IP/OBS/SDS Legal Record

Admission Information - Hospital Account/Patient Record

Arrival Date/Time:	None	Admit Date/Time:	08/09/2016 9:20 PM	IP Adm. Date/Time:	08/09/2016 9:20 PM
Admission Type:	Urgent	Point of Origin:	Admitted From Emergency Room	Admit Category:	None
Means of Arrival:	None	Primary Service:	Adult Mental Health	Secondary Service:	None
Transfer Source:	None	Service Area:	East Bay Region Acute Care Services	Unit:	Ehhc Psych 4ea Adult
Admit Provider:	Cruz, John Michael de Vera, MD	Attending Provider:	Cruz, John Michael de Vera, MD	Referring Provider:	None

Final Diagnoses (ICD-10-CM)

Principal	Code	Name	POA	CC	HAC	Affects DRG
[P]	F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified	Yes	No	No	No
	Z81.8	Family history of other mental and behavioral disorders	Exempt from POA reporting		No	
	L40.9	Psoriasis, unspecified	Yes		No	
	F43.10	Post-traumatic stress disorder, unspecified	Yes		No	
	F41.0	Panic disorder (episodic paroxysmal anxiety) without agoraphobia	Yes		No	
	M79.7	Fibromyalgia	Yes		No	
	R74.0	Nonspecific elevation of levels of transaminase and lactic acid dehydrogenase (ldh)	Yes		No	
	G89.4	Chronic pain syndrome	Yes		No	
	R10.2	Pelvic and perineal pain	Yes		No	
	K59.00	Constipation, unspecified	Yes		No	
	G43.909	Migraine, unspecified, not intractable, without status migrainosus	Yes		No	
	K21.9	Gastro-esophageal reflux disease without esophagitis	Yes		No	
	F32.9	Major depressive disorder, single episode, unspecified	Yes			

Discharge Information - Hospital Account/Patient Record

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
08/26/2016 4:15 PM	Home Or Self Care	None	Cruz, John Michael de Vera, MD	Ehhc Psych 4ea Adult

ADT Events

	Unit	Room	Bed	Service	Event
08/09/16 2120	EHHC PSYCH 4EB	4129	D	Adult Mental Health	Admission
08/10/16 1834	EHHC PSYCH 4EB	4129	D	Adult Mental Health	Transfer Out
08/10/16 1834	EHHC PSYCH 4EA ADULT	4112	P	Adult Mental Health	Transfer In
08/15/16 1456	EHHC PSYCH 4EA ADULT	4112	P	Adult Mental Health	Transfer Out
08/15/16 1456	EHHC PSYCH 4EA ADULT	4109	D	Adult Mental Health	Transfer In
08/17/16 2007	EHHC PSYCH 4EA ADULT	4109	D	Adult Mental Health	Transfer Out
08/17/16 2007	EHHC PSYCH 4EA ADULT	4109	W	Adult Mental Health	Transfer In
08/19/16 2103	EHHC PSYCH 4EA ADULT	4109	W	Adult Mental Health	Transfer Out
08/19/16 2103	EHHC PSYCH 4EA ADULT	4103	D	Adult Mental Health	Transfer In
08/26/16 1615	EHHC PSYCH 4EA ADULT	4103	D	Adult Mental Health	Discharge

ED Events

None

Discharge Summary

Discharge Summaries by Cruz, John Michael de Vera, MD at 08/10/16 0829

Author: Cruz, John Michael de Vera, MD
Service: Psychiatry
Author Type: Physician
Filed: 08/26/16 2053
Note Time: 08/10/16 0829
Status: Signed
Editor: Cruz, John Michael de Vera, MD (Physician)

BH MH IP DISCHARGE SUMMARY

Admit Date:

8/9/2016 9:20 PM

Discharge Date:
8/26/2016

Discharge Diagnosis:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

Procedures Performed:
none

Vital Signs at Discharge:
BP 113/77 | Pulse 95 | Temp (Src) 99.5 °F (37.5 °C) (Oral) | Resp 14 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 98%
Wt Readings from Last 3 Encounters:
08/09/16 : 58.514 kg (129 lb)
Ht Readings from Last 3 Encounters:
08/09/16 : 1.702 m (5' 7")

Significant Laboratory Findings:
* CBC:
A. 8-09-2016: Significant for WBC 2.2 (low), Hb 13.3 (low);
B. 8-12-2016: Significant for WBC 3.3 (low).
C. 8-24-2016: Significant for WBC 3.9 (low), Hemoglobin 12.5 (low), Hematocrit 38.4 (low), Platelet 100 (low)
* CMP: Significant for AST 39 (high), ALT 61 (high)
* HIV: Non-Reactive
* Mg: 2.5 (elevated)
* Phos: 2.9
* HbA1c: 5.1
* Lipid Panel: Total Cholesterol 185/ Triglyceride 190 (elevated)/ HDL 60/ LDL 87/ VLDL 38 (elevated)
* TSH: 0.67
* Vitamin B12: 545
* Folate: > 20
* RPR: Non-Reactive
* UA: 1+ Ketones
* UCx: Not indicated
* UTox: + Benzos
* EtOH: < 3
* Valproic Acid Trough:
A. 89.3 (on Divalproex ER 1500 mg PO at bedtime on 8/15/2016),

B. 89.4 (on Divalproex ER 2000 mg PO at bedtime on 8/18/2016),
C. 97.8 (on Divalproex ER 2250 mg PO at bedtime on 8/23/2016)

Hospital Course:
Please refer to admission note from 8/9/2016 for additional details.

