer called Orange County CPS regarding mother of patient's report of potential physical abuse of patient's brother Adam in Las Vegas NV by family friend (Al), they stated that statute of limitation had passed as incident had occurred in 2007, therefore filed report with Clark County (las vegas) CPS Lorea Arostegui referral # 1600635

5. Disposition: Appreciate CM assistance with placement following discharge

Above case was discussed with and supervised by attending psychiatrist Dr. Turakhia who agrees with above assessment and plan.

Billing Service Level:

- **Billing Service Level:** Level 2 - inpatient follow-up
- **Billing Modifiers:** GC

Attending Attestation:

- I personally coordinated care with: nurse; case manager; social worker.
- **Attending Attestation Statement:** I was present with the resident/fellow during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented by the resident. Any additions or revisions are included in the record.
- **Attestation Comments:** Patient disclosed sexual abuse for first time last night. +PTSD symptoms as described above. When she has flashbacks, she has urges for self-injurious behavior and suicidal ideation intermittently. She remains at high risk for self-harm and completed suicide outside of the hospital. Start Prazosin 1mg QHS to target nightmares associated with PTSD. CPS report filed by treatment team member.

Electronic Signatures:

NISENBAUM, DAVID (MD (R)) (Signed 03-27-2014 11:44)
Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan

TURAKHIA, ATUR V (MD (A)) (Signed 04-27-2014 19:11)
Authored: Subjective Findings, Billing Service Level, Attending Attestation, Note Finalization
Co-Signer: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan

Last Updated: 04-27-2014 19:11 by TURAKHIA, ATUR V (MD (A))

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: TURAKHIA, ATUR V

Gender: Female
DOB: [redacted]
Age: 17y

Admit Date: 03/18/2014 11:06
Discharge Date: 04/07/2014 13:27
Service: IP Mental Health Adolescent

Progress Note-Primary: Psychiatry

03/19/2014 10:37 NISENBAUM, DAVID (MD (R))

- **Evaluation Date and Time:** 03-19-2014 10:37

Role:
- **Role:** Primary Service

Hospital Days:
- **Hospital Days:** 2

Subjective Findings:
- **Active Problems:** Patient interviewed and discussed with treatment team. No acute events overnight. She slept 7.5 hours and consumed minimal amounts of meals approximately 5 percent. When resident entered her room she was sitting on the ground with her back against the wall with her knees tucked to her chest and her head resting against her knees. She had minimal contact and looked up at resident 2-3 times throughout interview, remaining selectively mute and smiling at the conclusion of interview. Per staff report she had been verbalizing thoughts of self harm but states she would inform staff if she was thinking of acting on this.

Medications:
- **Medications:** Scheduled Med(s):
  FLUoxetine Oral Soln 10 mg daily

  PRN Meds(s):
  acetaminophen Tablet 650 mg every 4 hours PRN
  alum hydrox/mag hyrox/simet II Oral Susp 15 mL every 4 hours PRN
  magnesium hydroxide Oral Susp 30 mL every 12 hours PRN

Objective Findings:

Vital Signs:
- **Vital Signs:** Weight (03/18/14) = 47.8 kg
  Temp (degrees C): 36.8 (36.8 - 37), HR (bpm): 92 (92 - 115), Respiration (breaths/min): 17 (17 - 18), SBP (mm Hg): 102 (102 - 117), DBP (mm Hg): 51 (51 - 74).

Psychiatric: MSE
Appearance: Caucasian thin female, avg height, appears their stated age, good grooming and hygiene, and is wearing clothing appropriate to weather and circumstance.
Behavior: Appears anxious, poor eye contact, +PMR, sitting on the ground against the wall with knees tucked to chest
Speech: Selectively mute
Mood: dysphoric
Affect: blunted, very guarded
Thought content: No evidence of RTIS, per staff she had verbalized thoughts of self harm
Thought processes: paucity of thought
Insight: poor
Judgment: poor

Diagnostic Data:
- **Lab Data:**

Chem [03-19-2014 06:35] CBC [03-19-2014 06:35]

Progress Note-Primary: Psychiatry

03/19/2014 10:37 NISENBAUM, DAVID (MD (R))

```
139     | 103     | 10      /
        |         |        /
------------------------------ 72        \  14.9  /
        |         |        \        4.8  ---------  239
3.8     | 27      | 0.7     \            /  43.7  \
```

Review of Medical Necessity:

- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.
- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

Assessment and Plan:

Global Assessment & Plan:

- Assessment and Plan: 19 yo F with depressive symptoms and anxiety that has resulted in decreased functioning over the past 3 weeks BIB mother after endorsing SI with plan to not eat so she'll pass out. She has had decreased PO intake, loss of appetite and emesis possibly due to recent exacerbation in anxiety and depression following stressful family encounter for the her brothers baptism and it is unlikely that patient has eating disorder. Although, this will require further assessment, she has had minimal consumption of meals on the unit. Patient has also had decreased communication with possible occasional selective mutism, per mother she has had frequent crying spells and has been unable to attend school recently. Patient is at increased risk of dangerousness to self and has had severe declines in functioning and requires inpatient hospitalization for medication initiation and stabilization.

  Patient states she will tell nursing staff if she is having thoughts of self harm and therefore does not require current 1:1 and we will continue to assess for this need

  Diagnosis
  Axis I: MDE vs adjustment disorder with depressed mood; social anxiety do; rule out autism spectrum
  Axis II: Deferred
  Axis III: No acute issues.
  Axis VI: Moderate- poor coping skills, poor social functioning
  Axis V: Global assessment of functioning on admission of 25

  Plan:
  1. Psychiatric Medication Management:
  -Continue Prozac PO liquid formulation 10mg PO QD
  -Obtain consent for Ativan 0.5mg PO TID before meals at 0700, 1030, 1630 with goals of controlling anxiety and improving appetite and compliance with meals
  2. Medical Issues: none acutely
  3. Continue individual, group, milieu, and allied services therapy
  4. Legal: vol by parent

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: TURAKHIA, ATUR V

Gender: Female
DOB: [redacted]
Age: 17y

Admit Date: 03/18/2014 11:06
Discharge Date: 04/07/2014 13:27
Service: IP Mental Health Adolescent

Progress Note-Primary: Psychiatry

03/19/2014 10:37 NISENBAUM, DAVID (MD (R))

Writer called Orange County CPS regarding mother of patient's report of potential physical abuse of patient's brother Adam in Las Vegas NV by family friend (Al), they stated that statute of limitation had passed as incident had occurred in 2007, therefore filed report with Clark County (las vegas) CPS Lorea Arostegui referral # 1600635
5_ Disposition: Appreciate CM assistance with placement following discharge

Above case was discussed with and supervised by attending psychiatrist Dr. Turakhia who agrees with above assessment and plan.

Billing Service Level:

- **Billing Service Level:** Level 2 - inpatient follow-up
- **Billing Modifiers:** GC

Attending Attestation:

- I personally coordinated care with: nurse; case manager; social worker.
- **Attending Attestation Statement:** I saw and examined the patient and discussed the case with the resident/fellow. I agree with the final findings and plan as documented in the record. We formulated the assessment and plan together. Any additions or revisions are included in the record.
- **Attestation Comments:** Patient continued initially with "I don' know" or "I'm not sure" answers. Intervention of providing simple questions with concrete answers such as basic arithmetic (i.e., 1 plus 2) to build confidence with decisiveness helped somewhat, though the patient acknowledged it was much harder verbally than writing the answer. Then had patient try answering questions with eyes closed. Patient had significant decrease in response latency, and even for some questions, displayed more decisiveness. She had some difficulty with indecision, but less often. She was able to smile some and actually quickly identified her current emotional state as "frustrated" due to the tasks being asked of her, though on clarification she reported frustration with the challenges, not the interviewer. Will continue to work to increase confidence and self-efficacy to decrease the significant functional impairment patient has been having. Tolerated Prozac solution. Will add Lorazepam wafers 0.5mg premeals to decrease anxiety then, which may be contributing to poor oral intake. Alternatives for future could include direct appetite stimulation with Mirtazapine or Olanzapine. Continues with thoughts of death and suicidal ideation. Needs inpatient psychiatric hospitalization for danger to self.

Electronic Signatures:

NISENBAUM, DAVID (MD (R)) (Signed 03-19-2014 14:10)
Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Diagnostic Data, Review of Medical Necessity, Assessment and Plan

TURAKHIA, ATUR V (MD (A)) (Signed 03-19-2014 16:06)
Authored: Billing Service Level, Attending Attestation, Note Finalization

Last Updated: 03-19-2014 16:06 by TURAKHIA, ATUR V (MD (A))

PL 000081

Progress Note-Primary: Psychiatry

03/20/2014 12:10 NISENBAUM, DAVID (MD (R))

- **Evaluation Date and Time:** 03-20-2014 12:10

Role:

- **Role:** Primary Service

Hospital Days:

- **Hospital Days:** 3

Subjective Findings:

- **Active Problems:** Patient interviewed and discussed with treatment team. No acute events overnight. She slept 7.5 hours and had minimal amount of meals, documented as 5 percent or less. Per nursing report she also had episode of emesis after drinking ensure shake this AM. When asked about the emesis, she stated that she didn't have an appetite and that it made her sad and stomach upset when she eats. She said she has felt this way for the past few days. Denied intentionally purging or concern about her weight. She was compliant with ativan and denied side effects including daytime sedation or dizziness. She says she is having thoughts of self harm without plan and this scares her.
  She had improvements in her willingness to converse as well as eye contact and discussed triggers for her anxiety that included performance in school, pressure to keep up academically with other students and speaking with strangers.
  Family meeting was held with mother, stepfather, and her father was on speaker phone from Las Vegas. Family agreed to treatment plan. Mother also indicated that Emily wants to stay in California to complete her school, and therefore this is restricting her and her brother Adam from going to Las Vegas later this year. This may be a source of guilt for Emily and may contribute to her current anxiety and depression as these discussions have taken place over the past 2 months. When patient was asked about her brother, she started to cry and hid her head in her mother's lap.

Medications:

- **Medications:** Scheduled Med(s):
  FLUoxetine Oral Soln 10 mg daily
  LORazepam Tablet 0.75 mg <User Schedule>
  multivitamin peds chewable Tablet 1 tablet(s) daily

  PRN Meds(s):
  acetaminophen Tablet 650 mg every 4 hours PRN
  alum hydrox/mag hyrox/simet II Oral Susp 15 mL every 4 hours PRN
  magnesium hydroxide Oral Susp 30 mL every 12 hours PRN

Objective Findings:

Vital Signs:

- **Vital Signs:** Weight (03/18/14) = 47.6 kg
  Temp (degrees C): 36.3 (36.3 - 36.8), HR (bpm): 71 (71 - 71), Respiration (breaths/min): 16 (16 - 17),

Psychiatric: MSE

Appearance: Caucasian thin female, avg height, appears their stated age, good grooming and hygiene, and is wearing clothing appropriate to weather and circumstance.
Behavior: Appears anxious, marginal eye contact, +PMR, sitting upright in chair
Speech: Selectively mute at times, when she did speak hypoverbal with decreased volume, pleasant

Progress Note-Primary: Psychiatry

03/20/2014 12:10 NISENBAUM, DAVID (MD (R))

tone
Mood: "nervous"
Affect: blunted
Thought content: +SI, denies HI, AH, VH
Thought processes: grossly linear, although paucity of thought
Insight: poor
Judgment: poor

Diagnostic Data:

- **Lab Data:**

Chem [03-19-2014 06:35]

```
139     |  103    |  10      /
        |         |        /              \   14.9   /
-----------------------------  72      4.8  ---------  239
        |         |        \              /   43.7   \
3.8     |  27     |  0.7     \
```

CBC [03-19-2014 06:35]

Review of Medical Necessity:

- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.
- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

Assessment and Plan:

Global Assessment & Plan:

- **Assessment and Plan:** 19 yo F with depressive symptoms and anxiety that has resulted in decreased functioning over the past 3 weeks BIB mother after endorsing SI with plan to not eat so she'll pass out. She has had decreased PO intake, loss of appetite and emesis possibly due to recent exacerbation in anxiety and depression likely related to unresolved emotional conflict involving her brother. Although, this will require further assessment. She has had minimal consumption of meals on the unit and observed episode of emesis likely due to anxiety and not meeting current criteria for eating disorder. Patient has also had decreased communication with possible occasional selective mutism, per mother she has had frequent crying spells and has been unable to attend school recently. She continues to endorse SI and patient is at increased risk of dangerousness to self and has had severe declines in functioning and requires inpatient hospitalization for medication initiation and stabilization.

  Patient states she will tell nursing staff if she is having thoughts of self harm and therefore does not require current 1:1 and we will continue to assess for this need

  Diagnosis
  Axis I: MDE vs adjustment disorder with depressed mood; social anxiety do; rule out autism spectrum
  Axis II: Deferred
  Axis III: No acute issues.
  Axis VI: Moderate- poor coping skills, poor social functioning

Progress Note-Primary: Psychiatry

03/20/2014 12:10 NISENBAUM, DAVID (MD (R))

Axis V: Global assessment of functioning on admission of 25

Plan:
1. Psychiatric Medication Management:
-Continue Prozac PO liquid formulation 10mg PO QD
-Increase Ativan to 0.75mg PO TID before meals at 0700, 1030, 1630 with goals of controlling anxiety and improving appetite and compliance with meals
-Will consider mirtazapine for benefit of improving depressive sxs and increasing appetite
-Both mother and father of patient have been consented and understand risks, benefits, and alternatives to treatment with above medications and are in agreement with treatment plan
-Appreciate Dietican recs, will continue MVI, check daily weights, and encourage Ensure Plus TID if there is minimal consumption of meals
2. Medical Issues: none acutely
3. Continue individual, group, milieu, and allied services therapy
4. Legal: vol by parent
Writer called Orange County CPS regarding mother of patient's report of potential physical abuse of patient's brother Adam in Las Vegas NV by family friend (Al), they stated that statute of limitation had passed as incident had occurred in 2007, therefore filed report with Clark County (las vegas) CPS Lorea Arostegui referral # 1600635
5. Disposition: Appreciate CM assistance with placement following discharge

Above case was discussed with and supervised by attending psychiatrist Dr. Turakhia who agrees with above assessment and plan.

Billing Service Level:

- **Billing Service Level:** Level 2 - inpatient follow-up
- **Billing Modifiers:** GC

Attending Attestation:

- I personally coordinated care with: nurse; case manager; social worker.
- **Attending Attestation Statement:** I saw and examined the patient and discussed the case with the resident/fellow. I agree with the final findings and plan as documented in the record. We formulated the assessment and plan together. Any additions or revisions are included in the record.
- **Attestation Comments:** Patient continues with significant guilt and depressive symptoms. Has suicidal ideation still. Contracts for safety in hospital. Poor oral intake even with Lorazepam 0.5mg premeal. Had one episode of emesis after Ensure supplementation. Will increase pre-meal Lorazepam to 0.75mg and monitor for benefit as well as emesis post-meals. Will consider Mirtazapine for appetite augmentation if continues to have inadequate oral intake.

Electronic Signatures:

NISENBAUM, DAVID (MD (R)) (Signed 03-20-2014 12:31)
Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Diagnostic Data, Review of Medical Necessity, Assessment and Plan

TURAKHIA, ATUR V (MD (A)) (Signed 03-20-2014 14:52)
Authored: Billing Service Level, Attending Attestation, Note Finalization

PL 000084

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: TURAKHIA, ATUR V

Gender: Female
DOB: [redacted]
Age: 17y

Admit Date: 03/18/2014 11:06
Discharge Date: 04/07/2014 13:27
Service: IP Mental Health Adolescent

Progress Note-Primary: Psychiatry

03/20/2014 12:10 NISENBAUM, DAVID (MD (R))

Co-Signer: Evaluation Data/Time, Subjective Findings, Medications, Objective Findings, Diagnostic Data, Review of Medical Necessity, Assessment and Plan

Last Updated: 03-20-2014 14:52 by TURAKHIA, ATUR V (MD (A))

PL 000085

Progress Note-Primary: Psychiatry

03/21/2014 15:02 NISENBAUM, DAVID (MD (R))

- **Evaluation Date and Time:** 03-21-2014 15:02

Role:
- **Role:** Primary Service

Hospital Days:
- **Hospital Days:** 4

Subjective Findings:
- **Active Problems:** Patient interviewed and discussed with treatment team. No acute events overnight. She slept 6.5 hours and had 2 episodes of emesis this AM after eating her breakfast and ensure shake. She says that eating makes her sad as she has decreased appetite and continues to deny intentionally vomiting or attempting to lose weight. Later in the afternoon, patient was observed to eat a majority of her meal without emesis. Patient continues to express thoughts of wanting to be dead as well as SI and that she is scared of these thoughts. She also states that last night she heard a voice for a brief period of time that may be consistent with AH. She was unable to make out what the voice said, and denies that it has occurred more than once.

Medications:
- **Medications:** Scheduled Med(s):
  FLUoxetine Oral Soln 20 mg daily
  LORazepam Tablet 0.75 mg <User Schedule>
  multivitamin peds chewable Tablet 1 tablet(s) daily
  OLANZapine Tablet 2.5 mg nightly at bedtime

  PRN Meds(s):
  acetaminophen Tablet 650 mg every 4 hours PRN
  alum hydrox/mag hyrox/simet II Oral Susp 15 mL every 4 hours PRN
  magnesium hydroxide Oral Susp 30 mL every 12 hours PRN

Objective Findings:

Vital Signs:
- **Vital Signs:** Weight (03/21/14) = 47.3 kg
  Temp (degrees C): 36.2 (36.2 - 36.8), HR (bpm): 96 (68 - 96), Respiration (breaths/min): 14 (14 - 17), SBP (mm Hg): 109 (109 - 109), DBP (mm Hg): 70 (70 - 70),

Psychiatric: MSE
Appearance: Caucasian thin female, avg height, appears their stated age, good grooming and hygiene, and is wearing clothing appropriate to weather and circumstance.
Behavior: Marginal eye contact, +PMR, sitting on the ground with her back against the wall
Speech: Selectively mute at times, when she did speak hypoverbal with decreased volume, pleasant tone
Mood: "scared"
Affect: blunted, guarded with her hair covering her face
Thought content: +SI, denies current HI, AH, VH
Thought processes: grossly linear, although paucity of thought
Insight: poor
Judgment: poor

Progress Note-Primary: Psychiatry

03/21/2014 15:02 NISENBAUM, DAVID (MD (R))

Diagnostic Data:

- **Lab Data:**

Review of Medical Necessity:

- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.
- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

Assessment and Plan:
Global Assessment & Plan:

- **Assessment and Plan:** 19 yo F with depressive symptoms and anxiety that has resulted in decreased functioning over the past 3 weeks BIB mother after endorsing SI with plan to not eat so she'll pass out. She has had decreased PO intake, loss of appetite and emesis possibly due to recent exacerbation in anxiety and depression likely related to unresolved emotional conflict involving her brother. Although, this will require further assessment. She has had minimal consumption of meals on the unit and observed episode of emesis likely due to anxiety and not meeting current criteria for eating disorder. Patient reports one episode of hearing a voice possibly consistent with non command type AH. Patient has also had decreased communication with possible occasional selective mutism, per mother she has had frequent crying spells and has been unable to attend school recently. She continues to endorse SI and patient is at increased risk of dangerousness to self and has had severe declines in functioning and requires inpatient hospitalization for medication initiation and stabilization.

  Patient states she will tell nursing staff if she is having thoughts of self harm and therefore does not require current 1:1 and we will continue to assess for this need

  Diagnosis
  Axis I: MDE, consider MDE with psychotic features; social anxiety do; rule out autism spectrum
  Axis II: Deferred
  Axis III: No acute issues.
  Axis VI: Moderate- poor coping skills, poor social functioning
  Axis V: Global assessment of functioning on admission of 25

  Plan:
  1. Psychiatric Medication Management:
  -Increase Prozac PO liquid formulation to 20mg PO QD
  -Continue Ativan to 0.75mg PO TID before meals at 0700, 1030, 1630 with goals of controlling anxiety and improving appetite and compliance with meals
  -Start Zyprexa 2.5mg PO qhs as patient had endorsed AH and goal of stimulating appetite
  -Both mother and father of patient have been consented and understand risks, benefits, and alternatives to treatment with above medications and are in agreement with treatment plan
  -Appreciate Dietican recs, will continue MVI, check daily weights, and encourage Ensure Plus TID if there is minimal consumption of meals
  2. Medical Issues: none acutely
  3. Continue individual, group, milieu, and allied services therapy

Progress Note-Primary: Psychiatry

03/21/2014 15:02 NISENBAUM, DAVID (MD (R))

4. Legal: vol by parent
Writer called Orange County CPS regarding mother of patient's report of potential physical abuse of patient's brother Adam in Las Vegas NV by family friend (Al), they stated that statute of limitation had passed as incident had occurred in 2007, therefore filed report with Clark County (las vegas) CPS Lorea Arostegui referral # 1600635
5.. Disposition: Appreciate CM assistance with placement following discharge

Above case was discussed with and supervised by attending psychiatrist Dr. Turakhia who agrees with above assessment and plan.

Billing Service Level:

- **Billing Service Level:** Level 2 - inpatient follow-up
- **Billing Modifiers:** GC

Attending Attestation:

- I personally coordinated care with: nurse; case manager; social worker.
- **Attending Attestation Statement:** I was present with the resident/fellow during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented by the resident. Any additions or revisions are included in the record.
- **Attestation Comments:** Poor appetite still. Emesis without nausea after eating. Still suicidal ideation. Increase Fluoxetine 20mg and add Olanzapine 2.5mg for psychosis and secondary benefit of appetite stimulation.

Electronic Signatures:

NISENBAUM, DAVID (MD (R)) (Signed 03-21-2014 15:12)
Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Diagnostic Data, Review of Medical Necessity, Assessment and Plan

TURAKHIA, ATUR V (MD (A)) (Signed 03-23-2014 19:07)
Authored: Billing Service Level, Attending Attestation, Note Finalization
Co-Signer: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Diagnostic Data, Review of Medical Necessity, Assessment and Plan

Last Updated: 03-23-2014 19:07 by TURAKHIA, ATUR V (MD (A))

REED, EMILY
MR#: [redacted] **Gender:** Female **Admit Date:** 03/18/2014 11:06
Visit#: **DOB:** [redacted] **Discharge Date:** 04/07/2014 13:27
DR: TURAKHIA, ATUR V **Age:** 17y **Service:** IP Mental Health Adolescent

Progress Note-Primary: Psychiatry

03/22/2014 15:23 PREDA, ADRIAN (MD (A))

- **Evaluation Date and Time:** 03-22-2014 15:23

Role:
- **Role:** Primary Service

Hospital Days:
- **Hospital Days:** 5

Subjective Findings:
- **Active Problems:**

I personally examined the patient, reviewed the chart, discussed the case with the treatment team.

Patient continues to report feeling depressed and anxious with persistent thoughts of self-harm and passive SI but no active plan/intent in hospital setting. Remains with poor overall po intake.

Last 24 hrs:
-acute events or behavioral problems: no
-report of SI: no
-report of HI: no
-report of AVH: no
-report of PI: yes, contracts for safety

Medication compliance: yes
Medication adverse effects: no

Visible in the milieu: yes
Groups
- attendance: yes
- participation: yes
Socialization with peers: yes

ROS: Naused post po intake. Denies pain, fever, chills, nausea, vomiting, diarrhea, constipation, headache, chest pain, or shortness of breath; remainder of the review of systems is negative.

Medications:
- **Medications:** Scheduled Med(s):
  FLUoxetine Oral Soln 20 mg daily
  LORazepam Tablet 0.75 mg <User Schedule>
  multivitamin peds chewable Tablet 1 tablet(s) daily
  OLANZapine Tablet 2.5 mg nightly at bedtime

Objective Findings:
Vital Signs:
- **Vital Signs:** Weight (03/22/14) = 47 kg
  Temp (degrees C): 36.8 (36.8 - 36.8), Respiration (breaths/min): 16 (16 - 16),

Psychiatric:
Appearance: good grooming and hygiene

Progress Note-Primary: Psychiatry

03/22/2014 15:23 PREDA, ADRIAN (MD (A))

Behavior: poor eye contact, NAD
Speech: hypoverbal with decreased volume
Mood: "anxious"
Affect: restricted and guarded
Thought content: +SI, denies current HI, AH, VH
Thought processes: linear, although paucity of thought
Insight: poor
Judgment: poor

Review of Medical Necessity:

- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.
- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

Assessment and Plan:
Global Assessment & Plan:

- **Assessment and Plan:**
  A: MDD, Social anxiety disorder, Eating D/O. Poor PO intake

  Plan:
  1. Psychiatric Medication Management:
  -Prozac PO liquid formulation 20mg PO QD
  -Continue Ativan to 0.75mg PO TID before meals at 0700, 1030, 1630 with goals of controlling anxiety and improving appetite and compliance with meals
  -Zyprexa 2.5mg PO qhs as patient had endorsed AH in the past and with goal of stimulating appetite
  2. Medical Issues: Poor PO intake: continue MVI, check daily weights, and encourage Ensure Plus TID if there is minimal consumption of meals
  3. Continue individual, group, milieu, and allied services therapy
  4. Legal: vol by parent
  5. Disposition: pending stabilization

Billing Service Level:

- **Billing Service Level:** Level 2 - inpatient follow-up

Attending Attestation:

- I personally coordinated care with: nurse.

Electronic Signatures:
PREDA, ADRIAN (MD (A)) (Signed 03-22-2014 15:31)
Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan, Billing Service Level, Attending Attestation

Last Updated: 03-22-2014 15:31 by PREDA, ADRIAN (MD (A))

Progress Note-Primary: Psychiatry

03/23/2014 12:24 PREDA, ADRIAN (MD (A))

- Evaluation Date and Time: 03-23-2014 12:25

Role:
- Role: Primary Service

Hospital Days:
- Hospital Days: 6

Subjective Findings:
- Active Problems:

I personally examined the patient, reviewed the chart, discussed the case with the treatment team.

Patient continues to report feeling depressed, anxious, with ambivalence about day to day decisions (i.e. what to eat or wear). +thoughts of self-harm (scratching and bitting self) and passive SI but no active plan/intent in hospital setting. Remains with poor overall po intake.

Last 24 hrs:
-acute events or behavioral problems: no
-report of SI: no
-report of HI: no
-report of AVH: no
-report of PI: yes, contracts for safety

Medication compliance: yes
Medication adverse effects: no

Visible in the milieu: yes
Groups
- attendance: yes
- participation: yes
Socialization with peers: yes

ROS: Nausea post po intake. Denies pain, fever, chills, nausea, vomiting, diarrhea, constipation, headache, chest pain, or shortness of breath; remainder of the review of systems is negative.

Medications:
- Medications: Scheduled Med(s):
  FLUoxetine Oral Soln 20 mg daily
  LORazepam Tablet 0.75 mg <User Schedule>
  multivitamin peds chewable Tablet 1 tablet(s) daily
  OLANZapine Tablet 2.5 mg nightly at bedtime

Objective Findings:
Vital Signs:
- Vital Signs: Weight (03/23/14) = 47.5 kg
  Temp (degrees C): 36.5 (36.5 - 36.5), HR (bpm): 81 (81 - 81), Respiration (breaths/min): 16 (15 - 16),

PL 000091

Progress Note-Primary: Psychiatry

03/23/2014 12:24 PREDA, ADRIAN (MD (A))

Psychiatric: .

Appearance: good grooming and hygiene
Behavior: poor eye contact, NAD
Speech: hypoverbal, + some spontaneous speech when discussing topics of interest
Mood: "anxious"
Affect: restricted and guarded
Thought content: +SI, denies current HI, AH, VH
Thought processes: linear, although paucity of thought
Insight: poor
Judgment: poor

Review of Medical Necessity:

- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.
- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

Assessment and Plan:

Global Assessment & Plan:

- **Assessment and Plan: .**

A: MDD, Social anxiety disorder. Eating D/O. Poor PO intake. Cluster C traits (OCPD, perfectionistic)

Plan:
1. Psychiatric Medication Management:
-Prozac PO liquid formulation 20mg PO QD
-For now continue Ativan to 0.75mg PO TID before meals at 0700, 1030, 1630 with goals of controlling anxiety and improving appetite and compliance with meals
-Start clonazepam 0.25 mg bid - with plan to tranzition lorazepam to clonazepam
-Zyprexa 2.5mg PO qhs as patient had endorsed AH in the past and with goal of stimulating appetite
2. Medical Issues: Poor PO intake: continue MVI, check daily weights, and encourage Ensure Plus TID if there is minimal consumption of meals
3. Continue individual, group, milieu, and allied services therapy
4. Legal: vol by parent
5. Disposition: pending stabilization

Billing Service Level:

- **Billing Service Level:** Level 2 - inpatient follow-up

Attending Attestation:

- I personally coordinated care with: nurse.

Electronic Signatures:

PREDA, ADRIAN (MD (A)) (Signed 03-23-2014 12:30)
Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan, Billing Service Level, Attending Attestation

Last Updated: 03-23-2014 12:30 by PREDA, ADRIAN (MD (A))

PL 000092

Progress Note-Primary: Psychiatry

03/24/2014 10:45 NISENBAUM, DAVID (MD (R))

- **Evaluation Date and Time:** 03-24-2014 10:45

Role:

- **Role:** Primary Service

Hospital Days:

- **Hospital Days:** 7

Subjective Findings:

- **Active Problems:** Patient interviewed and discussed with treatment team. She has had improved PO intake, however still decreased from baseline approximately 50 percent of meals. Patient weight has been stable during hospitalization currently 47.5 kg. She slept 7 hours and denied side effects of daytime sedation or dizziness. Per staff report patient was visited by her father over the weekend and had appropriate interaction and was observed smiling. She denies further AH other than one episode early in hospital course. Patient continues to endorse SI without plan, and when asked about why she was feeling this way she stated "I don't know". Over the weekend patient had episode of biting her arm, without causing laceration or bleeding, patient denied further self harm behavior and repeated she did not know why she did this but stated she was feeling anxious at that time.
  Following interview this AM, staff observed Emily laying on the ground and kicking her feet, when asked about her actions she stated "I don't want to grow up".

Medications:

- **Medications:** Scheduled Med(s):
  clonazePAM Tablet 0.25 mg null
  [Start:03/24/14] clonazePAM Tablet 0.5 mg 2 times a day
  FLUoxetine Oral Soln 30 mg daily
  multivitamin peds chewable Tablet 1 tablet(s) daily
  OLANZapine Tablet 2.5 mg nightly at bedtime

Objective Findings:

Vital Signs:

- **Vital Signs:** Weight (03/24/14) = 47.5 kg
  Temp (degrees C): 36.3 (36.3 - 36.8), Respiration (breaths/min): 16 (16 - 16),

Psychiatric MSE

Appearance: Caucasian thin female, avg height, appears their stated age, good grooming and hygiene, and is wearing clothing appropriate to weather and circumstance.
Behavior: Cooperative with interview, No PMR or PMA, sitting upright in chair in the general milieu
Speech: Hypoverbal with decreased volume, soft tone, decreased volume
Mood: "I don't know"
Affect: blunted, guarded
Thought content: +SI, denies current HI, AH, VH
Thought processes: grossly linear, although paucity of thought
Insight: poor
Judgment: poor

Review of Medical Necessity:

- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.

Progress Note-Primary: Psychiatry

03/24/2014 10:45 NISENBAUM, DAVID (MD (R))

- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

Assessment and Plan:
Global Assessment & Plan:

- **Assessment and Plan:** 19 yo F with depressive symptoms and anxiety that has resulted in decreased functioning over the past 3 weeks BIB mother after endorsing SI with plan to not eat so she'll pass out. She has had decreased PO intake, loss of appetite and emesis possibly due to recent exacerbation in anxiety and depression likely related to unresolved emotional conflict involving her brother. Although, this will require further assessment. She has had minimal consumption of meals on the unit and observed episode of emesis likely due to anxiety and not meeting current criteria for eating disorder. Patient reports one episode of hearing a voice possibly consistent with non command type AH. Patient has also had decreased communication with possible occasional selective mutism, per mother she has had frequent crying spells and has been unable to attend school recently. She continues to endorse SI and patient is at increased risk of dangerousness to self and has had severe declines in functioning and requires inpatient hospitalization for medication initiation and stabilization.

  Patient states she will tell nursing staff if she is having thoughts of self harm and therefore does not require current 1:1 and we will continue to assess for this need

  Diagnosis
  Axis I: MDE, consider MDE with psychotic features; social anxiety do; rule out autism spectrum
  Axis II: Deferred
  Axis III: No acute issues.
  Axis VI: Moderate- poor coping skills, poor social functioning
  Axis V: Global assessment of functioning on admission of 25

  Plan:
  1. Psychiatric Medication Management:
  -Increase Prozac PO liquid formulation to 30mg PO QD
  -Increase Klonopin to 0.5mg PO BID with goals of controlling anxiety and compliance with meals
  -Continue Zyprexa 2.5mg PO qhs as patient had endorsed AH and goal of stimulating appetite
  -Both mother and father of patient have been consented and understand risks, benefits, and alternatives to treatment with above medications and are in agreement with treatment plan
  -Appreciate Dietican recs, will continue MVI, check daily weights, and encourage Ensure Plus TID if there is minimal consumption of meals
  Weight has been stable during hospital course
  2. Medical Issues: none acutely
  3. Continue individual, group, milieu, and allied services therapy
  4. Legal: vol by parent
  Writer called Orange County CPS regarding mother of patient's report of potential physical abuse of patient's brother Adam in Las Vegas NV by family friend (AI), they stated that statute of limitation had passed as incident had occurred in 2007, therefore filed report with Clark County (las vegas) CPS Lorea Arostegui referral # 1600635
  5. Disposition: Appreciate CM assistance with placement following discharge

Progress Note-Primary: Psychiatry

03/24/2014 10:45 NISENBAUM, DAVID (MD (R))

Above case was discussed with and supervised by attending psychiatrist Dr. Turakhia who agrees with above assessment and plan.

Billing Service Level:

- **Billing Service Level:** Level 2 - inpatient follow-up
- **Billing Modifiers:** GC

Attending Attestation:

- I personally coordinated care with: nurse; case manager; social worker.
- **Attending Attestation Statement:** I saw and examined the patient and discussed the case with the resident/fellow. I agree with the final findings and plan as documented in the record. We formulated the assessment and plan together. Any additions or revisions are included in the record.
- **Attestation Comments:** Had self-injurious behavior. Still with suicidal ideation. Eating better (though not close to 100% yet) with Olanzapine. Increased anxiety since switch from Lorazepam to Clonazepam. Will increase Clonazepam to 0.5mg BID. Increase Fluoxetine to 30mg to target depression and anxiety. Needs inpatient psychiatric hospitalization for danger to self.

Electronic Signatures:

NISENBAUM, DAVID (MD (R)) (Signed 03-24-2014 12:38)
Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan

TURAKHIA, ATUR V (MD (A)) (Signed 03-24-2014 18:13)
Authored: Billing Service Level, Attending Attestation, Note Finalization
Co-Signer: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan

Last Updated: 03-24-2014 18:13 by TURAKHIA, ATUR V (MD (A))

University of California - Irvine Healthcare

REED, EMILY
MR#: [redacted]
Visit#:
DR: BOTA, ROBERT

Gender: Female
DOB: [redacted]
Age: 18y

Admit Date: 04/18/2015 12:31
Discharge Date: 04/20/2015 16:13
Service: IP Mental Health Adult Med

Discharge Note.

