**Identifying Data:**

Full Name: K.C.

Sex: Female

DOB: XX/XX/1953

Race/Nationality: Caucasian

Primary Language: English

Address: Queens, NY

Date & Time: 010:00AM 07/6/22

Location: QHC

Source of Information: Self and Medical Records

Reliability: reliable

Source of Referral: N/A

**Chief Complaint:** “I feel really anxious about my ex-boyfriend cheating on me and taunting me” x2 weeks

**HPI:**

K.C. is a 54-year-old COVID-negative white female who is single, unemployed, lives in a private home, with reported past psychiatric history of major depressive disorder, anxiety, and polysubstance abuse and past medical history of hypertension and hyperlipidemia. Patient was brought into CPEP by EMS after calling 911 for being anxious and paranoid about her ex-boyfriend cheating on her and taunting her by walking up and down the street with his new girlfriend. Patient admits to daily marijuana, cocaine, and benzodiazepine use. She admits to feelings of worthlessness, attempting to quit several times recently but has been unable to be she “needs it to take the edge off”. This morning the patient appears agitated but cooperative. She states she is angry with her ex-boyfriend but has no active suicidal or homicidal ideations. No hallucinations or delusions were noted. She gave her brother’s phone number for collateral information. Per brother, her boyfriend is “a good person and she is on angel dust” which is causing this behavior. Brother also states the “cheating is all in her head and her boyfriend is not walking down their street with another woman”. Brother denies patient having a history of suicidal/homicidal intent or history of violence. She receives psychiatric treatment from her primary care provider and states she did two sessions of mental health therapy in January but then stopped because she did not feel it helped.

Pt appeared active, alert, ambulatory with steady gait, moving all extremities. Denied skin rashes or itching. Refused skin assessment on chest, abdomen, and L/E. Denied arm and leg pain and cramping. No history of deep vein thrombosis/pulmonary embolism. Normal spontaneous breathing observed. Intact chewing and swallowing. Consumes healthy diet.

**Past Medical History:**

* Hypertension
* Hyperlipidemia
* *Immunizations*
* Up to date on adult immunizations
* Annual influenza 2021
* Sars-Covid-2 x3 doses (Pfizer)
* *No reported past surgical history*

**Past Psychiatric History:**

* Major Depressive Disorder – Diagnosed 2021
* Anxiety – Diagnosed 2021
* Polysubstance abuse – Began using 10 years prior

**Allergies:**

* No known drug allergies or environmental/food allergies

**Current Medications:**

*Outpatient Medications*

* Lisinopril 10mg PO one tablet daily
* Atorvastatin 20mg PO one tablet daily
* Sertraline 100mg PO one tablet daily

**Family History:**

* Patient and brother deny any known family history of psychiatric illnesses

**Social History:**

K.C. is a Caucasian female, unemployed receiving income from brother and ex-boyfriend. She previously worked in various retail positions. She states she is unable to get back to work because of her depression. When asked what she enjoys doing for fun she states, “I am too sad all the time to do anything fun”. She also admits to decreased concentration. Highest level of education is high school diploma. Parents are deceased and she has a close relationship with her brother, daughter, and multiple friends. She owns her home in Long Island where she has resided for all her life. She states she has an “off and on” relationship with her ex-boyfriend due to arguments and they broke up two weeks ago. She states she either oversleeps (12+ hours) or under-sleeps (2-3 hours per night). Her appetite is decreased, and she has lost 10lbs in in the last 2 months. She drinks alcohol occasionally and typically has 2-3 drinks a month. She admits to marijuana, cocaine, and benzodiazepine use and states she “would do more but cannot afford to buy a lot of drugs”. She states she uses the three drugs because they make her “feel numb which is better than feeling anxiety and depression”. She denies a history of criminal activity or arrest.

**Review of Systems:**

* General – Patient admits to decrease in appetite and recent weight loss. Denies fever or fatigue
* Skin – No evidence of skin rashes, intravenous drug use, skin picking, or self-inflicted wounds
* Neurologic – Patient denies loss of consciousness, history of trauma, unsteady gait, headaches, blurry vision, slurred speech, or unintentional body movements
* Psychiatric – **Admits to paranoia, anxiety, irritability, restlessness, increased & decreased sleep, interest deficit, concentration deficit, and decreased appetite.** Denies distractibility, excitement, grandiosity, flight of ideas, activity increase, talkativeness, suicidal/homicidal ideation.

**PHYSICAL EXAM**

Vital Signs:

BP: 124/81 mmHg – sitting supine, L arm RR: 18 breaths/min Pulse: 93 bpm

T: 97.7F (oral) O2 SAT: 97% room air

Height: 5’6 inches Weight: 202 lbs BMI: 32.60 kg/m2

General

**Appearance:** A&Ox3. No acute distress. Not diaphoretic. Appears reported age and well-groomed with appropriate clothing. Appears well nourished.

**Behavior and psychomotor activity:** Patient is sitting in chair with appropriate tone. Patient appears labile alternating between episodes of crying and agitation. Patient appears most agitated when discussing her boyfriend stating “He is a son of a bitch taunting me walking up and down the street with his new girlfriend stalking me”. There are no apparent tics, tremors, fasciculations, or retardation.

**Attitude Towards Examiner:** Patient is cooperative and answering questions appropriately. She is not aggressive towards the examiner or other staff members.

Sensorium and Cognition

**Alertness and Consciousness:** Patient was conscious and alert throughout the interview.

**Orientation:** Patient was oriented to the date, place, and time of interview

**Concentration and Attention:** Patient was able to maintain attention and concentration throughout the interview. She is not distracted or internally preoccupied. She appears talkative and goal oriented.

**Capacity to Read and Write:** Patient was able to write brother’s name and number with pen and paper. Patient was able to read and write answers for PHQ-9 score.

**Abstract Thinking:** Patient displayed abstract thinking by interpreting common English metaphors such as “the grass is always greener on the other side” and when asked “what is similar about apples and oranges” was able to answer that they are both round fruits.

**Memory:** The patients remote and recent memory appear intact. Patient is able to recall recent events leading up to coming into the hospital.

**Fund of Information and Knowledge:** Patient’s intellectual performance was average and consistent with her educational level and training which is high school diploma and former retail worker.

Mood and Affect

**Mood:** The patient’s mood oscillated between gloomy/sad and angry/irritable. Patient would become irritable when discussing the events with her boyfriend leading up to her presentation to the hospital and sad when discussing her recent drug use.

**Affect:** Patient’s affect was labile.

**Appropriateness:** Her mood and affect were congruent with her thought content throughout the interview.

Motor

**Speech:** Speech is normal rate and volume. Fluency and rhythm is clear and coherent.

**Eye contact:** Appropriate eye contact.

**Body movements:** Body posture and movement is appropriate without psychomotor retardation akathisia.

Reasoning and Control

**Thought Content:** When asked “are you worried about your ex-boyfriend following or spying on you?” The patient stated “Yes, I know he is”.

**Impulse Control:** Patient expresses good impulse control stating that “Even though she wants to kill her ex-boyfriend she would never do it”. She states she has no intent to harm herself or others.

**Judgement:** Patient recognizes consequences of her actions. When asked what she would do if she was in a burning movie theatre stated that she would “immediately leave through the fire exit”

**Insight:** Patient has good insight and was able to state why she was brought in today “for using a little cocaine and yelling at my ex-boyfriend”.

**Assessment:**

K.C. is a 54-year-old COVID-negative Caucasian female, unemployed receiving money from ex-boyfriend and brother, living alone in her home, with a reported past psychiatric history of major depressive disorder, anxiety, and polysubstance abuse (marijuana, cocaine, and benzodiazepines) who presents to CPEP for “irrational behavior and screaming in the street”, brought in by EMS activated by neighbors. Patient presents with labile affect and agitation. Collateral information obtained by brother is notable for patient having delusions and paranoia while she is taking illicit drugs. Patient agrees to take her medication and follow-up outpatient. Her behavior is thought to be related to her drug use and at present, she is not a danger to herself or others. She will be admitted to CPEP overnight and if she remains clinically stable in the AM she will be discharged home on her own with the recommendation to go an outpatient rehabilitation center for drug abuse.

Differential Diagnosis:

* **Substance-Use Disorder:** Patient has interpersonal relationship problems related to drug use, repeated attempts to quit, and drug cravings within the last 12 months which meets criteria for substance-use disorder. Paranoia is likely secondary to substance use.
* **Major Depression:** She has sleep disturbances, decreased interest in activities, decreased appetite, difficulty concentrating, and feelings of worthlessness. This is 5/8 of the symptoms for depression and meets criteria for clinical diagnosis.
* **Generalized Anxiety Disorder:** The patient admits to excessive worry accompanied by restlessness, irritability, and sleep disturbances within the last 6 months which meets criteria for diagnosis.
* **Dysthymia:** Although patient has depressed mood consistent with dysthymia, her symptoms have not persisted for 2 years to make the diagnosis.
* **Bipolar II Disorder:** Consideration was given to this diagnosis since the patient exhibits many symptoms of a mood disorder. She has the depressed mood consistent with Bipolar II, however, she does not exhibit symptoms of hypomania to make the diagnosis. Additionally, if she had exhibited symptoms, they could be accounted for by use of stimulants (cocaine).

Plan:

* Admit to Comprehensive Psychiatric Emergency Program (CPEP) under Mental Hygiene Law 9.40 legal status for observation, stabilization, and re-evaluation at 10:00AM tomorrow morning.
* Obtain Labs:
  + CBC, CMP, TSH – Assess baseline and rule out underlying medical conditions causing mood disorder
  + Screen for COVID-19 and provide face mask for prevention
  + Blood Alcohol Levels – Rule out acute alcohol intoxication
  + Urine Drug Screen – Assess for drugs of abuse
    - Upon review of labs, urine drug screen was positive for Cocaine, Benzodiazepines, and Marijuana use. Blood alcohol level was negative for acute intoxication. TSH, CBC, and CMP were within normal limits. COVID-19 PCR swab negative.
  + Continue Daily Medication
    - Lisinopril 10mg PO one tablet daily
    - Atorvastatin 20mg PO one tablet daily
    - Sertraline 100mg PO one tablet daily
  + Monitor for signs and symptoms of withdrawal
  + Begin Benzodiazepine Taper to prevent seizures
    - Patient admits to taking 2mg of Alprazolam daily that she buys from a friend.
    - Administer the equivalent Diazepam 20mg in 3 divided daily doses and have patient immediately follow up with outpatient psychiatry for tapered dosing
  + Provide patient education on substance use disorder, depression, and anxiety
  + Refer to social work to arrange outpatient psychiatric follow-up and counseling services
  + Repeat vitals in the AM and reassess to determine if patient is clinically stable for discharge or requires admission to extended observation unit (EOU) for additional care.