Vincent Ho is a 47 year old male with a history of Generalized Anxiety Disorder, panic attacks and Bipolar Disorder Type I without psychotic features who presents with worsening suicidal thoughts in the setting of reinitiation of Paroxetine. He was referred her by the emergency room. His family history is significant for a mother with anxiety, a younger sister with an eating disorder, a maternal grandmother with anxiety and grandfather who abuses alcohol, a paternal uncle with paranoid schizophrenia. His birth and developmental history is significant for being raised in Hong Kong. His personal history is significant for recently quitting his job, being physically abused by his father as a child, and having recalled sexual abuse by his paternal grandfather's concubine who raised him. His educational history is significant for having two master's degree. His substance abuse history is significant for not abusing any substances. His medical history is significant for Fibromyalgia, Psoriasis, Chronic Pelvic Pain Syndrome. His past psychiatric history is significant for having multiple psychiatric hospitalizations and being tried on a number of anti-depressants. Upon admission, his mental status exam was significant for being in a good mood, not having any suicidal or homicidal thoughts, appearing "desperate," and having linear goal directed thoughts.

On admission, to the inpatient unit , the following issues were addressed:

 # Bipolar Disorder Type I without Psychotic Features:
His current presentation is most suggestive of Bipolar Disorder Type I without Psychotic Features. In favor of this diagnosis is that he has experienced not needing to sleep for 36 hours, having inflated self-esteem, talking so fast that his friends cannot understand him, having a many musical scores floating around in his head, being distractible, buying numerous motorcycles and musical scores. In addition, he has also experienced having depressed mood, not being interested in teaching, not feeling like eating solid foods, losing significant amounts of weight, having difficulties staying asleep, and having thoughts about jumping out of his apartment window. During this hospitalization he was started on Divalproex ER titrated up to 2250 mg PO at bedtime. Refer above for Valproic Acid trough level. Divalproex was chosen over other mood stabilizers since Lithium is extensively metabolized by the kidneys which might be somewhat toxic for his kidneys since he also takes Methotrexate for his psoriasis. He had a difficult time swallowing the large pills of Divalproex ER, so it was split into two dosages of Divalproex DR. He continued having difficulties swallowing the Divalproex DR tabs, so he was converted to Divalproex DR Caps. He said that he had difficulties swallowing Divalproex DR tabs that were bigger than 250 mg. As a result, he was ordered for Divalproex DR 250 mg tabs. At the end of his hospitalization, his Divalproex DR was 1000 mg PO qam/ 1000 mg PO qhs. Refer to Valproic Acid trough levels above. In addition, he was not started on Lamotrigine since it takes a significant amount of time for it to be titrated to a therapeutic dosage. He had significant bouts of depression. As a result, he was started on Lurasidone which is indicated for patients with bipolar disorder currently in a depressive phase. The medication was titrated up to 40 mg PO with dinner. However, on this medication, he started to experience restlessness after taking it after dinner and this restless continued to bed time which made it hard for him to sleep. As a result, it was discontinued. In its place, he was started on Olanzapine ODT titrated up to 7.5 mg PO at bedtime since he says that it is effective for insomnia. Towards the end of his hospitalization, he reported being in a good mood, feeling very stable, not having any anxiety, not having any suicidal or homicidal thoughts and looking forward to learning more psychotherapeutic lessons to improve his emotional understanding of himself.

 # Post Traumatic Stress Disorder
His history of having experienced his home being invaded and having recurrent nightmares about the abuse are consistent with Post Traumatic Stress Disorder. He was ordered for PRN Gabapentin titrated up to 600 mg PO q4h but said that the medication was ineffective. As a result, he was ordered for PRN Olanzapine ODT titrated up to 2.5 mg PO for anxiety since he said that it has worked in the past for him. Towards the end of his hospitalization, he reported having some anxiety symptoms that were triggered by stimuli in the present moment that reminded him of stimuli associated with the traumas that he has had in the past.

 # Panic Attacks:
His history of having experienced spontaneous episodes of anxiety, dyspnea and dizziness is suggestive of Panic Attacks. Refer above for discussion about Gabapentin and Olanzapine.

 # Psoriasis
He was continued on his home medication of Methotrexate 7.5 mg PO at bedtime q7days (Mondays), Methotrexate 5 mg PO qam q7days (Tuesdays) and Folic Acid 1 mg PO daily. Of note, he states that his Methotrexate causes him to have low levels of all blood cell lines. His CBC was monitored during this hospitalization.

 # Fibromyalgia:
He was continued on his home medication of Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays). He was also continued on PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day). His PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain was held to prevent polypharmacy since he was already taking the Buprenorphine SL. He was continued on Lactulose 30 mg PO BID to prevent constipation from taking these medications.

 # Chronic Pelvic Pain Syndrome
He was continued on PRN Phenazopyridine 200 mg q8h for pelvic pain.

 # Job Loss
Because he was placed on a 5150 and even though he signed as a voluntary patient, he lost his license to have fire arms . As a result, he will not be able to work as a rifle coach for the junior olympians that he used to teach. He will ask the chair of the rifle junior olympic team to write him a letter of support so that he might be able to get his license to have fire arms sooner than the five years that is stipulated in his 5150.

 # Legal Issues:
He was a voluntary patient.

 # Disposition:
He was discharged home. Outpatient psychiatric care was continued with Herrick PHP. Outpatient psychotherapy was continued with Herrick PHP.

Mental Status Exam on Discharge:
His mental status exam on discharge was significant for having an even mood, not having any suicidal or homicidal thoughts, not having any anxiety, having good sleep which translated into having good energy and not having nay anxiety.

Physician Suicide Risk Assessment and Attestation:
1. Emotional and/or physical pain: **None**

Discharge Summary (continued)

Discharge Summaries by Cruz, John Michael de Vera, MD at 08/10/16 0829 (continued)

2. Withdrawal /inability to talk about feelings/ lack of participation: **None**
3. Current stress/losses/difficult life situation: **None**
4. Hopelessness/inability to think the future could be bright: **None**
5. Current thoughts of suicide, intent, plan: **None**
6. History of self-harm, especially in hospital or other healthcare facility: **None**
7. Estimated suicide risk in hospital: **Low**
8. Estimated suicide risk if discharged: **Low**

In reaching this opinion, I have considered the risks including the above, as well as protective factors.

1. Nursing Suicide Assessment Reviewed in Doc Flowsheet: **Yes**
2. Nursing Notes Reviewed: **Yes**
3. My assessment was discussed with RN: **Yes**

Additional Comments:
No additional comments

Discharge Instructions:
If he has increased thoughts to hurt himself or others, 911 should be called and he should be brought to the nearest emergency room.

Complications:
None

Consultations:
Internal Medicine

Condition on Discharge:
improved

Medications Upon Discharge:

Home Medication Instructions

Ho, Vincent
HAR:302047056
Printed on:08/26/16 2052

Medication Information								
buprenorphine (BUTRANS) 10mcg/hr Topical Patch 1 Patch to affected area(s) every 7 days.								
buprenorphine SL (SUBUTEX) 2mg Apply/place 2 mg under the tongue every 6 hours as needed. Not to exceed two dosages/ 24 hour Indications: Chronic Pelvic Pain Syndrome, Fibromyalgia Syndrome								

Discharge Summary (continued)

Discharge Summaries by Cruz, John Michael de Vera, MD at 08/10/16 0829 (continued)

divalproex 12Hr-DR (DEPAKOTE) 250mg Tab **Take 4 Tabs by mouth twice daily. Take 1000 mg PO qam/ 1000 mg PO qhs**								
foLIC acid 1mg TABS Tab **Take 1 Tab by mouth daily.**								
HYDROcodone/acetaminophen (NORCO 10) 10mg/325mg Tab **Take 1 Tab by mouth every 24 hours as needed for Pain.**								
lactulose (ENULOSE) 10g/15mL Oral Soln **Take 30 mL by mouth twice daily.**								
methotrexate 5mg Tab **Take 1 Tab by mouth every 7 days.**								
methotrexate 7.5mg Tab **Take 1 Tab by mouth every 7 days.**								
OLANZapine ODT (ZYPREXA ZYDIS) 5mg Solutab **Take 0.5 Tabs by mouth every 6 hours as needed (insomnia, anxiety).**								
OLANZapine ODT (ZYPREXA ZYDIS) 5mg Solutab **Take 1.5 Tabs by mouth daily at bedtime.**								
pantoprazole (PROTONIX) 40mg EC Tab **Take 1 Tab by mouth daily 30 minutes before breakfast.**								
phenazopyridine (PYRIDIUM) 200mg Tab **Take 200 mg by mouth three times daily as needed for urinary pain.**								
sennosides (SENOKOT) 8.6mg **Take 2 Tabs by mouth daily at bedtime.**								

Physical Activity:
as tolerated

Followup Care:

Discharge Summary (continued)

Discharge Summaries by Cruz, John Michael de Vera, MD at 08/10/16 0829 (continued)

PHP/IOP

Is patient being discharged on more than one antipsychotic?
No

Attending Physician:
John M Cruz, MD

Signed by Cruz, John Michael de Vera, MD at 08/26/16 2053

Discharge Instructions

Discharge Instructions

The following are after care appointments and resources to support your recovery and ongoing treatment after discharge. If possible, please follow up with appointments within one week.

If you feel you are in crisis, please go to the nearest emergency room or contact crisis support hotline: 1-800-273-TALK (8255).

Herrick PHP Program
2001 Dwight Way, Third Floor
Berkeley, Ca
510-204-4569
Date: 8/29/16 Patient should arrive at 8:30 and proceed to Admitting Office on first floor. After registering for PHP at Admitting Office, take elevator B to PHP Intake Office on 3rd Floor, Room 3388. The program begins at 9 am.

Oakland Community Support Center
7200 Bancroft Ave.
510-777-3800
With: Al Boozer (case manager). Call Al to schedule next appointment.

IHSS Provider (Willie Franklin) at 510-355-5016 will assist you with transportation to and from the Herrick PHP program.

How can I reduce the risk of suicide and/or rehospitalization?
Though not all suicides or rehospitalization can be prevented, some strategies can help reduce the risk. All of these factors are linked to well-being. These strategies include:

- Keeping scheduled after care appointments
- Taking medications as prescribed.
- Seeking treatment, care and support for mental health concerns—and building a good relationship with a doctor or other health professionals
- Building social support networks, such as family, friends, a peer support or support group, or connections with a cultural or faith community
- Learning good coping skills to deal with problems, and trusting in coping abilities

Discharge Instructions (continued)

- Calling a crisis telephone support line
- Connecting with family, friends, or a support group. It can be helpful to talk with others who have experienced thoughts of suicide to learn about their coping strategies
- Activities that calm you or take your mind off your thoughts
- Your own reasons for living
- Key people to call if you're worried about your safety
- Phone numbers for local crisis or suicide prevention helplines
- A list of safe places to go if you don't feel safe at home

Tips for family/friends to keep loved ones safe upon return home from the hospital:

- Support scheduled mental health after care appointments (offer assistance for transport or scheduling if needed)
- Ask directly if he or she is thinking about suicide.
- Eliminate access to firearms
- Focus on your concern for their wellbeing and avoid being accusatory.
- Remain calm and listen. Do not judge.
- Reassure them that there is help and they will not feel like this forever.
- Provide constant supervision if possible.
- If possible, remove means for self-harm from the home (secure over the counter and prescription medications, alcohol, etc.).
- If medications are prescribed, offer to maintain and supervise administration of medications
-

Medications List

START taking these medications - Nurse to fill in Last Dose Given/Next Dose Due

	Quantity/Refills	What Changed	Last Dose Given	Next Dose Due
divalproex 12Hr-DR 250mg Tab Take 4 Tabs by mouth twice daily. Take 1000 mg PO qam/ 1000 mg PO qhs Reason for Use: Bipolar I Disorder, Most Recent Episode Depressed (Hcc) Commonly known as: DEPAKOTE	Quantity: 240 Tab Refills: 0			
foLIC acid 1mg Tabs Tab Take 1 Tab by mouth daily. Reason for Use: Psoriasis	Quantity: 30 Tab Refills: 0			
pantoprazole 40mg EC Tab Take 1 Tab by mouth daily 30 minutes before breakfast. Reason for Use: Gastroesophageal Reflux Disease Without Esophagitis Commonly known as: PROTONIX	Quantity: 30 Tab Refills: 0			
sennosides 8.6mg Take 2 Tabs by mouth daily at bedtime. Reason for Use: Chronic Pelvic Pain In Male Commonly known as: SENOKOT	Quantity: 60 Tab Refills: 0			

CHANGE how you take these medications

Medications List (continued)

CHANGE how you take these medications (continued)

	Quantity/Refills	What Changed	Last Dose Given	Next Dose Due
lactulose 10g/15mL Oral Soln Take 30 mL by mouth twice daily. Reason for Use: Chronic Pelvic Pain In Male Commonly known as: ENULOSE	Quantity: 1800 mL Refills: 0	**- when to take this** **- additional instructions**		
methotrexate 5mg Tab Take 1 Tab by mouth every 7 days.	Refills: 0	**- medication strength** **- when to take this**		
methotrexate 7.5mg Tab Take 1 Tab by mouth every 7 days.	Refills: 0	**You were already taking a medication with the same name, and this prescription was added. Make sure you understand how and when to take each.**		

CONTINUE taking these medications - Nurse to fill in Last Dose Given/Next Dose

	Quantity/Refills	What Changed	Last Dose Given	Next Dose Due
buprenorphine SL 2mg Apply/place 2 mg under the tongue every 6 hours as needed. Not to exceed two dosages/ 24 hour Indications: Chronic Pelvic Pain Syndrome, Fibromyalgia Syndrome Commonly known as: SUBUTEX	Refills: 0			
BUTRANS 10mcg/hr Topical Patch 1 Patch to affected area(s) every 7 days. Generic drug: buprenorphine	Refills: 0			
HYDROcodone/acetaminophen 10mg/325mg Tab Take 1 Tab by mouth every 24 hours as needed for Pain. Commonly known as: NORCO 10	Refills: 0			
phenazopyridine 200mg Tab Take 200 mg by mouth three times daily as needed for urinary pain. Commonly known as: PYRIDIUM	Refills: 0			

STOP taking these medications

DIAZEPAM PO

methotrexate (anti-rheumatic) 2.5 MG Tab
Commonly known as: RHEUMATREX

PAXIL PO

Where to Get Your Medications

You need to pick up these prescriptions. We sent them to a specific pharmacy, so go there to get them.

WELLSPRING PHARMACY - OAKLAND, CA - 4184C PIEDMONT AVE
4184C Piedmont Ave
Oakland CA 94611
Phone: 510-428-1559

- divalproex 12Hr-DR 250mg Tab
- foLIC acid 1mg Tabs Tab
- lactulose 10g/15mL Oral Soln
- pantoprazole 40mg EC Tab
- sennosides 8.6mg

ED Arrival Information

Patient not seen in ED

ED Arrival Information (continued)

Chief Complaint

Chief Complaint

None

ED Notes

Behavioral Health Note by Tangorra, Joseph Peter, PHD at 08/09/16 1350

Author: Tangorra, Joseph Peter, PHD | Service: Adult Mental Health | Author Type: Psychologist
Filed: 08/09/16 1355 | Note Time: 08/09/16 1350 | Status: Signed
Editor: Tangorra, Joseph Peter, PHD (Psychologist)

Psychiatric Intake Note

Presenting Clinical:
The patient is a 47 yo male with an hx of mood disorder who presents to ABER on the advice of his outpatient psychiatrist secondary to acute SI. The patient's friend had to stop him from jumping out of a window. The patient has been increasingly depressed after stopping his Paxil rx two months ago. The patient was placed on a 5150 in the ED. No medical issues reported, labs and vital signs WNL per Dr. Brown. No violence toward others reported. No substance abuse reported, UDS positive for benzos in the ED.

Prior Psychiatric Treatment:

Hospitalizations: Unknown
Outpatient Therapist:
Outpatient Psychiatrist**:**

Drug and Alcohol History: No substance abuse reported, UDS positive for benzos in the ED.

Medical Problems: No medical issues reported, labs and vital signs WNL per Dr. Brown.

Admit Unit: 4EB

Admitting Doctor : 8AM-12PM
12PM-6PM STANGER
6PM-8AM MICHEL

Admitting Diagnosis: Mood dx NOS.

Signed by Tangorra, Joseph Peter, PHD at 08/09/16 1355

Behavioral Health Note by Tangorra, Joseph Peter, PHD at 08/09/16 1356

Author: Tangorra, Joseph Peter, PHD | Service: Adult Mental Health | Author Type: Psychologist
Filed: 08/09/16 1357 | Note Time: 08/09/16 1356 | Status: Signed
Editor: Tangorra, Joseph Peter, PHD (Psychologist)

ED Notes (continued)

Behavioral Health Note by Tangorra, Joseph Peter, PHD at 08/09/16 1356 (continued)

The patient has been cleared for a bed at Herrick after 7:30pm, unit 4EB. Please phone report to x4452.

Signed by Tangorra, Joseph Peter, PHD at 08/09/16 1357

Behavioral Health Note by Silver, Amy E, RN at 08/09/16 1848

Author: Silver, Amy E, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/09/16 1851 | Note Time: 08/09/16 1848 | Status: Signed
Editor: Silver, Amy E, RN (Registered Nurse)

BEHAVIORAL HEALTH HAND OFF COMMUNICATION TOOL

☒ **ADMISSION** ☐ **PHP / OP** ☐ **ECT**

S = SITUATION

The patient is a 47 yo male with an hx of mood disorder who presents to ABER on the advice of his outpatient psychiatrist secondary to acute SI. The patient's friend had to stop him from jumping out of a window. The patient has been increasingly depressed after stopping his Paxil rx two months ago. The patient was placed on a 5150 in the ED. No medical issues reported, labs and vital signs WNL per Dr. Brown. No violence toward others reported. No substance abuse reported, UDS positive for benzos in the ED.

B = BACKGROUND

Special Needs: ☐ Vision ☐ Hearing ☐ Language(specify):

Mobility: ☐ With Assistance ☒ Without Assistance ☐ Total Assistance Needed
Type of assistive device used:

Abnormal / significant lab or test results: UDS positive for benzos
Abnormal / significant vital signs:

Infection control: ☐ Contact ☐ Airborne ☐ Droplet ☐ Other(Specify):

A = ASSESSMENT: *Assessment about the patient situation.*

Current mental status:
Anxious but calm and cooperative

Current Behavior: pleasant and calm

Active Medical Problems: hx of appendectomy and in 2004 had TURP

Skin: intact

Restraints:no

ED Notes (continued)

Behavioral Health Note by Silver, Amy E, RN at 08/09/16 1848 (continued)

Has the client been searched? ☐ Yes ☒ No

Medication received: none

Pain status / intensity (1 – 10):
Location:
Last pain med given at:
Name of med:

R = RECOMMENDATION
Comments:

Information received from:Jocelle,RN
Phone number / extension:x2500

Signed by Silver, Amy E, RN at 08/09/16 1851

Behavioral Health Note by Silver, Amy E, RN at 08/09/16 2255

Author: Silver, Amy E, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/09/16 2255 | Note Time: 08/09/16 2255 | Status: Signed
Editor: Silver, Amy E, RN (Registered Nurse)

	08/09/16 2248
Legal Status	
Legal status	2 - 5150 - involuntary
Legal Status - 5150	
Start Date 5150	08/09/16
Start Time 5150	0925
End Date 5150	08/12/16
End Time 5150	0925
Precautions/Isolation	
Precautions (displays in banner)	13
Precautions Interventions	
Interventions Performed	yes
Level of	every 15 minutes

ED Notes (continued)

Behavioral Health Note by Silver, Amy E, RN at 08/09/16 2255 (continued)

Observation	
Suicide Precautions	potential cords (belt, shoe laces, scarves, ties, etc.) removed from patient's possession;patient checked for contraband
Mental Status	
Orientation	oriented x 4
Level Of Consciousness	alert
General Appearance WDL	ex
General Appearance	unkempt;unshaven;bizarre appearance
Mood	anxious;depressed;feelings of doom;mood shifts
Mood/Behavior/ Affect WDL	ex
Behavior (WDL)	Ex
Mood/Behavior	anxious;cooperative;hyperactive;increased energy
Speech	ex
Speech	rapid;pressured;hyperverbal
Judgment and Insight	insight appropriate to situation;judgment appropriate to situation
Insight	fair
Concentration	fair
Memory Deficit	intact
Thought (WDL)	WDL
Psychiatric Symptoms	
Anxiety Symptoms (WDL)	Ex
Anxiety Symptoms	excessive anxiety or worry
Manic Symptoms (WDL)	Ex
Manic Symptoms	flight of ideas;increased energy;pressured speech hyperverbal
Psychotic symptoms (WDL)	WDL
Danger to Self	
Danger to Self (WDL)	WDL

ED Notes (continued)

Behavioral Health Note by Silver, Amy E, RN at 08/09/16 2255 (continued)

Danger to Self	no suicidal ideation or behavior indicators observed or expressed
Keeps Self Safe	yes (describe)
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed
Agreement not to Harm Self	yes (describe)
Description of Agreement	verbal contract
Assessment Type	
Assessment timing	Admission
Assessment of contributing factors	
Assessment of Risk Factors	Prior suicide attempts;Sense of powerlessness/hopelessness
Assessment of Protective Factors	Good access to health care/therapy
Suicide Risk Assessment- Mood	
Agitation	None
Anxiety or Fearfulness	Moderate
Loss of Pleasure or Interest	Moderate
Depression or Sadness	Moderate
Suicide Plan for Today	None
Hopeless or Overwhelmed	High
Suicide Risk Assessment - Thinking	
Sleep Disturbances	Low
Cognition Problems	None
Psychotic Symptoms	None
Suicide Risk Assessment- Behavior	
Withholding Information	None
Resistance to Treatment	None
Impulsivity	None
Aggressive	None

ED Notes (continued)

Behavioral Health Note by Silver, Amy E, RN at 08/09/16 2255 (continued)

towards self/others	
Suicide Risk Assessment- Health	
Pain, real or perceived	None
Perceived Loss of Health	Moderate
Suicidal Inquiry	
Suicide Ideation for Today	None
Behavior congruent with Verbal and Non-Verbal	Yes
Assessment of Current Suicide Risk	
Assessment of Current Suicide Risk	low in hospital, higher if discharged
Danger to Others	
Danger to Others (WDL)	WDL

Signed by Silver, Amy E, RN at 08/09/16 2255

Behavioral Health Note by Silver, Amy E, RN at 08/09/16 2100

Author: Silver, Amy E, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/09/16 2316 | Note Time: 08/09/16 2100 | Status: Signed
Editor: Silver, Amy E, RN (Registered Nurse)

☐Day Shift ☒PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0

ED Notes (continued)

Behavioral Health Note by Silver, Amy E, RN at 08/09/16 2100 (continued)

Total	1	2	3.5	2

Signed by Silver, Amy E, RN at 08/09/16 2316

Behavioral Health Note by Silver, Amy E, RN at 08/09/16 2319

Author: Silver, Amy E, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/09/16 2321 | Note Time: 08/09/16 2319 | Status: Addendum
Editor: Silver, Amy E, RN (Registered Nurse)
Related Notes: Original Note by Silver, Amy E, RN (Registered Nurse) filed at 08/09/16 2247

Pt arrived on unit via AMR. Pt appears disheveled and unkempt. Pt was hyperverbal with pressured speech, but stated that he has hx of depression and bipolar but "I haven't been manic for a long time." Pt does appear to have flight of ideas. Pt denies A/V hallucinations and SI/HI. States that now that he is here in the hospital he is not feeling suicidal. Pt has on at this time a Butran patch 10mcg/h which is a q week patch. Pt stated that he has Chronic Pelvic Pain Syndrome since 2003 and Fibromyalgia since 2009. Pt is treated at the Highland Pain Clinic, Amy Smith at 510 437-8377 is his contact person. Pt is on the Butran patch, Butran 2 mg prn and Norco 10/325 mg prn. Pt has Psoriasis all over his chest and legs, with no open wounds but is quite red with rashes. Pt states that he is going through "Paxil withdrawal." Pt is "overwhelmed and traumatized" by his "Paxil withdrawal" which started in May and ended up with him trying to jump out a window on Saturday. He has been having "panic attacks, " severe depression, and a suicide attempt that was stopped by a friend. Pt wants help and is contractible for safety in the hospital. Pt denies allergies or any other medical problems. Pt described sexual abuse that was between 4-9 years of age. Pt never smoked and denies using any ETOH or recreational drugs. This recent suicide attempt was the first time he has ever had an attempt. Pt has lost "a huge amount of weight" in the past few weeks and has a very poor appetite, a nutritional consult was ordered for this pt. Pt is stable for admit.

Signed by Silver, Amy E, RN at 08/09/16 2247
Signed by Silver, Amy E, RN at 08/09/16 2321

Behavioral Health Note by Himot, Craig at 08/10/16 1122

Author: Himot, Craig | Service: Social Services | Author Type: Others
Filed: 08/10/16 1140 | Note Time: 08/10/16 1122 | Status: Signed
Editor: Himot, Craig (Others)

Received chart for review and discussed case with inpatient care team. Met with patient to introduce self and explain role as Treatment Coordinator. Oriented patient to inpatient setting, provided emotional support and psycho education, and explored treatment and discharge planning goals. Patient identified to get my medications right as treatment goal/s and return to his current residence as discharge planning goal/s. Patient participated in and is in agreement with plan of care.

Plan to continue to work with patient and care team to develop appropriate treatment and discharge planning goals. Will work to secure consent to contact patient's outpatient care team to coordinate care and ensure follow up care and support upon discharge.

This is a 47 y/o single, disabled, male who was admitted on a 5150 as DTS because of worsening depressed mood. On 8/6/16 he called his friend and told her he took medications and was having thoughts/urges to jump out of the window. He reports that he quit Paxil cold turkey approximately two months ago. He finally went to Sausal Creek last week and began to take 5 mg of Paxil per day. His psychiatrist increased it to 10 mg due to the severity of his depression. Pt denies current or past illicit drug or alcohol use. His current UDS was positive for benzo's. Pt reports having several prior psych hospitalizations in New Mexico, in 2006 and 2007. He was

ED Notes (continued)

Behavioral Health Note by Himot, Craig at 08/10/16 1122 (continued)

eventually diagnosed with Bipolar Disorder. He lives alone in an Oakland apartment, for the past 8 years and plans/wants to return there post discharge. He receives outpatient mental health services at Oakland Community Support Services. He also has a PCP as well as receiving services at the Highland Pain Clinic, for Fibromyalgia and Pelvic Pain Syndrome. He reports being estranged from his 2 sisters. He identifies Katy Kaminsky as a supportive friend and his case manager as part of his support system. Pt states that he graduated from William and Mary's and then received 2 graduate degrees at San Francisco State in music and business admin. Pt is cooperative with interview. He hypomanic, pressured, mood somewhat elevated. He denies prior suicide attempts. He denies any family history of suicide attempts. **Plan: Called pt's case manager for collateral information. Awaiting call back. Consider PHP referral.**

	08/10/16 1000
Referral Information	
Arrived From	emergency department
Referral Source	community
Reason For Consult	care coordination/care conference;discharge planning;mental health concerns
Record Reviewed	medical record
Social Worker Assigned to Case	Himot
Contact Information	
Comments	Pt gives verbal permission to talk with his case manager, psychiatrist, friend Katy Kaminski)
Community Case Manager Information	
Name	Al Boozer and Maureen Costello at Oakland Community Support Services
Phone	510-777-3820 and 510- 777-3850
Fax	510-777-3806
Psychiatrist Information	
Name	Dr. James Hinson at Oakland Community Support Services
Phone	510-777-3847
Primary Care Physician Information	
Name	Dr. Mark Robinson G.P. at Lifelong Medical Care
Phone	510-430-8740
Living Environment	
Lives With	alone
Living Arrangements	apartment
Provides Primary Care For	no one
Able to Return to Prior Living Arrangements	yes
Living Arrangement	Pt has lived at this residence in Oakland for the past 8 years and plans to return there upon discharge.

ED Notes (continued)

Behavioral Health Note by Himot, Craig at 08/10/16 1122 (continued)

Comments	
Values/Beliefs	
(F) Faith: Importance of Culture, Spirituality, Religion in Life	Christian. Not currently active or involved in the chruch.
Substance Use, Patient	
Substance Use Comment	Pt denies current or past illicit drug or alcohol use.
Substance Use, Family	
Substance Use Comments	Did not ask.
Cognitive/Perceptual/Developmental	
Recent Changes in Mental Status/Cognitive Functioning	mood
Developmental Stage (Eriksson's Stages of Development)	Stage 7 (35-65 years/Middle Adulthood) Generativity vs. Stagnation
Employment/Financial	
Source Of Income	disability
Emotional/Psychological	
Affect	other (see comments) *(hypomanic)*
Mood	elevated
Verbal Skills	no deficits noted
Current Interpersonal Conduct/Behavior	appropriate to situation
Mental Health Conditions/Symptoms	bipolar affective disorder;labile mood;suicide attempt
Previous Mental Health Treatment	case management;inpatient treatment;medication;outpatient treatment;psychiatrist
Previous Mental Health Treatment Date	Several prior hospitalizations in 2006 and 2007 in New Mexico.

ED Notes (continued)

Behavioral Health Note by Himot, Craig at 08/10/16 1122 (continued)

Mental Health Treatment	case management;inpatient treatment;medication;outpatient treatment;psychiatrist
Suicide Risk	
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed
Coping/Stress	
Major Change/Loss/Stressor	other (see comments) *(recent tapering of his psych medications)*
Patient Personal Strengths	able to adapt;expressive of emotions;expressive of needs;flexibility;future/goal oriented;positive attitude;resourceful;successful coping history
Sources Of Support	friend(s);mental health providers
Reaction To Health Status	accepting
Understanding Of Condition And Treatment	partial understanding of medical condition;partial understanding of treatment
Coping/Stress Comments	Thought about jumping out of the window on Saturday. Pt reports that his doctor at Oakland community Support (intern, now no longer works there) tapered his psych medications over the past several months. Pt believes he is going through "Paxil withdrawal". He has been having "panic attacks," epression. Recent wt loss. Feels "overwhelmed and traumatized" by his "Paxil withdrawl."
Legal	
Criminal Activity/Legal Involvement Pertinent to Current Situation/Hospitalization	Denies current or past legal involvement.
Discharge Needs Assessment	
Concerns To Be Addressed	care coordination/care conferences;coping/stress concerns;mental health concerns;suicidal concerns
Concerns Comments	This is pt's first suicide attempt/gesture. He lives alone. He denies any family hx of suicide attempts or gestures. Will contact his case manager for collateral information and request his current medication list. Consider referral to PHP program.
Readmission Within The Last 30 Days	no previous admission in last 30 days
Community Agency Name(S)	Oakland Community Support Services.
Anticipated Changes	none

ED Notes (continued)

Behavioral Health Note by Himot, Craig at 08/10/16 1122 (continued)

Related to Illness	
Equipment Currently Used at Home	none
Equipment Needed After Discharge	none
Discharge Facility/Level Of Care Needs	other (see comments) *(Home, referral to PHP)*
Transportation Available	public transportation
Current Discharge Risk	lives alone;psychiatric illness
Discharge Disposition	still a patient
Discharge Planning Comments	See SW Plan
Social Work Plan	
Plan	Contact pt's case manager for collateral information, discharge planning recommendations and outpatient treatment follow-up appointments.

Signed by Himot, Craig at 08/10/16 1140

Behavioral Health Note by Leveton, Julian at 08/12/16 0930

Author: Leveton, Julian
Filed: 08/12/16 1729
Editor: Leveton, Julian (Others)
Service: (none)
Note Time: 08/12/16 0930
Author Type: Others
Status: Signed

Check-in (Community) Meeting

Group focused on review of program schedule and guidelines, identification of treatment issues, mood rating and identification and formulation of daily therapeutic goal(s).

AFFECT: Appropriate

APPEARANCE/BEHAVIOR: appropriate:

COGNITION: coherent and goal directed

INTERVENTION: Unit orientation, Individual patient check-in, mood identification, goal setting. Provided support

ED Notes (continued)

Behavioral Health Note by Leveton, Julian at 08/12/16 0930 (continued)

PATIENT RESPONSE: Attentive/Engaged

GOAL SET: set treatment goal for day

COMMENTS: Discuss pass Trauma, and learn to let go of negative feelings brought on by past events

Signed by Leveton, Julian at 08/12/16 1729

Behavioral Health Note by Leveton, Julian at 08/12/16 1100

Author: Leveton, Julian | Service: (none) | Author Type: Others
Filed: 08/12/16 1738 | Note Time: 08/12/16 1100 | Status: Signed
Editor: Leveton, Julian (Others)

Process Group

Group focused on promotion of improved communication and positive, interpersonal experiences—generalizable to relationships outside of the program—to provide opportunity for verbal expression and processing.

AFFECT: Appropriate

APPEARANCE/BEHAVIOR: appropriate:

COGNITION: coherent and goal directed

INTERVENTION/EDUCATION: Provided support

PATIENT RESPONSE: Attentive/Engaged

COMMENTS: This patient attended this group, and was able to join in on the group process. This patient discussed past traumatic events not in detail, but in the negative feelings brought on by them, and wanting and needing to find way's to let go, and feel calm. This patient and writer talked about discussing his feelings with his therapist, and or others, and letting people know when he feels triggered or angered by something, and then letting go of it. The patient is very interested in practicing this, while also practicing meditation, learning to do walking meditations, to try something different. This patient found a lot of support from his peers, as he was also supportive of them, as they shared as well.

Signed by Leveton, Julian at 08/12/16 1738

Behavioral Health Note by Leveton, Julian at 08/12/16 1400

Author: Leveton, Julian | Service: (none) | Author Type: Others
Filed: 08/12/16 1741 | Note Time: 08/12/16 1400 | Status: Signed
Editor: Leveton, Julian (Others)

Creative Writing Group

ED Notes (continued)

Behavioral Health Note by Leveton, Julian at 08/12/16 1400 (continued)

AFFECT: Appropriate

APPEARANCE/BEHAVIOR: appropriate:

COGNITION: coherent and goal directed

INTERVENTION/EDUCATION: Provided support

PATIENT RESPONSE: Attentive/Engaged

COMMENTS: This patient joined the group, and was able to complete the prompt given by this writer. In group patients were invited to either write, a guided imagery focussed meditation, or do free writing, and see what occur's. This patient explored a walking meditation process, and read his writing aloud to the group.

Signed by Leveton, Julian at 08/12/16 1741

Behavioral Health Note by Abend, Marquel Marie, RN at 08/12/16 2309

Author: Abend, Marquel Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/12/16 2311 | Note Time: 08/12/16 2309 | Status: Signed
Editor: Abend, Marquel Marie, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☒PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	2	2.5	2

ED Notes (continued)

Behavioral Health Note by Abend, Marquel Marie, RN at 08/12/16 2309 (continued)

Signed by Abend, Marquel Marie, RN at 08/12/16 2311

Behavioral Health Note by Webb, Gina Marie, RN at 08/13/16 1055

Author: Webb, Gina Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/13/16 1055 | Note Time: 08/13/16 1055 | Status: Signed
Editor: Webb, Gina Marie, RN (Registered Nurse)

STAT labs drawn. Courier notified to p/u.

Signed by Webb, Gina Marie, RN at 08/13/16 1055

Behavioral Health Note by Webb, Gina Marie, RN at 08/13/16 1133

Author: Webb, Gina Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/13/16 1133 | Note Time: 08/13/16 1133 | Status: Signed
Editor: Webb, Gina Marie, RN (Registered Nurse)

1130: Specimens picked up by courier

Signed by Webb, Gina Marie, RN at 08/13/16 1133

Behavioral Health Note by Richardson, Cleo, RN at 08/15/16 0152

Author: Richardson, Cleo, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/15/16 0154 | Note Time: 08/15/16 0152 | Status: Signed
Editor: Richardson, Cleo, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☐PM Shift ☒Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☒2	☐3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	3	2.5	1

Signed by Richardson, Cleo, RN at 08/15/16 0154

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/15/16 0912

ED Notes (continued)

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/15/16 0912 (continued)

Author: Marin, Lisa Nicole, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/15/16 0913 | Note Time: 08/15/16 0912 | Status: Signed
Editor: Marin, Lisa Nicole, RN (Registered Nurse)

EVALYSIS

☒Day Shift ☐PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	1	2.5	2

Signed by Marin, Lisa Nicole, RN at 08/15/16 0913

Behavioral Health Note by Harris, Stephanie, RN at 08/15/16 1051

Author: Harris, Stephanie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/15/16 1051 | Note Time: 08/15/16 1051 | Status: Signed
Editor: Harris, Stephanie, RN (Registered Nurse)

	08/15/16 1000
Legal Status	
Legal status	1 - voluntary
Pain Assessment: Number Scale (0-10)	
Pain Rating (0-10): Rest	0
Pain Rating (0-10): Activity	0
Comfort/Acceptable Pain Level	0
Skin WDL	
Skin WDL	WDL
Fall Risk Assessment	

ED Notes (continued)

Behavioral Health Note by Harris, Stephanie, RN at 08/15/16 1051 (continued)

Fall Risk Indicators	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male
Fall Risk Score	9
Precautions/Isolation	
Precautions (displays in banner)	1
Precautions Interventions	
Interventions Performed	yes
Level of Observation	every 30 minutes
Activities of Daily Living	
ADL's (WDL)	WDL
Daily Sleep	
Daily Sleep (WDL)	WDL
Daily Nutrition	
Daily Nutrition (WDL)	Ex
Appetite Change	decreased
Barriers to Nutrition	constipation
Level of Assistance	needs encouragement
Mental Status	
Orientation	oriented x 4
Level Of Consciousness	alert
General Appearance WDL	ex;appearance *(Does look dischelved)*
General Appearance	body odor
Mood	anxious;depressed;withdrawn
Mood/Behavior/ Affect WDL	ex;all
Affect	guarded;restricted
Behavior (WDL)	Ex
Mood/Behavior	isolative
Speech	WDL

ED Notes (continued)

Behavioral Health Note by Harris, Stephanie, RN at 08/15/16 1051 (continued)

Speech	clear
Judgment and Insight	judgment not appropriate to situation;insight not appropriate to situation
Insight	fair
Concentration	fair
Memory Deficit	intact
Thought (WDL)	WDL
Coping/Psychosocial Response	
Observed Emotional State	anxious;withdrawn;withholds information;quiet
Verbalized Emotional State	anxiety;depression
Coping/Psychosocial Response Interventions	
Plan Of Care Reviewed With	patient
Supportive Measures	active listening utilized
Psychiatric Symptoms	
Anxiety Symptoms (WDL)	Ex
Anxiety Symptoms	generalized
Manic Symptoms (WDL)	WDL
Psychotic symptoms (WDL)	WDL
Danger to Self	
Danger to Self (WDL)	WDL
Danger to Others	
Danger to Others (WDL)	WDL

Signed by Harris, Stephanie, RN at 08/15/16 1051

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/15/16 1055

Author: Marin, Lisa Nicole, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/15/16 1058 | Note Time: 08/15/16 1055 | Status: Cosign Needed
Editor: Marin, Lisa Nicole, RN (Registered Nurse) | Cosign Required: Yes

Continues with panic attacks, feelings of hopelessness; remains disheveled; revealed history of sexual abuse;

ED Notes (continued)

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/15/16 1055 (continued)

has not been attending groups recently; Continue with medication stabilization; When stable may go home with in current in home support service, or attend PHP

	08/15/16 1054
Patient Assets/Stressors	
Patient Assets	general fund of knowledge;average or above intelligence;motivation for treatment/growth;capable of independent living;supportive family/friends;work skills;physical health;ability for insight;communication skills
Patient Stressors	medication change or non-compliance
Discharge Planning	
Discharge Criteria	improved stabilization in mood, thinking and/or behavior;verbal commitment to aftercare and medication compliance
Recommended Discharge Plan	return to previous living environment;medication management with psychiatrist or other physician
Pt's Acceptance of Discharge Plan	yes
Why Continues to Need Hospitalization	severe impairment of level of functioning;danger to self or others;medication stabilization
Estimated Length of Stay	3-5 days
Provisional DSM 5 Diagnoses	
Problem Being Addressed	refer to problem list
Goal: Will work with social	

ED Notes (continued)

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/15/16 1055 (continued)

worker/treatment coordinator to develop safe discharge plan	
Goal Status	goal initiated
Goal: Will attend Occupational Therapy groups up to seven days weekly as tolerated	
Objectives	increase coping skills
Goal Status	progress made toward outcome
Treatment Plan Reviewed by	
Psychiatric Social Worker	Himot
Registered Nurse	Marin
Occupational Therapist	Bailey
Other	Byrne

Signed by Marin, Lisa Nicole, RN at 08/15/16 1058

Behavioral Health Note by McCullough, Elizabeth Ann, RN at 08/16/16 2232

Author: McCullough, Elizabeth Ann, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/16/16 2233 | Note Time: 08/16/16 2232 | Status: Signed
Editor: McCullough, Elizabeth Ann, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☒PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	2	3.5	2

ED Notes (continued)

Behavioral Health Note by McCullough, Elizabeth Ann, RN at 08/16/16 2232 (continued)

Signed by McCullough, Elizabeth Ann, RN at 08/16/16 2233

Behavioral Health Note by Padrul, