

Psychiatry Inpatient SOAP Note

S: P.N. is very happy about her weekend venture. She was given passes to go to visit her home and she used 4 hrs each day and had an "ok" weekend. She said that on Saturday, her former boyfriend and her went out for a nice lunch and then she got to see her dog and had a wonderful time. She said that she felt better than being in the hospital. She felt so good to smile after a long time. On Sunday, she said she went to visit her daughter and they got into an argument. She was not happy that her daughters didn't come to the family meeting and she wanted to let them know about that. She says that her sons are good and are understanding but her daughters don't understand. She is very worried about her grandson and wants to see what she can do to help. She says that overall she feels better than when she came in but still needs to be stronger in terms of her decision making. Her motivation, energy and interest levels have improved as per the patient. She is eating better now and she says she gets ample sleep here. She is anticipating discharge on Wednesday and she is hoping that it will happen. She denies any problems with her medications and says they are ok. She says this morning, when she got up, she felt dizzy and felt her head was going back and forth and her legs were trembling. She thought she was having a seizure. She also said on Saturday and Sunday, she had a 5/10 HA that wasn't going away with Tylenol. She took Ibuprofen and it felt better. She denies any CP, SOB or any other physical problems.

O: $T_m = 36.0$, $T_c = 36.0$, BP = 120/75. HR = 85, RR = 18

MSE: *Appearance*-The patient is well groomed, showered and well dressed. *Behavior*- appropriate with no abnormal movements. She has good *eye contact* and her *speech* is not low, pressured or productive. Her *mood* is neutral and her *affect* is still sad but better than Friday. She denies any *delusions*, *suicidal ideations* or *homicidal ideations*. She has *hallucinations*. Her *insight* and *judgment* are good. In terms of her *sensorium*, she spells "world" backwards. She performs digit span forward and backwards on 5492. She does serial 7's until 72.

A/P: Patient is a 57 year old white single female with MDD, HD #14.

1. Depression:

- Based on today's conversation and observation, the patient appears more motivated, with better sleep and appetite. Her mood seems much better than last week. .
- Continue with CBT and DBT skills training and encourage her to attend all workshops
- Continue Effexor 225 mg PO qhs for now. Shall discuss with the team if need to decrease dose
- Consider pet therapy as patient is missing her dog a lot

2. Dizziness/HA:

- Patient is having dizzy spells today and had HA over past weekend. She had these spells before and it was thought to be attributed to dilantin and she was taken off the medication. Another possibility could be the effexor. Effexor can cause increased BP, and HA in 20% of the patients. Will get more frequent vital signs.
- Patient might be having orthostatic hypotension, which is also caused by Effexor. Will check for orthostatics BP and HR.
- Order BMP and finger stick to r/o any metabolic causes.
- EKG as patient has hx of MVP and had a previous EKG with T wave inversions and QTc prolongation, which was attributed to the dilantin.

3. Hypothyroidism:

- Patient on Synthroid 0.125mg, week two now and without any side effects
- TSH and FT4 to be done in 3 weeks as outpatient

4. Disposition:

- Patient is improving with terms of mood and we shall discuss a d/c date of Wednesday with her.
- Needs outpatient appointments with UHCC clinic and a therapist.
- Also will get an appt with Dr. O'Neil for relation therapy.

KJ – MS3

Psychiatry Admission Note / New patient Note

HPI: A.Z. is a 45-year-old white male who has been referred by the NPOD for medication management. The patient has a past history of schizoaffective disorder and multiple past hospitalizations. The patient had been previously being treated in Chicago, Illinois where he lived. He moved back to CNY in January 2003 after breaking up with his

girlfriend. He had grown up in the Rome area and moved here to find his brother. After not being able to find his brother, the patient became depressed and apparently suicidal. The patient also stated that he had not been taking his medications because he had lost them. He was admitted (by 2pc) to Good Samaritan Hospital in February 2003 for treatment. The patient states that his medications were changed while he was there. After being discharged, the patient followed up with the on-call psychiatrist in order to renew his medications, and was given a referral to the Office of Mental Health for f/u treatment. The patient states that he is currently in a normal mood; he is not overtly depressed or euphoric, with no current suicidal or homicidal ideations or intent at this time. His mood can fluctuate at times however. He does c/o feeling a bit agitated/anxious during the day. He does not have any complaints about sleep or appetite. He does express interest in having a therapist.

Past psychiatric History: The patient states that he has been hospitalized 10 times in the past. He states that he began to have psychiatric problems 10 years ago when he got divorced from his wife and tried to commit suicide by taking an overdose of pills and cutting his wrist. He states that he has had auditory hallucinations of voices, however, he has generally not felt controlled by them and can often ignore them. He admits to having episodes of feeling "high" in the past (by this he means not sleeping enough, talking and thinking too fast, and trying to do too much, thinking he could). Sometimes there are hallucinations with these feelings. He could not give much hx about meds. His psychiatrist in Chicago was Dr. Smith, but cannot recall the name of his psychotherapist. The patient states that he used to drink a lot of alcohol but quit in the 1980's. He denies any history of seizures or delirium tremens. He denies any illicit drug use. Pt smokes 2 packs of cigarettes per day, down from 4 ppd. The patient denies any family history of psychiatric illness.

Past Medical History: GERD - treated with rabeprazole

Allergies: NKDA

Medications: lorazepam 2mg bid, depakote 1500mg qhs, risperidone 2mg bid, zolpidem 5mg qhs, rabeprazole 20mg bid

Family History: The patient's mother and father are both deceased from heart disease. The patient states that his younger brother died of an accidental gunshot wound at the age of 18 (patient was 22 years old at the time). Patient had a sister who passed away from AIDS. Patient states that he has two living brothers but did not provide any more information.

Social History: The patient grew up in upstate New York. The patient currently lives in the Rome area. He had previously been living in Chicago for 5 years with his girlfriend, however the relationship recently ended and he moved to Rome in March. He had been previously married and got divorced about 10 years ago. The patient is currently unemployed and states that he is not able to hold a job because he is "explosive". Pt states that he has trouble with authority figures. The patient denies any physical or sexual abuse during childhood. No major losses (other than sister and brother's death), illnesses, marital discord. States his childhood was "normal".

Military History (if a VA patient): The patient was in the Army during the Vietnam era but was never in combat. He received an honorable discharge due to physical injuries.

Mental Status Exam: This is a 45-year-old white male who looks his stated age. His dress is appropriate wearing jeans and at-shirt. He is able to answer questions and sustain attention appropriately, however, he rushed the interview in order to go to another appointment. His psychomotor activity appears appropriate. No overt signs of involuntary movements. His speech is mildly pressured with a normal rhythm and is coherent. There does not appear to be any problems with articulation or vocabulary. His mood is euthymic. His affect is appropriate with normal range. He uses humor and sarcasm during the interview and readily expresses hostility about various issues. He is vague about many details of his medical history but this does not seem to be due to any cognitive problems. His thought process seems normal and there do not appear to be any current hallucinations or delusions. His thought content is appropriate for the situation, no real bizarre ideations. He denies any current suicidal or homicidal ideation or intent at this time, although he has had such ideation in the past. He has generally been able to control this. His insight and judgment seem adequate at present.

Diagnosis

Axis I - schizoaffective disorder - seems fairly euthymic

Axis II - Deferred

Axis III - GERD

Axis IV - unemployed, break up with girlfriend

Axis V - GAF 50

Plan

- 1) Continue depakote, risperidone, zolpidem
- 2) Increase lorazepam to 1mg po bid prn anxiety/agitation
- 3) Will arrange for individual supportive therapy
- 4) Return to clinic in 1 month or sooner as needed