04/20/2015 13:47 CHOI, BRIAN (MD (R))

Admission/Discharge Dates:
- **Admission Date** 04-18-2015
- **Discharge Date:** 04-20-2015

Discharge Attending:

Provider Role	Provider Name	Occupation	Specialty
Attending	BOTA, ROBERT	MD (A)	Psychiatry

HPI/Hospital Course:
- **Brief HPI/Hospital Course by Diagnosis:** Ms Reed is an 18 year old female with a history of PTSD, Depression w/psychotic features who was BIBA today after she became agitated at school and was rolling around on the asphalt at her high school (Marina HS).

School psychologist said that she was shaking in the bus on the way to school. She told her school counselor, 'it is loud in my head, I don't want to go back, I don't understand, I don't want to go to the hospital.' Then she took off running in the parking lot at the school then dropped down in the middle of the street rolling around on the ground in the fetal position for 35 minutes. Per psychologist report, She continued to scream in the middle of the street for the entire 35 minutes she was rolling around on the ground. The school counselor was concerned she was going to hurt herself.

Parametrics transported the patient to UCIMC.
She was given IM Versed 5mg during transport. On arrival to UCIMC she required restraints and IM Haldol and Benadryl for agitation. She was placed on 5150 for DTS 4/16/15 @ 1400.

Patient is asleep at time of interview with restraints removed.

The following information was provided by pts mother and step father who were bedside:
She went back to school after changing pathway program IEP on Monday. She has 2 classes to graduate. Over spring break she was functioning fine and had no escalation. School triggers her to feel more anxiety but she wanted to try. She would call and check in with mother and her anxiety was 7-8/10. She also told mother it was because this class was smaller 3-4 kids and so she feels everyone is watching her. She met with new therapist this week Therapist Elisse Collier (562-335-9552); seen her twice last Mon and Wed before but she isn't opening up to therapist. Her psychiatrist is also new and mother could not provide name of that person. They have seen her new psychiatrist once. Mother said since starting back Monday, she was anxious everyday after school. Monday was difficult for her and she talked to psychologist outside the classroom for most of the 2 hour session. Yesterday she did well (per step father.) Today she ran into parking lot and the parents don't know the details. They called paramedics to come and she was given Ativan IM (versed per EMS) at the scene. Recently she has been doing trauma processing work and has been dissociating. Her therapist is using a rock to help her stay in the moment. She talked to mother earlier and repeated the affirmations, "I'm loved" and "I can get through it" She told mother she had suicidal ideation with plan but wouldn't act on it. Per mother: "She doesn't want to die". Mother and daughter have safety contract and she also has one with the counselor and psychiatrist. When asked about AH, mother said "She said her 'head was really loud' but she wasn't able to explain it". She puts in earplugs because the outside voices are loud (she currently has earplugs in and is holding rock in plastic bag). She told mother there were two voices and she said 'I knew it' ..repeating that sentence numerous times.

Discharge Note.

04/20/2015 13:47 CHOI, BRIAN (MD (R))

Another significant stressor is the upcoming case against the man who is accused of sexually abused her. She is scheduled to testify in court which includes see the alleged man again. Per the patients mother - The man's mother lives 20 minutes from them and the man has made threats against the family and has shown them a gun. The patient mother reports that the police are unable to file a restraining order against the alleged perpetrator. She said "she won't feel safe until he is prison and he won't go to prison until she testifies.

Until then, he is on home arrest.

Her last hospitalization was DelAmo hospital (Feb/March 2015) where she was admitted on a 5150 for suicidal ideation. It is believed that attempting to return to school was the inciting stressor. She was there for almost a month and was discharged 3 weeks ago. Since that time, she has seemed to do well but was complaining to mother she didn't like the Abilify because it was making her have tremors and she was agitated and didn't feel safe driving the car so that was recently stopped. She is currently on Prozac 40mg but mother isn't sure about other medications or even name of new psychiatrist. Her first hospitalization was at UCI in 3/2014 when she first told staff about her sexual abuse at the hands of a friend of her father's and was beginning to talk about the events. She was given dx of PTSD, MDD and SAD and started on Prozac 40mg daily, Clonazepam 1.5mg po BID, Prazosin 2mg po nightly, Melatonin 3mg po nightly and Lorazepam 1mg po q6H prn anxiety.

Mother said that she took those medication for 3 months then stopped them all complains of various side effects of which the step father seems unconvinced were real. She was also going to Center for Discovery for 4 weeks after getting out of UCI but mother said she was on so much medication she was falling down. She saw a new psychiatrist who stopped the Abilify recently. Mother thinks that her attempting to go back to school has been trigger for last two admission. She has been working with a therapist and mother said she is beginning to open up but it has also caused some flashbacks and panic attacks making her want to kill herself. Mother said "she is still holding a lot of anxiety". Of note: Mother was clearly anxious and speaking quickly during interview.

Robin Moses Case mgr 714-373-0517
Brain optimization assessment Mon Rick Tomey- Per collateral it showed that she is always in a state of trauma and unable to talk about her feelings.

Psychiatric ROS -
Depression ROS not completed at this time due to patient sedation
SUICIDE: suicidal ideation with plan (per mothers report)
HOMICIDE: no per mother

Mania: unknown at this time
HALLUCINATIONS: Told mother she had AH
ANXIETY: mother reports that patient gets agitated, heart papillations and very scared
PTSD: per mother: positive for Flashbacks, Hypervigilance and nightmares from sexual abuse.
Eating Disorders: no know hx, no parental observation consistant with ED behaviors

Access to firearms? no

Discharge Note.

04/20/2015 13:47 CHOI, BRIAN (MD (R))

Ms Reed reports feeling "ok". She denies current suicidal ideation, homicidal ideation, paranoid ideation, and visual hallucinations. She reports auditory hallucinations last night. Patient reporting to notify staff if they have any thoughts of self-harm or suicide.

Collateral: Alicia Draper (714 916 1524)- mother;

PAST PSYCHIATRIC HISTORY:
-Diagnoses: PTSD, MDD w/psychotic features,
-Prior hospitalizations: # 2
-First hospitalization: UCI 4/2014 x 1 mo; Del Amo 5150 DTS 3/2015 x 1 mo
-Last hospitalization: 3 weeks ago Del Amo
-Suicide attempts: no
-Psych MD: Dr. Shah 714-841-6227; Therapist Elisse Collier (562-335-9552);
-Self Harm behaviors: no

MEDICATION HISTORY:

CURRENT: Prozac 40mg daily

PAST med trials: Abilify- akathisia,
Clonazepam 1.5mg po BID, (d/c'd)
Prazosin 2mg po nightly, (d/c'd)
Melatonin 3mg po nightly (d/c'd)
Lorazepam 1mg po q6H prn anxiety. (d/c'd)

PAST MEDICAL/SURGICAL HISTORY:
none

LMP: unknown

Family: 13 yo brother with MDD, unknown medication hx
Substance abuse hx: Denies use of etoh, illicit, or tobacco

Social:
Developmental: Patient met all developmental milestones as expected. She has always had A's in school, although mother reports that she tested at 1st grade reading level while in 4th grade. She had failed multiple hearing tests but her repeat tests were inconsistent indicating possible malingering and her brainstem testing in 2013 demonstrated no hearing loss.
She grew up in Las Vegas and moved to Huntington Beach with her mother 3 years previously. She lives with her mother, and 2 brothers age 13,15. Mother has remarried although (Jeff) new husband lives in Brea do to work. Parents divorced in 2006 and parents have joint legal custody and mother Alicia Draper (714 916 1524) has majority physical custody. Emily and her 2 brothers go to Vegas to stay with their father (Jeff) 702 241 2486, every other weekend and 7 weeks in the summer. Patient has an IEP through school started in 5th grade. Recently went back to school for a few hours a day to get 2 courses done to get GED.
Per mother sexual abuse at hands of friend of fathers and is going to have to testify soon.

Discharge Note

04/20/2015 13:47 CHOI, BRIAN (MD (R))

Cognitive Exam
Alert and oriented x 4
Memory: Intact, as tested by recalling 3/3 objects after 5 min.
Attention: Intact, as tested by asking pt to spell "WORLD" backwards.
Concentration: Intact, as tested by asking patient to perform serial 7's.
Fund of knowledge: Intact, as tested by asking patient to name the current president.
Ability to name common objects: Intact

Appearance: patient appears stated age; appropriate grooming and hygiene; street clothing sitting up in her bed
Behavior: cooperative; poor eye contact; no PMR/ no PMA noted
Speech: average rate, monotone tone; decreased spontaneous speech, increased latency
Mood: "ok"
Affect: Congruent, restricted
Thought Process: linear with associations
Thought Content: denies SI, states with notify staff of thoughts of suicide or self harm. Denies HI. Reports auditory hallucinations last night, denying VH, and PI
Insight: poor
Judgment: poor"

Interval History: On 4/17 patient was transferred to medicine after a rapid response was called for dystonic like reaction. It is believed that this was related to the haldol injection that she received the day prior when she was agitated in the emergency department. Patient was transferred to medicine and stabilized with IV fluid hydration and 25mg benadryl q8H. Lab work significant for elevated CK which trended down prior to transfer back to psychiatry. Upon readmission to 2s, patient was observed to be back to baseline, was able to state that she felt safe on the unit and willing to restart her previous medications. She stated that she would be able to alert staff members if she did not feel safe.

Hospital Course: Patient transferred back to 2S after she was stabilized medically following her dystonic reaction. As haldol was the only new medication that patient had received after coming to the hospital, it was assumed that this was a reaction to this medication. She was found to have elevated CK while on the medical service which down trended appropriately with IV fluids and a normal EEG. Her reaction was treated with benadryl which was continued after she was transferred back to psychiatry service. She was continued on her antidepressant and observed for adverse reactions. Ativan 1mg Q6H prn was added for anxiety as patient stated another patient had reminded her of a man that had sexually abused her in the past. This caused her significant anxiety but she was able to avoid the other patient and staff was able to help patient feel safe. Patient was visited by her mom and she was able to state that she wanted the patient to be discharged so that she could be taken to her assessment appointment at the center for discovery. She felt safe taking the patient home and there were plans for the patient's grandmother to move in with the family and help watch over and take care of the patient. She denied SI/HI/AVH/PD at time of discharge and was provided with prescriptions for her medications. She was discharged to the care of her mother in stable condition.

Discharge Diagnosis:
Axis I: PTSD, Major Depressive Disorder, Social Anxiety Disorder.
Axis II: Deferred
Axis III: No acute issues.

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: BOTA, ROBERT

Gender: Female
DOB: [redacted]
Age: 18y

Admit Date: 04/18/2015 12:31
Discharge Date: 04/20/2015 16:13
Service: IP Mental Health Adult Med

Discharge Note.

04/20/2015 13:47 CHOI, BRIAN (MD (R))

Axis VI: Moderate - poor coping skills, poor social and occupational functioning
Axis V: Global assessment of functioning on discharge of 45

Discharge Psychiatric Medications:
- Fluoxetine 40mg daily
- Lorazepam 1mg Q6H PRN anxiety, agitation

Physical Exam on Day of Discharge:

- Vital Signs: Temp (degrees C): 37 (36.7 - 37), HR (bpm): 79 (79 - 99), Respiration (breaths/min): 18 (18 - 18), SBP (mm Hg): 100 (100 - 100), DBP (mm Hg): 61 (61 - 61), SpO2 (%): 100 (99 - 100),

- Exam: .

Appearance: patient appears stated age; appropriate grooming and hygiene; street clothing sitting up in her bed
Behavior: cooperative; intermittent eye contact; no PMR/ no PMA noted
Speech: average rate, monotone tone; decreased spontaneous speech, increased latency
Mood: "ok"
Affect: Congruent, restricted
Thought Process: linear with associations
Thought Content: denies SI, states with notify staff of thoughts of suicide or self harm. Denies HI/AVH/PI
Insight: poor
Judgment: poor

Discharge Type and Core Measures:

- **Discharge Type** Standard
- **Smoking Status** never smoker

Discharge Instructions:

- **Discharge Disposition:** home
- **Condition at Discharge:** stable, improved
- **Diet at discharge::** regular
- **Activity on discharge::** activity as tolerated
- **Equipment::** none
- **Medication List:**

Discharge Medications

- LORazepam 1 mg oral tablet
  Instructions: 1 tab(s) orally every 6 hours, As Needed, anxiety
  (written prescription)

- FLUoxetine 20 mg oral tablet
  Instructions: 2 tab(s) orally once a day
  Indication: for depression
  (written prescription)

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: BOTA, ROBERT

Gender: Female
DOB: [redacted]
Age: 18y

Admit Date: 04/18/2015 12:31
Discharge Date: 04/20/2015 16:13
Service: IP Mental Health Adult Med

Discharge Note.

04/20/2015 13:47 CHOI, BRIAN (MD (R))

Blood Thinners:
no.

Questions Regarding Prescriptions:
For more information about safe medication practices, please visit: http://www.consumermedsafety.org/.

Follow Up Appointments:
Follow up with your primary care provider .

Referrals: Adult

• Private Physician	An appointment has been made for you with Dr Nayana Shah on Thursday 04/23/2015 at 2:00pm. The office is located at 16152 Beach Blvd Suite 200 Huntington Beach, CA. If unable to keep this appointment please make sure to reschedule 714-841-6772.

Note Completion:

- **Attending Attestation:** I was present with the resident/fellow during the history and exam. I discussed the case with the resident/fellow and agree with the findings and plan as documented by the resident/fellow. My additions or revision are included in the record.
- **Attending Comments/Additional Findings/Exceptions:** Not a danger to self/other or gravely disabled at time of discharge - no longer meets criteria for hospitalization. she has significantly improved with interventions. not suicidal, future oriented. tolerate meds without side effects

Diet as indicated above.
Patient encouraged to remain active with daily light physical activity.
Instructed to take medications as prescribed and to abstain from use of heavy alcohol or illicit drugs.
To follow-up with outpatient treatment as indicated in the note.
Instructed to call 911 or proceed to the nearest ER should they experience an exacerbation of suicidal thoughts, homicidal thoughts, auditory hallucinations, paranoid ideation, psychotic symptoms.
Discharged in stable condition.

Billing:
Billing Level:

- **Billing Level::** Thirty minutes or greater of discharge planning, education and care coordination were spent at the attending level.

Other Instructions-UCI Health Care Team:
Nursing:

Additional information for the patient	Pt discharged home with mom per MD. Reviewed all discharge instructions, explained discharge instructions and copy given to patient. All pt's belongings given to pt. Pt left the unit walking in stable condition and in care of mom. Pt denies SI, AVH, and SH.
The patient left the hospital:	walking
The patient left the hospital with	parent, mom
Medication information sheets were	for all discharge medications

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: BOTA, ROBERT

Gender: Female
DOB: [redacted]
Age: 18y

Admit Date: 04/18/2015 12:31
Discharge Date: 04/20/2015 16:13
Service: IP Mental Health Adult Med

Discharge Note.

04/20/2015 13:47 CHOI, BRIAN (MD (R))

provided Discharge instructions

patient and/or family verbalizes understanding of post-hospital plans, patient and/or family given a copy of the Discharge Note

Authors:
ELECTRONIC SIGNATURES MAY BE ATTRIBUTED TO INDIVIDUALS THAT REVIEWED DOCUMENTATION IN THE LISTED SECTIONS WITHOUT AUTHORING CHANGES.

Electronic Signatures:
BOTA, ROBERT (MD (A)) (Signed 04-22-2015 12:47)
Authored: Admission/Discharge Dates, Note Completion, Billing
Co-Signer: Note Completion
CHOI, BRIAN (MD (R)) (Signed 04-21-2015 18:53)
Authored: Admission/Discharge Dates, Providers, Discharge Diagnoses/Procedures/Hospital Course/Patient Data, Physical Exam on Day of Discharge, Discharge Information/Instructions/Core Measures, Note Completion, Authorship Disclaimer
DU, CHRIS KIEN (RN) (Signed 04-20-2015 15:58)
Authored: Admission/Discharge Dates, Other Instructions-UCI Health Care Team
LEE, NANCY (Pharmacist) (Signed 04-20-2015 14:01)
Authored: Admission/Discharge Dates, Discharge Information/Instructions/Core Measures
LIZARRAGA, REYNA (Amb Frt Office) (Signed 04-20-2015 15:30)
Authored: Admission/Discharge Dates, Discharge Information/Instructions/Core Measures
MARTINEZ, LILIANA (HUSC) (Signed 04-20-2015 16:17)
Authored: Admission/Discharge Dates, Other Instructions-UCI Health Care Team

Last Updated: 04-22-2015 12:47 by BOTA, ROBERT (MD (A))

PL 000102

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: BOTA, ROBERT

Gender: Female
DOB: [redacted]
Age: 18y

Admit Date: 04/18/2015 12:31
Discharge Date: 04/20/2015 16:13
Service: IP Mental Health Adult Med

H&P-Primary-Psychiatry

04/18/2015 15:29 CHOI, BRIAN (MD (R))

Evaluation and Admission Date:

- **Evaluation Date and Time:** 04-18-2015 15:29
- **Admission Date:** 04-18-2015

JC Irvine Health:

Clinician Documentation: Per Initial Psychiatry H&P written on 4/16/15 by Dr. Rocha

Ms Reed is an 18 year old female with a history of PTSD, Depression w/psychotic features who was BIBA today after she became agitated at school and was rolling around on the asphalt at her high school (Marina HS).

School psychologist said that she was shaking in the bus on the way to school. She told her school counselor, 'it is loud in my head, I don't want to go back, I don't understand, I don't want to go to the hospital.' Then she took off running in the parking lot at the school then dropped down in the middle of the street rolling around on the ground in the fetal position for 35 minutes. Per psychologist report, She continued to scream in the middle of the street for the entire 35 minutes she was rolling around on the ground. The school counselor was concerned she was going to hurt herself.

Parametrics transported the patient to UCIMC.
She was given IM Versed 5mg during transport. On arrival to UCIMC she required restraints and IM Haldol and Benadryl for agitation. She was placed on §150 for DTS 4/16/15 @ 1400.

Patient is asleep at time of interview with restraints removed.

The following information was provided by pts mother and step father who were bedside:
She went back to school after changing pathway program IEP on Monday. She has 2 classes to graduate. Over spring break she was functioning fine and had no escalation. School triggers her to feel more anxiety but she wanted to try. She would call and check in with mother and her anxiety was 7-8/10. She also told mother it was because this class was smaller 3-4 kids and so she feels everyone is watching her. She met with new therapist this week Therapist Elisse Collier (562-335-9552); seen her twice last Mon and Wed before but she isn't opening up to therapist. Her psychiatrist is also new and mother could not provide name of that person. They have seen her new psychiatrist once. Mother said since starting back Monday, she was anxious everyday after school. Monday was difficult for her and she talked to psychologist outside the classroom for most of the 2 hour session. Yesterday she did well (per step father.) Today she ran into parking lot and the parents don't know the details. They called paramedics to come and she was given Ativan IM (versed per EMS) at the scene. Recently she has been doing trauma processing work and has been dissociating. Her therapist is using a rock to help her stay in the moment. She talked to mother earlier and repeated the affirmations, "I'm loved" and "I can get through it" She told mother she had suicidal ideation with plan but wouldn't act on it. Per mother; "She doesn't want to die". Mother and daughter have safety contract and she also has one with the counselor and psychiatrist. When asked about AH, mother said "She said her 'head was really loud' but she wasn't able to explain it". She puts in earplugs because the outside voices are loud (she currently has earplugs in and is holding rock in plastic bag). She told mother there were two voices and she said 'I knew it' ..repeating that sentence numerous times.

Another significant stressor is the upcoming case against the man who is accused of sexually abused her. She is scheduled to testify in court which includes see the alleged man again. Per the patients mother - The man's mother lives 20 minutes from them and the man has made threats against the family and has shown them a

H&P-Primary-Psychiatry

04/18/2015 15:29 CHOI, BRIAN (MD (R))

gun. The patient mother reports that the police are unable to file a restraining order against the alleged perpetrator. She said "she won't feel safe until he is prison and he won't go to prison until she testifies.

Until then, he is on home arrest.

Her last hospitalization was DelAmo hospital (Feb/March 2015) where she was admitted on a 5150 for suicidal ideation. It is believed that attempting to return to school was the inciting stressor. She was there for almost a month and was discharged 3 weeks ago. Since that time, she has seemed to do well but was complaining to mother she didn't like the Abilify because it was making her have tremors and she was agitated and didn't feel safe driving the car so that was recently stopped. She is currently on Prozac 40mg but mother isn't sure about other medications or even name of new psychiatrist. Her first hospitalization was at UCI in 3/2014 when she first told staff about her sexual abuse at the hands of a friend of her father's and was beginning to talk about the events. She was given dx of PTSD, MDD and SAD and started on Prozac 40mg daily, Clonazepam 1.5mg po BID, Prazosin 2mg po nightly, Melatonin 3mg po nightly and Lorazepam 1mg po q6H prn anxiety.

Mother said that she took those medication for 3 months then stopped them all complains of various side effects of which the step father seems unconvinced were real. She was also going to Center for Discovery for 4 weeks after getting out of UCI but mother said she was on so much medication she was falling down. She saw a new psychiatrist who stopped the Abilify recently. Mother thinks that her attempting to go back to school has been trigger for last two admission. She has been working with a therapist and mother said she is beginning to open up but it has also caused some flashbacks and panic attacks making her want to kill herself. Mother said "she is still holding a lot of anxiety". Of note: Mother was clearly anxious and speaking quickly during interview.

Robin Moses Case mgr 714-373-0517
Brain optimization assessment Mon Rick Tomey- Per collateral it showed that she is always in a state of trauma and unable to talk about her feelings.

Psychiatric ROS -
Depression ROS not completed at this time due to patient sedation
SUICIDE: suicidal ideation with plan (per mothers report)
HOMICIDE: no per mother

Mania: unknown at this time
HALLUCINATIONS: Told mother she had AH
ANXIETY: mother reports that patient gets agitated, heart papillations and very scared
PTSD: per mother: positive for Flashbacks, Hypervigilance and nightmares from sexual abuse.
Eating Disorders: no know hx, no parental observation consistent with ED behaviors

Access to firearms? no

Ms Reed reports feeling "oK". She denies current suicidal ideation, homicidal ideation, paranoid ideation, and visual hallucinations. She reports auditory hallucinations last night. Patient reporting to notify staff if they have any thoughts of self-harm or suicide.

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: BOTA, ROBERT

Gender: Female
DOB: [redacted]
Age: 18y

Admit Date: 04/18/2015 12:31
Discharge Date: 04/20/2015 16:13
Service: IP Mental Health Adult Med

H&P-Primary-Psychiatry

04/18/2015 15:29 CHOI, BRIAN (MD (R))

Collateral: Alicia Draper (714 916 1524)- mother;

PAST PSYCHIATRIC HISTORY:
-Diagnoses: PTSD, MDD w/psychotic features.
-Prior hospitalizations: # 2
-First hospitalization: UCI 4/2014 x 1 mo; Del Amo 5150 DTS 3/2015 x 1 mo
-Last hospitalization: 3 weeks ago Del Amo
-Suicide attempts: no
-Psych MD: Dr. Shah 714-841-6227; Therapist Elisse Collier (562-335-9552);
-Self Harm behaviors: no

MEDICATION HISTORY:

CURRENT: Prozac 40mg daily

PAST med trials: Abilify- akathisia,
Clonazepam 1.5mg po BID, (d/c'd)
Prazosin 2mg po nightly, (d/c'd)
Melatonin 3mg po nightly (d/c'd)
Lorazepam 1mg po q6H prn anxiety. (d/c'd)

PAST MEDICAL/SURGICAL HISTORY:
none

LMP: unknown

Family: 13 yo brother with MDD, unknown medication hx
Substance abuse hx: Denies use of etoh, illicit, or tobacco

Social:
Developmental: Patient met all developmental milestones as expected. She has always had A's in school, although mother reports that she tested at 1st grade reading level while in 4th grade. She had failed multiple hearing tests but her repeat tests were inconsistent indicating possible malingering and her brainstem testing in 2013 demonstrated no hearing loss.
She grew up in Las Vegas and moved to Huntington Beach with her mother 3 years previously. She lives with her mother, and 2 brothers age 13,15. Mother has remarried although (Jeff) new husband lives in Brea do to work. Parents divorced in 2006 and parents have joint legal custody and mother Alicia Draper (714 916 1524) has majority physical custody. Emily and her 2 brothers go to Vegas to stay with their father (Jeff) 702 241 2486, every other weekend and 7 weeks in the summer. Patient has an IEP through school started in 5th grade. Recently went back to school for a few hours a day to get 2 courses done to get GED.
Per mother sexual abuse at hands of friend of fathers and is going to have to testify soon.

Cognitive Exam
Alert and oriented x 4
Memory: Intact, as tested by recalling 3/3 objects after 5 min.
Attention: Intact, as tested by asking pt to spell "WORLD" backwards.

H&P-Primary-Psychiatry

04/18/2015 15:29 CHOI, BRIAN (MD (R))

Concentration: Intact, as tested by asking patient to perform serial 7's.
Fund of knowledge: Intact, as tested by asking patient to name the current president.
Ability to name common objects: Intact

Appearance: patient appears stated age; appropriate grooming and hygiene; street clothing sitting up in her bed
Behavior: cooperative; poor eye contact; no PMR/ no PMA noted
Speech: average rate, monotone tone; decreased spontaneous speech, increased latency
Mood: "ok"
Affect: Congruent, restricted
Thought Process: linear with associations
Thought Content: denies SI, states with notify staff of thoughts of suicide or self harm. Denies HI. Reports auditory hallucinations last night, denying VH, and PI
Insight: poor
Judgment: poor"

Interval History: On 4/17 patient was transferred to medicine after a rapid response was called for dystonic like reaction. It is believed that this was related to the haldol injection that she received the day prior when she was agitated in the emergency department. Patient was transferred to medicine and stabilized with IV fluid hydration and 25mg benadryl q8H. Lab work significant for elevated CK which trended down prior to transfer back to psychiatry. Upon readmission to 2s, patient was observed to be back to baseline, was able to state that she felt safe on the unit and willing to restart her previous medications. She stated that she would be able to alert staff members if she did not feel safe.

Allergies & Intolerances:

Allergies:

- **Haldol:** Drug, Spasms/Dystonia

Vital Signs:

- **Vitals:** -

Recent set of Vital Signs
[04/18/2015 15:49] Temp (degrees C): 36.7 (36.1 - 36.7); HR (bpm): (84 - 84); Respirations (breaths/min): 18 (18 - 19); SBP (mm Hg): (116 - 116); DBP (mm Hg): (67 - 67);

Physical Exam:

- **Exam:** _

GEN: Awake, Alert, No apparent distress
HEENT: NC/AT. Pupils equally round and reactive to light, moist mucous membranes.
NECK: FROM, moving spontaneously.
CVS: Regular rate and rhythm, normal S1 and S2, no murmurs, gallops, or rubs.
CHEST: Breath sounds equal bilaterally
ABD: Soft, non-tender, non-distended. Normoactive bowel sounds.
EXT: no cyanosis, clubbing or edema noted
SKIN: No rash. Skin intact.
NEUROLOGICAL: Cranial nerves II-XII are grossly intact. Motor System: 5/5 strength UE and LE. The patient has stable gait. No tremor or pronator drift. Sensory system: Intact to light touch. Reflexes: 2+ at patellar

Assessment and Plan:

- **Assessment and Plan:** Ms Reed is an 18 year old female with a history of PTSD. Depression w/psychotic

H&P-Primary-Psychiatry

04/18/2015 15:29 CHOI, BRIAN (MD (R))

features admitted initially after she became agitated at school. She has significant stressors and was too disorganized to protect her own safety at school. She required sedation and emergency medications, after which she is unable contribute additional information to interview. Without her narrative we are unable to determine if her disorganized behavior was due to dissociative episode related to PTSD, psychotic exacerbation related to recent discontinuation of Abilify, behavioral demonstration motivated by desire to escape from school, result of acute stress reaction. The patient has risk factors for suicide including loss of rational thought process, h/o depression, anxiety, organized plan/access (but won't tell mother what it is). Patient is at high immediate risk for suicide. Patient experienced a dystonic like reaction which required transfer to medicine for investigation. Patient without any significant lab abnormalities besides elevated CK which downtrended with IV fluid hydration. Dystonic like reaction being attributed to haldol injection that patient received in the emergency department. Will continue benadryl for a few days as this medication helped her while she was on the medicine service.

I agree with the nursing admission Suicide Risk Assessment. I asked the patient, "do you feel safe in the hospital?" and their reply was Yes.

Axis I: PTSD. Major Depressive Disorder. Social Anxiety Disorder.
Axis II: Deferred
Axis III: No acute issues.
Axis VI: Moderate- poor coping skills, poor social and occupational functioning, lack of primary support system.
Axis V: Global assessment of functioning on admission of 15

Plan:
1. We will admit the patient to 2S on an involuntary psychiatric 5150 for DTS 4/16/15 @ 1400.
2. Begin q.15 minutes safety checks. The patient is a high risk for suicide, self-harm, assault. EtOH withdrawal.
3. For the treatment of psychiatric symptoms:
- Prozac 40mg po daily
- Benadryl 25mg @ 700, 1430, and 2130
- Risk, benefits, and alternatives for the above medications were discussed with the patient, who appears to understand.
4. Medical Issues: no acute issues
5. We will attempt to increase collateral information contacting prior providers and family as well.
6. We will follow up on routine admission laboratory assessments.
7. Begin individual, group, milieu, and allied therapy services.
8. Disposition: To appropriate facility once psychiatrically stable. Appreciate social work and case management assistance regarding arranging aftercare.

Discussed with attending Dr. Bera who agrees with the above assessment and plan.

- **Attending Attestation:** I saw and examined the patient the next day and discussed the case with the resident/fellow. I agree with the final findings and plan as documented in the record.
- **Attending Comments/Additional Findings/Exceptions:** Agree with plan.

Attending Attestation:
- **Attending Evaluation Date and Time:** 04-19-2015 08:38

Billing:

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: BOTA, ROBERT

Gender: Female
DOB: [redacted]
Age: 18y

Admit Date: 04/18/2015 12:31
Discharge Date: 04/20/2015 16:13
Service: IP Mental Health Adult Med

H&P-Primary-Psychiatry

04/18/2015 15:29 CHOI, BRIAN (MD (R))

- **Billing Service Level:** Level 1 - initial hospital care

Electronic Signatures:
BERA, RIMAL BABULAL (MD (A)) (Signed 04-19-2015 08:38)
Authored: Note Completion, Attending Attestation, Billing
Co-Signer: Evaluation and Admission Date, UC Irvine Health, Allergies & Intolerances, Home Medications (Outpatient Medication Review), Vital Signs, Physical Exam, Assessment and Plan, Note Completion
CHOI, BRIAN (MD (R)) (Signed 04-18-2015 23:13)
Authored: Evaluation and Admission Date, UC Irvine Health, Allergies & Intolerances, Home Medications (Outpatient Medication Review), Vital Signs, Physical Exam, Assessment and Plan, Note Completion

Last Updated: 04-19-2015 08:38 by BERA, RIMAL BABULAL (MD (A))

UC Irvine Health
Department of Pathology & Laboratory Medicine | Edwin S. Monuki, M.D., Ph.D. and Associates
101 The City Drive, Orange, CA 92868
Laboratory Result Report

REED, EMILY

MR#: [redacted]
Visit#:
Dr: BOTA, ROBERT
Service: IP Mental Health Adult Med

Gender: F
DOB: [redacted]
Age: 19y

Admit Date: 04/18/2015
Discharge Date: 04/20/2015

Microbiology

MRSA Screen
Ordered: 04/18/2015 16:21
Requested By: BERA, RIMAL BABULAL (MD (A))

Anc ID: S61625
Collected: 04/18/2015 16:21

Order ID: 001DKTPLL
Resulted: 04/19/2015 22:13
1 or more Final Results Received

		Reference Range	
Specimen Description	NARES		Final
Special Information	NONE		Final
Culture Results	NEGATIVE for METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS NEGATIVE for Methicillin susceptible STAPHYLOCOCCUS AUREUS		Final
Report Status	FINAL 04/19/2015		Final

Result Indicator: L = Low, H = High, A = Abnormal

PL 000109

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: BOTA, ROBERT

Gender: Female
DOB: [redacted]
Age: 18y

Admit Date: 04/18/2015 12:31
Discharge Date: 04/20/2015 16:13
Service: IP Mental Health Adult Med

Progress Note-Primary: Psychiatry

04/19/2015 11:11 NELSON, MICHELE (MD (R))

- **Evaluation Date and Time:** 04-19-2015 11:11

Service Provided:
- **Role:** Primary Service

Hospital Days:
- **Hospital Days:** 2

Subjective Findings:
- **Subjective:** Patient was seen, examined, and chart reviewed this morning. Discussed with nursing. There were no acute overnight events. Slept well overnight. Was transferred from medicine yesterday. Pt states she is stressed about upcoming trial about person who assaulted her. Pt has been on prozac for the past few weeks, was on abilify about a month ago discontinued secondary to akathesia and latuda discontinued for akathesia about 2 weeks ago. States she was unable to tolerate prazosin in the past for nightmares because of low blood pressure. Endorses anxiety, agreeable to prn ativan. Pt agrees to sign in voluntarily. Denies medication side effects. Denies SI/HI/AH/VH. Agrees to let staff know if have thoughts of self harm or hurting others. Feels safe in the hospital. Likes her therapist, wants to feel better.

Does not report CP, SOB, nausea, headache, and dysuria, all others are negative.

Inpatient Medications:
- **Medications:** Scheduled Med(s):
  diphenhydrAMINE Capsule/Tablet 25 mg <User Schedule>
  FLUoxetine Capsule/Tablet 40 mg daily

PRN Meds(s):
  acetaminophen Tablet 650 mg every 4 hours PRN
  alum hydrox/mag hyrox/simet II Oral Susp 15 mL every 4 hours PRN
  camphor/phenol Oint 1 application(s) Q1H PRN
  LORazepam Tablet 1 mg every 6 hours PRN
  magnesium hydroxide Oral Susp 30 mL every 12 hours PRN
  menthol cough suppressant 1 lozenge every 4 hours PRN

Physical Exam:
- **Vital Signs:** Temp (degrees C): 37 (36.1 - 37), HR (bpm): 96 (73 - 96), Respiration (breaths/min): 17 (16 - 19), SBP (mm Hg): 126 (98 - 126), DBP (mm Hg): 71 (66 - 71), SpO2 (%): 98 (98 - 98).

- **Exam:** Appearance: patient appears stated age; appropriate grooming and hygiene; street clothing sitting up in her bed

Behavior: cooperative; intermittent eye contact; no PMR/ no PMA noted
Speech: average rate, monotone tone; decreased spontaneous speech, increased latency
Mood: "ok"
Affect: Congruent, restricted
Thought Process: linear with associations
Thought Content: denies SI, states with notify staff of thoughts of suicide or self harm. Denies HI. Reports auditory hallucinations last night, denying VH, and PI
Insight: poor

Progress Note-Primary: Psychiatry

04/19/2015 11:11 NELSON, MICHELE (MD (R))

Judgment: poor"

Review of Medical Necessity:

- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.
- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

Assessment and Plan:

- **Assessment and Plan:** Ms Reed is an 18 year old female with PTSD, Depression w/psycholic features admitted initially after she became agitated at school. She was admitted to psychiatry, then transferred to medicine presumably for a dystonic reaction treated with benadryl Q8. Pt is on prozac for depression and Post Traumatic Stress Disorder. Was unable to tolerate prazosin in the past for nightmares. She is agreeable to prn ativan. The patient has risk factors for suicide including loss of rational thought process, h/o depression, anxiety, organized plan/access (but won't tell mother what it is). Patient is at high immediate risk for suicide. Will continue benadryl for a few days as this medication helped her while she was on the medicine service. Need to obtain collateral and coordinate safe discharge, with medication adjustments. Needs hospitalization for medication management.

Axis I: PTSD. Major Depressive Disorder, Social Anxiety Disorder.
Axis II: Deferred
Axis III: No acute issues.
Axis VI: Moderate- poor coping skills, poor social and occupational functioning, lack of primary support system.
Axis V: Global assessment of functioning on admission of 15

Plan:
Legal 5150 for DTS 4/16/15 @ 1400. Signed in vol on 4/19/15
For the treatment of psychiatric symptoms:
- Prozac 40mg po daily
- Benadryl 25mg @ 700, 1430, and 2130 (per medicine recs for acute dystonic reaction) - want to continue for a few days
- Ativan 1 mg Q6-8 hr prn anxiety
- Risk, benefits, and alternatives for the above medications were discussed with the patient, who appears to understand.

Attempt to increase collateral information contacting prior providers and family as well.
Continue individual, group, milieu, and allied therapy services.
Disposition: To appropriate facility once psychiatrically stable. Appreciate social work and case management assistance regarding arranging aftercare.

This case was discussed with and supervised by attending psychiatrist, Dr. Bera, who agrees with the above assessment and plan.

- **Attending Attestation:** I saw and examined the patient, and discussed the case with the resident/fellow. I agree with the final findings and plan as documented in the record. We formulated the assessment and plan together. Any additions or revisions are included in the record.
- **Attending Comments/Additional Findings/Exceptions:** No muscle stiffness noted. I agree with the plan

Attending Attestation:

Progress Note-Primary: Psychiatry

04/19/2015 11:11 NELSON, MICHELE (MD (R))

- **Attending Evaluation Date and Time: 04-19-2015 13:21**

Billing:

- **Billing Service Level:** Level 1 - inpatient follow-up

Electronic Signatures:

BERA, RIMAL BABULAL (MD (A)) (Signed 04-19-2015 13:21)
Authored: Note Completion, Attending Attestation, Billing
Co-Signer: Accessing Provider and Discipline, Subjective Findings, Inpatient Medications, Physical Exam, Review of Medical Necessity, Assessment and Plan, Note Completion

NELSON, MICHELE (MD (R)) (Signed 04-19-2015 11:18)
Authored: Accessing Provider and Discipline, Subjective Findings, Inpatient Medications, Physical Exam, Review of Medical Necessity, Assessment and Plan, Note Completion

Last Updated: 04-19-2015 13:21 by BERA, RIMAL BABULAL (MD (A))

University of California - Irvine Health
Department of Pathology, 101 The City Drive, Orange, CA 92868
Edwin S. Monuki, M.D., Ph.D. and Associates
Laboratory Results Report

REED, EMILY
MR#: [redacted]
Visit#:
Dr: TURAKHIA, ATUR V
Service: IP Mental Health Adolescent

Gender: F
DOB: [redacted]
Age: 18y

Admit Date: 03/18/2014
Discharge Date: 04/07/2014

Chemistry

Lipid Screen — Anc ID: W43612 — Order ID: 001BLMLSS
Ordered: 03/19/2014 06:35 — Collected: 03/19/2014 06:35 — Resulted: 03/19/2014 08:41
Requested By: NISENBAUM, DAVID (MD (R)) — 1 or more Final Results Received

		Reference Range	
Cholesterol	127	[<200 MG/DL]	Final
	<200mg/dL desirable by NCEP guidelines.		
Triglycerides	29	[<150 MG/DL]	Final
	<150mg/dL desirable by NCEP guidelines.		
HDL Cholesterol	41	[>40 MG/DL]	Final
	>40mg/dL desirable by NCEP guidelines.		
Lp(A) Cholesterol	0.8	[0-5 MG/DL]	Final
	Reference Range: 0-5 mg/dL = No increased risk for CHD 6-10 mg/dL = Slight increased risk for CHD 11-15 mg/dL = Moderately increased risk for CHD >15 mg/dL = Significantly increased risk for CHD		
VLDL Cholesterol	1	[MG/DL]	Final
	No target levels have been established by NCEP guidelines.		
LDL Cholesterol	84	[<160 MG/DL]	Final
	Target levels for LDL cholesterol by NCEP guidelines depend on the number of major risk factors: <100mg/dL for patients with diabetes or CHD. <130mg/dL for patients with 2 or more risk factors excluding diabetes and CHD. <160mg/dL for patients with <2 major risk factors.		
Non HDL Cholesterol	86	[<130 MG/DL]	Final
	Target levels for non HDL cholesterol by NCEP guidelines depend on the number of major risk factors. <130 mg/dl for patients with diabetes or CHD. <160 mg/dl for patients with 2 or more risk factors excluding diabetes and CHD. <190 mg/dl for patients with <2 major risk factors.		

Comprehensive Metabolic Panel — Anc ID: T71067 — Order ID: 001BLKVDK
Ordered: 03/18/2014 01:39 — Collected: 03/18/2014 01:39 — Resulted: 03/18/2014 02:07
Requested By: BREED, WYNNE (MD (R)) — 1 or more Final Results Received

		Reference Range	
Sodium, Plasma	142	[135-145 MEQ/L]	Final
Potassium, Plasma	3.7	[3.3-4.8 MEQ/L]	Final
Chlorides, Plasma	105	[101-111 MEQ/L]	Final
CO2, Plasma	29	[25-34 MEQ/L]	Final

Result Indicator: L = Low, H = High, A = Abnormal

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Dr: TURAKHIA, ATUR V
Service: IP Mental Health Adolescent

Gender: F
DOB: [redacted]
Age: 18y

Admit Date: 03/18/2014
Discharge Date: 04/07/2014

Chemistry

Comprehensive Metabolic Panel Anc ID: W43612 Order ID: 001BLMLSQ
Ordered: 03/19/2014 06:35 Collected: 03/19/2014 06:35 Resulted: 03/19/2014 08:41
Requested By: NISENBAUM, DAVID (MD (R)) 1 or more Final Results Received

			Reference Range	
Sodium, Plasma	139		[135-145 MEQ/L]	Final
Potassium, Plasma	3.8		[3.3-4.8 MEQ/L]	Final
Chlorides, Plasma	103		[101-111 MEQ/L]	Final
CO2, Plasma	27		[25-34 MEQ/L]	Final
Electrolyte Balance	9		[2-12 MEQ/L]	Final
Glucose, Plasma	72		[70-115 MG/DL]	Final
	Normal Fasting Glucose: <100 mg/dl Impaired Fasting Glucose: 100-125 mg/dl Provisional DX of diabetes(must be confirmed) >125 mg/dl.			
BUN, Plasma	10		[8-26 MG/DL]	Final
Creatinine, Plasma	0.7		[0.5-1.3 MG/DL]	Final
Calcium, Plasma	9.5		[8.4-10.2 mg/dL]	Final
Protein, Total Plasma	7.1		[6.1-8.2 G/DL]	Final
Albumin, Plasma	3.9		[3.2-5.5 G/DL]	Final
Alkaline Phosphatase, Plasma	93		[26-110 IU/L]	Final
AST, Plasma	20		[8-40 IU/L]	Final
ALT, Plasma	15		[0-60 IU/L]	Final
Bilirubin, Total Plasma	2.2	H	[0.0-1.4 MG/DL]	Final

Annotations

Date/Time	Type	Status	Annotation	User
03/19/2014 08:56	Bilirubin, Total Plasma	Active	Dr. Nisenbaum aware	SEXON, DJOHANNA

Thyroid Function Panel (Ultrasensitive TSH + Free T4) Anc ID: W43612 Order ID: 001BLMLSR
Ordered: 03/19/2014 06:35 Collected: 03/19/2014 06:35 Resulted: 03/19/2014 09:13
Requested By: NISENBAUM, DAVID (MD (R)) 1 or more Final Results Received

			Reference Range	
Free T4	0.90		[0.60-1.12 ng/dL]	Final
TSH, Ultrasensitive	1.228		[0.500-5.000 uIU/mL]	Final

Result Indicator: L = Low, H = High, A = Abnormal

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REED, EMILY
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Visit#:
Dr: TURAKHIA, ATUR V
Service: IP Mental Health Adolescent

Gender: F
DOB: [redacted]
Age: 18y

Admit Date: 03/18/2014
Discharge Date: 04/07/2014

Electrolyte Balance	8		[2-12 MEQ/L]	Final
Glucose, Plasma	92		[70-115 MG/DL]	Final
	Normal Fasting Glucose: <100 mg/dl Impaired Fasting Glucose: 100-125 mg/dl Provisional DX of diabetes(must be confirmed) >125 mg/dl.			
BUN, Plasma	5	L	[8-26 MG/DL]	Final
Creatinine, Plasma	0.6		[0.5-1.3 MG/DL]	Final
Calcium, Plasma	9.2		[8.4-10.2 mg/dL]	Final
Protein, Total Plasma	6.4		[6.1-8.2 G/DL]	Final
Albumin, Plasma	3.7		[3.2-5.5 G/DL]	Final
Alkaline Phosphatase, Plasma	91		[26-110 IU/L]	Final
AST, Plasma	19		[8-40 IU/L]	Final
ALT, Plasma	14		[0-60 IU/L]	Final
Bilirubin, Total Plasma	1.4		[0.0-1.4 MG/DL]	Final

Hematology

CBC With Diff
Ordered: 03/19/2014 06:35
Requested By: NISENBAUM, DAVID (MD (R))

Anc ID: W43612
Collected: 03/19/2014 06:35

Order ID: 001BLML SP
Resulted: 03/19/2014 08:18
1 or more Final Results Received

		Reference Range	
White Blood Cell Count	4.8	[4.5-13.5 THOUS/MCL]	Final
RBC	4.89	[3.70-5.00 MILL/MCL]	Final
Hemoglobin	14.9	[11.5-15.0 G/DL]	Final
Hematocrit	43.7	[34.0-44.0 %]	Final
MCV	89.3	[81.5-97.0 FL]	Final
MCH	30.5	[27.0-33.5 PG]	Final
MCHC	34.1	[32.0-35.5 G/DL]	Final
RDW-CV	13.5	[11.6-14.4 %]	Final
Platelet Count	239	[150-450 THOUS/MCL]	Final
Neutrophils	2.2 45%	[1.8-8.0 THOUS/MCL]	Final
Lymphocyte	2.0 42%	[1.2-5.2 THOUS/MCL]	Final
Monocyte	0.5 10%	[0-0.8 THOUS/MCL]	Final
Eosinophil	0.1	[0-0.5 THOUS/MCL]	Final

Result Indicator: L = Low, H = High, A = Abnormal

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
Gender: F
DOB: [redacted]
Admit Date: 03/18/2014
Discharge Date: 04/07/2014
Dr: TURAKHIA, ATUR V
Age: 18y
Service: IP Mental Health Adolescent

	2%		
Basophil	0.0	[0-0.2 THOUS/MCL]	Final
	1%		
RBC Morphology	NO RBC ABNORMALITIES DETECTED BY AUTOMATED ANALYSIS.		Final
Plt Morph/Comm	DIFFERENTIAL PERFORMED BY AUTOMATED ANALYSIS. NO-PLATELET ABNORMALITIES DETECTED BY AUTOMATED ANALYSIS.		Final

Microbiology

MRSA Screen — Anc ID: T72499 — Order ID: 001BLLQXB
Ordered: 03/18/2014 11:20 — Collected: 03/18/2014 11:20 — Resulted: 03/19/2014 22:15
Requested By: TURAKHIA, ATUR V (MD (A)) — 1 or more Final Results Received

		Reference Range	
Specimen Description	NARES		Final
Special Information	NONE		Final
Culture Results	NEGATIVE for METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS NEGATIVE for Methicillin susceptible STAPHYLOCOCCUS AUREUS		Final
Report Status	FINAL 03/19/2014		Final

Serology

Syphilis Antibody Screen — Anc ID: W43612 — Order ID: 001BLMLST
Ordered: 03/19/2014 06:35 — Collected: 03/19/2014 06:35 — Resulted: 03/20/2014 12:30
Requested By: NISENBAUM, DAVID (MD (R)) — 1 or more Final Results Received

		Reference Range	
Treponema pallidum Antibody			Final

Result Indicator: L = Low, H = High, A = Abnormal

PL 000116

ROA1381

University of California - Irvine Health
Department of Pathology, 101 The City Drive, Orange, CA 92868
Edwin S. Monuki, M.D., Ph.D. and Associates
Laboratory Results Report

REED, EMILY
MR#: [redacted]
Visit#:
Dr: TURAKHIA, ATUR V
Service: IP Mental Health Adolescent

Gender: F
DOB: [redacted]
Age: 18y

Admit Date: 03/18/2014
Discharge Date: 04/07/2014

Serology

NONREACTIVE
NO TREPONEMA PALLIDUM ANTIBODIES DETECTED
(NOTE)
A reactive result indicates that antibody is present in the sample as a result of previous or present infection with T. pallidum. All reactive ELISA results will be tested by the Rapid Plasma Reagin test (RPR). Those with a reactive RPR will be titrated to determine the level of anti-cardiolipin antibodies, a result that subsequently can be used to assess the response to therapy. Patients with a reactive ELISA and nonreactive RPR results will be tested with the T. pallidum particle agglutination (TP-PA) assay. If the TP-PA is nonreactive the most likely explanation is that the ELISA was a false-positive. A new specimen can be submitted in 2-4 weeks for testing. If the TP-PA is reactive the patient most likely has been treated in the past for syphilis. However, treatment is indicated unless a history of treatment exists.

A nonreactive result indicates that no, or undetectable antibody levels are present in the sample, but does not rule out a recent or current infection. In case of suspicious primary syphilis recollect and retest 2-4 weeks later.

An equivocal result indicates that a low level of antibody is detected, and the patient should be monitored for antibody status. A second sample should be collected 2-4 weeks later and tested for any change in antibody response.

Result Indicator: L = Low, H = High, A = Abnormal

PL 000117

University of California - Irvine Health
Department of Pathology, 101 The City Drive, Orange, CA 92868
Edwin S. Monuki, M.D., Ph.D. and Associates
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REED, EMILY
MR#: [redacted]
Visit#:
Dr: TURAKHIA, ATUR V
Service: IP Mental Health Adolescent

Gender: F
DOB: [redacted]
Age: 18y

Admit Date: 03/18/2014
Discharge Date: 04/07/2014

Barbiturates	NEGATIVE	[NEG]	Final
MDMA	NEGATIVE	[NEG]	Final

UA, Urines

Pregnancy, Urine (Qual) — Anc ID: M48200 — Order ID: 001BLKMFH
Ordered: 03/17/2014 20:05 — Collected: 03/17/2014 20:05 — Resulted: 03/17/2014 20:32
Requested By: BREED, WYNNE (MD (R)) — 1 or more Final Results Received

		Reference Range	
Pregnancy, Urine (Qual)	NEGATIVE		Final

Urinalysis with Reflex to Culture, Random Urine — Anc ID: M48200 — Order ID: 001BLKMMS
Ordered: 03/17/2014 20:05 — Collected: 03/17/2014 20:05 — Resulted: 03/17/2014 20:31
Requested By: BREED, WYNNE (MD (R)) — 1 or more Final Results Received

			Reference Range	
Urine Sample Site, UA	URINE, CLEAN CATCH			Final
Color, UA	YELLOW			Final
Clarity, UA	CLEAR			Final
Urine Specific Grav, UA	1.016		[1.003-1.030]	Final
pH, UA	5.5		[5.0-8.0]	Final
Protein, UA	NEGATIVE		[NEG MG/DL]	Final
Glucose, UA	NEGATIVE		[NEG MG/DL]	Final
Ketones, UA	NEGATIVE		[NEG MG/DL]	Final
Bilirubin, UA	NEGATIVE		[NEG]	Final
Hemoglobin, UA	NEGATIVE		[NEG]	Final
Leukocyte Esterase, UA	NEGATIVE		[NEG]	Final
Nitrite, UA	NEGATIVE		[NEG]	Final
Urobilinogen, UA	<2.0		[<2.0 MG/DL]	Final
RBC, UA	<1		[0-3 #/HPF]	Final
WBC, UA	<1		[0-5 #/HPF]	Final
WBC Clumps, UA	NONE		[NONE #/HPF]	Final
Bacteria, UA	NONE		[NONE]	Final
UA Culture	CULTURE PARAMETERS NEGATIVE, URINE NOT SENT TO MICROBIOLOGY			Final
Squamous Epithelial, UA	2		[0-10 /HPF]	Final
Mucous, UA	FEW	A	[NONE /LPF]	Final

Result Indicator: L = Low, H = High, A = Abnormal

[redacted] [redacted]
REED, EMILY DOB: [redacted] F
AKA:

UNIVERSITY of CALIFORNIA · IRVINE HEALTHCARE

Neuropsychiatric Center
INTERDISCIPLINARY ADMISSION
Clinical Social Work Assessment

Complete within 72 hours

CLINICAL SOCIAL WORK ASSESSMENT:

☐ **CONSERVATORSHIP** (Type and details) N/A

☐ **AHCD/POA:** N/A

1. **REASON FOR ADMISSION** (Date, legal status, stressors): 03/18/14 VOL BIB mother for depressive symptoms for the past 3 weeks, SI

CURRENT LIVING SITUATION: (Type of residence and with whom): Apartment 2 mother & 2 brothers
ADDRESS: 2217 Florida St. #3 Huntington Beach, CA 92648
Length of time at current address: 3 years total in Huntington Beach but pt unsure of length at current household.
PHONE NO.: (714) 916-1524

2. **PLACEMENT DIFFICULTIES PAST/PRESENT:** (Violence, AWOL, physical & mental disabilities): Sx of depression SI

3. **SOURCES OF FINANCIAL SUPPORT:** Salary $ ∅ Retirement pension $ ∅ SDI $ ∅
SSI $ ∅ SSD $ ∅ SSA $ ∅
Other Income $: ∅ Payee Name and Phone Number:
Pt is a minor and is financially supported by mother and father

4. **INSURANCE:** Blue Cross

5. **RELIGION/CULTURAL ORIENTATION & CONSIDERATIONS:** (Preferences and practices that we need to respect/facilitate while you are hospitalized): Christianity

6. **SUPPORT SYSTEMS:** (Family, friends, community, phone #'s): Mother, Father, school psychologist

Family Spokesperson: Mother - Alicia Draper (714-916-1524)/Father - Geoffrey Draper (714-916-1524)
Out Pt. Psychiatrist / Care Coordinator/Therapist: Psychologist T. Fanny Dea @ IEP since age 15
(Pt will refuse referral)

7. **PERSONAL, FAMILY HISTORY, PAST/PRESENT PSYCHOSOCIAL, FUNCTIONING** (Include family of origin and current family dynamics & relationships, occupational, social, sexual and marital/family role functioning, responses to stressors/losses, interests & strengths, place of birth, mother's name - current/maiden, history of abuse): Pt is a single 17yo Caucasian female who lives w her mother and 2 brothers ages 13 and 15 in Huntington Beach for the past 3 years and previously lived in Las Vegas, NV. Pt and her brothers live w their bio father in Vegas every other weekend and 7 weeks during the summer. Pt has no friends she can identify at school, just peers that she knows of. Pt is an 11th grade student at Huntington Beach High School and is not sexually active or in a relationship. Pt stated she responds to stressors by sitting on the floor and rolling rapidly about. Pt's interests include engineering and running. Pt stated her strengths is learning the American Sign Language. Pt was born "somewhere in Southern California" and moved to Las Vegas soon after. Per pt, her mother's maiden name is "Masitis" but she is unsure of spelling. Pt stated mother has 2 ex-husbands and her current last name is Draper. Pt reports having never been abused or neglected

[redacted]
REED, EMILY
AKA:

[redacted]
DOB: [redacted]

UNIVERSITY of CALIFORNIA · IRVINE
HEALTHCARE
Neuropsychiatric Center
INTERDISCIPLINARY ADMISSION
Clinical Social Work Assessment
Complete within 72 hours

CLINICAL SOCIAL WORK ASSESSMENT (...CONTINUED)

8. **SOURCES OF PSYCHOSOCIAL INFORMATION** (Reliable, verified): MD assessment, 1:1 interviews

9. **FAMILY/PATIENT PSYCHIATRIC HISTORY** (Including first diagnosis): Pt has no previous hospitalizations, suicide attempts, or outpatient psychiatrists. Pt has been followed by psychologist Tiffany Doe at ITP since age 15 and has been engaging for past 3 weeks and therapist Stephanie Frazier 2x last week. Family hx includes 13 y/o brother ? MDD.

10. **EDUCATIONAL, OCCUPATIONAL AND/OR MILITARY HISTORY:** Currently high school student, grade 11. No occupational or military hx.

11. **INVOLVEMENT WITH LAW** (Arrests, jail/prison, probation, pending court cases, CPS/APS involvement, dates & time frame):
None.

12. **ALCOHOL/SUBSTANCE ABUSE HISTORY**
None.

13. **CLINICAL IMPRESSIONS** (Strengths, weaknesses, support systems, use of previous resources):
Strengths: Good support from parents

Weaknesses: Poor historian, poor coping skills, poor insight, poor communicative skills

PATIENT'S/FAMILY'S GOALS FOR HOSPITALIZATION AND DESIRED DISCHARGE PLAN Pt's goals are to "feel better," "feel ready for the future," and become better at making decisions.

RECOMMENDED DISCHARGE PLAN
Return home with outpatient treatment and therapeutic support.

SOCIAL WORK TREATMENT FOCUS AND REFERRALS
- Provide supportive interventions and assess psychosocial support systems
- Collaborate w/ treatment team and develop interdisciplinary treatment plan
- 1:1, milieu, group, and family intervention
- Schedule family meeting Thursday 3/20/14 @ 9:15 AM.

PSYCHOSOCIAL ASSESSMENT ATTEMPTS

C.S.W. signature: [signature] **Date/Time:** 03/12/14 @ 5:00 PM
MSW Intern name/signature: _____ **Date/Time:** _____
Interpreter name/signature: _____ **Date/Time:** _____

58029 (Rev. 10-15-12)

Progress Note-Primary: Psychiatry

03/26/2014 10:26 NISENBAUM, DAVID (MD (R))

- **Evaluation Date and Time:** 03-26-2014 10:26

Role:

- **Role:** Primary Service

Hospital Days:

- **Hospital Days:** 9

Subjective Findings:

- **Active Problems:** Patient interviewed and discussed with treatment team. No acute events overnight. She slept 7 hours and was compliant with medications. She denies side effects including dizziness or daytime sedation. She refused lunch and dinner and had Ensure x 3 yesterday. She also reported one episode of emesis last night because she "made herself due it by being nervous". She feels overwhelmed today and stated that last night she bit her right arm because she couldn't sleep. No evidence of bleeding, laceration or wound on arm on physical exam.
  She feels that her anxiety is mildly improved compared to yesterday. However, she continues to endorse SI without plan and when asked about these thoughts she states repeatedly "I don't know".

Medications:

- **Medications:** Scheduled Med(s):
  clonazePAM Tablet 1 mg 2 times a day
  docusate sodium Capsule 100 mg daily
  FLUoxetine Oral Soln 30 mg daily
  multivitamin peds chewable Tablet 1 tablet(s) daily
  OLANZapine Tablet 2.5 mg nightly at bedtime
  senna Tablet 8.6 mg nightly at bedtime

Objective Findings:

Vital Signs:

- **Vital Signs:** Weight (03/26/14) = 47.5 kg
  Temp (degrees C): 36.6 (36.4 - 36.6), HR (bpm): 78 (78 - 78), Respiration (breaths/min): 16 (16 - 16), SpO2 (%): 98 (98 - 98),

Psychiatric: MSE
Appearance: Caucasian thin female, avg height, appears their stated age, good grooming and hygiene with hair in pigtails, and is wearing sweatshirt appropriate to weather and circumstance.
Behavior: Cooperative with interview, calm, intermittent eye contact, No PMR or PMA, sitting upright in chair
Speech: Hypoverbal with decreased volume, soft tone
Mood: "overwhelmed"
Affect: blunted, guarded
Thought content: +SI, denies current HI, AH, VH
Thought processes: grossly linear, although paucity of thought
Insight: poor
Judgment: poor

Review of Medical Necessity:

- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.

Progress Note-Primary: Psychiatry

03/26/2014 10:26 NISENBAUM, DAVID (MD (R))

- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

Assessment and Plan:
Global Assessment & Plan:

- **Assessment and Plan:** 19 yo F with depressive symptoms and anxiety that has resulted in decreased functioning over the past 3 weeks BIB mother after endorsing SI with plan to not eat so she'll pass out. She has had decreased PO intake, loss of appetite and emesis possibly due to recent exacerbation in anxiety and depression likely related to unresolved emotional conflict involving her brother. Although, this will require further assessment. She has had minimal consumption of meals on the unit and observed episode of emesis likely due to anxiety and not meeting current criteria for eating disorder. Patient reports one episode of hearing a voice possibly consistent with non command type AH. Patient has also had decreased communication with possible occasional selective mutism, per mother she has had frequent crying spells and has been unable to attend school recently. During hospital course she has had self injurious behavior of biting her arm. She continues to endorse SI and patient is at increased risk of dangerousness to self and has had severe declines in functioning and requires inpatient hospitalization for medication initiation and stabilization.

  Patient states she will tell nursing staff if she is having thoughts of self harm and therefore does not require current 1:1 and we will continue to assess for this need

  Diagnosis
  Axis I: MDE, consider MDE with psychotic features; social anxiety do; rule out autism spectrum
  Axis II: Deferred
  Axis III: No acute issues.
  Axis VI: Moderate- poor coping skills, poor social functioning
  Axis V: Global assessment of functioning on admission of 25

  Plan:
  1. Psychiatric Medication Management:
  -Continue Prozac PO liquid formulation to 30mg PO QDay with eventual goal of titration to 40mg PO QDay
  -Continue Klonopin 1mg PO BID with goals of controlling anxiety and compliance with meals, consider titration as tolerated if anxiety is not controlled with current dosage.
  -Increase Zyprexa to 5mg PO qhs as patient had endorsed AH and goal of stimulating appetite
  -Both mother and father of patient have been consented and understand risks, benefits, and alternatives to treatment with above medications and are in agreement with treatment plan
  -Appreciate Dietician recs, will continue MVI, check daily weights, and encourage Ensure Plus TID PRN for less than 100 percent consumption
  Weight has been stable during hospital course

  2. Medical Issues:
  Patient reports +BM yesterday, although does not recall previous BM therefore we will continue Senna and request patient to complete log for dates of BM

  3. Continue individual, group, milieu, and allied services therapy

Progress Note-Primary: Psychiatry

03/26/2014 10:26 NISENBAUM, DAVID (MD (R))

4. Legal: vol by parent
Writer called Orange County CPS regarding mother of patient's report of potential physical abuse of patient's brother Adam in Las Vegas NV by family friend (AI), they stated that statute of limitation had passed as incident had occurred in 2007, therefore filed report with Clark County (las vegas) CPS Lorea Arostegui referral # 1600635

5. Disposition: Appreciate CM assistance with placement following discharge

Above case was discussed with and supervised by attending psychiatrist Dr. Turakhia who agrees with above assessment and plan.

Billing Service Level:

- **Billing Service Level:** Level 2 - inpatient follow-up
- **Billing Modifiers:** GC

Attending Attestation:

- I personally coordinated care with: nurse; case manager; social worker.
- **Attending Attestation Statement:** I saw and examined the patient and discussed the case with the resident/fellow. I agree with the final findings and plan as documented in the record. We formulated the assessment and plan together. Any additions or revisions are included in the record.
- **Attestation Comments:** Emesis and self-injurious behavior as noted above. On my interview, shared her written letter to herself. She identified avoiding tasks as afraid of not doing things in a "perfect" way as well as burying things deep and needing to allow herself to get help. She was educated on anger as an emotion versus actions that could convey anger and also educated on Aggressive vs Assertive vs Passive styles of interacting. She identified herself as using the Passive style extensively. She was open to learning more Assertive techniques. I also challenged her to take a greater control of her treatment and seek out help from the various professionals here to figure out how not to feel like hurting herself anymore rather than waiting for the answers to be given to her. I also encouraged her to try making a mistake so she could experience it as not being as catastrophic as she imagines it would be. Will increase Olanzapine dose as above.

Electronic Signatures:

NISENBAUM, DAVID (MD (R)) (Signed 03-26-2014 11:45)
Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan

TURAKHIA, ATUR V (MD (A)) (Signed 03-26-2014 17:33)
Authored: Assessment and Plan, Billing Service Level, Attending Attestation, Note Finalization
Co-Signer: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity

Last Updated: 03-26-2014 17:33 by TURAKHIA, ATUR V (MD (A))

Progress Note-Primary: Psychiatry

03/28/2014 13:57 SAGAR, ANGELA N (MD (A))

- **Evaluation Date and Time:** 03-28-2014 13:57

Role:
- **Role:** Primary Service

Hospital Days:
- **Hospital Days:** 11

Subjective Findings:
- **Active Problems:** Pt stated her sleep was "good" and her appetite is "not good".

  She stated that despite sleep being good, she had nightmares at night and flashbacks during the day of her abuse. She stated "I had a breakdown in the shower" and was able to allow staff to help her.

  During the interview she stated she felt uncomfortable returning to the milieu programing and chose to stay with her nurse.

Medications:
- **Medications:** Scheduled Med(s):
  - clonazePAM Tablet 1 mg 2 times a day
  - FLUoxetine Oral Soln 30 mg daily
  - multivitamin peds chewable Tablet 1 tablet(s) daily
  - OLANZapine Tablet 5 mg nightly at bedtime
  - prazosin Capsule 1 mg nightly at bedtime
  - senna Tablet 8.6 mg nightly at bedtime

  PRN Meds(s):
  - LORazepam Tablet 1 mg every 6 hours PRN

Objective Findings:
Vital Signs:
- **Vital Signs:** Weight (03/28/14) = 47.6 kg
  Temp (degrees C): 36.5 (36 - 36.7), HR (bpm): 55 (55 - 55), Respiration (breaths/min): 16 (14 - 16).

Psychiatric: Appearance: Caucasian thin female, avg height, appears their stated age, good grooming and hygiene, and is dressed appropriate to weather and circumstance.
Behavior: Cooperative with interview, calm, intermittent eye contact,
motor: No PMR or PMA, sitting upright
Speech: Hypoverbal with decreased volume, soft tone
Mood: "very sad"
Affect: blunted, guarded
Thought content: +SI, denies current HI, AH, VH
Thought processes: grossly linear
Insight: poor
Judgment: poor

Review of Medical Necessity:
- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.

Progress Note-Primary: Psychiatry

03/28/2014 13:57 SAGAR, ANGELA N (MD (A))

- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

Assessment and Plan:
Global Assessment & Plan:

- **Assessment and Plan:** 19 yo F with depressive symptoms and anxiety that has resulted in decreased functioning over the past 3 weeks BIB mother after endorsing SI. She has had minimal consumption of meals on the unit and observed episode of emesis likely due to anxiety and not meeting current criteria for eating disorder. Patient disclosed extensive hx of sexual abuse by family friend AI, she previously denied his to treatment team and mother, although felt more comfortable reporting the abuse following discussion with her aunt. She is also endorsing sxs consistent with PTSD including reexperiencing and avoidance cluster of sxs.

  Patient has also had decreased communication with possible occasional selective mutism, per mother she has had frequent crying spells and has been unable to attend school recently. During hospital course she has had self injurious behavior of biting her arm. She continues to endorse SI and patient is at increased risk of dangerousness to self and has had severe declines in functioning and requires inpatient hospitalization for medication initiation and stabilization.

  Patient states she will tell nursing staff if she is having thoughts of self harm and therefore does not require current 1:1 and we will continue to assess for this need

  Diagnosis
  Axis I: MDE; social anxiety do; PTSD
  Axis II: Deferred
  Axis III: No acute issues.
  Axis VI: Moderate- poor coping skills, poor social functioning
  Axis V: Global assessment of functioning on admission of 25

  Plan:
  1. Psychiatric Medication Management:
  -Continue Prozac 30 PO QD liquid formulation with goal of titration to 40mg PO QDay
  -Continue Klonopin to 1 mg PO BID with goals of controlling anxiety and compliance with meals, consider titration as tolerated if anxiety is not controlled with current dosage.
  -Continue Zyprexa 5mg PO qhs as patient had endorsed AH and goal of stimulating appetite
  -continue Prazosin 1mg PO QHS for nightmares associated with PTSD
  -Both mother and father of patient have been consented and understand risks, benefits, and alternatives to treatment with above medications and are in agreement with treatment plan
  -Appreciate Dietician recs, will continue MVI, check daily weights, and encourage Ensure Plus TID PRN for less than 100 percent consumption
  Weight has been stable during hospital course

  2. Medical Issues:
  Patient reports +BM 2 days previously, although does not recall previous BM therefore we will continue Senna and request patient to complete log for dates of BM

PL 000125

ROA1390

Progress Note-Primary: Psychiatry

03/28/2014 13:57 SAGAR, ANGELA N (MD (A))

3. Continue individual, group, milieu, and allied services therapy

4. Legal: vol by parent
Writer called Orange County CPS regarding mother of patient's report of potential physical abuse of patient's brother Adam in Las Vegas NV by family friend (Al). they stated that statute of limitation had passed as incident had occurred in 2007, therefore filed report with Clark County (las vegas) CPS Lorea Arostegui referral # 1600635

5. Disposition: Appreciate CM assistance with placement following discharge

Billing Service Level:

- **Billing Service Level:** Level 2 - inpatient follow-up

Attending Attestation:

- I personally coordinated care with: nurse.

Electronic Signatures:

SAGAR, ANGELA N (MD (A)) (Signed 03-28-2014 14:06)
Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan, Billing Service Level, Attending Attestation

Last Updated: 03-28-2014 14:06 by SAGAR, ANGELA N (MD (A))

Progress Note-Primary: Psychiatry

03/29/2014 12:29 SAGAR, ANGELA N (MD (A))

- **Evaluation Date and Time:** 03-29-2014 12:29

Role:
- **Role:** Primary Service

Hospital Days:
- **Hospital Days:** 12

Subjective Findings:
- **Active Problems:** Pt stated her appetite was "I don't like eating. I get sad when I eat" and that she doesn't feel hungry. Pt encouraged to continue to eat meals. Stated her sleep was okay.

Medications:
- **Medications:** Scheduled Med(s):
  clonazePAM Tablet 1 mg 2 times a day
  FLUoxetine Oral Soln 30 mg daily
  multivitamin peds chewable Tablet 1 tablet(s) daily
  OLANZapine Tablet 5 mg nightly at bedtime
  prazosin Capsule 1 mg nightly at bedtime
  senna Tablet 8.6 mg nightly at bedtime

  PRN Meds(s):
  LORazepam Tablet 1 mg every 6 hours PRN

Objective Findings:

Vital Signs:
- **Vital Signs:** Weight (03/29/14) = 48.3 kg
  Temp (degrees C): 36.7 (36.3 - 37.1), Respiration (breaths/min): 16 (16 - 16), SBP (mm Hg): 111 (111 - 111), DBP (mm Hg): 64 (64 - 64),

Psychiatric: Appearance: Caucasian thin female, avg height, appears their stated age, good grooming and hygiene, and is dressed appropriate to weather and circumstance.
Behavior: Cooperative with interview, calm, intermittent eye contact,
motor: No PMR or PMA, sitting upright
Speech: Hypoverbal with decreased volume, soft tone, increased latency of response
Mood: "not good. very sad"
Affect: blunted, guarded
Thought content: +SI, denies current HI, AH, VH
Thought processes: grossly linear
Insight: poor
Judgment: poor

Review of Medical Necessity:
- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.
- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

Assessment and Plan:

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: TURAKHIA, ATUR V

Gender: Female
DOB: [redacted]
Age: 17y

Admit Date: 03/18/2014 11:06
Discharge Date: 04/07/2014 13:27
Service: IP Mental Health Adolescent

Progress Note-Primary: Psychiatry

03/29/2014 12:29 SAGAR, ANGELA N (MD (A))

Global Assessment & Plan:

- **Assessment and Plan:** 19 yo F with depressive symptoms and anxiety that has resulted in decreased functioning over the past 3 weeks BIB mother after endorsing SI. She has had minimal consumption of meals on the unit and observed episode of emesis likely due to anxiety and not meeting current criteria for eating disorder. Patient disclosed extensive hx of sexual abuse by family friend AI, she previously denied his to treatment team and mother, although felt more comfortable reporting the abuse following discussion with her aunt. She is also endorsing sxs consistent with PTSD including reexperiencing and avoidance cluster of sxs.

  Patient has also had decreased communication with possible occasional selective mutism, per mother she has had frequent crying spells and has been unable to attend school recently. During hospital course she has had self injurious behavior of biting her arm. She continues to endorse SI and patient is at increased risk of dangerousness to self and has had severe declines in functioning and requires inpatient hospitalization for medication initiation and stabilization.

  Patient states she will tell nursing staff if she is having thoughts of self harm and therefore does not require current 1:1 and we will continue to assess for this need

  Diagnosis
  Axis I: MDE; social anxiety do; PTSD
  Axis II: Deferred
  Axis III: No acute issues.
  Axis VI: Moderate- poor coping skills, poor social functioning
  Axis V: Global assessment of functioning on admission of 25

  Plan:
  1. Psychiatric Medication Management:
  -Continue Prozac 30 PO QD liquid formulation with goal of titration to 40mg PO QDay
  -Continue Klonopin to 1 mg PO BID with goals of controlling anxiety and compliance with meals, consider titration as tolerated if anxiety is not controlled with current dosage.
  -Continue Zyprexa 5mg PO qhs as patient had endorsed AH and goal of stimulating appetite
  -continue Prazosin 1mg PO QHS for nightmares associated with PTSD
  -Both mother and father of patient have been consented and understand risks, benefits, and alternatives to treatment with above medications and are in agreement with treatment plan
  -Appreciate Dietician recs, will continue MVI, check daily weights, and encourage Ensure Plus TID PRN for less than 100 percent consumption
  Weight has been stable during hospital course

  2. Medical Issues:
  Patient reports +BM 2 days previously, although does not recall previous BM therefore we will continue Senna and request patient to complete log for dates of BM

  3. Continue individual, group, milieu, and allied services therapy

  4. Legal: vol by parent
  primary team called Orange County CPS regarding mother of patient's report of potential

Progress Note-Primary: Psychiatry

03/29/2014 12:29 SAGAR, ANGELA N (MD (A))

physical abuse of patient's brother Adam in Las Vegas NV by family friend (Al), they stated that statute of limitation had passed as incident had occurred in 2007, therefore filed report with Clark County (las vegas) CPS Lorea Arostegui referral # 1600635

5. Disposition: Appreciate CM assistance with placement following discharge

Billing Service Level:

- **Billing Service Level:** Level 2 - inpatient follow-up

Attending Attestation:

- I personally coordinated care with: nurse.

Electronic Signatures for Addendum Section:

SAGAR, ANGELA N (MD (A)) (Signed Addendum 03-29-2014 14:05)

Will increase fluoxetine to 40mg PO Q day per primary team recommendations and pt current c/o depressed mood.

Electronic Signatures:

SAGAR, ANGELA N (MD (A)) (Signed 03-29-2014 12:35)

Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Diagnostic Data, Review of Medical Necessity, Assessment and Plan, Billing Service Level, Attending Attestation, Note Finalization

Last Updated: 03-29-2014 14:05 by SAGAR, ANGELA N (MD (A))

Progress Note-Primary: Psychiatry

03/30/2014 15:04 SAGAR, ANGELA N (MD (A))

- **Evaluation Date and Time:** 03-30-2014 15:04

Role:
- **Role:** Primary Service

Hospital Days:
- **Hospital Days:** 13

Subjective Findings:
- **Active Problems:** Pt stated she feels "frustrated" but unable to state why. Said her sleep was "pretty good" and her appeite is "I'm eating" but that she doesn't want to eat

Medications:
- **Medications:** Scheduled Med(s):
  clonazePAM Tablet 1 mg 2 times a day
  FLUoxetine Oral Soln 40 mg daily
  multivitamin peds chewable Tablet 1 tablet(s) daily
  OLANZapine Tablet 5 mg nightly at bedtime
  prazosin Capsule 1 mg nightly at bedtime
  senna Tablet 8.6 mg nightly at bedtime

  PRN Meds(s):
  LORazepam Tablet 1 mg every 6 hours PRN

Objective Findings:
Vital Signs:
- **Vital Signs:** Weight (03/30/14) = 47.3 kg
  Temp (degrees C): 36.3 (36.3 - 36.7), HR (bpm): 72 (72 - 72), Respiration (breaths/min): 16 (16 - 17), SpO2 (%): 98 (98 - 98),

Psychiatric: Appearance: Caucasian thin female, avg height, appears their stated age, good grooming and hygiene, and is dressed appropriate to weather and circumstance.
Behavior: Cooperative with interview; calm, intermittent eye contact,
motor: No PMR or PMA, sitting upright
Speech: Hypoverbal with decreased volume, soft tone, increased latency of response
Mood: "frustrated"
Affect: blunted, guarded
Thought content: +SI, denies current HI, AH, VH
Thought processes: grossly linear
Insight: poor
Judgment: poor

Diagnostic Data:
- **Additional Lab Data:** no new labs

Review of Medical Necessity:
- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.
- Is an indwelling urethral catheter present? not present.

Progress Note-Primary: Psychiatry

03/30/2014 15:04 SAGAR, ANGELA N (MD (A))

- Is a mechanical ventilator present? not present.

Assessment and Plan:
Global Assessment & Plan:

- **Assessment and Plan:** 19 yo F with depressive symptoms and anxiety that has resulted in decreased functioning over the past 3 weeks BIB mother after endorsing SI. She has had minimal consumption of meals on the unit and observed episode of emesis likely due to anxiety and not meeting current criteria for eating disorder. Patient disclosed extensive hx of sexual abuse by family friend AI, she previously denied his to treatment team and mother, although felt more comfortable reporting the abuse following discussion with her aunt. She is also endorsing sxs consistent with PTSD including reexperiencing and avoidance cluster of sxs.

  Patient has also had decreased communication with possible occasional selective mutism, per mother she has had frequent crying spells and has been unable to attend school recently. During hospital course she has had self injurious behavior of biting her arm. She continues to endorse SI and patient is at increased risk of dangerousness to self and has had severe declines in functioning and requires inpatient hospitalization for medication initiation and stabilization.

Diagnosis
Axis I: MDE; social anxiety do; PTSD
Axis II: Deferred
Axis III: No acute issues.
Axis VI: Moderate- poor coping skills, poor social functioning
Axis V: Global assessment of functioning on admission of 25

Plan:
1. Psychiatric Medication Management:
-Continue Prozac 30 PO QD liquid formulation with goal of titration to 40mg PO QDay
-Continue Klonopin to 1 mg PO BID with goals of controlling anxiety and compliance with meals, consider titration as tolerated if anxiety is not controlled with current dosage.
-Continue Zyprexa 5mg PO qhs as patient had endorsed AH and goal of stimulating appetite
-continue Prazosin 1mg PO QHS for nightmares associated with PTSD
-Both mother and father of patient have been consented and understand risks, benefits, and alternatives to treatment with above medications and are in agreement with treatment plan
-Appreciate Dietician recs, will continue MVI, check daily weights, and encourage Ensure Plus TID PRN for less than 100 percent consumption
Weight has been stable during hospital course
--Continue 1:1 for safety

2. Medical Issues:
Patient reports +BM 2 days previously, although does not recall previous BM therefore we will continue Senna and request patient to complete log for dates of BM

3. Continue individual, group, milieu, and allied services therapy

4. Legal: vol by parent

Progress Note-Primary: Psychiatry

03/30/2014 15:04 SAGAR, ANGELA N (MD (A))

primary team called Orange County CPS regarding mother of patient's report of potential physical abuse of patient's brother Adam in Las Vegas NV by family friend (Al), they stated that statute of limitation had passed as incident had occurred in 2007, therefore filed report with Clark County (las vegas) CPS Lorea Arostegui referral # 1600535

5_ Disposition: Appreciate CM assistance with placement following discharge

Billing Service Level:

- **Billing Service Level:** Level 2 - inpatient follow-up

Attending Attestation:

- I personally coordinated care with: nurse.

Electronic Signatures:

SAGAR, ANGELA N (MD (A)) (Signed 03-30-2014 15:18)

Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Diagnostic Data, Review of Medical Necessity, Assessment and Plan, Billing Service Level, Attending Attestation, Note Finalization

Last Updated: 03-30-2014 15:18 by SAGAR, ANGELA N (MD (A))

PL 000132

ROA1397

Progress Note-Primary: Psychiatry

03/31/2014 09:53 NISENBAUM, DAVID (MD (R))

- **Evaluation Date and Time:** 03-31-2014 09:53

Role:

- **Role:** Primary Service

Hospital Days:

- **Hospital Days:** 14

Subjective Findings:

- **Active Problems:** Patient interviewed and discussed with treatment team. No acute events overnight. She slept 7 hours. She consumed 100/100/ and had ensure for dinner last night. She denies emesis for multiple days. Patient denies self injurious behavior since 3/29 when she bit her arm and one to one supervision was started. She states "I wish I was not alive", and reports thoughts of self injurious behavior but will alert staff if she thinks she will act on it. Patient was compliant with medications and denies side effects of dizziness or lightheadedness currently.
  She reports continuing to feel overwhelmed by "everything going on". +flashbacks and nightmares of "bad things that happened".

Medications:

- **Medications:** Scheduled Med(s):
  clonazePAM Tablet 1 mg 2 times a day
  FLUoxetine Oral Soln 40 mg daily
  multivitamin peds chewable Tablet 1 tablet(s) daily
  OLANZapine Tablet 5 mg nightly at bedtime
  prazosin Capsule 1 mg nightly at bedtime
  senna Tablet 8.6 mg nightly at bedtime

  PRN Meds(s):
  LORazepam Tablet 1 mg every 6 hours PRN

Objective Findings:

Vital Signs:

- **Vital Signs:** Weight (03/31/14) = 48 kg
  Temp (degrees C): 36 (36 - 36.8), HR (bpm): 72 (72 - 72), Respiration (breaths/min): 16 (16 - 16), SpO2 (%): 98 (98 - 98),

Psychiatric: MSE
Appearance: Caucasian thin female, avg height, appears their stated age, good grooming and hygiene, and is wearing sweatshirt appropriate to weather and circumstance.
Behavior: Cooperative with interview, calm, good eye contact, No PMR or PMA, sitting upright in chair
Speech: Hypovarbal with decreased volume, soft tone
Mood: "overwhelmed"
Affect: guarded
Thought content: denies current SI, HI, AH, VH
Thought processes: linear with tight associations
Insight: poor
Judgment: poor

Progress Note-Primary: Psychiatry

03/31/2014 09:53 NISENBAUM, DAVID (MD (R))

Review of Medical Necessity:

- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.
- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

Assessment and Plan:
Global Assessment & Plan:

- **Assessment and Plan:** 19 yo F with depressive symptoms and anxiety that has resulted in decreased functioning over the past 3 weeks BIB mother after endorsing SI. She has had minimal consumption of meals on the unit and observed episode of emesis likely due to anxiety and not meeting current criteria for eating disorder. Patient disclosed extensive hx of sexual abuse by family friend AJ, she previously denied this to treatment team and mother, although felt more comfortable reporting the abuse following discussion with her aunt. She is also endorsing sxs consistent with PTSD including reexperiencing and avoidance cluster of sxs.
  During hospital course she has had self injurious behavior of biting her arm. She continues to endorse SI and patient is at increased risk of dangerousness to self and has had severe declines in functioning and requires inpatient hospitalization for medication initiation and stabilization.

  Patient states she will tell nursing staff if she is having thoughts of self harm and therefore does not require current 1:1 and we will continue to assess for this need

  Diagnosis
  Axis I: MDE; social anxiety do; PTSD
  Axis II: Deferred
  Axis III: No acute issues.
  Axis VI: Moderate- poor coping skills, poor social functioning
  Axis V: Global assessment of functioning on admission of 25

  Plan:
  1. Psychiatric Medication Management:
  -Continue Prozac 40mg PO liquid formulation Q day
  -Increase Klonopin to 1.25 mg PO BID with goals of controlling anxiety and compliance with meals, consider titration as tolerated if anxiety is not controlled with current dosage.
  -Decrease Zyprexa to 2.5mg PO qhs as patient had endorsed AH and goal of stimulating appetite
  -Increase Prazosin to 2mg PO QHS for nightmares associated with PTSD
  -Both mother and father of patient have been consented and understand risks, benefits, and alternatives to treatment with above medications and are in agreement with treatment plan
  -Appreciate Dietician recs, will continue MVI, check daily weights, and encourage Ensure Plus TID PRN for less than 100 percent consumption
  Weight has been stable during hospital course

  2. Medical Issues:
  Patient denies BM x 4 days, will increase Senna, dulcolax 5mg PO x1, 3/31and request patient to complete log for dates of BM

Progress Note-Primary: Psychiatry

03/31/2014 09:53 NISENBAUM, DAVID (MD (R))

3. Continue individual, group, milieu, and allied services therapy

4. Legal: vol by parent
Writer called Orange County CPS regarding mother of patient's report of potential physical abuse of patient's brother Adam in Las Vegas NV by family friend (Al), they stated that statute of limitation had passed as incident had occurred in 2007, therefore filed report with Clark County (las vegas) CPS Lorea Arostegui referral # 1600635

Also CPS report filed based on hx of sexual trauma, taken by Orange County CPS, Senior Social Worker Hanaa Hanna at 3/26/14 @ 20:00.

5. Disposition: Appreciate CM assistance with placement following discharge

Above case was discussed with and supervised by attending psychiatrist Dr. Turakhia who agrees with above assessment and plan.

Billing Service Level:

- **Billing Service Level:** Level 2 - inpatient follow-up
- **Billing Modifiers:** GC

Attending Attestation:

- I personally coordinated care with: nurse; case manager; social worker.
- **Attending Attestation Statement:** I saw and examined the patient and discussed the case with the resident/fellow. I agree with the final findings and plan as documented in the record. We formulated the assessment and plan together. Any additions or revisions are included in the record.
- **Attestation Comments:** Increased flashbacks since disclosure of sexual trauma, which has perpetuated suicidal ideation. Prazosin not help yet though tolerated. Will increase Prazosin 2mg QHS. Increase Clonazepam to 1.25mg BID to target anxiety. Start taper off Olanzapine as eating better since disclosure and will try to minimize long-term risks as well as decrease total number of medications. Needs inpatient psychiatric hospitalization for danger to self.

Electronic Signatures:

NISENBAUM, DAVID (MD (R)) (Signed 03-31-2014 10:32)
Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan

TURAKHIA, ATUR V (MD (A)) (Signed 03-31-2014 18:21)
Authored: Billing Service Level, Attending Attestation, Note Finalization
Co-Signer: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan

Last Updated: 03-31-2014 18:21 by TURAKHIA, ATUR V (MD (A))

Progress Note-Primary: Psychiatry

04/01/2014 09:38 SEEGAN, ALEXIS (MD (R))

- **Evaluation Date and Time:** 04-01-2014 09:38

Role:

- **Role:** Primary Service

Hospital Days:

- **Hospital Days:** 15

Subjective Findings:

- **Active Problems:** Patient seen and evaluated this morning and discussed with the treatment team. Patient adherent to medication regimen and tolerating medications without adverse effect. Ate 10% of dinner and drank Ensure, and had 100% of breakfast. Pt states she is feeling tired this morning because she woke up in the middle of the night after a nightmare. Denies that she thinks the medications are making her tired today and attributes it to poor sleep. She did not recall what the nightmare was about but says she woke up feeling "freaked out." She continues to have thoughts of wanting to self-harm and bite herself, and says the urge to hurt herself comes about when she is feeling anxious and overwhelmed. She reports having a flashback last night during group, and was given her PM meds at that time. Also endorses having flashbacks frequently in the shower, and when asked how she thought she could cope while showering, she said she "makes up stories in my head" and asked if she could chew gum in the shower to have something to "bite down on." She says that she wants to bite herself, but has not because she is "afraid of going back to level R" and getting placed on a 1:1. Participating in groups, present in milieu. She denies current homicidal ideation, paranoid ideation, or auditory or visual hallucinations.

  ROS: Had BM yesterday. Does not endorse shortness of breath, chest pain, nausea, vomiting, constipation, and headache. All others negative.

Medications:

- **Medications:** Scheduled Med(s):
  - clonazePAM Tablet 1.25 mg 2 times a day
  - FLUoxetine Oral Soln 40 mg daily
  - multivitamin peds chewable Tablet 1 tablet(s) daily
  - OLANZapine Tablet 2.5 mg nightly at bedtime
  - prazosin Capsule 2 mg nightly at bedtime
  - senna Tablet 17.2 mg nightly at bedtime

  PRN Meds(s):
  - LORazepam Tablet 1 mg every 6 hours PRN

Objective Findings:

Vital Signs:

- **Vital Signs:** Weight (04/01/14) = 47.7 kg
  Temp (degrees C): 36.7 (36 - 37), HR (bpm): 82 (82 - 82), Respiration (breaths/min): 14 (14 - 16),

Psychiatric: Appearance: Patient appears younger than their stated age, has fair grooming and hygiene, and is wearing clothing appropriate to weather and circumstance.
Behavior: Mild psychomotor retardation noted, lying in chair in dayroom alone, staring in front of her. Fair eye contact. No abnormal movements.
Speech: Impoverished, lack of spontaneous speech, soft.

Progress Note-Primary: Psychiatry

04/01/2014 09:38 SEEGAN, ALEXIS (MD (R))

Mood: "Anxious, overwhelmed"
Affect: Restricted to depression and anxiety, reactive. Congruent with stated mood.
Thought content: Endorses suicidal ideations and desire to self-harm by biting self, denies intent to hurt self in the hospital and verbalizes that she could tell staff if she felt like hurting herself. She denies current homicidal ideation, paranoid ideation, or auditory or visual hallucinations.
Thought processes: Linear, logical, goal-directed.
Associations: Intact.
Insight: impaired.
Judgment: impaired.

Review of Medical Necessity:

- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.
- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

Assessment and Plan:
Global Assessment & Plan:

- **Assessment and Plan:** Assessment: 17 yo F with PTSD, MDD, and social anxiety disorder that resulted in decreased functioning over the past 3 weeks prior to admission and was BIB mother after endorsing SI. While in the hospital she disclosed extensive history of sexual abuse going back to age 7 by family friend. After this disclosure, she was able to discuss that she has symptoms of PTSD including reexperiencing, avoidance, and nightmares. She has had episodes of self-harm on the unit where she has bitten her arm, which she says helps her manage extreme anxiety. Due to prolonged sexual abuse, she has immature coping skills and has poor distress tolerance, leading to self-injurious behavior and suicidal ideation. She has poor oral intake at meals which she attributes to her anxiety. She continues to endorse SI and patient is at increased risk of dangerousness to self and has had severe declines in functioning and requires inpatient hospitalization for medication initiation and stabilization.

  Patient states she will tell nursing staff if she is having thoughts of self harm and therefore does not require current 1:1 and we will continue to assess for this need.

  Diagnosis
  Axis I: Major Depressive Disorder, Social Anxiety Disorder, PTSD.
  Axis II: Deferred
  Axis III: No acute issues.
  Axis VI: Moderate- poor coping skills, poor social functioning.
  Axis V: Global assessment of functioning of 25

  Plan:
  1. Psychiatric Medication Management:
  - Continue Prozac 40mg PO liquid formulation daily
  - Continue Klonopin1.25 mg PO BID with goals of controlling anxiety and compliance with meals, consider titration as tolerated if anxiety is not controlled with current dosage.
  - Continue Zyprexa 2.5mg PO qhs, was initiated as patient had endorsed AH and goal of stimulating appetite
  - Continue Prazosin 2mg PO QHS for nightmares associated with PTSD
  - Both mother and father of patient have been consented and understand risks, benefits, and

Progress Note-Primary: Psychiatry

04/01/2014 09:38 SEEGAN, ALEXIS (MD (R))

alternatives to treatment with above medications and are in agreement with treatment plan
2. Medical Issues:
Poor PO intake: Appreciate Dietician recs, will continue MVI, check daily weights, and encourage Ensure Plus TID PRN for less than 100 percent consumption. Weight has been stable during hospital course.
Constipation: Had BM yesterday, continue Senna 17.2 mg QHS.
3. Continue individual, group, milieu, and allied services therapy
4. Legal: vol by parent
5. CPS reports filed:
Report of potential physical abuse of patient's brother Adam in Las Vegas NV by family friend (AI), filed report with Clark County with CPS Lorea Arostegui referral # 1600635.
CPS report filed for sexual abuse by family friend, taken by Orange County CPS, Senior Social Worker Hanaa Hanna at 3/26/14 @ 20:00. Expect CPS worker to interview pt within 10 days.
5. Disposition: Appreciate CM assistance with placement following discharge

Above case was discussed with and supervised by attending psychiatrist Dr. Turakhia who agrees with above assessment and plan.

Billing Service Level:

- **Billing Service Level:** Level 2 - inpatient follow-up
- **Billing Modifiers:** GC

Attending Attestation:

- I personally coordinated care with: nurse; case manager.
- **Attending Attestation Statement:** I saw and examined the patient and discussed the case with the resident/fellow. I agree with the final findings and plan as documented in the record. We formulated the assessment and plan together. Any additions or revisions are included in the record.
- **Attestation Comments:** Tolerating Prazosin increase without orthostasis. Little more tired today, though attributes this to poor sleep from nightmare rather than medication side effect. Needs inpatient psychiatric hospitalization for danger to self.

Electronic Signatures:

SEEGAN, ALEXIS (MD (R)) (Signed 04-01-2014 11:35)
Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Diagnostic Data, Review of Medical Necessity, Assessment and Plan
TURAKHIA, ATUR V (MD (A)) (Signed 04-01-2014 18:39)
Authored: Billing Service Level, Attending Attestation, Note Finalization
Co-Signer: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Diagnostic Data, Review of Medical Necessity, Assessment and Plan

Last Updated: 04-01-2014 18:39 by TURAKHIA, ATUR V (MD (A))

Progress Note-Primary: Psychiatry

04/02/2014 09:55 SEEGAN, ALEXIS (MD (R))

- **Evaluation Date and Time:** 04-02-2014 09:55

Role:

- **Role:** Primary Service

Hospital Days:

- **Hospital Days:** 16

Subjective Findings:

- **Active Problems:** Patient seen and evaluated this morning and discussed with the treatment team. Patient adherent to medication regimen and tolerating medications without adverse effect. Ate 0% of lunch and drank Ensure, 0% of lunch, and had 100% of breakfast. When asked why she is not eating meals, she said that prior to hospitalization her pattern of eating has always been to eat small meals and graze throughout the day, and is having difficulty with pressure to finish her meals as they are larger than she is used to and would prefer to snack throughout the day. Also requested restriction to stay in dayroom after meals to be lifted, saying she had not vomited since day of admission and has no desire to purge at this time. Pt endorses feeling lightheaded this morning with dizziness upon standing. Reports having difficulty falling asleep, but able to sleep well once she fell asleep without nightmares. She continues to have thoughts of wanting to self-harm and bite herself, and says the urge to hurt herself comes about when she is feeling anxious and overwhelmed. She says that she wants to bite herself, but has not because she is "afraid of going back to level R" and getting placed on a 1:1. Also having passive SI, but says she does not have intent to kill herself at this time. Also endorses having flashbacks frequently in the shower. Discussed that CPS SW said she may come today to interview pt, and pt said she was anxious but understood that she needed to be as honest and descriptive as possible in interview. Discussed importance of pt advocating for herself and verbalizing her needs by asking for what she needs. Later in morning, pt did ask for prn anxiety medication from nurse. Participating in groups, present in milieu. She denies current homicidal ideation, paranoid ideation, or auditory or visual hallucinations.

  ROS: Does not endorse shortness of breath, chest pain, nausea, vomiting, constipation, and headache. All others negative.

Medications:

- **Medications:** Scheduled Med(s):
  clonazePAM Tablet 1.25 mg 2 times a day
  FLUoxetine Oral Soln 40 mg daily
  multivitamin peds chewable Tablet 1 tablet(s) daily
  OLANZapine Tablet 2.5 mg nightly at bedtime
  prazosin Capsule 2 mg nightly at bedtime
  senna Tablet 17.2 mg nightly at bedtime
  PRN Meds(s):
  LORazepam Tablet 1 mg every 6 hours PRN

Objective Findings:

Vital Signs:

- **Vital Signs:** Weight (04/02/14) = 48.3 kg
  Temp (degrees C): 36.6 (36.6 - 36.8), HR (bpm): 67 (67 - 67), Respiration (breaths/min): 16 (14 -

Progress Note-Primary: Psychiatry

04/02/2014 09:55 SEEGAN, ALEXIS (MD (R))

16),
Lying: BP 104/58 HR 74
Standing: BP 98/59 HR 110

Psychiatric: Appearance: Patient appears younger than their stated age, has fair grooming and hygiene, and is wearing clothing appropriate to weather and circumstance.
Behavior: Mild psychomotor retardation noted. Shaking foot when discussing trauma. Good eye contact. Smiled and laughed several times at appropriate moments. No abnormal movements.
Speech: Increased spontaneous speech compared to previous interview. Soft. Normal tone.
Mood: "Anxious"
Affect: Restricted to depression and anxiety, reactive and able to have periods of bright mood. Congruent with stated mood.
Thought content: Endorses suicidal ideations and desire to self-harm by biting self, denies intent to hurt self in the hospital and verbalizes that she could tell staff if she felt like hurting herself. Endorses current passive SI. She denies current homicidal ideation, paranoid ideation, or auditory or visual hallucinations.
Thought processes: Linear, logical, goal-directed.
Associations: Intact.
Insight: marginal, improving.
Judgment: impaired.

Review of Medical Necessity:

- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.
- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

Assessment and Plan:
Global Assessment & Plan:

- **Assessment and Plan:** Assessment: 17 yo F with PTSD, MDD, and social anxiety disorder that resulted in decreased functioning over the past 3 weeks prior to admission and was BIB mother after endorsing SI. While in the hospital she disclosed extensive history of sexual abuse going back to age 7 by family friend. After this disclosure, she was able to discuss that she has symptoms of PTSD including reexperiencing, avoidance, and nightmares. She has had episodes of self-harm on the unit where she has bitten her arm, which she says helps her manage extreme anxiety. Due to prolonged sexual abuse, she has immature coping skills and has poor distress tolerance, leading to self-injurious behavior and suicidal ideation. She has poor oral intake at meals which she attributes to her anxiety as well as difficulty eating larger meals as her usual pattern is to eat small meals throughout the day. She continues to endorse SI and patient is at increased risk of dangerousness to self and has had severe declines in functioning and requires inpatient hospitalization for medication initiation and stabilization.

  Patient states she will tell nursing staff if she is having thoughts of self harm and therefore does not require current 1:1 and we will continue to assess for this need.

  Diagnosis
  Axis I: Major Depressive Disorder, Social Anxiety Disorder, PTSD.
  Axis II: Deferred
  Axis III: No acute issues.

Progress Note-Primary: Psychiatry

04/02/2014 09:55 SEEGAN, ALEXIS (MD (R))

Axis VI: Moderate- poor coping skills, poor social functioning,
Axis V: Global assessment of functioning of 25

Plan:
1. Psychiatric Medication Management:
- Discontinue Zyprexa 2.5mg PO qhs due to resolution of AH and orthostasis.
- Continue Prozac 40mg PO liquid formulation daily
- Continue Klonopin1.25 mg PO BID with goals of controlling anxiety and compliance with meals, consider titration as tolerated if anxiety is not controlled with current dosage.
- Continue Prazosin 2mg PO QHS for nightmares associated with PTSD
- Both mother and father of patient have been consented and understand risks, benefits, and alternatives to treatment with above medications and are in agreement with treatment plan
2. Medical Issues:
Poor PO intake: Appreciate Dietician recs, will continue MVI, check daily weights, and encourage Ensure Plus TID PRN for less than 100 percent consumption. Weight has been stable during hospital course. Encourage pt to eat larger snacks. Discontinue dayroom support post-meals.
Constipation: Continue Senna 17.2 mg QHS.
3. Pt allowed to chew gum during shower to help with flashbacks and anxiety. Continue individual, group, milieu, and allied services therapy.
4. Legal: vol by parent
5. CPS reports filed:
Report of potential physical abuse of patient's brother Adam in Las Vegas NV by family friend (Al), filed report with Clark County with CPS Lorea Arostegui referral # 1600635.
CPS report filed for sexual abuse by family friend, taken by Orange County CPS, Senior Social Worker Hanaa Hanna at 3/26/14 @ 20:00. Expect CPS worker to interview pt within 10 days.
5. Disposition: Appreciate CM assistance with placement following discharge. Mother has expressed interest in transition to Center for Discovery.

Above case was discussed with and supervised by attending psychiatrist Dr. Turakhia who agrees with above assessment and plan.

Billing Service Level:

- **Billing Service Level:** Level 2 - inpatient follow-up
- **Billing Modifiers:** GC

Attending Attestation:

- I personally coordinated care with: nurse; case manager; social worker.
- **Attending Attestation Statement:** I saw and examined the patient and discussed the case with the resident/fellow. I agree with the final findings and plan as documented in the record. We formulated the assessment and plan together. Any additions or revisions are included in the record.
- **Attestation Comments:** Patient seen after interview by CPS worker today. She felt it was very difficult but was able to complete the interview. She had no nightmares last night. Significant flashbacks today. Will discontinue Olanzapine now to minimize long-term side effects. Monitor further for lightheaded feeling and objective orthostasis. Clear instructions to patient about how to prevent orthostasis and syncope. Needs inpatient psychiatric hospitalization for danger to self. She is at especially high risk for hurting herself today due to trigger of recounting abuse, so will benefit from continuing in the hospital setting.

REED, EMILY

MR#:	[redacted]	**Gender:** Female	**Admit Date: 03/18/2014 11:06**
Visit#:		**DOB:** [redacted]	**Discharge Date: 04/07/2014 13:27**
DR:	TURAKHIA, ATUR V	**Age:** 17y	**Service: IP Mental Health Adolescent**

Progress Note-Primary: Psychiatry

04/02/2014 09:55 SEEGAN, ALEXIS (MD (R))

Electronic Signatures:

SEEGAN, ALEXIS (MD (R)) (Signed 04-02-2014 10:48)
Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan

TURAKHIA, ATUR V (MD (A)) (Signed 04-02-2014 19:08)
Authored: Billing Service Level, Attending Attestation, Note Finalization
Co-Signer: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan

Last Updated: 04-02-2014 19:08 by TURAKHIA, ATUR V (MD (A))

REED, EMILY

MR#:	[redacted]	**Gender:**	Female	**Admit Date:**	03/18/2014 11:06
Visit#:	[redacted]	**DOB:**	[redacted]	**Discharge Date:**	04/07/2014 13:27
DR:	TURAKHIA, ATUR V	**Age:**	17y	**Service:**	IP Mental Health Adolescent

Progress Note-Primary: Psychiatry

04/03/2014 10:34 SEEGAN, ALEXIS (MD (R))

- **Evaluation Date and Time:** 04-03-2014 10:34

Role:

- **Role:** Primary Service

Hospital Days:

- **Hospital Days:** 17

Subjective Findings:

- **Active Problems:** Patient seen and evaluated this morning and discussed with the treatment team. Patient adherent to medication regimen and tolerating medications without adverse effect. Ate 0% of breakfast and drank Ensure, ate 100% of meals yesterday. Denies feeling lightheaded today. Reports having more difficulty falling asleep and said she did not fall asleep until 11:30-12 at night. Denies nightmares. Continues to have flashbacks. CPS SW spoke with pt yesterday, and pt provided in-depth details of sexual abuse. She was very tearful afterwards but able to be engaged in 1:1 activities with physician. She continues to have thoughts of wanting to self-harm and bite herself, but they are strong today and today she said "I want to die" and "I can't stand feeling this way forever." She discussed feeling "guilty" about "everything" and that she feels she is "a burden" to everyone, and just wants "it to end." Said she is having "bad thoughts" about what would happen when she is discharged, but was reluctant to provide details. Said she is "afraid I'll need to come back here" if she leaves tomorrow. She says she does feel that Center For Discovery would be a good place for her, but is worried about leaving the hospital because she feels "safe" here. She is able to say she will tell staff if having thoughts of hurting self in the hospital. Participating in groups, present in milieu. She denies current homicidal ideation, paranoid ideation, or auditory or visual hallucinations.

  Spoke with pt's mother who stated she had planned for pt to go to Las Vegas this weekend to give her statement to Clark County CPS. Upon questioning, Emily stated that the combination of leaving the hospital, going to Las Vegas, and going to Center for Discovery was overwhelming, and caused her significant anxiety. She said that her suicidal thoughts had increased since hearing this news, and that she feels that if she were to go to Las Vegas this weekend, "I would try to kill myself." Discussed with mom that should allow pt to go through one stressor at a time, and that pt should remain here with higher structure and monitoring through the weekend, and then anticipate possible discharge early next week. Mom agreed, and said she would postpone the CPS reporting until a later date.

  ROS: Does not endorse shortness of breath, chest pain, nausea, vomiting, constipation, and headache. All others negative.

Medications:

- **Medications:** Scheduled Med(s):
  - clonazePAM Tablet 1.25 mg 2 times a day
  - FLUoxetine Oral Soln 40 mg daily
  - multivitamin peds chewable Tablet 1 tablet(s) daily
  - prazosin Capsule 2 mg nightly at bedtime
  - senna Tablet 17.2 mg nightly at bedtime

  PRN Meds(s):
  - LORazepam Tablet 1 mg every 6 hours PRN

Objective Findings:

Progress Note-Primary: Psychiatry

04/03/2014 10:34 SEEGAN, ALEXIS (MD (R))

Vital Signs:

- **Vital Signs:** Weight (04/03/14) = 48.6 kg
  Temp (degrees C): 36.4 (36.4 - 36.6). HR (bpm): 93 (62 - 93). Respiration (breaths/min): 16 (16 - 16), SpO2 (%): 98 (98 - 98).
  Lying: BP 122/61 HR 93
  Standing: BP 105/50 HR 113

Psychiatric: Appearance: Patient appears younger than their stated age, has fair grooming and hygiene, and is wearing clothing appropriate to weather and circumstance.
Behavior: Mild psychomotor retardation noted. Fair eye contact. Tearful. No abnormal movements.
Speech: Increased spontaneous speech compared to previous interview. Soft. Normal tone.
Mood: "worried"
Affect: Restricted to depression and anxiety, less reactive today. Congruent with stated mood.
Thought content: Endorses suicidal ideations and desire to self-harm by biting self, denies intent to hurt self in the hospital and verbalizes that she could tell staff if she felt like hurting herself. Endorses current SI, and said today "I want to die." She denies current homicidal ideation, paranoid ideation, or auditory or visual hallucinations.
Thought processes: Linear, logical, goal-directed.
Associations: Intact.
Insight: marginal, improving.
Judgment: impaired.

Review of Medical Necessity:

- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.
- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

Assessment and Plan:
Global Assessment & Plan:

- **Assessment and Plan:** Assessment: 17 yo F with PTSD, MDD, and social anxiety disorder that resulted in decreased functioning over the past 3 weeks prior to admission and was BIB mother after endorsing SI. While in the hospital she disclosed extensive history of sexual abuse going back to age 7 by family friend. After this disclosure, she was able to discuss that she has symptoms of PTSD including reexperiencing, avoidance, and nightmares. She has had episodes of self-harm on the unit where she has bitten her arm, which she says helps her manage extreme anxiety. Due to prolonged sexual abuse, she has immature coping skills and has poor distress tolerance, leading to self-injurious behavior and suicidal ideation. She has poor oral intake at meals which she attributes to her anxiety as well as difficulty eating larger meals as her usual pattern is to eat small meals throughout the day. After describing abuse to CPS SW yesterday, she has experienced worsened depression, re-experiencing, feelings of guilt, and suicidal ideation. Given recent stressor of having to describe sexual abuse in detail to CPS worker, she requires additional hospitalization to ensure her safety, and is not stable for discharge at this time. She continues to endorse SI that is worse today, she is at increased risk of dangerousness to self, and requires inpatient hospitalization to maintain her safety, for medication management, and psychiatric stabilization.

  Patient states she will tell nursing staff if she is having thoughts of self harm and therefore does not require current 1:1 and we will continue to assess for this need.

Progress Note-Primary: Psychiatry

04/03/2014 10:34 SEEGAN, ALEXIS (MD (R))

Diagnosis
Axis I: Major Depressive Disorder, Social Anxiety Disorder, PTSD.
Axis II: Deferred
Axis III: No acute issues.
Axis VI: Moderate- poor coping skills, poor social functioning.
Axis V: Global assessment of functioning of 25

Plan:
1. Psychiatric Medication Management:
- Start Melatonin 3 mg QHS for insomnia, also provide Benadryl prn insomnia.
- Change Prozac 40 mg to capsule form, daily
- Increase Klonopin to 1.5 mg PO BID for anxiety.
- Continue Prazosin 2mg PO QHS for nightmares associated with PTSD
- Both mother and father of patient have been consented and understand risks, benefits, and alternatives to treatment with above medications and are in agreement with treatment plan
2. Medical Issues:
Poor PO intake: Appreciate Dietician recs, will continue MVI, check daily weights, and encourage Ensure Plus TID PRN for less than 75% percent consumption, decreased % to make pt feel less pressure to finish meals. Weight has been stable during hospital course. Encourage pt to eat larger snacks.
Constipation: Continue Senna 17.2 mg QHS.
3. Pt allowed to chew gum during shower to help with flashbacks and anxiety per Dr. Turakhia, but must spit out as soon as out of shower. Continue individual, group, milieu, and allied services therapy.
4. Legal: vol by parent
5. CPS reports filed:
Report of potential physical abuse of patient's brother Adam in Las Vegas NV by family friend (Al), filed report with Clark County with CPS Lorea Arostegui referral # 1600635.
CPS report filed for sexual abuse by family friend, taken by Orange County CPS, Senior Social Worker Hanaa Hanna at 3/26/14 @ 20:00. Expect CPS worker to interview pt within 10 days.
5. Disposition: Appreciate CM assistance with placement following discharge. Mother has expressed interest in transition to Center for Discovery, will aim for discharge from hospital early next week pending psychiatric stabilization.

Above case was discussed with and supervised by attending psychiatrist Dr. Turakhia who agrees with above assessment and plan.

Billing Service Level:
- **Billing Service Level:** Level 2 - inpatient follow-up
- **Billing Modifiers:** GC

Attending Attestation:
- I personally coordinated care with: nurse; case manager; social worker.
- **Attending Attestation Statement:** I saw and examined the patient and discussed the case with the resident/fellow. I agree with the final findings and plan as documented in the record. We formulated the assessment and plan together. Any additions or revisions are included in the record.

REED, EMILY
MR#: [redacted]
Visit#:
DR: TURAKHIA, ATUR V

Gender: Female
DOB: [redacted]
Age: 17y

Admit Date: 03/18/2014 11:06
Discharge Date: 04/07/2014 13:27
Service: IP Mental Health Adolescent

Progress Note-Primary: Psychiatry

04/03/2014 10:34 SEEGAN, ALEXIS (MD (R))

- **Attestation Comments:** Patient with increasing suicidal ideation in past 24 hours. Says to me a few times, "I'm done" in reference to dealing with her distress and living. Related to mother's plan of going to report to CPS in Nevada over weekend before starting Center for Discovery. Will increase Clonazepam to 1.5mg BID. Dr. Seegan advised mother against having patient go to Las Vegas soon as this would be too destabilizing and put her at increased risk for suicide. Patient contracted for safety in hospital after news that we advised against that trip. Will need continued inpatient hospitalization for stabilization and no longer acute danger to self before going to Residential Treatment Center. Of note, patient continues to eat better. Will add Melatonin 3mg for insomnia.

Electronic Signatures:
SEEGAN, ALEXIS (MD (R)) (Signed 04-03-2014 15:21)
Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Diagnostic Data, Review of Medical Necessity, Assessment and Plan
TURAKHIA, ATUR V (MD (A)) (Signed 04-03-2014 17:43)
Authored: Billing Service Level, Attending Attestation, Note Finalization
Co-Signer: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Diagnostic Data, Review of Medical Necessity, Assessment and Plan

Last Updated: 04-03-2014 17:43 by TURAKHIA, ATUR V (MD (A))

Progress Note-Primary: Psychiatry

04/04/2014 09:51 SEEGAN, ALEXIS (MD (R))

- **Evaluation Date and Time:** 04-04-2014 09:51

Role:
- **Role:** Primary Service

Hospital Days:
- **Hospital Days:** 18

Subjective Findings:
- **Active Problems:** Patient seen and evaluated this morning and discussed with the treatment team. Patient refused qhs medications last night, and is tolerating medications without adverse effect. Last night pt stated she started having flashbacks of her molestation while in the shower. This lead to a panic attack, during which she crouched down on the floor of the shower, and "felt like I was drowning." Pt then impulsively hit her head 3 times against the shower wall, saying that she was trying to not think about the flashback. She then was placed on level R, which she felt was "a punishment" and out of anger at staff for this, refused her qhs medications, but did take all of her medications this morning. She required 2 doses of ativan prn throughout the day yesterday. Ate 0% of breakfast and drank Ensure, ate 100% of lunch, and 25% of dinner with Ensure. Continues to have flashbacks. She continues to have thoughts of wanting to self-harm and bite herself, and said she is "scared of what I might do to myself." She feels that if she were to go home prior to going to Center For Discovery, she would likely harm herself in some way due to feeling anxious at home. Continues to endorse passive SI. She is able to say she will tell staff if having thoughts of hurting self in the hospital. Participating in groups, present in milieu. Worked with patient today on developing strategy to manage flashbacks in the shower, which she says occur 75% of the time. She identified that she could "make a game" in the shower of "naming as many countries or animals as I can." Also agreed to ask for Ativan prn 20-30 min prior to shower. She denies current homicidal ideation, paranoid ideation, or auditory or visual hallucinations.

  ROS: Does not endorse shortness of breath, chest pain, nausea, vomiting, constipation, and headache. All others negative.

Medications:
- **Medications:** Scheduled Med(s):
  - clonazePAM Tablet 1.5 mg 2 times a day
  - FLUoxetine Capsule/Tablet 40 mg daily
  - multivitamin peds chewable Tablet 1 tablet(s) daily
  - Non-Formulary Med 3 mg nightly at bedtime
  - prazosin Capsule 2 mg nightly at bedtime
  - senna Tablet 17.2 mg nightly at bedtime

  PRN Meds(s):
  - acetaminophen Chewable Tablet 80 mg every 6 hours PRN
  - diphenhydrAMINE Capsule/Tablet 25 mg nightly at bedtime PRN
  - LORazepam Tablet 1 mg every 6 hours PRN

Objective Findings:

Vital Signs:
- **Vital Signs:** Weight (04/04/14) = 47.5 kg

Progress Note-Primary: Psychiatry

04/04/2014 09:51 SEEGAN, ALEXIS (MD (R))

Temp (degrees C): 37 (36.4 - 37.4), HR (bpm): 68 (68 - 129), Respiration (breaths/min): 18 (16 - 20), SpO2 (%): 98 (98 - 98),
Lying: BP 104/56 HR 83
Standing: BP 111/59 HR 72

Psychiatric: Appearance: Patient appears younger than their stated age, has fair grooming and hygiene, and is wearing clothing appropriate to weather and circumstance.
Behavior: Mild psychomotor retardation noted. Fair eye contact. No abnormal movements.
Speech: Increased speech latency, hypoverbal. Soft. Normal tone.
Mood: "feeling like I did something wrong."
Affect: Restricted to depression and anxiety, reactive. Congruent with stated mood.
Thought content: Endorses suicidal ideations and desire to self-harm by biting self, denies intent to hurt self in the hospital and verbalizes that she could tell staff if she felt like hurting herself. Endorses current SI. She denies current homicidal ideation, paranoid ideation, or auditory or visual hallucinations.
Thought processes: Linear, logical, goal-directed.
Associations: Intact.
Insight: marginal, improving.
Judgment: impaired.

Review of Medical Necessity:

- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.
- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

Assessment and Plan:
Global Assessment & Plan:

- **Assessment and Plan:** Assessment: 17 yo F with PTSD, MDD, and social anxiety disorder that resulted in decreased functioning over the past 3 weeks prior to admission and was BIB mother after endorsing SI. While in the hospital she disclosed extensive history of sexual abuse going back to age 7 by family friend. After this disclosure, she was able to discuss that she has symptoms of PTSD including reexperiencing, avoidance, and nightmares. She has had episodes of self-harm on the unit where she has bitten her arm, which she says helps her manage extreme anxiety. Due to prolonged sexual abuse, she has immature coping skills and has poor distress tolerance, leading to self-injurious behavior and suicidal ideation. She has poor oral intake at meals which she attributes to her anxiety as well as difficulty eating larger meals as her usual pattern is to eat small meals throughout the day. Given recent stressor of having to describe sexual abuse in detail to CPS worker, she requires additional hospitalization to ensure her safety, and is not stable for discharge at this time. She feels unsafe and that she would be at risk of self-harm if she were to go home before going to Center For Discovery next week. She continues to endorse SI and had act of self-harm yesterday. She is at increased risk of dangerousness to self, and requires inpatient hospitalization to maintain her safety, for medication management, and psychiatric stabilization.

  Patient states she will tell nursing staff if she is having thoughts of self harm and therefore does not require current 1:1 and we will continue to assess for this need.

  Diagnosis
  Axis I: Major Depressive Disorder, Social Anxiety Disorder, PTSD.

Progress Note-Primary: Psychiatry

04/04/2014 09:51 SEEGAN, ALEXIS (MD (R))

Axis II: Deferred
Axis III: No acute issues.
Axis VI: Moderate- poor coping skills, poor social functioning,
Axis V: Global assessment of functioning of 25

Plan:
1. Psychiatric Medication Management:
- Add Ativan 0.5 mg daily prn anxiety, to give prior to going into shower.
- Continue Melatonin 3 mg QHS for insomnia, also provide Benadryl prn insomnia.
- Continue Prozac 40 mg daily for MDD, PTSD, anxiety.
- Continue Klonopin 1.5 mg PO BID for anxiety.
- Continue Prazosin 2mg PO QHS for nightmares associated with PTSD
- Ativan 1 mg q6 hrs prn anxiety.
- Both mother and father of patient have been consented and understand risks, benefits, and alternatives to treatment with above medications and are in agreement with treatment plan
2. Medical Issues:
Poor PO intake: Appreciate Dietician recs, will continue MVI, check daily weights, and encourage Ensure Plus TID PRN for less than 75% percent consumption, decreased % to make pt feel less pressure to finish meals. Weight has been stable during hospital course. Encourage pt to eat larger snacks.
Constipation: Continue Senna 17.2 mg QHS.
3. Pt allowed to chew gum during shower to help with flashbacks and anxiety per Dr. Turakhia, but must spit out as soon as out of shower. Continue individual, group, milieu, and allied services therapy.
4. Legal: vol by parent
5. CPS reports filed:
Report of potential physical abuse of patient's brother Adam in Las Vegas NV by family friend (Al), filed report with Clark County with CPS Lorea Arostegui referral # 1600635.
CPS report filed for sexual abuse by family friend, taken by Orange County CPS, Senior Social Worker Hanaa Hanna at 3/26/14 @ 20:00. Expect CPS worker to interview pt within 10 days.
5. Disposition: Appreciate CM assistance with placement following discharge. Pt will transition to Center for Discovery after discharge, will aim for discharge from hospital early next week pending psychiatric stabilization.

Above case was discussed with and supervised by attending psychiatrist Dr. Turakhia who agrees with above assessment and plan.

Billing Service Level:

- **Billing Service Level:** Level 2 - inpatient follow-up
- **Billing Modifiers:** GC

Attending Attestation:

- I personally coordinated care with: nurse; case manager; social worker.
- **Attending Attestation Statement:** I was present with the resident/fellow during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented by the resident. Any additions or revisions are included in the record.
- **Attestation Comments:** Engaged in self-injurious behavior yesterday in context of flashback. Then

REED, EMILY
MR#: [redacted] **Gender:** Female **Admit Date:** 03/18/2014 11:06
Visit#: [redacted] **DOB:** [redacted] **Discharge Date:** 04/07/2014 13:27
DR: TURAKHIA, ATUR V **Age:** 17y **Service:** IP Mental Health Adolescent

Progress Note-Primary: Psychiatry

04/04/2014 09:51 SEEGAN, ALEXIS (MD (R))

refused bedtime medications. Now compliant with medications again. Showering seems to be major trigger for reexperiencing, so supportive measures as above to be implemented, including Lorazepam 0.5mg prior to shower - close monitoring for fall risk. I spent 20 minutes speaking to patient's mother by phone providing psychoeducation (including diagnosis, expected course of illness/treatment which will involve episodic decompensations during an overall improving trajectory) as well as my concerns about patient going to Nevada prior to starting at Residential Treatment Center. Needs inpatient psychiatric hospitalization for danger to self.

Electronic Signatures:
SEEGAN, ALEXIS (MD (R)) (Signed 04-04-2014 11:25)
Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan
TURAKHIA, ATUR V (MD (A)) (Signed 04-06-2014 10:24)
Authored: Billing Service Level, Attending Attestation, Note Finalization
Co-Signer: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan

Last Updated: 04-06-2014 10:24 by TURAKHIA, ATUR V (MD (A))

Progress Note-Primary: Psychiatry

04/05/2014 16:49 RAWLES, JODY (MD (A))

- **Evaluation Date and Time:** 04-05-2014 16:49

Role:

- **Role:** Primary Service

Hospital Days:

- **Hospital Days:** 19

Subjective Findings:

- **Active Problems:** Patient was seen today, chart reviewed, and care plan discussed with treatment team. Patient remains depressed with suicidal ideation and is not safe to discharge at this time. Patient continues to require inpatient hospitalization.

  Nursing reports good sleep and oral intake. Patient is participating in groups and working on daily goals.

  Denies pain, fever, chills, nausea, vomiting, diarrhea, constipation, headache, chest pain, or shortness of breath; remainder of the review of systems is negative except as stated above.

Medications:

- **Medications:** Scheduled Med(s):
  clonazePAM Tablet 1.5 mg 2 times a day
  FLUoxetine Capsule/Tablet 40 mg daily
  multivitamin peds chewable Tablet 1 tablet(s) daily
  Non-Formulary Med 3 mg nightly at bedtime
  prazosin Capsule 2 mg nightly at bedtime
  senna Tablet 17.2 mg nightly at bedtime

Objective Findings:

- **Physical Exam:** Appearance: patient appears stated age, with appropiate appearance but in no acute distress
  Behavior: awake and alert, cooperative with interview
  Speech: slow rate, rhythm, reduced volume, and monotone.
  Mood: depressed
  Affect: restricted range but congruent
  Thought process: linear and goal-directed
  Thought content: positive suicidal ideation but feels safe within the hospital, no homicidal ideation, auditory hallucinations, visual hallucinations
  Attention span: poor
  Insight: fair
  Judgment: fair
  Impulse control: fair
  cognition: subjectively impaired but oriented to self, date, locations, and circumstance
  station/gait: normal muscle tone with no involuntary movements, stable gait.

Review of Medical Necessity:

- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.
- Is an indwelling urethral catheter present? not present.

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: TURAKHIA, ATUR V

Gender: Female
DOB: [redacted]
Age: 17y

Admit Date: 03/18/2014 11:06
Discharge Date: 04/07/2014 13:27
Service: IP Mental Health Adolescent

Progress Note-Primary: Psychiatry

04/05/2014 16:49 RAWLES, JODY (MD (A))

- Is a mechanical ventilator present? not present.

Assessment and Plan:
Global Assessment & Plan:

- **Assessment and Plan:** Axis I: Major Depressive Disorder, Social Anxiety Disorder. PTSD.
  Axis II: Deferred
  Axis III: No acute issues.

Plan:
1. Level of care: continue inpatient care.
2. Management of psychiatric illness - continue current medications
3. Management of medical illness – no acute issues.
4. Psychosocial - continue to encourage participation in individual, group, occupational, and milieu therapies
5. Disposition/Discharge plan - home when stable.

Billing Service Level:

- **Billing Service Level:** Level 2 - inpatient follow-up

Electronic Signatures:
RAWLES, JODY (MD (A)) (Signed 04-05-2014 16:51)
Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan, Billing Service Level

Last Updated: 04-05-2014 16:51 by RAWLES, JODY (MD (A))

PL 000152

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: TURAKHIA, ATUR V

Gender: Female
DOB: [redacted]
Age: 17y

Admit Date: 03/18/2014 11:06
Discharge Date: 04/07/2014 13:27
Service: IP Mental Health Adolescent

Progress Note-Primary: Psychiatry

04/06/2014 18:15 RAWLES, JODY (MD (A))

- **Evaluation Date and Time:** 04-06-2014 18:15

Role:
- **Role:** Primary Service

Hospital Days:
- **Hospital Days:** 20

Subjective Findings:
- **Active Problems:** Patient was seen today, chart reviewed, and care plan discussed with treatment team. Patient remains depressed continues to require inpatient hospitalization.

  Nursing reports good sleep and oral intake. Patient is participating in groups and working on daily goals.

  Denies pain, fever, chills, nausea, vomiting, diarrhea, constipation, headache, chest pain, or shortness of breath; remainder of the review of systems is negative except as stated above.

Medications:
- **Medications:** Scheduled Med(s):
  clonazePAM Tablet 1.5 mg 2 times a day
  FLUoxetine Capsule/Tablet 40 mg daily
  multivitamin peds chewable Tablet 1 tablet(s) daily
  Non-Formulary Med 3 mg nightly at bedtime
  prazosin Capsule 2 mg nightly at bedtime
  senna Tablet 17.2 mg nightly at bedtime

Objective Findings:
Vital Signs:
- **Vital Signs:** Weight (04/06/14) = 47.6 kg
  Temp (degrees C): 36.5 (36 - 36.9), HR (bpm): 71 (59 - 71), Respiration (breaths/min): 15 (15 - 17), SBP (mm Hg): 97 (97 - 97), DBP (mm Hg): 47 (47 - 47), MAP (mm Hg): 58 (58 - 58),

- **Physical Exam:** Appearance: patient appears stated age, with appropriate appearance but in no acute distress
  Behavior: awake and alert, cooperative with interview
  Speech: slow rate, rhythm, reduced volume, and normal tone.
  Mood: depressed
  Affect: restricted range but congruent
  Thought process: linear and goal-directed
  Thought content: positive suicidal ideation but feels safe within the hospital, no homicidal ideation, auditory hallucinations, visual hallucinations
  Attention span: poor
  Insight: fair
  Judgment: fair
  Impulse control: fair
  cognition: subjectively impaired but oriented to self, date, locations, and circumstance
  station/gait: normal muscle tone with no involuntary movements, stable gait.

PL 000153

Progress Note-Primary: Psychiatry

04/06/2014 18:15 RAWLES, JODY (MD (A))

Review of Medical Necessity:

- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.
- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

Assessment and Plan:
Global Assessment & Plan:

- **Assessment and Plan:** Axis I: Major Depressive Disorder, Social Anxiety Disorder, PTSD.
  Axis II: Deferred
  Axis III: No acute issues.

Plan:
1. Level of care: continue inpatient care.
2. Management of psychiatric illness - continue current medications, Schedule family meeting to discuss diagnosis, prognosis, and discharge plan.
3. Management of medical illness - no acute issues.
4. Psychosocial - continue to encourage participation in individual, group, occupational, and milieu therapies
5. Disposition/Discharge plan - home when stable.

Billing Service Level:

- **Billing Service Level:** Level 2 - inpatient follow-up

Attending Attestation:

- I personally coordinated care with: nurse.

Electronic Signatures:
RAWLES, JODY (MD (A)) (Signed 04-06-2014 18:17)
Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan, Billing Service Level, Attending Attestation

Last Updated: 04-06-2014 18:17 by RAWLES, JODY (MD (A))

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: TURAKHIA, ATUR V

Gender: Female
DOB: [redacted]
Age: 17y

Admit Date: 03/18/2014 11:06
Discharge Date: 04/07/2014 13:27
Service: IP Mental Health Adolescent

Progress Note-Primary: Psychiatry

03/25/2014 10:27 NISENBAUM, DAVID (MD (R))

- **Evaluation Date and Time:** 03-25-2014 10:27

Role:
- **Role:** Primary Service

Hospital Days:
- **Hospital Days:** 8

Subjective Findings:
- **Active Problems:** Patient interviewed and discussed with treatment team. No acute events overnight. She slept 7.5 hours but reports intermittent sleep disruptions. She consumed 50/50/100 percent of meals. Also reported episode of emesis one hour after dinner last night. Denies abdominal pain. She is unsure of when her last BM occurred, and was asked by nursing staff to complete a log so that she could mark when she has her next BM. She has had visits from her father over the weekend and he had to return to Las Vegas today. She reported with excitement that "I have good news, my father is going to move back to be closer to us". She continues to endorse anxiety although appears less anxious than previous interview. Following interview, patient quickly walked to resident and said "I do want to die" and became tearful.

Medications:
- **Medications:** Scheduled Med(s):
  clonazePAM Tablet 0.5 mg 2 times a day
  FLUoxetine Oral Soln 30 mg daily
  multivitamin peds chewable Tablet 1 tablet(s) daily
  OLANZapine Tablet 2.5 mg nightly at bedtime

Objective Findings:
Vital Signs:
- **Vital Signs:** Weight (03/25/14) = 47.3 kg
  Temp (degrees C): 36.5 (36.3 - 37), Respiration (breaths/min): 16 (16 - 16),

Psychiatric MSE
Appearance: Caucasian thin female, avg height, appears their stated age, good grooming and hygiene with hair in pigtails, and is wearing sweatshirt appropriate to weather and circumstance.
Behavior: Cooperative with interview, intermittently tearful, poor eye contact with her neck flexed looking at the ground, No PMR or PMA, sitting upright in chair
Speech: Hypoverbal with decreased volume, soft tone, decreased volume
Mood: "nervous"
Affect: blunted, guarded
Thought content: +SI, denies current HI, AH, VH
Thought processes: grossly linear, although paucity of thought
Insight: poor
Judgment: poor

Review of Medical Necessity:
- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.
- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

PL 000155

Progress Note-Primary: Psychiatry

03/25/2014 10:27 NISENBAUM, DAVID (MD (R))

Assessment and Plan:
Global Assessment & Plan:

- **Assessment and Plan:** 19 yo F with depressive symptoms and anxiety that has resulted in decreased functioning over the past 3 weeks BIB mother after endorsing SI with plan to not eat so she'll pass out. She has had decreased PO intake, loss of appetite and emesis possibly due to recent exacerbation in anxiety and depression likely related to unresolved emotional conflict involving her brother. Although, this will require further assessment. She has had minimal consumption of meals on the unit and observed episode of emesis likely due to anxiety and not meeting current criteria for eating disorder. Patient reports one episode of hearing a voice possibly consistent with non command type AH. Patient has also had decreased communication with possible occasional selective mutism, per mother she has had frequent crying spells and has been unable to attend school recently. She continues to endorse SI and patient is at increased risk of dangerousness to self and has had severe declines in functioning and requires inpatient hospitalization for medication initiation and stabilization.

  Patient states she will tell nursing staff if she is having thoughts of self harm and therefore does not require current 1:1 and we will continue to assess for this need

  Diagnosis
  Axis I: MDE, consider MDE with psychotic features; social anxiety do; rule out autism spectrum
  Axis II: Deferred
  Axis III: No acute issues.
  Axis VI: Moderate- poor coping skills, poor social functioning
  Axis V: Global assessment of functioning on admission of 25

  Plan:
  1. Psychiatric Medication Management:
  -Continue Prozac PO liquid formulation to 30mg PO QD with goal of titration to 40mg PO QD
  -Increase Klonopin to 1mg PO BID with goals of controlling anxiety and compliance with meals
  -Continue Zyprexa 2.5mg PO qhs as patient had endorsed AH and goal of stimulating appetite
  -Both mother and father of patient have been consented and understand risks, benefits, and alternatives to treatment with above medications and are in agreement with treatment plan
  -Appreciate Dietican recs, will continue MVI, check daily weights, and encourage Ensure Plus TID PRN for less than 100 percent consumption
  Weight has been stable during hospital course
  2. Medical Issues:
  Patient has been unable to remember date of last BM, we will start Colace 100mg PO QD and Senna and request patient to complete log for dates of BM
  3. Continue individual, group, milieu, and allied services therapy
  4. Legal: vol by parent
  Writer called Orange County CPS regarding mother of patient's report of potential physical abuse of patient's brother Adam in Las Vegas NV by family friend (Al), they stated that statute of limitation had passed as incident had occurred in 2007, therefore filed report with Clark County (las vegas) CPS Lorea Arostegui referral # 1600635
  5.. Disposition: Appreciate CM assistance with placement following discharge

Progress Note-Primary: Psychiatry

03/25/2014 10:27 NISENBAUM, DAVID (MD (R))

Above case was discussed with and supervised by attending psychiatrist Dr. Turakhia who agrees with above assessment and plan.

Electronic Signatures:
NISENBAUM, DAVID (MD (R)) (Signed 03-25-2014 15:00)
Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan
TURAKHIA, ATUR V (MD (A)) (Signature Pending)
Co-Signer: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan

Last Updated: 03-25-2014 15:00 by NISENBAUM, DAVID (MD (R))

Progress Note-Primary: Psychiatry

03/27/2014 10:55 NISENBAUM, DAVID (MD (R))

- **Evaluation Date and Time:** 03-27-2014 10:55

Role:
- **Role:** Primary Service

Hospital Days:
- **Hospital Days:** 10

Subjective Findings:
- **Active Problems:** Patient interviewed and discussed with treatment team. She slept 7 hours with intermittent sleep disturbances. Patient disclosed a long hx of sexual abuse from family friend AI, for multiple years with the last incident possibly in the past few months. This is more extensively documented in event note by Dr. Seegan 3/26/14, which was reviewed by treatment team this AM. Patient states that she was able to talk about the abuse now because her aunt had shared a story with her that made her feel more comfortable sharing what happened to her. She reports feeling "scared" but feels safe here in the hospital. She also is now endorsing sxs including flashbacks and "memories of being touched" and that this has been what is occuring when she takes showers here in the hospital and has occasionally bitten her arm as she is "having a panic". She also endorsed avoidance behavior, as she does not like taking baths reporting that this reminded her of abuse in the past. Also, has occasional nightmares multiple times during the week, although unsure of how frequent.

  She consumed 20 percent of dinner with Ensure supplementation and 100 percent of breakfast without episodes of emesis x 24 hours. She denies daytime sedation or dizziness and orthostatics were negative.
  This AM she reports SI without plan and when asked about details of this replied "I don't know". She reports her anxiety has had mild improvements from earlier in the week, although she "feels scared".

Medications:
- **Medications:** Scheduled Med(s):
  clonazePAM Tablet 1 mg 2 times a day
  FLUoxetine Oral Soln 30 mg daily
  multivitamin peds chewable Tablet 1 tablet(s) daily
  OLANZapine Tablet 5 mg nightly at bedtime
  senna Tablet 8.6 mg nightly at bedtime

Objective Findings:
Vital Signs:
- **Vital Signs:** Weight (03/27/14) = 48 kg
  Temp (degrees C): 36 (36 - 37), Respiration (breaths/min): 14 (14 - 16),

Psychiatric: MSE
Appearance: Caucasian thin female, avg height, appears their stated age, good grooming and hygiene, and is wearing sweatshirt appropriate to weather and circumstance.
Behavior: Cooperative with interview, calm, intermittent eye contact, No PMR or PMA, sitting upright in chair
Speech: Hypoverbal with decreased volume, soft tone
Mood: "scared"
Affect: blunted, guarded

Progress Note-Primary: Psychiatry

03/27/2014 10:55 NISENBAUM, DAVID (MD (R))

Thought content: +SI, denies current HI, AH, VH
Thought processes: grossly linear
Insight: poor
Judgment: poor

Review of Medical Necessity:

- Number of Active Central Lines/PICC Sites (according to flowsheet documentation) not present.
- Is an indwelling urethral catheter present? not present.
- Is a mechanical ventilator present? not present.

Assessment and Plan:
Global Assessment & Plan:

- **Assessment and Plan:** 19 yo F with depressive symptoms and anxiety that has resulted in decreased functioning over the past 3 weeks BIB mother after endorsing SI. She has had minimal consumption of meals on the unit and observed episode of emesis likely due to anxiety and not meeting current criteria for eating disorder. Patient disclosed extensive hx of sexual abuse by family friend AI, she previously denied his to treatment team and mother, although felt more comfortable reporting the abuse following discussion with her aunt. She is also endorsing sxs consistent with PTSD including reexperiencing and avoidance cluster of sxs.
  Patient has also had decreased communication with possible occasional selective mutism, per mother she has had frequent crying spells and has been unable to attend school recently. During hospital course she has had self injurious behavior of biting her arm. She continues to endorse SI and patient is at increased risk of dangerousness to self and has had severe declines in functioning and requires inpatient hospitalization for medication initiation and stabilization.

  Patient states she will tell nursing staff if she is having thoughts of self harm and therefore does not require current 1:1 and we will continue to assess for this need

  Diagnosis
  Axis I: MDE; social anxiety do; consider PTSD
  Axis II: Deferred
  Axis III: No acute issues.
  Axis VI: Moderate- poor coping skills, poor social functioning
  Axis V: Global assessment of functioning on admission of 25

  Plan:
  1. Psychiatric Medication Management:
  -Continue Prozac 30 PO QD liquid formulation with goal of titration to 40mg PO QDay
  -Continue Klonopin to 1 mg PO BID with goals of controlling anxiety and compliance with meals, consider titration as tolerated if anxiety is not controlled with current dosage.
  -Continue Zyprexa 5mg PO qhs as patient had endorsed AH and goal of stimulating appetite
  -Start Prazosin 1mg PO QHS for nightmares associated with PTSD
  -Both mother and father of patient have been consented and understand risks, benefits, and alternatives to treatment with above medications and are in agreement with treatment plan
  -Appreciate Dietician recs, will continue MVI, check daily weights, and encourage Ensure Plus TID PRN for less than 100 percent consumption

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: TURAKHIA, ATUR V

Gender: Female
DOB: [redacted]
Age: 17y

Admit Date: 03/18/2014 11:06
Discharge Date: 04/07/2014 13:27
Service: IP Mental Health Adolescent

Progress Note-Primary: Psychiatry

03/27/2014 10:55 NISENBAUM, DAVID (MD (R))

Weight has been stable during hospital course

2. Medical Issues:
Patient reports +BM 2 days previously, although does not recall previous BM therefore we will continue Senna and request patient to complete log for dates of BM

3. Continue individual, group, milieu, and allied services therapy

4. Legal: vol by parent
Writer called Orange County CPS regarding mother of patient's report of potential physical abuse of patient's brother Adam in Las Vegas NV by family friend (Al), they stated that statute of limitation had passed as incident had occurred in 2007, therefore filed report with Clark County (las vegas) CPS Lorea Arostegui referral # 1600635

5.. Disposition: Appreciate CM assistance with placement following discharge

Above case was discussed with and supervised by attending psychiatrist Dr. Turakhia who agrees with above assessment and plan.

Electronic Signatures:
NISENBAUM, DAVID (MD (R)) (Signed 03-27-2014 11:44)
Authored: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan
TURAKHIA, ATUR V (MD (A)) (Signature Pending)
Co-Signer: Evaluation Date/Time, Subjective Findings, Medications, Objective Findings, Review of Medical Necessity, Assessment and Plan

Last Updated: 03-27-2014 11:44 by NISENBAUM, DAVID (MD (R))

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: TURAKHIA, ATUR V

Gender: Female
DOB: [redacted]
Age: 17y

Admit Date: 03/18/2014 11:06
Discharge Date: 04/07/2014 13:27
Service: IP Mental Health Adolescent

Discharge Note.

04/07/2014 10:50 SEEGAN, ALEXIS (MD (R))

Admission/Discharge Dates:
- **Admission Date** 03-18-2014
- **Discharge Date** 04-07-2014

Discharge Attending:

Provider Role	Provider Name	Occupation	Specialty
Attending	TURAKHIA, ATUR V	MD (A)	Psychiatry

DC Diagnosis:
1. **Major depressive disorder**
2. **Chronic post-traumatic stress disorder**
3. **Social anxiety disorder**

HPI/Hospital Course:
- **Brief HPI/Hospital Course by Diagnosis:** Date of Admission: March 18, 2014
  Date of Discharge: April 7, 2014

From H&P dated 3/18/14:
HPI: Per recent consult note "17 y/o F w/ no previous psychiatric history BIB mother for 'depression' x 3 weeks. Mother reports that pt had been doing very well in school ('straight A's') and didn't report any mood symptoms until about 3 weeks ago, when she started crying during class and stated "I don't want to live anymore." Pt denies any recent stressors, and is not sure why she feels so sad. About 1 week ago pt began to eat very little 2/2 decreased appetite. Her mother reports that pt won't eat unless her parents make her eat. She reports feeling 'numb', and states "I can't think; I have no thoughts." Earlier today pt started crying in class, laying on the floor in the fetal position, so the school psychologist recommended mother take her to the ED. Mother reports that pt is withdrawn and guarded at home, isolating herself in her room frequently, and answers most questions with "I don't know." Pt reported earlier that she wanted to 'not eat' and 'exercise' so that she'll 'pass out and never wake up.'

Today during interview patient was hypoverbal and answered with very soft tone and decreased volume, "I don't know" to almost all lines of questioning. She did endorse that she was feeling anxious, and reports that her anxiety has led to few episodes of emesis in the past few weeks. She denies hx of purging, restricting diet to lose weight and report that she currently believes she is at a good weight. She runs cross country but denies this is an attempt to lose weight. She denies SI, HI, AH, VH.

Majority of hx obtained from collateral information from mother who states that patient has not had depressive sxs until 3 weeks previously and she is unsure of any acute stressor. She also reports that recent depression and anxiety has generally been isolated to while she is at school and that at home she appears happy and has not had decreases in functioning at home only at school.

She also report that patient's communication has been severely impaired during the past 3 weeks, but that she has had difficulty communicating throughout childhood that they attributed to "being shy" and what they previously thought was hearing loss, however recent tests have shown no evidence of hearing loss. She also has difficulty forming friendships and responding to social cues. When patient is at psychologist office at school she often "sits on the floor, rather than chair so that she won't feel important".

Mother of patient also told of hx in 2007 that Emily was hiding possessions, keys, wallets, shoes of

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: TURAKHIA, ATUR V

Gender: Female
DOB: [redacted]
Age: 17y

Admit Date: 03/18/2014 11:06
Discharge Date: 04/07/2014 13:27
Service: IP Mental Health Adolescent

Discharge Note.

04/07/2014 10:50 SEEGAN, ALEXIS (MD (R))

multiple family members as well as family friend Al in Las Vegas. The family assumed it was her younger brother Adam that was doing this and therefore Adam was punished for this. Per mother, the family friend Al also may have physically abused Adam, she states that he had admitted during a court deposition that he had tied Adam's hands in long sleeved shirt behind his back, and duct taped his hands and locked him in a room. Mother of patient says that Emily believes that she blamed herself for the punishment that Adam received and that she had nightmares 2 years later. Unclear if any other PTSD sxs were present.

Psychiatric History: No previous hospitalizations, suicide attempts, or outpatient psychiatrists.
She has been followed by psychologist Tiffany Doe at IEP since age 15, has seen every day for past 3 weeks
Seen therapist Stephanie Frasier 2 times last week for the first time
Medical History: Unremarkable
Allergies: NKDA
Medication History: No current medications

Social History:
Denies use of etoh, illicit, or tobacco
Developmental: Patient met all developmental milestones as expected. She has always had A's in school, although mother reports that she tested at 1st grade reading level while in 4th grade. She had failed multiple hearing tests but her repeat tests were inconsistent indicating possible malingering and her brainstem testing in 2013 demonstrated no hearing loss.
She grew up in Las Vegas and moved to Huntington Beach with her mother 3 years previously. She lives with her mother, and 2 brothers age 13,15. Mother has remarried although (Jeff) new husband lives in Brea do to work. Parents divorced in 2006 and parents have joint legal custody and mother Alicia Draper (714 916 1524) has majority physical custody. Emily and her 2 brothers go to Vegas to stay with their father (Jeff) 702 241 2486, every other weekend and 7 weeks in the summer. Patient has an IEP through school started in 5th grade. Per mother patient has denied hx of sexual activity and has never been in a relationship. Mother reports that patient has denied hx of physical, emotional or sexual abuse to her.

Family History: Family: 13 yo brother with MDD, unknown medication hx

Physical Exam on Admission:
GEN: Awake, Alert, No apparent distress
HEENT: moist mucous membranes.
NECK: FROM.
CVS: tachycardic, normal S1 and S2, no murmurs, gallops, or rubs
CHEST: Breath Sounds equal bilaterally
ABD: Soft, non-tender, non-distended. Normoactive bowel sounds.
EXT: no cyanosis, clubbing or edema
SKIN: No rash. Skin intact
NEUROLOGICAL: Cranial nerves II-XII are intact. Motor System: 5/5 strength throughout. The patient has stable gait on narrow base. Sensory system: Intact throughout to light touch. A&Ox3

MSE on Admission

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: TURAKHIA, ATUR V

Gender: Female
DOB: [redacted]
Age: 17y

Admit Date: 03/18/2014 11:06
Discharge Date: 04/07/2014 13:27
Service: IP Mental Health Adolescent

Discharge Note.

04/07/2014 10:50 SEEGAN, ALEXIS (MD (R))

Appearance: Caucasian thin female, avg height, appears their stated age, good grooming and hygiene, and is wearing clothing appropriate to weather and circumstance.
Behavior: Appears anxious, poor eye contact, +PMR
Speech: Hypoverbal, increased latency, very soft tone,
Mood: "I don't know"
Affect: blunted, very guarded
Thought content: denies SI, although reported SI during recent ED interview, denies HI/AH/VH
Thought processes: grossly linear, although paucity of thought
Insight: poor
Judgment: poor
Cognitive
Alert and oriented x4
Memory: Marginal
Attention: Marginal
Concentration: Diminished
Fund of knowledge: Intact
Ability to name common objects: Intact.

Hospital Course:

The patient was admitted to the adolescent inpatient psychiatric unit under the care of attending psychiatrist Dr. Atur Turakhia on a voluntarily by parent, mother Alicia Draper (714) 916-1524. On admission, she was started on fluoxetine 10 mg solution to target symptoms of anxiety and depression as patient initially reported difficulty swallowing pills, which was titrated up to 40 mg and tolerated well without reported side effect. Fluoxetine started as liquid formulation as patient reported difficulty swallowing pills, but changed to capsule form as hospitalization continued. She had minimal oral intake and endorsed mealtime anxiety, so oral lorazepam was started prior to meals to increase consumption. As she continued to endorse anxiety at baseline, lorazepam was discontinued, and clonazepam was started and titrated up to 1.5 mg BID. Emily endorsed one episode of auditory hallucinations, so olanzapine 2.5 mg qhs was started with goal to target AH and increase appetite. The olanzapine was increased to 5 mg qhs, and titrated off prior to discharge. Dietician saw patient and recommended small meals throughout the day as this was patient's preference at home, and her diet improved during hospital course as she was consuming a majority of meals with occasional ensure supplementation. Early in hospital course patient had frequent emesis with meals and stated that eating "makes me sad". Patient's symptoms were not consistent with eating disorder, and were thought to be secondary to severe anxiety, although later during hospital course patient reported extensive history of sexual abuse being forced into oral sex and this may have correlation with her aversion to meals.

Early in hospital course, patient was hypoverbal and answered many questions with the phrase "I don't know" to even basic lines of questioning. She also regressed to childlike behaviors, such as sitting on the floor, and asking to sleep in her closet. She also had intermittent self-injurious behaviors including biting her arm. While patient had denied abuse in the past for years per mother, the mother had suspected that she may have been abused. The patient's paternal aunt came to visit and shared her own history of trauma, and this allowed for Emily to disclose history of being sexually abused on HD#6. She informed family and physician that she had been sexually abused by a family friend Alan Gorry, who is her father's roommate in Las Vegas Nevada. She reported that he had forced her to watch pornographic film and engage in oral sex for multiple years. This report is described in detail in event note by Dr. Seegan on 3/26/14. Report taken by Orange County CPS, Senior Social Worker

Discharge Note.

04/07/2014 10:50 SEEGAN, ALEXIS (MD (R))

Hanaa Hanna at 3/26/14 @ 20:00.

After she disclosed abuse, further interview found that patient endorsed many symptoms consistent with PTSD including nightmares, flashbacks, and avoidance symptoms. Prazosin was initiated and increased to 2mg PO QHS. She continued to endorse SI early during hospital course without plan, although she had improvements in terms of her anxiety and ability to communicate verbally with treatment team. Over course of hospitalization, Emily had significant improvements in her ability to communicate her needs with family and staff, to describe her emotions, and developed coping skills to help her manage flashbacks and feeling overwhelmed. At time of discharge, she denied urges to self-harm and suicidal ideation for 48 hours. Mother arranged for patient to go to Center For Discovery in Long Beach after discharge from hospital for continued intensive therapy and residential care. Patient expressed that she would feel more comfortable going to a residential program after the hospital rather than returning to home. Admission to CFD was confirmed with admissions worker Annette Valdez. Mother was given patient's prescriptions on discharge, and Emily verbally stated that she felt able to tell staff or family if she had urges to self-harm or had suicidal ideation after discharge.

Of note at time of admission mother of patient informed resident that the family friend Al Gorry had disciplined, Emily's younger brother Adam when he was 6 years old by duct taping his hands and locking him in a room. Therefore Writer called Orange County CPS regarding mother of patient's report of potential physical abuse of patient's brother Adam in Las Vegas NV by family friend (Al), they stated that statute of limitation had passed as incident had occurred in 2007, therefore filed report with Clark County (las vegas) CPS Lorea Arostegui referral # 1600635

Medical Issues during admission:
Poor oral intake: As described in above hospital course. Pt's weight remained stable throughout admission, and oral intake was improved with addition of Ensures with meals and providing pt with smaller, more frequent meals throughout the day.
Patient had intermittent constipation that was relieved with senna and dulcolax.

Assessment on discharge:
Axis I: PTSD, Major Depressive Disorder. Social Anxiety Disorder.
Axis II: Deferred
Axis III: Intermittent constipation.
Axis VI: Mod-severe: prolonged abuse, decline in social and academic functioning, complex family dynamics.
Axis V: Global Assessment of Functioning on Discharge is 50

Discharge medications:
1. Fluoxetine 40 mg po daily
2. Clonazepam 1.5 mg po BID
3. Prazosin 2 mg po qhs
4. Melatonin 3 mg po qhs
5. Lorazepam 1 mg po q6 hours prn anxiety

Physical Exam on Day of Discharge:

- **Vital Signs:** Weight (04/07/14) = 47.5 kg
  Temp (degrees C): 36.4 (36 - 36.5). HR (bpm): 71 (71 - 71). Respiration (breaths/min): 16 (15 - 16).
- **Physical Exam:** Mental Status Exam on Discharge:

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: TURAKHIA, ATUR V

Gender: Female
DOB: [redacted]
Age: 17y

Admit Date: 03/18/2014 11:06
Discharge Date: 04/07/2014 13:27
Service: IP Mental Health Adolescent

Discharge Note.

04/07/2014 10:50 SEEGAN, ALEXIS (MD (R))

Appearance: Appears younger than stated age. Fair grooming and hygiene. Clothing appropriate to weather and circumstance.
Behavior: No psychomotor agitation or retardation. Fair eye contact. No abnormal movements.
Speech: Normal rate and rhythm, soft.
Mood: "Good, a little anxious"
Affect: Congruent with mood, appropriate.
Thought content: Denies suicidal ideation, intent, or plan. Denies homicidal ideation, paranoid ideation, and auditory or visual hallucinations.
Thought process: Linear, logical, goal-oriented.
Insight: Fair
Judgment: Fair

Discharge Type and Core Measures:

- **Discharge Type** Standard
- **Smoking Status** never smoker

Discharge Instructions:

- **Discharge Disposition:** home, Center for Discovery, Long Beach
- **Condition at Discharge:** stable, improved
- **Diet at discharge::** regular 6 small meals per day
- **Activity on discharge::** activity as tolerated
- **Equipment::** none
- **Additional instructions for the patient:** Discharge Instructions: The patient was discharged with a diet as indicated above, encouraged to remain active with daily light physical activity, and instructed to take medications as prescribed. Patient was also instructed to follow-up with outpatient treatment as indicated below. Pt was also instructed to call 911 or proceed to the nearest ER should they experience an exacerbation of suicidal thoughts, homicidal thoughts, auditory hallucinations, paranoid ideations, psychotic symptoms. They were also instructed to abstain from the use of heavy alcohol or illicit drugs. Lastly, the patient was discharged in stable condition.
- **Medication List:**

Discharge Medications

- clonazepam 1 mg oral tablet
  Instructions: 1.5 tab(s) orally 2 times a day
  Comments: Caution federal law prohibits the transfer of this drug to any person other than the person for whom it was prescribed.
  Do not drink alcoholic beverages when taking this medication.
  Do not take this drug if you are pregnant.
  It is very important that you take or use this exactly as directed. Do not skip doses or discontinue unless directed by your doctor.
  May cause drowsiness. Alcohol may intensify this effect. Use care when operating dangerous machinery.
  Obtain medical advice before taking any non-prescription drugs as some may affect the action of this medication.
  This drug may impair the ability to drive or operate machinery. Use care until you become familiar with its effects.
  (written prescription)

REED, EMILY
MR#: [redacted] **Gender:** Female **Admit Date:** 03/18/2014 11:06
Visit#: [redacted] **DOB:** [redacted] **Discharge Date:** 04/07/2014 13:27
DR: TURAKHIA, ATUR V **Age:** 17y **Service:** IP Mental Health Adolescent

Discharge Note.

04/07/2014 10:50 SEEGAN, ALEXIS (MD (R))

- Prozac 40 mg oral capsule
  Instructions: 1 cap(s) orally once a day
  Comments: It is very important that you take or use this exactly as directed. Do not skip doses or discontinue unless directed by your doctor.
  May cause drowsiness. Alcohol may intensify this effect. Use care when operating dangerous machinery.
  Obtain medical advice before taking any non-prescription drugs as some may affect the action of this medication.
  (written prescription)

- prazosin 2 mg oral capsule
  Instructions: 1 cap(s) orally once a day (at bedtime)
  Comments: It is very important that you take or use this exactly as directed. Do not skip doses or discontinue unless directed by your doctor.
  May cause drowsiness. Alcohol may intensify this effect. Use care when operating dangerous machinery.
  Some non-prescription drugs may aggravate your condition. Read all labels carefully. If a warning appears, check with your doctor before taking.
  (written prescription)

- lorazepam 1 mg oral tablet
  Instructions: 1 tab(s) orally every 6 hours, As Needed - as needed for anxiety
  Comments: Caution federal law prohibits the transfer of this drug to any person other than the person for whom it was prescribed.
  Do not take this drug if you are pregnant.
  May cause drowsiness. Alcohol may intensify this effect. Use care when operating dangerous machinery.
  (written prescription)

- melatonin 3 mg oral tablet
  Instructions: 1 tab(s) orally once a day (at bedtime)
  Comments:
  (written prescription)

Blood Thinners:
no.

Follow Up Appointments:
Follow up with your primary care provider .

Billing Level:

- **Billing Level:** Less than 30mins of discharge planning, education and care coordination by Attending
- **Attending Attestation Statement:** I saw and examined the patient and discussed the case with the resident/fellow. I agree with the final findings and plan as documented in the record. We formulated the assessment and plan together. Any additions or revisions are included in the record.
- **Note Status:** This report constitutes the full discharge summary for this patient in lieu of a dictated discharge summary.
- **Additional Attending Comments:** Patient seen and examined by me on date of discharge 4/7/14. Patient was admitted for danger to self and poor self care. Hospital course notable for disclosure of sexual

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: TURAKHIA, ATUR V

Gender: Female
DOB: [redacted]
Age: 17y

Admit Date: 03/18/2014 11:06
Discharge Date: 04/07/2014 13:27
Service: IP Mental Health Adolescent

Discharge Note

04/07/2014 10:50 SEEGAN, ALEXIS (MD (R))

abuse several days in to hospitalization. Significant psychoeducatin and psychotherapy provided addressing this significant development. Child Protective Services was also involved. Medication adjustments made were titration of Fluoxetine to 40mg, titration of Prazosin to 2mg, and titration of Clonazepam to 1.5mg BID. Other medications which were stopped by time of discharge are noted above. No suicidal ideation on discharge examination. Follow-up scheduled with psychiatrist and therapist at Residential Treatment Center.

Other Instructions-UCI Health Care Team:

Nursing:

The patient left the hospital:	walking
The patient left the hospital with	parent
Medication information sheets were provided	for all discharge medications
Discharge Instructions	patient and/or family verbalizes understanding of post-hospital plans

Case Management:

Additional Information for the patient	Emily you will be going to Center for Discover 425 East 31 st, Long Beach - (562) 981-0700, You will be seen in intake on arrival. Your emotional, social, new coping skills and behavioral support will be managed by staff at the facility and a program psychiatrist and therapist will see you.

Authors:
ELECTRONIC SIGNATURES MAY BE ATTRIBUTED TO INDIVIDUALS THAT REVIEWED DOCUMENTATION IN THE LISTED SECTIONS WITHOUT AUTHORING CHANGES.

Electronic Signatures:
CHUNG, PATRICK (Pharmacist) (Signed 04-07-2014 11:36)
Authored: Admission/Discharge Dates, Discharge Information/Instructions/Core Measures
HALPIN, ANGELA (RN) (Signed 04-07-2014 13:10)
Authored: Admission/Discharge Dates, Other Instructions-UCI Health Care Team
SEEGAN, ALEXIS (MD (R)) (Signed 04-07-2014 10:57)
Authored: Admission/Discharge Dates, Providers, Discharge Diagnoses/Procedures/Hospital Course/Patient Data, Physical Exam on Day of Discharge, Discharge Information/Instructions/Core Measures, Authorship Disclaimer
SEXON, DJOHANNA (RN) (Signed 04-07-2014 13:36)
Authored: Admission/Discharge Dates, Other Instructions-UCI Health Care Team
TURAKHIA, ATUR V (MD (A)) (Signed 04-08-2014 08:46)
Authored: Admission/Discharge Dates, Discharge Diagnoses/Procedures/Hospital Course/Patient Data, Attending Attestation, Note Finalization
Co-Signer: Admission/Discharge Dates, Providers, Discharge Diagnoses/Procedures/Hospital Course/Patient Data, Physical Exam on Day of Discharge, Discharge Information/Instructions/Core Measures, Authorship Disclaimer

Last Updated: 04-08-2014 08:46 by TURAKHIA, ATUR V (MD (A))

REED, EMILY
MR#: [redacted] Gender: Female Admit Date: 03/18/2014 11:06
Visit#: DOB: [redacted] Discharge Date: 04/07/2014 13:27
DR: TURAKHIA, ATUR V Age: 17y Service: IP Mental Health Adolescent

Emergency Physician Treatment Record

03/17/2014 19:54 BREED, WYNNE (MD (R))

Faculty Comments:

• Faculty Comments	17F with suicidal ideation with plan . ddx - depression, suicidality, doubt psychosis.

History of Present Illness:
A 17 year old female patient presented with mother wants a psych eval. pt expressed SI with plan to not eat, very emotional at school, sleeping 4 days "not eating will make me pass out" no hi no hallucinations mom states rocking back in forth in a fetal position and then started laughing immediately after.

Onset	acute
Contributing History	17F no pmh p/w SI, anhedonia, altered sleep x1wk, decreased appetite, uncontrolled bouts of crying. Per mother pt has been seen by pmd for same, but worsening over past week. Pt has been refusing food unless pressured by mom at home. Food makes her nauseas. Denies fever, chills, nausea, vomiting, sob, CP, dysuria, hematuria, black or bloody stool, constipation, diarrhea. Denies audio or visual hallucinations, denies suicidal plan, denies danger to others.

Allergies & Intolerances:
Allergies:
- No Known Allergies:

Past Medical, Family and Social History:

Past Medical History Comments	denies
Past Surgical History Other	denies
Frequency of Alcohol Intake	never(1)
Smoking Status	never smoker(1)
Chewing Tobacco	no(2)

Review of Systems:

System Review negative symptoms include	All systems negative except for that noted below no fever, no chills, no nausea, no vomiting, no diarrhea, no cough, no shortness of breath

Nursing/Medications Reviewed:

Nursing/Medications Reviewed	nursing notes and vital signs reviewed, medication profile reviewed from nursing triage note

Initial Vitals:
Temp:

• Temperature degrees C	37.6 degrees C
• Temperature degrees F	99.6 degrees F
• Site	Oral

Heart Rate:

REED, EMILY
MR#: [redacted]
Visit#:
DR: TURAKHIA, ATUR V

Gender: Female
DOB: [redacted]
Age: 17y

Admit Date: 03/18/2014 11:06
Discharge Date: 04/07/2014 13:27
Service: IP Mental Health Adolescent

Emergency Physician Treatment Record

03/17/2014 19:54 BREED, WYNNE (MD (R))

- Heart Rate (beats/min): 109 beat(s) per minute

Blood Pressure:
- Systolic BP: 124 mm Hg
- Diastolic: 76 mm Hg

Resp/Pulse Ox:
- Resp Rate breaths/min: 16 / minute
- Pulse Oximetry: ↑ 99 %
- Patient on: Room air

Pain Assessment:
- Pain Level: 0[2]
- Pain Scale Used: numeric[3]

Physical Exam:
- PE Details

General: Well developed, well nourished, minimal distress.
HEENT: normocephalic/atraumatic, PERRL, EOMI, mucous membranes moist
Neck: Supple
Chest: CTAB w/o wheezes, rales, rhonchi
CV: RRR w/ no murmurs, rubs, gallops
Abdomen: +bowel sounds, soft, nontender/nondistended, no rebound, no guarding. No CVA tenderness
Ext: warm, well perfused; no cyanosis, clubbing, edema
Neurological: moves all extremities, CN II-XII intact grossly
Skin: No jaundice, no rash
Psych: Appropriate

Medical Decision Making:

Impression/MDM: Mental health crisis: Differential diagnosis includes anxiety, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar affective disorder with manic or depressive phase, neurotic disorders including borderline, oppositional defiant, obsessive compulsive, and others. Patient is unable to cope with social situation and needs urgent evaluation by psychiatrist. If patient expresses suicidal or homicidal ideation and is here voluntarily, will maintain patient safety with Level II observation by security officer. If involuntary yet graveley disabled, or danger of self harm or to others, will place on 5150 legal hold. Will exclude acute medical illness such as electrolyte disorder, dehydration, intoxication, delirium, withdrawal and overdose.

Assessment and Plan:

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: TURAKHIA, ATUR V

Gender: Female
DOB: [redacted]
Age: 17y

Admit Date: 03/18/2014 11:06
Discharge Date: 04/07/2014 13:27
Service: IP Mental Health Adolescent

Emergency Physician Treatment Record

03/17/2014 19:54 BREED, WYNNE (MD (R))

Plan	ua, upreg, utox, level II
Diagnosis	Depression Suicidality
Billing	99285

Physician Hand Off Note:

Physician Hand Off Note	Marino to Dr. Mark Langdorf at 7am: 17 year old girl with suicidal ideation and depression x 1 week, may be going to Loma Linda University for adolescent psychiatric service, had bed at Cerritos but Mom did not agree.

ED Course:
20:21 No evidence of acute organic disease to rule out psychiatric evaluation at this time. Medically cleared. - Breed.

TREATMENT NOTE FINALIZATION:

NOTE IS READY TO BE COMPLETED	Chart is complete and signed

PATH STATEMENT:
Physicians at Teaching Hospitals:

Attending Physician Statement	I personally evaluated patient and discussed the management plan with the resident. I reviewed the resident's note and agree with the documented findings and plan of care. Any additions or revisions are included in the record.

Electronic Signatures:
BREED, WYNNE (MD (R)) (Signed 03-17-2014 20:21)
Authored: HPI, ALLERGIES, OUTPATIENT MEDICATIONS, PFSH, ROS, NURSING/MED PROFILE, Vitals, Physical Exam, MEDICAL DECISION MAKING, ASSESSMENT AND PLAN, ED COURSE
LANGDORF, MARK I (MD (A)) (Signed 03-18-2014 07:24)
Authored: ATTENDING'S HAND OFF NOTE
WIECHMANN, WARREN F (MD (A)) (Signed 03-25-2014 23:03)
Authored: FACULTY COMMENTS, PFSH, ASSESSMENT AND PLAN, TREATMENT NOTE FINALIZATION, PATH STATEMENT

Last Updated: 03-25-2014 23:03 by WIECHMANN, WARREN F (MD (A))

References:
1. Data Referenced From "ED Primary Assessment" 17-Mar-2014 6:09 PM
2. Data Referenced From "H&P-Primary-Psychiatry" 18-Mar-2014 1:44 PM
3. Data Referenced From "ED Rapid Screening Exam" 17-Mar-2014 6:35 PM

REED, EMILY
MR#: [redacted] **Gender:** Female **Admit Date:** 03/18/2014 11:06
Visit#: [redacted] **DOB:** [redacted] **Discharge Date:** 04/07/2014 13:27
DR: TURAKHIA, ATUR V **Age:** 17y **Service:** IP Mental Health Adolescent

H&P-Primary-Psychiatry

03/18/2014 13:44 NISENBAUM, DAVID (MD (R))

Evaluation and Admission Date/Time:

- **Evaluation Date and Time:** 03-18-2014 13:44
- **Admission Date:** 03-18-2014

Chief Complaint and History of Present Illness:

- **History of Present Illness:** ID: 17 yo Caucasian female student

CC: suicidal ideations, decreased functioning

HPI: Per recent consult note " 17 y/o F w/ no previous psychiatric history BIB mother for 'depression' x 3 weeks. Mother reports that pt had been doing very well in school ('straight A's') and didn't report any mood symptoms until about 3 weeks ago, when she started crying during class and stated "I don't want to live anymore." Pt denies any recent stressors, and is not sure why she feels so sad. About 1 week ago pt began to eat very little 2/2 decreased appetite. Her mother reports that pt won't eat unless her parents make her eat. She reports feeling 'numb', and states "I can't think; I have no thoughts." Earlier today pt started crying in class, laying on the floor in the fetal position, so the school psychologist recommended mother take her to the ED. Mother reports that pt is withdrawn and guarded at home, isolating herself in her room frequently, and answers most questions with "I don't know." Pt reported earlier that she wanted to 'not eat' and 'exercise' so that she'll 'pass out and never wake up.' Today during interview patient was hypoverbal and answered with very soft tone and decreased volume, "I don't know" to almost all lines of questioning. She did endorse that she was feeling anxious, and reports that her anxiety has led to few episodes of emesis in the past few weeks. She denies hx of purging, restricting diet to lose weight and report that she currently believes she is at a good weight. She runs cross country but denies this is an attempt to lose weight. She denies SI,HI, AH, VH.
Majority of hx obtained from collateral information from mother who states that patient has not had depressive sxs until 3 weeks previously and she is unsure of any acute stressor. She also reports that recent depression and anxiety has generally been isolated to while she is at school and that at home she appears happy and has not had decreases in functioning at home only at school.
She also report that patient's communication has been severely impaired during the past 3 weeks, but that she has had difficulty communicating throughout childhood that they attributed to "being shy" and what they previously thought was hearing loss, however recent tests have shown no evidence of hearing loss. She also has difficulty forming friendships and responding to social cues. When patient is at psychologist office at school she often "sits on the floor, rather than chair so that she won't feel important".

Mother of patient also told of hx in 2007 that Emily was hiding possessions, keys, wallets, shoes of multiple family members as well as family friend Al in Las Vegas. The family assumed it was her younger brother Adam that was doing this and therefore Adam was punnished for this. Per mother, the family friend Al also may have physically abused Adam, she states that he had admitted during a court deposition that he had tied Adam's hands in long sleeved shirt behind his back, and duct taped his hands and locked him in a room.
Mother of patient says that Emily believes that she blamed herself for the punnishment that Adam received and that she had nightmares 2 years later. Unclear if any other PTSD sxs were present.

Psychiatric History: No previous hospitalizations, suicide attempts, or outpatient psychiatrists.
She has been followed by psychologist Tiffany Doe at IEP since age 15, has seen every day for past 3

H&P-Primary-Psychiatry

03/18/2014 13:44 NISENBAUM, DAVID (MD (R))

weeks
Seen therapist Stephanie Frasier 2 times last week for the first time

Medical History: Unremarkable

Allergies:NKDA

Medication History: No current medications

RoS: Denies HA, CP, SOB, N/V or abdominal pain remainder negative.

Allergies & Intolerances:

Allergies:

- **No Known Allergies:**

Social History:

- **Smoking Status:** never smoker[1]
- **Chewing Tobacco:** no[1]
- **Frequency of Alcohol Intake:** never[1]
- **Substance Use:** Substance abuse hx: Denies use of etoh, illicit, or tobacco
- **Details:** Social:

  Developmental: Patient met all developmental milestones as expected. She has always had A's in school, although mother reports that she tested at 1st grade reading level while in 4th grade. She had failed multiple hearing tests but her repeat tests were inconsistent indicating possible malingering and her brainstem testing in 2013 demonstrated no hearing loss.
  She grew up in Las Vegas and moved to Huntington Beach with her mother 3 years previously. She lives with her mother, and 2 brothers age 13,15. Mother has remarried although (Jeff) new husband lives in Brea do to work. Parents divorced in 2006 and parents have joint legal custody and mother Alicia Draper (714 916 1524) has majority physical custody. Emily and her 2 brothers go to Vegas to stay with their father (Jeff) 702 241 2486, every other weekend and 7 weeks in the summer. Patient has an IEP through school started in 5th grade.
  Per mother patient has denied hx of sexual activity and has never been in a relationship. Mother reports that patient has denied hx of physical, emotional or sexual abuse to her.

Family History:

- **Details:** Family: 13 yo brother with MDD, unknown medication hx

Physical Exam:

- **Exam:** Physical Exam:

  GEN: Awake, Alert, No apparent distress
  HEENT: moist mucous membranes.
  NECK: FROM.
  CVS: tachycardic, normal S1 and S2, no murmurs, gallops, or rubs
  CHEST: Breath Sounds equal bilaterally
  ABD: Soft, non-tender, non-distended. Normoactive bowel sounds.
  EXT: no cyanosis, clubbing or edema

H&P-Primary-Psychiatry

03/18/2014 13:44 NISENBAUM, DAVID (MD (R))

SKIN: No rash. Skin intact.
NEUROLOGICAL: Cranial nerves II-XII are intact. Motor System: 5/5 strength throughout. The patient has stable gait on narrow base. Sensory system: Intact throughout to light touch. A&Ox3

MSE
Appearance: Caucasian thin female, avg height, appears their stated age, good grooming and hygiene, and is wearing clothing appropriate to weather and circumstance.
Behavior: Appears anxious, poor eye contact, +PMR
Speech: Hypoverbal, increased latency, very soft tone,
Mood: "I don't know"
Affect: blunted, very guarded
Thought content: denies SI, although reported SI during recent ED interview, denies HI/AH/VH
Thought processes: grossly linear, although paucity of thought
Insight: poor
Judgment: poor

Cognitive
Alert and oriented x 4
Memory: Marginal
Attention: Marginal
Concentration: Diminished
Fund of knowledge: Intact
Ability to name common objects: Intact.

Data Review:

- **Lab Data:**

Chem [03-18-2014 01:39]

```
142     |  105     |  5        /
        |          |          /
-----------------------------  92
        |          |          \
3.7     |  29      |  0.6       \
```

Assessment and Plan:

- **Assessment and Plan:** 19 yo F with depressive symptoms and anxiety that has resulted in decreased functioning over the past 3 weeks BIB mother after endorsing SI with plan to not eat so she'll pass out. She has had decreased PO intake, loss of appetite and emesis possibly due to recent exacerbation in anxiety and depression following stressful family encounter for the her brothers baptism and it is unlikely that patient has eating disorder. Although, this will require further assessment. She denies other acute stressors. Patient has also had decreased communication with possible occasional selective mutism, per mother she has had frequent crying spells and has been unable to attend school recently. Patient is at increased risk of dangerousness to self and has had severe declines in functioning and requires inpatient hospitalization for medication initiation and stabilization.

H&P-Primary-Psychiatry

03/18/2014 13:44 NISENBAUM, DAVID (MD (R))

I concur with the nursing admission suicide risk assessment: pending
I asked the patient "Do you feel safe in the hospital", replied: Y

Patient states she will tell nursing staff if she is having thoughts of self harm and therefore does not require current 1:1 and we will continue to assess for this need

Diagnosis
Axis I: Mood do nos, consider MDE vs adjustment disorder with depressed mood; social anxiety do; rule out autism spectrum
Axis II: Deferred
Axis III: No acute issues.
Axis VI: Moderate- poor coping skills, poor social functioning
Axis V: Global assessment of functioning on admission of 25

1. We will admit the patient to 2N voluntarily by mother

2. Begin q.15 minutes safety checks. The patient is a high risk for suicide, self harm

3. For the treatment of psychiatric symptoms; Risk, benefits, and alternatives for the above medications were discussed with the mother of patient who appears to understand. Mother signed consent, will discuss with father prior to initiation
-Consider Prozac 10mg PO QD to target anxiety, and depressive sxs
-Dietician consult, calorie count

4. We will attempt to increase collateral information contacting prior providers and family as well.

5. We will follow up on routine admission laboratory assessments.

6. Begin individual group, milieu, and allied services therapy

7. Disposition: To home once psychiatrically stable. Appreciate social work and case management assistance regarding arranging aftercare.

This patient was discussed with Dr. Turakhia who agrees with the above assessment and plan

Billing:
- **Billing Service Level:** Level 3 - initial hospital care

Attending Attestation:
- **Attending Attestation Statement:** I saw and examined the patient and discussed the case with the resident/fellow. I agree with the final findings and plan as documented in the record. We formulated the assessment and plan together. Any additions or revisions are included in the record.
- **Attending Attestation Comments** Patient seen and examined by me within 24 hours of admission on 3/18/14. Admitted for depression with suicidal ideation as well as grave disability with minimal eating and loss of functioning academically.

REED, EMILY
MR#: [redacted]
Visit#: [redacted]
DR: TURAKHIA, ATUR V

Gender: Female
DOB: [redacted]
Age: 17y

Admit Date: 03/18/2014 11:06
Discharge Date: 04/07/2014 13:27
Service: IP Mental Health Adolescent

H&P-Primary-Psychiatry

03/18/2014 13:44

NISENBAUM, DAVID (MD (R))

Will stabilize with medications and individual/group/milieu/recreational therapies. Start Fluoxetine liquid (patient not want to swallow pills). Will schedule family meeting. Dietician consult and calorie count. Will discharge when stable condition and no longer high risk of danger to self.

Electronic Signatures:
NISENBAUM, DAVID (MD (R)) (Signed 03-19-2014 10:18)
Authored: Evaluation and Admission Date/Time, Chief Complaint and History of Present Illness, Allergies & Intolerances, Home Medications,(Outpatient Medication Review), Social History, Family History, Physical Exam, Data Review, Assessment and Plan
TURAKHIA, ATUR V (MD (A)) (Signed 03-20-2014 17:36)
Authored: Billing, Attending Attestation, Select Note Finalization

Last Updated: 03-20-2014 17:36 by TURAKHIA, ATUR V (MD (A))

References:
1. Data Referenced From "Patient Profile-Psych" 18-Mar-2014 11:41

ELECTRONICALLY SERVED
8/1/2020 9:16 AM

EXHIBIT 6

EXHIBIT 6

EXHIBIT 6

4281 Katella Ave, Suite 111
Los Alamitos, CA 90720
Phone: 714-828-1800 ext. 313
Fax: (714) 388-3894

CENTER FOR DISCOVERY

URGENT MEDICAL RECORD REQUEST

Date: 5/13/15

From: Shelbi Cox – Medical Records

To: Alecia Draper

Re: E. Reed

Notes: [redacted]

CENTER FOR DISCOVERY

I understand that the Protected Information may include references to, comments made by, and discussions regarding either parent signing below, which disclosures may or may not be flattering or positive. The execution of this Authorization by either parent is with the knowledge and consent that such references may be included in the Protected Information and the parent signing below consents to its release and/or disclosure.

Effective date for this Authorization: 05/21/15 and it shall remain in effect for a period of one year thereafter.

This Authorization will expire at the end of the above period.

I understand I have the right to:

1. Revoke this Authorization at any time by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this Authorization.
2. Knowledge of any compensation involved due to any marketing activity as allowed by this Authorization, and as a result of this Authorization.
3. Inspect a copy of Protected Information being used or disclosed under federal law.
4. Refuse to sign this Authorization.
5. Receive a copy of this Authorization.
6. Restrict what is disclosed with this Authorization.

I authorize my Protected Information to be faxed. I have read both pages of this Authorization and/or had its contents read to me. I have had an opportunity to ask questions about the uses and/or disclosures of my Information described above and all of my questions have been answered to my satisfaction. I understand that this Authorization may be signed in counterpart and that a copy or facsimile of this Authorization shall be considered as effective and as valid as the original.

Miley Rose — Signature of Client — Date: 5-11-15

Alicia A Thompson — Signature of Parent or Personal Representative — Date: 5 5 15

Signature of Parent or Personal Representative — Date

Mother @ Birth — Description of Personal Representative's Authority to Sign for Patient (Attach documents which show authority)

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide Authorization to use or disclose Protected Information.

CENTER FOR DISCOVERY

Authorization to Use, Disclose, and/or Receive Protected Health Information

HIPAA Compliant Pursuant To 45 C.F.R. § 164.508

Client Name: Emily [redacted]
Address: [redacted]
DOB: [redacted] **Date of Request:** 05-02-15
Dates of Service: 4-7-14 to 5-12-14

I understand that Center for Discovery may not use or disclose my protected health information, except as provided in the Center for Discovery Notice of Privacy Practices, without my prior written authorization.

I hereby authorize Center for Discovery to disclose my medical, psychiatric, and treatment records in its possession (collectively the "Protected Information") to the following person(s), entity(s), or business (the "Recipients of Protected Information"):

Name: Alexis Draper **Fax number:** [redacted]
Relationship to client: Mother **Phone Number:** [redacted]
Address: [redacted]

Requested Records (please check all that apply and/or notate any additional documents on the lines given):

- X Medical Records
- X Discharge Summaries
- X Psychological Evaluations
- X Psychiatric Evaluations and Information
- X Lab results and reports

_____
_____

I authorize for the Protected Information to be used and/or disclosed in connection with the following purpose (the "Purpose"):

SSI for Emily and Court case in Las Vegas (June 23rd Hearing)

I hereby authorize the Recipients of the Protected Information designated above to re-disclose the Protected Information obtained by means of this Authorization only to the parties and their attorneys for the Purpose. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand that this Authorization may include disclosure of Protected Information relating to **ALCOHOL, DRUG ABUSE** and **MENTAL HEALTH TREATMENT**, only if I place my initials on the appropriate line below. In such case, if I initial the line below, I specifically authorize release of such Protected Information.

Include disclosure of: (*indicate by initialing*)

AV Alcohol or Drug Abuse
AV Mental Health Treatment

PL 000178

Integrated Master Treatment Summary

Client Name: Emily Reed
DOB: [redacted]

Comprehensive Problems List:
#1 - Major Depressive Disorder
#2 - Posttraumatic Stress Disorder
#3 - Social Phobia
#4 - Problems with Primary Support Group
#5 - Problem Related to Interaction with the Legal System/Crime
#6 - Educational Problems
#7 - Problem Related to the Social Environment

Presenting Symptoms:
Ct is a 17 year old female admitting to residential treatment due to significant difficulties with depression, anxiety, self harm, and panic attacks. Ct was brought to treatment by her mother, stepfather, and maternal grandmother following a discharge from UCI's inpatient unit. Ct admitted to UCI on March 18, 2014 due to depression, isolating, loss of appetite, panic attacks, and passive SI. During her inpatient stay ct disclosed an 11 year history of sexual abuse by a close family friend. This has been reported to CPS and an investigation is ongoing.

Upon admission ct and/or mother reported the following mood symptoms and behaviors: depression, anxiety, panic, worry about panic attacks, irritability, shame, guilt, hopelessness, helplessness, low self esteem, decreased appetite, difficulty sleeping, isolation, decreased energy, nightmares, self harm behaviors (biting arms and legs), passive SI . Ct denied any plan, intent or means and contracted for safety. Ct denied any HI. Ct denied any history of substance use.

Ct is currently enrolled in 11th grade and reports that she is determined in school and works hard to learn and get good grades. Ct and mother reported that ct has a history of hearing difficulties and was diagnosed with a processing issues. Ct currently has an IEP. Ct lives with her mother, step father, and brothers in Huntington Beach, CA. Ct reports a "pretty good" relationship with most family members. Ct's brother is currently in treatment at another CFD location and is struggling with intense conflict with mother. Ct reported that this if very hurtful and stressful for her.

Interventions:
Emily will receive individual therapy 3x/week, family therapy 1x/week, group therapy 2-4x/day, weekly medical monitoring, nutrition consultation 1x/week, psychiatric consult and follow-up weekly, and therapy and art assignments weekly.

I am involved in my care, including the development of my treatment plan. I feel that the interventions involved in my treatment plan consider and respect my views.

_____
Client Signature **Date**

_____
Therapist Signature **Date**

Sara Tucker, MSW, ACSW 36722

--Digitally Signed: 05/12/2014 02:51 pm: Primary Therapist: Sara Tucker, MSW, ACSW 36722

--Digitally Signed: 05/12/2014 02:52 pm: Emily Reed

Initial Psychiatric Evaluation

Patient Name: Emily Reed
Date of Birth: [redacted]
Date of Service: 4-8-2014

History of Present Illness:
17 year old with chronic history of abuse. Depressed for on and off for several years. Much worse since she saw her abuse.

Depression symptoms include: sad/depressed mood, irritable, worry, loneliness/isolated, frustrated, hopeless, helpless, guilty, worthless, and sluggish, poor concentration, low self-esteem, difficulty going to sleep and staying asleep, and recurrent passive SI with no current plan or intent.

Patient has difficulty with timeline.

Panic attacks multiple times per week.

Easy startle, Flashbacks, Avoidance, bracken sleep, nightmares.

Endorses generalized anxiety.
Denies Manic like episodes.
Denies clinically significant OCD (won't eat odd number of things, organizing - but not causing problem).
Denies psychotic symptoms.

Per Record:
Presenting Problem: CT admitting from UCI for suicidal ideation. CT disclosed an 11 year history of sexual abuse by a close family friend which was reported to CPS and an investigation is ongoing. CT has panic attacks, especially in the shower (states "I feel like I'm drowning") and engages in SIB by biting herself (mostly after flashback, panic attack, or nightmare). Mo. reported that CT recently saw family friend when Fa. came to visit from Las Vegas and spiraled downward after this.

Symptoms: CT endorses *feeling*: irritability, shame, sadness, anger, hopelessness, helplessness, anxiety, guilt, panic, fear of panic, worry, numb/empty, depressed mood, lonely/isolated; CT endorses *thoughts/behaviors*: poor concentration, indecisiveness, low self-esteem, difficulty staying asleep and going to sleep, nightmares, racing thoughts, isolation; CT endorses *somatic*: dizziness, headaches, noise sensitivity, stomach pain, chest pain

High Risk BX: CT engages in SIB by biting (last incident this morning 4/8/14 during shower), CT has been not eating due to loss of appetite and has been drinking Ensure to supplement.

Self-Harm:
CT bites arms, wrists, and legs especially when experiencing a flashback or nightmare

Parent report of client's presenting symptoms:
How is appetite? Poor **How many meals each day?** 3

How many snacks each day? 3

-CT will not eat if she is given the choice; CT will throw up if she feels she eats too much
-CT is 5'3" and was 106 in the ER - Mo. thinks CT has lost more weight
-CT loves exercise and loves running; does track and cross country
How is sleep? nightmares, wakes up throughout the night; trauma mostly happened between 12am and 4am Broken
Feel ashamed? Yes **How often?** ashamed all the time due to hx of abuse

Feel alone/isolated? Yes **How often?** "she will say things like that she wants to be alone and that people make her anxious and fearful"

Feel sad? Yes **How often?** doesn't want to make people feel bad, always wants to help other; "feels sad all the time"

Feel hopeless? [95% of the time hopeless, 5% of the time feels she can get through it] **[Helpless?** she feels it is hard, is very fearful]

Feel hurt? Yes **About what?** abuse hx

Moods swing? No **How often?** mostly just sad, hasn't been very happy; laughs rarely
How many Hours: 6 hours

Energy level? Low **Explain:** CT has had low energy since feeling increased depression

Are you angry/irritable? Yes **How often?** both; "all the time with everything. everything frustrates her, having to eat, get a pencil"

Feel tense? Yes **How often?** "most of the time, maybe 85% of the time, very anxious and tense"

Feel guilty? Yes **How often?** "all the time, always. feels guilty about brother (used to hide things and blame it on brother, he would get punished)"

Thoughts of suicide? Yes
Why? flashbacks, nightmares
Thought: Angry, screams into pillow (loses voice), "wants it to go away" wants to smother herself with a pillowcase

Psychosocial Stressors:
Lost an important relationship? Yes **Who/When/How:** maternal grandmother passed away in October 2013; mother's best friend passed away when CT was 13, "she was like a mom to her"

Any accidents? No

How's client's health? Good **Problems:** none reported

Death in family? Yes **Who/When/How:** see above

Anyone threatening client? Yes **Who/When/How:** Al (abuser) has been threatening her "threatening to rape her, kick her out, kick the family out, threatens to harm her parents, brothers, etc"

Legal problems? Yes going to court due to abuse; custody case was 2.5 years ago (very traumatic, was possibly coached by Fa. on what to say, gave deposition against Mo.)

Family problems? Yes **With whom/about what:** sexual abuse by father's family friend, legal case going on as a result; younger brother also in treatment and "hates mom, wants to kill me"; siblings had "plan" to move back to NV once youngest brother turned 13, CT decided she wanted to stay and school recommended she not move due to IEP, youngest brother blames her "you're ruining my life" and Al (abuser) is threatening as a result"

Past Psychiatric History:
IP - UCI: Suicidal ideation (was not going to eat and then go run so she could pass out) **Length:** 3 weeks (end of March 2014-April 7, 2014)

Saw school psychologist (Tiffany Do) at school

OP - Stephanie Fraiser, 2x total

OP - Tiffany Doe (school psychologist), weekly

Past Medical History:
No active medical problems reported. Complains of HA - Squeezing pain in whole head. HA more frequent with current

medications.

Current Medications:

Medication/Supplement	Dose	Route AM/PM	Frequency	Medication Time Frame
Clonazepam - Tired	1mg	am/pm	2x	From: march 2014 To: Present
Prozac - slight improved depression	40mg	am	1x/day	From: march 2014 To: Present
Prazosin - Helps with nightmares	2mg	pm	1x/day	From: march 2014 To: Present
lorazepam - used about 4 times per week.	1 mg	as needed		From: march 2014 To: Present
Melatonin	3mg	pm	1x/day	From: march 2014 To: Present

Allergies:
NKDA

Family History:
No known family psychiatric history

Social History:
With whom/where does client live? Huntington Beach, CA; with Anthony, Adam, Mom

Marital Status (Parent)
How Long? Mo. remarried in Nov 2013

Adopted? No **What age?** n/a

Relationship with Parents? Biological

Approve of parents selection of second spouse? Yes

Relationship with siblings? Anthony (14, almost 15), Adam (13)

Relationship with step-siblings? Noah, 17

Describe atmosphere in Household: "with Adam, it has been totally a nightmare. he is very verbally abusive to me" "Anthony, Emily and I would do things together on the weekend and Adam would complain, not go, or cause turmoil"

Drugs/ETOH in home at present? n/a
Violence at home present? No

Lived in other states/countries? Yes **Where?** NV

Substance Abuse HX: denied.

HX of Abuse: CT endorsed sexual and emotional abuse by family friend; reported that abuse went on for 11 years; details of abuse are UNK at this time but CT plans to share details through her treatment assignment. Abuser is currently threatening family; investigation is ongoing and CT is expected to give her statement as soon as Thursday 4/10. CPS, just reported from UCI, ongoing investigation; CT will most likely fly to NV on Thursday April 10 to give her deposition to police for the investigation.

School: CT is currently enrolled in 11th grade and reports that she is determined in school and works hard to learn and get good grades. CT and mother reported that ct has a history of hearing difficulties and was diagnosed with a processing issues. CT currently has an IEP.

Enrolled in school? Yes **GPA** 3.84

Name/location? Huntington Beach High School (IEP) **Highest Grade Completed?** 10th

Learning problems? [Processing disorder, she struggles with short-term memory (-2 out of 100)]

Enjoy school? Yes

College? Yes

Career hopes/goals? "wants to be a world traveler, likes to travel, loves culture and learning new things, still figuring out her strengths with sign language, might want to be a nutritionist, possibly something in the Christian Ministry field" **Plan?** wants to go to a small Christian school, travel, etc

Want marriage/family? Yes **When?**

Prefer one best friend or a group? "she had one best friend in Las Vegas, but here in CA it has been a group of 3 girls" **Friendship of long standing?** McKenna, known since kindergarten

Closest friends boys or girls? Girls

Trust boys or girls more? [but says she doesn't trust anyone]

Romantic/significant relationship? No

Sexually Active? No

Sexuality Heterosexual

Long term hopes/dreams: "She wants to finish high school, wants to go to a small Christian college, wants to have 8 kids (some adopted), wants a garden, and have a pig"

Ever worked a job? No **What/Where/When?**

Ever been charged with a crime? No **What/Where/When?**

Probation officer's name and telephone:

Court date/location?

Greatest strength or asset? hard working, determined, goal-oriented, helping others, loving, kind, generous **Greatest weakness or liability?** anxiety, fear, low self-esteem

Support System? Yes and Strong **List most supportive person, love the most, safest person, best friend:** "a lot of people, Me, Geoff, her aunts, uncles (on both sides), grandparents,

Spirituality? Spiritual needs, Believe in God, Higher being and Pray, Christian, goes to non-denominational church, attends a youth group at her church and at a friend's church (winter camp)

Mental Status Exam:
Casually groomed, slightly disheveled, Positive psychomotor retardation, Mood depressed, Affect blunted, TP: L/L/GD, TC: No HI/AVH, patient does endorse passive SI with no current plan or intent. Speech is slow. I/J fair to poor.

Impression:
296.3x Major Depressive Disorder, Recurrent
309.81 Posttraumatic Stress Disorder
300.23 Social Phobia

Assessment:
Axis I:
296.3x Major Depressive Disorder, Recurrent
309.81 Posttraumatic Stress Disorder
300.23 Social Phobia
Axis II:
Deferred
Axis III:
No active medical problems reported.
Axis IV:
Family, Social, Academic
Axis V:
34

Treatment Plan:
Individual Psychotherapy 2-3x's weekly, Family psychotherapy 1-2x's weekly, Group psychotherapy and psycho-education 2-3x's daily, Nutrition consultation 1-2x's weekly, Physician consultation 1-2x's weekly, Psychiatric consultation 1x weekly, Physical Trainer 3x's weekly (when cleared by the physician and TX team), any additional services that the TX team, patient, and family believe will benefit patient's treatment during their stay at Center for Discovery.

Additional Treatment Plan Information:
-Improve overall mood through cognitive restructuring, behavioral activation, and increase varied and effective coping skills
-Decrease flashbacks and nightmares through effective coping techniques and challenging guilt and cognitive distortions associated with trauma, and increasing self-care
-Increase open and effective communication, decrease stressors associated with home environment

Look into which med could be increasing HA.
Taper slowly off Klonopin as tolerated due to sedation.

Doctor: Jeff Litzinger, MD

--Digitally Signed: 06/03/2014 08:54 pm: Psychiatrist: Jeff Litzinger, MD

Psychiatrist Progress Note

Client Name: Emily Reed
Date of Birth: [redacted]
Date of Service: 5-7-2014

Interval History:
Continues to "not want to be alive". Thoughts are frequent. Sleep brocken - does't remember dreams. Some improvement in anxiety, but sleep and depression still a problem.

Prozac 30mg QAM
gabapentin 300mg TID

Mental Status Exam:
Casually groomed, slightly disheveled, Positive psychomotor retardation, Mood depressed, Affect blunted, TP: L/L/GD, TC: No HI/AVH, patient does endorse passive SI with no current plan or intent. Speech is slow. I/J fair to poor.

Impression:
296.3x Major Depressive Disorder, Recurrent
309.81 Post Traumatic Stress Disorder
300.23 Social Phobia

Treatment Plan:
Increase Neurtontin to 600mg QHS and continue 300mg BID

--Digitally Signed: 06/03/2014 08:52 pm: Psychiatrist: Jeff Litzinger, MD

Discharge Summary

Demographics

Client Name:	Emily Reed	**Date:**	05/12/2014
Provider:	Sara Tucker, MSW, ACSW 36722	**Date of Original MTP:**	04/07/2014
MR#:	[redacted]	**Admit Date:**	04/07/2014
Date of Birth:		**Date of Discharge:**	05/12/2014
Age:	17		

Length of Stay (in days)

RTC	35 days
PHP	0
IOP	0

Reason for Admission

CT is stepping down to RTC MH from IP at UCI. CT was IP from 3/18/14-4/7/14. While in the hospital, CT disclosed extensive abuse history (sexual, emotional, mental) which was reported to CPS. CT has a significant history of abuse, chronic depression and anxiety, self harm, and suicidal ideation. Additionally CT has a processing disorder.

Discharge Diagnosis

Axis I:	296.3x Major Depressive Disorder, Recurrent 309.81 Posttraumatic Stress Disorder 300.23 Social Phobia
Axis II:	799.9 Diagnosis Deferred on Axis II
Axis III:	None
Axis IV:	Problems with Primary Support Group Problems Related to Interaction with the Legal System/Crime Educational Problems Problems Related to the Social Environment
Axis V:	Current GAF: 45 Highest Past Year GAF:

Explanation of Changes to Diagnosis

GAF was raised to 45 upon discharge

Master Problem List

Date	#	Problem	EST Completed	Date Resolved
04/07/2014	1	Major Depressive Disorder	06/07/2014	
04/07/2014	2	Posttraumatic Stress Disorder	06/07/2014	
04/07/2014	3	Social Phobia	06/07/2014	
04/07/2014	4	Problems with Primary Support Group	06/07/2014	
04/07/2014	5	Problem Related to Interaction with the Legal System/Crime	06/07/2014	
04/07/2014	6	Educational Problems	06/07/2014	
04/07/2014	7	Problem Related to the Social Environment	06/07/2014	

Summary of Progress

Problem #		Long Term/Discharge/Graduation Goals
1	Major Depressive Disorder	Emily will report a significant improvement in mood and sense of well-being.

Emily reported a slight decrease in depressive symptoms throughout her stay in treatment. Emily identified many positive coping skills to assist with depressive symptoms and was often observed to be carrying around a coping skills box in order to remind her to use various coping skills throughout the day. Emily described both an increase and a decrease in symptoms throughout her stay, and noted that often her suicidal thoughts and self-injurious behaviors increase as a result of panic attacks, nightmares, and flashbacks. Emily noted active SI the night before discharging but was able to contract for safety and identify ways to keep herself safe.

Problem #		Long Term/Discharge/Graduation Goals
2	Posttraumatic Stress Disorder	Emily will achieve a significant reduction is anxiety symptom's associated with PTSD, (i.e., distress no longer causes clinical impairment).

Emily noted a high amount of anxiety and endorsed experiencing multiple panic attacks per day while in treatment. Emily was receptive to staff feedback and was able to implement a variety of coping skills including relaxation and imagery. Emily discussed her PTSD symptoms in depth with her therapist and observed a slight decrease in her anxiety symptoms and an increase in her ability to manage anxiety symptoms. Emily described many psychosomatic symptoms related to anxiety, such as nausea, stomachache, headache, irritability, and fatigue.

Problem #		Long Term/Discharge/Graduation Goals
3	Social Phobia	Emily will achieve a significant reduction in symptoms of Anxiety.

Emily described significant anxiety related to social interactions, especially speaking in front of a group, asking for help or assistance, and presenting in front of a group. Emily initially did not participate in groups but was observed to be actively listening. Over time, Emily pushed herself to participate more in groups. Emily also led a Psych Ed group about American Sign Language and reported feeling positively afterward.

Problem #		Long Term/Discharge/Graduation Goals
4	Problems with Primary Support Group	Emily will experience a significant improvement in parent child communication.

Emily fully participated in all family sessions and noted an increase in her ability to communicate effectively with both of her parents. Emily frequently reflected upon her communication style, her parents' communication styles, and how to improve. Emily practiced using her voice and speaking up for herself in passes and in family sessions.

Problem #		Long Term/Discharge/Graduation Goals
5	Problem Related to Interaction with the Legal System/Crime	Emily will work toward giving her deposition to the detective involved in the ongoing investigation.

Emily traveled to Las Vegas, NV on her third day of residential treatment in order to provide the detectives with her deposition. Emily reported significant anxiety both before and after the event and was observed to be self-critical. Emily was receptive to using positive coping skills and to reaching out for support from her mother during the trip.

Problem #		Long Term/Discharge/Graduation Goals
6	Educational Problems	Emily will continue to work towards gaining credit for a high school diploma

Emily worked toward catching up on her academic work while in treatment. Emily reported low to moderate motivation for working on the assignments. Emily was unable to get up-to-date on her school work.

Problem #		Long Term/Discharge/Graduation Goals
7	Problem Related to the Social Environment	Emily will experience a significant improvement in mood.

Emily was observed to be engaging in positive interactions with peers throughout her treatment stay. Emily reported feeling connected to several of her peers. Emily was observed to be frequently offering support and receiving support from her peers. Emily received positive feedback and encouragement from peers in her goodbye group at the end of her treatment.

Strengths and Weaknesses

Strengths	caring, hard-working, generous
Needs	coping skills, trauma processing
Abilities	ASL, runner (track/cross-country)
Preferences	

Medication

Psychotropic Medications

Type	Status	PS	Medication	Indication	Dosage (Qty/Form)	Frequency
Rx	*Active*	PS	**CLONAZEPAM**		0.5mg (tablet)	twice daily
			4/28/2014: New Dose			
	Active	PS	**PROZAC**		30mg (capsule)	daily
			4/28/2014: New Dose			
	Active	PS	**NEURONTIN**		300mg (capsule)	three times daily
			Notes: morning and noon			
			5/6/2014: New Dose			
	Discontinued	PS	**CLONAZEPAM**		1.5mg (tablet)	twice daily
			4/28/2014: Status Changed: Discontinued 4/7/2014: Medication Added			

	Discontinued	PS	**PROZAC**	40mg (capsule)	daily
			4/28/2014: Status Changed: Discontinued 4/8/2014: Medication Added		
	Discontinued	PS	**NEURONTIN** *Notes*: morning and noon	100mg (capsule)	twice daily
			5/1/2014: Status Changed: Discontinued 4/28/2014: Medication Added		
	Discontinued	PS	**NEURONTIN**	300mg (capsule)	daily at bedtime
			5/6/2014: Status Changed: Discontinued 4/28/2014: Medication Added		
	Discontinued	PS	**NEURONTIN** *Notes*: morning and noon	200mg (capsule)	twice daily morning and noon
			5/6/2014: Status Changed: Discontinued 5/1/2014: New Dose		

Other Medications	Type	Status	PS	Medication	Indication	Dosage (Qty/Form)	Frequency
	Rx	*Active*		**melatonin**		3mg	daily at bedtime
				4/7/2014: Medication Added			
		Active		**LORAZEPAM**		0.5mg (tablet)	every 6 hrs - as needed
				4/28/2014: New Dose			
		Discontinued		**LORAZEPAM**		1mg (tablet)	every 6 hrs - as needed
				4/28/2014: Status Changed: Discontinued 4/7/2014: Medication Added			
		Discontinued		**PRAZOSIN HYDROCHLORIDE**		2mg (capsule)	daily at bedtime
				4/28/2014: Status Changed: Discontinued 4/8/2014: Medication Added			

Explanation of Changes	4/28: Neurontin added 3x per day due to heightened anxiety symptoms Prozac dose decreased Lorazepam dose decreased due to sedative effect Klonopin dose decreased due to side effects Prazosin discontinued due to symptomatic hypotension 5/1: Neurontin dose increased due to continued anxiety 5/6: Neurontin dose increased due to continued increased anxiety

Discharge Planning

Anticipated Discharge Date	5/23/14
Living Arrangements	will return to living with mom, will resume visitation with dad
Education	will return to Huntington Beach High School
Therapy (Specify individual, family or group treatment)	will refer to PHP program
Discharge Transition Obstacles	none anticipated

Condition on Discharge

CT dressed appropriately and appeared younger than her stated age. ADL's were fair. CT appeared nervous and was cooperative with therapist, staff, and peers. CT presented with anxious and depressed mood with tearful affect. Thought process was linear and coherent. Rhythm, rate, and speed of speech was soft and low. Judgment, insight, and impulse control all poor. CT was oriented x4. CT endorsed passive SI, SIB urges. Ct denied HI, hallucinations, delusions, and substance use.

Reason for Discharge

Emily was discharged from the RTC level of care due to insurance denial for further authorization.

Family/Guardian Participation in Treatment

Emily's mother fully participated in her intake session, family therapy appointments, and discharge. The family sessions focused on assertive communication, validation, and having Emily explain how the Complex PTSD symptoms apply to her. Emily's father participated in one family session which focused on assertive communication. Emily's family members participated in therapeutic visits and passes throughout her stay, as well as frequent phone calls throughout each week. Emily frequently reflected on the support of her family and ways to continue to strengthen their relationships.

Critical Events & Interaction

On her third day of residential, Emily traveled to Las Vegas, NV to talk with detectives about her report of sexual abuse. Emily was able to prepare for this ahead of time by identifying and practicing positive coping skills as well as relaxation techniques in order to ensure that she could successfully manage her anxiety.

Emily struggled with self-harm behaviors throughout her treatment stay. Emily often bit, pinched, or scratched herself following a panic attack or flashback. Throughout her treatment stay, Emily was able to decrease the self-harm behaviors and increase the use of positive coping skills, such as squeezing a stress ball and deep breathing. Emily also struggled with restricting or purging, relating this to either self-harm or psychosomatic symptoms of anxiety. Emily met with the dietitian once per week in order to address nutritional concerns and to work on healthy eating patterns.

Course of Treatment

At the beginning of her treatment stay, Emily appeared nervous, fragile, guarded, and appeared much younger than her stated age. Emily struggled to open up in groups, individual therapy, and family therapy. Although she stated she was motivated, she often struggled with anxiety and depressive symptoms, as well as self-harm in the form of biting, and suicidal thoughts. Emily initially worked on identifying and implementing coping skills, identifying and reframing cognitive distortions, and practicing assertive communication skills. A couple of weeks into her treatment stay, Emily slowly began processing aspects of her trauma history, specifically the anxiety and panic attacks she experiences in the shower. Emily was extremely tearful throughout the trauma processing work and reported increased anxiety after sessions. Despite struggling in and out of sessions due to processing the trauma, she was able to maintain her progress and reported feeling both determined and productive in sessions. Emily identified her core thought as "I am unsafe" or "People are unsafe." Emily was receptive to cognitive restructuring in therapy sessions, however struggled to apply this skill autonomously outside of session. Emily reported feeling nervous, scared, and hesitant at the end of treatment, but also reported feeling hopeful and determined.

Number of binge episodes per month at discharge?	n/a (non-ED treatment)
Number of self-induced vomiting (purge) episodes per month at discharge?	n/a (non-ED treatment)
Hours of exercise per month at dicharge?	n/a (non-ED treatment)
Doses of laxatives without doctor recommendation PER MONTH at discharge:	n/a (non-ED treatment)
Doses of diuretics without doctor recommendation PER MONTH at discharge:	n/a (non-ED treatment)
Doses of diet pills PER MONTH discharge:	n/a (non-ED treatment)
Primary reason for discharge	Insurance denied further authorization for RTC stay; Family was unable to accommodate PHP care.

Did client need a higher level-of-care (e.g., brief hospital stay) for ED purposes during this treatment episode?	n/a (non-ED treatment)
Is the client being discharged on dietetic exchanges?	n/a (non-ED treatment)
Did client/client's family consent to research?	No
Therapist	Sara Tucker, MSW, ACSW 36722
Insurance provider	Anthem Blue Cross (contracted through CHIPA)
Type of treatment (RTC, PHP, or IOP)	RTC MH
Number of treatment days	35 days

Prognosis

Emily's prognosis is good as long as she continues to advocate for her needs, utilize positive coping skills, reach out for support when needed, and is compliant with all outpatient therapy appointments.

Recommendations

It is the recommendation of the treatment team at Center for Discovery Atlantic House that Emily receive services at the PHP level of care.

Contact Signatures

Treatment Team Signatures

--Digitally Signed: 05/15/2014 10:29 am: Primary Therapist: Sara Tucker, MSW, ACSW 36722

--Digitally Signed: 05/15/2014 11:01 am: Therapist: Danielle Newman, PhD PSY26184

Social Security Administration
IMPORTANT INFORMATION

SOCIAL SECURITY
SUITE B
17075 NEWHOPE STREET
FOUNTAIN VALLEY, CA 92708
Date: 06/01/2015
Number: 604-94-3768

On 06/01/2015, we talked to you and completed your application to be representative payee for EMILY CHRISTINE REED. We stored your application information electronically in our records and provided you with a copy showing your statements.

WHAT YOU NEED TO DO

- If you disagree with any of your statements, you should contact us within 10 days.
- If any of the information changes, let us know as soon as possible.

IMPORTANT REMINDER

Penalty of Perjury

You declared under penalty of perjury that you examined all the information on the application and it is true and correct to the best of your knowledge. You were told that you could be held liable under law for providing false statements.

SUSPECT SOCIAL SECURITY FRAUD?

Please visit http://oig.ssa.gov/r or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

IF YOU HAVE QUESTIONS

If you have any questions, you may call, write or visit any Social Security office. If you call or visit this office, please have this letter with you and ask for any rep. The telephone number where I can be reached is 877-304-1566. We can answer most questions over the phone. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly.

Manager

[redacted]

PL 000222

[redacted] TOP/GS/CC SG-SSA-11
MTH/B/PYE

S00

REQUEST TO BE SELECTED AS PAYEE [redacted]

I request that the Supplemental Security Income Benefits for EMILY CHRISTINE REED be paid to me as representative payee.

EMILY CHRISTINE REED needs a payee because she SHE HAS ANXIETY AND DEPRESSION.

I would be the best payee for EMILY CHRISTINE REED because I am her relative.

I will know about EMILY CHRISTINE REED's needs because she lives with me.

INFORMATION ABOUT THE PERSON FOR WHOM YOU ARE APPLYING

The following people show interest in EMILY CHRISTINE REED:
GEOFFREY DRAPER STEP-FATHER
[redacted]

EMILY CHRISTINE REED does not owe me any money and I do not expect her to in the future.

EMILY CHRISTINE REED does not have a legal guardian.

INFORMATION ABOUT PAYEE APPLICANT

My name is ALECIA ANN DRAPER. My social security number is [redacted] I was born on [redacted]

I submitted CA DL [redacted] EXP [redacted], ISS [redacted] as my proof of identity.

I am the NATURAL OR ADOPTIVE MOTHER of EMILY CHRISTINE REED.

When I am away, GEOFFREY DRAPER, who is EMILY CHRISTINE REED's STEP-FATHER, takes care of her.

I have never been convicted of a felony.

I have never been imprisoned for more than one year.

I do not have an unsatisfied felony warrant.

My mailing address is [redacted]

[redacted] TOP/GS/CC SG-SSA-11
MTH/B/PYE

I have lived at this address since June 2012.

EMILY CHRISTINE REED lives with me.

My telephone number is [redacted]

ADDITIONAL REMARKS

I HAVE RECEIVED A BOOK ON BEING A REPRESENTATIVE PAYEE.

I/my organization:
- Must use all payments made to me/my organization as the representative payee for the claimant's current needs or (if not currently needed) save them for his/her future needs.
- May be held liable for repayment if I/my organization misuses the payments or if I/my organization am/is at fault for any overpayment of benefits.
- May be punished under Federal law by fine, imprisonment or both if I/my organization am/is found guilty of misuse of Social Security or SSI benefits.

I/my organization will:
- Use the payments for the claimant's current needs and save any currently unneeded benefits for future use.
- File an accounting report on how the payments were used, and make all supporting records available for review if requested by the Social Security Administration.
- Reimburse the amount of any loss suffered by any claimant due to misuse of Social Security or SSI funds by me/my organization.
- Notify the Social Security Administration when the claimant dies, leaves my/my organization's custody or otherwise changes his/her living arrangements or he/she is no longer my/my organization's responsibility.
- Comply with the conditions for reporting certain events (listed on the attached sheet(s) which I/my organization will keep for my/my organization's records) and for returning checks the claimant is not due.
- File an annual report of earnings if required.
- Notify the Social Security Administration as soon as I/my organization can no longer act as representative payee or the claimant no longer needs a payee.

I know that anyone who makes or causes to be made a false statement or representation of material fact relating to a payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I affirm that all information I have given in this document is true.

Signature Alexa A. Draper

Date June 1, 2015

[redacted] TOP/GS/CC SG-SSA-11
MTH/B/PYE

YOU MUST NOTIFY THE SOCIAL SECURITY ADMINISTRATION PROMPTLY IF ANY OF THE FOLLOWING EVENTS OCCUR AND PROMPTLY RETURN ANY PAYMENT TO WHICH THE CLAIMANT IS NOT ENTITLED:

- o the claimant or any member of the claimant's household DIES (SSI eligibility ends with the month in which the claimant dies);
- o the claimant's HOUSEHOLD CHANGES (someone moves in/out of the place where the claimant lives);
- o the claimant LEAVES THE U.S. (the 50 states, the District of Columbia, and the Northern Mariana Islands) for 30 consecutive days or more;
- o the claimant MOVES or otherwise changes the place where he/she actually lives;
- o the claimant is ADMITTED TO A HOSPITAL, skilled nursing facility, nursing home, intermediate care facility, or other institution;
- o the INCOME of the CLAIMANT or anyone in the claimant's household CHANGES (this includes income paid by an organization or employer, as well as monetary benefits from other sources);
- o the RESOURCES of the claimant or anyone in the claimant's household CHANGES;
- o the claimant or anyone in the claimant's household MARRIES;
- o the marriage of the claimant or anyone in the claimant's household ends in DIVORCE or ANNULMENT;
- o the claimant SEPARATES from his/her spouse.
- o the claimant is CONFINED TO JAIL, PRISON, PENAL INSTITUTION OR CORRECTIONAL FACILITY;
- o the claimant is CONFINED TO A PUBLIC INSTITUTION by court order in connection with a crime.
- o the claimant has an UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for his/her arrest;
- o the claimant is VIOLATING a condition of probation or parole under State or Federal law;

IF THE CLAIMANT IS RECEIVING PAYMENTS DUE TO DISABILITY OR BLINDNESS OR VISUAL IMPAIRMENT,
YOU MUST ALSO REPORT IF:

- o the claimant's MEDICAL CONDITION IMPROVES;
- o the claimant GOES TO WORK;
- o the claimant's VISION IMPROVES, if the claimant is entitled due to blindness or visual impairment;

[redacted] TOP/GS/CC SG-SSA-11
MTH/B/PYE

In addition to these events about the claimant, you must also notify us if:
- o YOU change your address;
- o YOU are convicted of a felony or any offense under State or Federal law which results in imprisonment for more than 1 year;
- o YOU have an UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for your arrest.

PAYMENT MAY STOP IF ANY OF THE ABOVE EVENTS OCCUR. You should read the informational booklet we will send you to see how these events affect benefits. You may make your reports by telephone, mail or in person.

REMEMBER:

- o payments must be used for the claimant's current needs or saved if not currently needed. (Savings are considered resources and may affect the claimant's eligibility to payment.);
- o you may be held liable for repayment of any payments not used for the claimant's needs or of any overpayment that occurred due to your fault;
- o you must account for benefits when so asked by the Social Security Administration. You will keep records of how benefits were spent so you can provide us with a correct accounting;
- o to let us know as soon as you know you are unable to continue as representative payee or the claimant no longer needs a payee;
- o you will be asked to help in periodically redetermining the claimant's eligibility for payment. You will need to keep evidence to help us with the redetermination (e.g. evidence of income and living arrangements).
- o You may be required to obtain medical treatment for the claimant's disabling condition if he/she is eligible under the childhood disability provision.

Keep in mind that payments may be deposited directly into an account set up for the claimant with you as payee. As soon as you set up such an account, contact us for more information about receiving the claimant's payments using direct deposit.

THE PRIVACY AND PAPERWORK REDUCTION ACTS

We are required by section 205(j) and 205(a) of the Social Security Act to ask you to give us the information on this form. This information is needed to determine if you are qualified to serve as representative payee. Although responses to these questions are voluntary, you will not be named representative payee unless you give us the answers to these questions.

[redacted] TOP/GS/CC SG-SSA-11
MTH/B/PYE

Sometimes the law requires us to give out the facts on this form without your consent. We must release this information to another person or government agency if Federal law requires that we do so or to do the research and audits needed to administer or improve our representative payee program.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by Federal government. The law allows us to do this even if you do not agree to it.

These and other reasons why information about you may be used or given out are explained in the Federal Register. If you want to learn more about this, contact any Social Security office.

We invite you to visit our website at www.socialsecurity.gov on the Internet to find general information about Social Security. If you have any specific questions, you may call us toll-free at 1-800-772-1213, or call your local Social Security office at 877-304-1566. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY number 1-800-325-0778. You can also write or visit any Social Security office. The office that serves your area is located at:

SOCIAL SECURITY
SUITE B
17075 NEWHOPE STREET
FOUNTAIN VALLEY, CA 92708

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

SSA OFFICE A78

RECIPIENT: [redacted] EMILY CHRISTINE REED

EMILY CHRISTINE REED
[redacted]

REVIEW STATEMENT SUMMARY FOR SUPPLEMENTAL SECURITY INCOME

The following information is provided to support this application for Supplemental Security Income.

What You Need To Do

- Review this summary to ensure we recorded your statements correctly.
- If you agree with all your statements, you should keep this summary for your records.
- If you disagree with any of your statements, you should contact us within 10 days after receiving this summary to let us know.

o IDENTIFICATION

The claimant's name is EMILY CHRISTINE REED. Her social security number is [redacted]

She is not blind.

She is disabled. Her disability began on March 18, 2014.

She was disabled prior to age 22.

She never was married.

o FUGITIVE FELON AND PAROLE OR PROBATION VIOLATION INFORMATION

The following statements describe EMILY CHRISTINE REED's fugitive felon/parole or probation violator status as of June 1, 2015.

She has not been accused or convicted of a felony or an attempt to commit a felony.

She is not on parole or probation under Federal or State law.

o LIVING ARRANGEMENTS

She has not been outside the United States for a calendar month or 30 consecutive days since June 1, 2015.

RECIPIENT: [redacted] EMILY CHRISTINE REED

She has not spent a calendar month in a hospital, nursing home, correctional facility, or any type of institution since June 1, 2015.

The following statements describe EMILY CHRISTINE REED's living arrangements as of April 1, 2015.

She began living at [redacted] on June 1, 2012.

She lived in a house/apartment/mobile home/houseboat.

She did not get help or money from any person not living with her or any agency to pay for food, rent, mortgage payments, property insurance, property taxes, heating fuel, gas, electricity, garbage removal, water or sewerage.

The household consisted of the following people:

NAME	RELATIONSHIP	AGE OR BIRTHDATE	BLIND OR DISABLED	MARRIED	STUDENT
E REED	Claimant	[redacted]	Yes	No	Yes
A DRAPER	Mother		Yes	Yes	No
A REED	Other Relative		No	No	Yes
A REED	Other Relative		No	No	Yes

Not all of the people she lived with got public assistance.

ALECIA DRAPER rented the home where she lived. The rent was $1,340.00 monthly.

No one in the household was a parent or child of either the landlord or his/her spouse.

She did not buy food separately from the other household members.

She did not eat all of her meals out.

She did not make payments toward the household expenses.

She did not receive any food or shelter from the people she lived with for which she has an agreement to repay.

She did not need help in personal care, hygiene or upkeep of a home.

She had adequate cooking and food storage facilities.

The following statements describe EMILY CHRISTINE REED's living arrangements as of July 2, 2015.

She began living at [redacted] on June 1, 2012.

She lives in a house/apartment/mobile home/houseboat.

RECIPIENT: [redacted] EMILY CHRISTINE REED

She does not get help or money from any person not living with her or any agency to pay for food, rent, mortgage payments, property insurance, property taxes, heating fuel, gas, electricity, garbage removal, water or sewerage.

The household consists of the following people:

NAME	RELATIONSHIP	AGE OR BIRTHDATE	BLIND OR DISABLED	MARRIED	STUDENT
E REED	Claimant	[redacted]	Yes	No	Yes
A DRAPER	Mother		Yes	Yes	No
A REED	Other Relative		No	No	Yes
A REED	Other Relative		No	No	Yes

Not all of the people she lives with get public assistance.

ALECIA DRAPER rents the home where she lives. The rent is $1,377.00 monthly.

No one in the household is a parent or child of either the landlord or his/her spouse.

She does not buy food separately from the other household members.

She does not eat all of her meals out.

She does not make payments toward the household expenses.

She is not receiving any food or shelter from the people she lives with for which she has an agreement to repay.

She does not need help in personal care, hygiene or upkeep of a home.

She has adequate cooking and food storage facilities.

There have not been any other changes in her living arrangements.

She does not expect these arrangements to change.

o RESOURCES

This report of resources is valid for any and all SSI claims in which she is involved.

She owns the following from June 1, 2015 to continuing:

Checking account:

Financial institution name: [redacted]

Value: $60.00 From: June 2015 To: September 2015

Value: $60.00 From: October 2015 To: continuing

RECIPIENT: [redacted] EMILY CHRISTINE REED

She does not own any other type of resource.

o INCOME

This report of income is valid for any and all SSI claims in which she is involved.

She receives or expects to receive the following income from June 1, 2015 to continuing:

Social Security:

Amount $0.00

From: June 2015 To: June 2015

Voluntary child support:

Amount $241.66

From: June 2015 To: June 2015

Source name: Jeffrey Reed

Contact: unknown

Phone: unknown

She does not receive any other type of income.

o MEDICAID

She may be eligible for Medicaid. However, she must help her State identify other sources that may pay for medical care. Also, she must give information to help the State get medical support for any child(ren) who are her legal responsibility. This includes information to help the State determine who a child's father is.

If she wants Medicaid, she must agree to allow her State to seek payments from sources, such as insurance companies, that are available to pay for her medical care. This includes payments for medical care for her or any person who receives Medicaid and is her legal responsibility. The State cannot provide her Medicaid if she does not agree to this Medicaid requirement. If she needs further information, she may contact her Medicaid agency.

o MEDICAL ASSISTANCE

I agree that any payments from sources responsible for paying for medical care will go to the State if Medicaid already has paid for this care.

She has health insurance that pays towards the cost of her medical care.

RECIPIENT: [redacted] EMILY CHRISTINE REED

o PERMISSION TO CONTACT FINANCIAL INSTITUTIONS FOR EMILY CHRISTINE REED

We have asked you for permission to obtain, from any financial institution, any financial record about you that is held by the institution. We will ask financial institutions for this information whenever we think it is needed to decide if you are eligible or if you continue to be eligible for SSI benefits. Once authorized, our permission to contact financial institutions remains in effect until one of the following occurs: (1) you notify us in writing that you are canceling your permission, (2) your application for SSI is denied in a final decision, or (3) your eligibility for SSI terminates. If you do not give or cancel your permission you will not be eligible for SSI and we will deny your claim or stop your payments.

I give SSA permission to contact any financial institution and request any financial records that financial institution may have about me.

She would like any SSI payments due her to be deposited to her checking account.

IMPORTANT REMINDER

Penalty of Perjury

You declared under penalty of perjury that all the information on this summary is true and correct to the best of your knowledge. Anyone who knowingly gives a false or misleading statement about a material fact in an application, or causes someone else to do so, commits a crime and may be sent to prison or may face other penalties, or both.

IMPORTANT INFORMATION--PLEASE READ CAREFULLY

You must report any change within 10 days after the end of the month it occurs. If you don't, a penalty amount may be deducted from the claimant's benefit.

We will check your statements and compare our records with records from other State and Federal agencies, including the Internal Revenue Service, to make sure the claimant is paid the correct amount.

If you have a question or something to report, call 877-304-6994 Ext 15361 and ask for MRS. NGUYEN. If you call or visit our office, please have this summary with you. For general information about Social Security, visit our web site at www.socialsecurity.gov on the Internet.

You may visit or write to the Social Security Office at:

SOCIAL SECURITY
SUITE B
17075 NEWHOPE STREET
FOUNTAIN VALLEY CA 92708

We will process this application for Supplemental Security Income as quickly as possible. If you have trouble getting any information or records we have asked for, please contact us and we will help you.

RECIPIENT: [redacted] EMILY CHRISTINE REED

You should hear from us within 90 to 120 days after you have given us all the information we requested. Some claims may take longer if we need more information. If you do not get a payment or a letter by then, please get in touch with us.

HELPFUL HEALTH CARE WEBSITES

Health Information

The U.S. Department of Health and Human Services provides information on many health topics at www.healthfinder.gov on the Internet. You may wish to visit that site to review that information, which may be helpful to her.

Prescription Drug Assistance Programs

She may be able to get help paying for prescription drugs. To find out what programs are offered by drug companies, state and local governments, and local organizations, please visit www.healthfinder.gov/rxdrug on the Internet.

REPORTING RESPONSIBILITIES FOR SUPPLEMENTAL SECURITY INCOME

The amount of a Supplemental Security Income payment is based on the information told to us. You must tell Social Security every time there is a change while we process this application AND if you start receiving Supplemental Security Income.

Remember, a change may make the SSI monthly payment bigger or smaller. Report changes in income of your ineligible spouse who lives with you, or your sponsor or sponsor's spouse if you are an alien. You must also report changes in things of value that these people own. Report changes in income, school attendance and marital status of ineligible children who live with you.

You must tell us about any change within 10 days after the month it happens. If you do not report changes, we may have to take as much as $25, $50, or $100 out of future payments.

HOW TO REPORT CHANGES FOR SUPPLEMENTAL SECURITY INCOME

You can make your reports by telephone at the telephone number shown or you may report in person or by mail at the address shown. Always give the Social Security number when writing or telephoning us. If you have any questions, we will be glad to help you. See "Changes to Report for Supplemental Security Income".

CHANGES TO REPORT FOR SUPPLEMENTAL SECURITY INCOME

WHERE SHE LIVES -- You must report to Social Security if:

- She moves.
- She (or her spouse) leaves her household for a calendar month or longer. For example, she enters a hospital or visits a relative.
- She is no longer a legal resident of the United States.

RECIPIENT: [redacted] EMILY CHRISTINE REED

- She leaves the United States for 30 days or more.
- She is admitted to, for a calendar month or longer, or released from a hospital, nursing home, prison or other institution.

HOW SHE LIVES -- You must report to Social Security:

- If someone moves into or out of her household.
- If the amount of money she pays toward household expenses changes.
- Births and deaths of any people with whom she lives.
- Her marital status changes:
  - She gets married.
  - Her marriage ends in divorce or is annulled.
  - She separates from her spouse or starts living together again after a separation.
  - She begins living with someone as husband and wife.
  - Her spouse or former spouse dies.

INCOME -- You must report to Social Security if:

- The amount of money (or checks or any other type of payment) she receives from someone or someplace goes up or down or she starts to receive money (or checks or any other type of payment).
- She starts work or stops work.
- Her earnings go up or down.
- She becomes eligible for benefits other than SSI.

HELP SHE GETS FROM OTHERS -- You must report to Social Security if:

- The amount of help (money, food or payment of household expenses) she receives goes up or down.
- Someone stops helping her.
- Someone starts helping her.

THINGS OF VALUE THAT SHE OWNS -- You must report to Social Security if:

- The value of her resources goes over $2,000 when you add them all together ($3,000 if she is married and living with her spouse).
- She sells or gives any things of value away.
- She buys or is given anything of value.

RECIPIENT: [redacted] EMILY CHRISTINE REED

SHE IS BLIND OR DISABLED -- You must report to Social Security if:

- Her condition improves or her doctor says she can return to work.
- She goes to work.

SHE IS UNMARRIED AND UNDER AGE 22 -- A report to Social Security must be made if:

- She is under age 18 and live with her parent(s): Ask her parents to report if they have a change in income, a change in their marriage, a change in the value of anything they own, or either has a change in residence. Also, she should report changes in the income, school attendance (if between ages 18 and 21) or marital status of ineligible children who live in the household.
- She starts or stops school.
- She gets married.

IF A WARRANT HAS BEEN ISSUED FOR HER ARREST -- You must report to Social Security if:

- She has a felony warrant for her arrest.
- She has a Federal or State warrant for a parole or probation violation.

RECIPIENT: [redacted] EMILY CHRISTINE REED

PRIVACY ACT STATEMENT

Collection and Use of Personal Information

Section 1631(e) of the Social Security Act, as amended, authorizes us to collect this information. The information you provide us will be used to enable the Social Security Administration to determine if you are eligible for Supplemental Security Income (SSI) payments.

The information you furnish on this form is voluntary. However, failure to provide the requested information may keep us from making an accurate and timely decision on your claim, which in turn may result in loss of some payments.

We rarely use the information you supply for any purpose other than for determining eligibility for SSI. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal Laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Complete lists of routine uses for this information are available in System of Records Notice 60-0103, Supplemental Security Income Record and Special Veterans Benefits, and also in System of Records Notice 60-0089, Claims Folder Systems. The Notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at www.socialsecurity.gov or at your local Social Security office.

RECIPIENT: [redacted] EMILY CHRISTINE REED

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 40 minutes to read the instructions, gather the facts, and answer the questions. SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

Social Security Administration
Supplemental Security Income
Notice of Change in Payment

SOCIAL SECURITY
17075 NEWHOPE STREET
SUITE B
FOUNTAIN VALLEY CA 92708
Date: February 18, 2016
Claim Number: [redacted]

[redacted]

EMILY CHRISTINE REED
[redacted]

Your current monthly Supplemental Security Income (SSI) payment is $648.50 for March 2016. You will continue to get this amount each month unless there is a change in the information we use to figure your payment. This amount includes $159.83 from the State of California.

We are changing the amount you were due for October 2015 through February 2016. Your amount changed because your situation changed.

We explain how we figured the monthly payment amount on the worksheet(s) at the end of this letter. The explanation shows how your income, other than any SSI payments, affects your SSI payment. We include explanations only for months where payment amounts change.

Your Payments Will Be Changed As Follows:

From	Through	Amount Due Each Month
October 1, 2015	October 31, 2015	$645.07 This includes $156.40 from the State of California.

When You Will Receive Your Payments

Your representative payee will receive your monthly payment of $648.50 around March 1, 2016, and on the first of each month after that.

See Next Page

SSA-L8100

Information Used In Making The Decision

- The amount of SSI we pay depends on your living arrangements. Your living arrangements are where you live, with whom you live, and how your food and shelter expenses are paid. Based on the information we have, your Federal living arrangement is:

  -- Category A for October 2015

  Please see the enclosed "Fact Sheet on SSI Federal Living Arrangement Categories" for a description of this Federal living arrangement category and others.

- The amount of money we pay you from the State of California depends on the State's rules.

  You were living independently with cooking facilities for October 2015.

- Based on the information we have, your State living arrangement is:

  -- Category A for October 2015 for California

  Please see the enclosed "Fact Sheet on SSI Living Arrangement Categories For the State of California" for a description of this State living arrangement category and others.

- We use income to figure your eligibility and payments. By law, we use different rules to count your income based on what kind of income you have and when you receive it. The enclosed fact sheet called "Income and SSI Payments" explains the most common rules.

- You had monthly income which must be considered in figuring your eligibility as follows:

  The food or shelter you got from someone. We value the food or shelter at $264.33 for October 2015.

Your Reporting Responsibilities

Your SSI payments may change if your situation changes. You are required to report any changes that may affect your SSI no later than 10 days after the month the change takes place.

Please call 1-800-772-1213 or contact your local Social Security office to report any of the following changes:

- You start or stop work, or your wages increase or decrease
- Your bank account balance goes over $2,000.00
- You move
- Anyone else moves into or out of your household
- Someone in your household dies

- You marry, separate, or divorce (including same-sex marriage)
- Income or resources change for you or members of your household
- Your medical condition improves
- You start or stop attending school regularly
- You leave the United States and expect to be gone for a full calendar month or for 30 consecutive days
- You are in a hospital, jail, or other institution for a full calendar month
- A felony warrant for flight or escape or a warrant for violating a condition of parole or probation is issued for your arrest

You Can Review The Information in Your Case

The decisions in this letter are based on the law and information in our records. You have a right to review and get copies of the information in our records that we used to make the decisions explained in this letter. You also have a right to review and copy the laws, regulations, and policy statements used in deciding your case. To do so, please contact us. Our telephone number and address are shown under the heading "If You Have Questions".

Things You Should Know

- We have made a new decision on your case. It replaces all earlier decisions for the above period.
- We are also sending this information to your representative payee.

If You Disagree

If you disagree with this decision, you have the right to appeal. A person who has not seen your case will look at it. We call this appeal a hearing. When you appeal, we review your entire case, even the parts with which you agree. We consider any new facts we have and then make a new decision. The new decision could be more favorable, less favorable, or the same as the one you already have.

Time To File An Appeal

- You have 60 days to request a hearing in writing.
- The 60 days start the day after you receive this letter. We assume you received this letter 5 days after the date on the letter.
- You must have a good reason for waiting more than 60 days to request a hearing.

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How To Appeal

You can file an appeal with any Social Security office. You must request the appeal in writing. Please use our "Request for Hearing" form, HA-501-U5, which is available on our website at www.socialsecurity.gov on the Internet. You can also contact us by phone, by mail, or come into the office to obtain the form. If you need assistance, we can help you fill out the form.

How A Hearing Works

If you ask for a hearing, we will send your case to an Administrative Law Judge (ALJ). The ALJ will mail you a letter at least 20 days before the hearing to tell you the date, time, and place of the hearing. The letter will explain the law in your case and tell you what the ALJ has to decide. Since the ALJ will review all the facts in your case, it is important that you give us any new facts as soon as you can.

The hearing is your chance to tell the ALJ why you disagree with the decision in your case. You can give the ALJ new evidence and bring people to help explain your case. The ALJ also can require people to bring important papers to your hearing and give facts about your case. You can question these people at your hearing.

It Is Important To Go To The Hearing

We will ask if you want to go to the hearing in person. If you say you want to go, you should attend. If for any reason you can't go, please contact the ALJ as soon as possible before the hearing and explain why. The ALJ will reschedule the hearing if you have a good reason. If you do not come to the hearing after telling us you will be there, we may dismiss your appeal. You will not be able to appeal further. You should know that being there may help the ALJ decide your case.

If You Want Help With Your Appeal

You may choose to have a representative help you. We will work with this person just as we would work with you. If you decide to have a representative, you should find one quickly so that person can start preparing your case.

Many representatives charge a fee only if you receive benefits. Others may represent you for free. Usually, your representative may not charge a fee unless we approve it. Your local Social Security office can give you a list of groups that can help you find a representative.

If you get a representative, you or that person must notify us in writing. You may use our Form SSA-1696-U4 Appointment of Representative. Any local Social Security office can give you this form.

Suspect Social Security Fraud?

Please visit http://oig.ssa.gov/r or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

If You Have Questions

If you have any questions, please:

- Visit our website at www.socialsecurity.gov to find general information about SSI;
- Visit our website at www.socialsecurity.gov/SSIrules/ to find the law and regulations about SSI eligibility and payments;
- Call us toll-free at 1-800-772-1213 or call your local office at 877-304-6994. We can answer most questions over the phone. If you are deaf or hard of hearing, our toll-free TTY number is 1-800-325-0778; or
- Write or visit any Social Security office. If you plan to visit an office, you may call ahead to make an appointment. The office that serves your area is located at:

SOCIAL SECURITY
SUITE B
17075 NEWHOPE STREET
FOUNTAIN VALLEY CA 92708

Please have this letter with you if you call or visit an office. If you write, please include a copy of the first page of this letter. It will help us answer your questions. We are busiest early in the week and early in the month. If your business can wait, it is best to call or visit at other times.

Social Security Administration

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Enclosure(s):
Fact Sheet on SSI Federal Living Arrangement Categories
Fact Sheet on SSI Living Arrangement Categories For the State of California
Income and SSI Payments - What You Need To Know
How We Figured Your Payment

Fact Sheet on SSI
Federal Living Arrangement Categories

Category	Definition
A	Living in Own Household -- You fit in this category if you are eligible for SSI and you meet one of the following conditions: 1. You live in your own household whether or not you receive help paying your food or housing costs. 2. You live in a foster care or family care situation. 3. You are homeless or have no permanent living arrangement. 4. You live in an institution for all or part of a month and Medicaid does not pay more than 50 percent of the cost of your care. You do not fit in this category if you are considered an inmate of a public institution such as a prison. 5. You live alone. 6. You live only with your child, spouse, or persons whose income is being used to compute the amount of your SSI payment. 7. You do not fit in categories B, C or D described below. In Category "A" The Maximum Federal SSI Money Is Used To Compute Your SSI payment.
B	Living in the Household of Another -- You fit in this category if you are eligible for SSI and you meet both of the following conditions: 1. You live in a household other than your own throughout a month with at least one other person who is not your child, your spouse or an ineligible person whose income is being used to compute the amount of your SSI payment. 2. And you receive food and housing from someone in that household. In Category "B" The Federal SSI Money is Reduced By One-Third Because Another Person Helps Pay For Your Food And Housing Costs.
C	Child Living in Parents' Household -- You fit in this category if you are eligible for SSI and you meet both of the following conditions: 1. You are under 18 years old. 2. You live in the same household as your parents. In Category "C" The Maximum Federal SSI Money Is Used To Compute Your SSI payment.

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D Medicaid Facility - You fit in this category if you are eligible for SSI and meet both of the following conditions:

1. You live in a public or private medical institution throughout a month.
2. Medicaid is paying more than 50 percent of the cost of your care.

In Category "D" The Federal SSI Money Cannot Exceed $30.

Fact Sheet on SSI
Living Arrangement Categories
For the State of California

Category	Definition
A	Living Independently with Cooking Facilities – You fit in this category if you are eligible for SSI and you meet one of the following conditions: 1. You meet the definition for Federal Living Arrangement Category A and you have cooking and food storage facilities. 2. You meet the definition for Federal Living Arrangement Category A and meals are provided to you as part of your living arrangement. 3. You are blind and live in an independent living arrangement with or without cooking facilities. 4. You live in a private medical facility and Medi-Cal does not pay for more than half of the cost of your care. 5. You live in a private medical facility that is certified by the State of California but is not certified for Medi-Cal coverage.
B	Living with Others and Receiving Personal Care -- You fit in this category if you are eligible for SSI and you meet the definition for Federal Living Arrangement Category A and you meet one of the following conditions: 1. You need nonmedical care or supervision, you are over age 18 and you reside in the home of a relative, legal conservator, or guardian. 2. You need nonmedical care or supervision and you reside in a State-licensed, nonmedical, out-of-home care facility (such as a board and care home or certified foster family home). 3. You need nonmedical care or supervision and you reside in a Family Home certified by a State Family Home Agency. 4. You are a blind child and you reside in the home of a relative who is not your parent or legal guardian. 5. You are a disabled child and reside in the home of a legal guardian who is not a relative or in the home of a relative who is not your parent.
C	Living Independently Without Cooking Facilities -- You fit in this category if you are eligible for SSI and you meet one of the following conditions: 1. Your dwelling does not have cooking or food storage facilities that you can use to prepare your daily meals. 2. In your dwelling you do not have access to cooking or food storage facilities that you can use as part of your living arrangement.

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3. You live in a boarding house that does not have a kitchen with cooking or food storage facilities that you can use to prepare your meals.
4. You live in a room and board facility and the facility does not provide you with meals as part of the living arrangement.
5. You live with relatives or friends in a private dwelling and do not eat meals with them and do not have access to cooking or food storage facilities that you can use to prepare your own meals.
6. You do not have a permanent place of residence or you are homeless.

D Living in Someone Else's Home -- You fit in this category if you are eligible for SSI and you meet all of the following conditions:

1. You meet the definition for Federal Living Arrangement Category B.
2. You live in the household of another person who provides you with at least part of your food and shelter.
3. You do not pay for all of the food and shelter that person provides to you.

E Living with a Parent, Guardian or Relative -- You fit in this category if you are eligible for SSI and you meet all of the following conditions:

1. You are a disabled (not blind) child under age 18.
2. You reside with a parent or relative by blood or marriage.
3. You meet the definition for Federal Living Arrangement Category A or C.

F Living with Others and Receiving Personal Care -- You fit in this category if you are eligible for SSI and you meet both of the following conditions:

1. You meet the definition for Federal Living Arrangement Category B.
2. You are receiving non-medical care or supervision.

G Living with a Parent, Guardian or Relative -- You fit in this category if you are eligible for SSI and you meet all of the following conditions:

1. You are a disabled (not blind) child under age 18.
2. You reside with a parent or relative by blood or marriage.
3. You meet the definition for Federal Living Arrangement Category B.

J In a medical care facility, like a hospital or nursing home, and Medi-Cal pays for or would usually pay for more than half the cost of your care -- You fit in this category if you are eligible for SSI and you live in a medical facility where Medi-Cal pays more than half of the cost of your care.

Y Optional Supplementation Waived -- You fit in this category if you are eligible for SSI and you told us that you do not want to receive a supplementary payment from the State of California.

Z No State Supplement Payable -- The State of California does not pay a supplement if you meet one of the following conditions.

1. You live in a private medical facility which is not licensed by the State of California and not eligible for Medi-Cal payments.
2. You live in a publicly operated emergency shelter.
3. You are receiving SSI benefits under the special expedited procedure for reinstating benefits.
4. You are under age 18, live in a public medical facility, and private health insurance pays more than half the cost of your care.

Income and SSI Payments
What You Need To Know

What is income for SSI purposes?

The amount of income you get is one of the factors we use to determine your eligibility for SSI payments. Usually the more income you have, the less your SSI payment will be.

Income is any money you receive. Under the SSI program, income is divided into earned income and unearned income. Earned income is income received from wages and self-employment. Unearned income is all income that is not earned income. This includes Social Security payments, Department of Veterans Affair's payments, private pensions, and also the value of the help you receive with food or housing.

Whose income is considered?

We consider your own income. We also consider the income of your spouse if you live in the same household.

How does income affect the amount of your SSI payment?

We compute the amount of your SSI payment after we determine how much income you receive. By law, we use different rules based on the kind of income you have. The most common rules are:

- Certain federally-funded payments based on need, such as Temporary Assistance for Needy Families, are counted dollar for dollar. If you receive a $200.00 payment of this type your SSI payment goes down $200.00.

- We do not count the first $20.00 of other types of unearned income. If you receive a Social Security benefit of $200.00 each month, we don't count $20.00 of the benefit. The remaining $180.00 is counted as your income. If you have less than $20.00 of unearned income, we subtract the balance of the $20.00 from your earned income.

- For earned income, we do not count the first $65.00. Then we do not count one-half of what is left after we have subtracted the $65.00. If earnings are the only income you have, we also do not count $20.00 per month from your earnings. For example, if your only income is $300.00 per month in earnings, we first subtract $20.00 leaving $280.00. Then we subtract $65.00 and half of the remainder as shown on next page.

Example of how we count someone's earnings:

Earnings	$300.00
Subtract (-) $20 Deduction	-20.00
	$280.00
Subtract (-) $65 Earnings Deduction	-65.00
	$215.00
Subtract (-) One Half (1/2 of $215.00)	-107.50
Income We Count	$107.50

After subtracting and not counting these amounts, the remaining earnings reduce your SSI. In this example the wages are $300.00 and $107.50 is counted as income used to determine the SSI payment.

When does income affect your SSI payment?

Our general rule is to use the income you receive in a month to figure the SSI benefit you get two months later. For example, we use income you receive in April to figure your benefit for June. There are some exceptions to this general rule as follows:

- When you first become eligible for SSI payment or you become eligible after a month you were not eligible for SSI, we use the income received in that month to figure your payment for that month and the following two months. After that we use our general rule. For example, if April is the first month you get an SSI payment, we use the income you receive in April to figure your SSI payment for April, May and June. In July we would apply the general rule and use the income you receive in May to figure July's SSI payment.

- When you first receive SSI or when your SSI begins again after you were ineligible, and if income is received only in the first month, we use that income as well as any income you usually receive to compute the SSI payment for the first month. For example, if the first month of SSI payment is April, and you receive a one-time pension payment in April and not in May, we use the one-time pension income to compute the April SSI payment, but not the May or June SSI payments. Beginning with the July payment, we apply the general rule and use the income received in May.

- We always count federally-funded payments based on need (such as Temporary Assistance for Needy Families) in the month you receive them.

HOW WE FIGURED YOUR PAYMENT FOR October 2015

Your Payment Amount

The most Federal SSI money the law allows us to pay	$733.00
Minus (-) "Total income we count" (see below)	-244.33
Federal SSI money	$488.67
Plus (+) the most State SSI money the law allows us to pay	+156.40
We didn't subtract (-) any income from State SSI money	- 0.00
Total SSI Payment for October 2015	$645.07

Your Income Other Than Your SSI

Income you receive in August 2015 affects your payment for October 2015

Value of food and shelter	$244.33
Total income we count	$244.33

Social Security Administration
Supplemental Security Income
Notice of Change in Payment

SOCIAL SECURITY
17075 NEWHOPE STREET
SUITE B
FOUNTAIN VALLEY CA 92708
Date: March 21, 2016
Claim Number: [redacted]

[redacted]

ALECIA ANN DRAPER
FOR EMILY CHRISTINE REED
[redacted]

We are starting EMILY C. REED's Supplemental Security Income (SSI) payments again because you gave us the information we needed.

EMILY C. REED's current monthly Supplemental Security Income (SSI) payment is $648.50 for April 2016. She will continue to get this amount each month unless there is a change in the information we use to figure her payment. This amount includes $159.83 from the State of California.

We explain how we figured the monthly payment amount on the worksheet(s) at the end of this letter. The explanation shows how her income, other than any SSI payments, affects her SSI payment. We include explanations only for months where payment amounts change.

The Payments of EMILY C. REED Will Be Changed As Follows:

From	Through	Amount Due Each Month
April 1, 2016	Continuing	$648.50 This includes $159.83 from the State of California.

When You Will Receive Her Payments

Your bank or other financial institution will receive her monthly payment of $648.50 around April 1, 2016, and on the first of each month after that.

Information Used In Making The Decision

- She was found disabled on April 29, 2015.

See Next Page

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- In April 2016 on, she is not regularly attending school.
- She is living in the State of California for April 2016 on.
- The amount of money we pay her from the State of California depends on the State's rules.

  She is living in someone else's home for April 2016 on.
- She has monthly income which must be considered in figuring her eligibility as follows:

  The food and shelter she gets in someone else's home or apartment. We value that food and shelter at $244.33 for February 2016 on.

Information About Medicaid

An agency of her State will advise her about the Medicaid program. If she has any questions about her eligibility for Medicaid or needs immediate medical assistance, she should get in touch with the county welfare department.

Your Reporting Responsibilities

EMILY C. REED's SSI payments may change if her situation changes. You are required to report any changes that may affect her SSI no later than 10 days after the month the change takes place.

Please call 1-800-772-1213 or contact your local Social Security office to report any of the following changes:

- She starts or stops work, or her wages increase or decrease
- Her bank account balance goes over $2,000.00
- She moves
- Anyone else moves into or out of her household
- Someone in her household dies
- She or someone in her household marries, separates, or divorces (including same-sex marriage)
- Income or resources change for her or members of her household
- Her medical condition improves
- She starts or stops attending school regularly
- She leaves the United States and expects to be gone for a full calendar month or for 30 consecutive days
- She is in a hospital, jail, or other institution for a full calendar month
- A felony warrant for flight or escape or a warrant for violating a condition of parole or probation is issued for her arrest

You Can Review The Information in EMILY C. REED's Case

The decisions in this letter are based on the law and information in our records. You have a right to review and get copies of the information in our records that we used to make the decisions explained in this letter. You also have a right to review and copy the laws, regulations, and policy statements used in deciding her case. To do so, please contact us. Our telephone number and address are shown under the heading "If You Have Questions".

Things You Should Know

- She is living in someone else's house or apartment. We may be able to pay her more SSI money if she is paying her share of the household expenses. Contact us if you think she is paying her share.
- We have made a new decision on her case. It replaces all earlier decisions for the above periods.
- We are also sending this information to EMILY C. REED.

If You Disagree

If you disagree with this decision, you have the right to appeal. A person who did not make the first decision will decide the appeal. We call this appeal a reconsideration. When you appeal, we review her entire case, even the parts with which you agree. We consider any new facts we have and then make a new decision. The new decision could be more favorable, less favorable, or the same as the one you already have.

Time To File An Appeal

- You have 60 days to file an appeal in writing.
- The 60 days start the day after you receive this letter. We assume you received this letter 5 days after the date on the letter.
- You must have a good reason for waiting more than 60 days to file an appeal.

How To Appeal

You can file an appeal with any Social Security office. You must request the appeal in writing. Please use our "Request for Reconsideration" form, SSA-561-U2, which is available on our website at www.socialsecurity.gov on the Internet. You can also contact us by phone, by mail, or come into the office to obtain the form. If you need assistance, we can help you fill out the form.

There are 2 types of appeals. In most cases, you can choose the one you want.

- Case Review: You will not meet with the person who decides her case. You have a right to review the facts in her file. You can give us more facts to add to her file. Then we will decide her case again. This is the only kind of appeal you can have for a medical decision.

- Informal Conference: You will talk with the person who decides her case either in person or over the phone. You can tell that person why you disagree with our decision. If you meet with us in person, it may help her case. You have a right to review the facts in her file. You can give us more facts to add to her file. You can have other people help explain her case. Then we will decide her case again.

If You Want Help With Your Appeal

You may choose to have a representative help you. We will work with this person just as we would work with you. If you decide to have a representative, you should find one quickly so that person can start preparing your case.

Many representatives charge a fee only if you receive benefits. Others may represent you for free. Usually, your representative may not charge a fee unless we approve it. Your local Social Security office can give you a list of groups that can help you find a representative.

If you get a representative, you or that person must notify us in writing. You may use our Form SSA-1696-U4 Appointment of Representative. Any local Social Security office can give you this form.

Suspect Social Security Fraud?

Please visit http://oig.ssa.gov/r or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

If You Have Questions

If you have any questions, please:

- Visit our website at www.socialsecurity.gov to find general information about SSI;

- Visit our website at www.socialsecurity.gov/SSIrules/ to find the law and regulations about SSI eligibility and payments;

- Call us toll-free at 1-800-772-1213 or call your local office at 877-304-6994. We can answer most questions over the phone. If you are deaf or hard of hearing, our toll-free TTY number is 1-800-325-0778; or

- Write or visit any Social Security office. If you plan to visit an office, you may call ahead to make an appointment. The office that serves your area is located at:

SOCIAL SECURITY
SUITE B
17075 NEWHOPE STREET
FOUNTAIN VALLEY CA 92708

Please have this letter with you if you call or visit an office. If you write, please include a copy of the first page of this letter. It will help us answer your questions. We are busiest early in the week and early in the month. If your business can wait, it is best to call or visit at other times.

Social Security Administration

Enclosure(s):
How We Figured EMILY C. REED's Payment

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SSA-L8151

HOW WE FIGURED EMILY C. REED'S PAYMENT FOR April 2016 ON

Her Payment Amount

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We didn't subtract (-) any income from State SSI money	- 0.00
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Her Income Other Than Her SSI

Income she receives in February 2016 on affects her payment for April 2016 on

Value of food and shelter	$244.33
Total income we count	$244.33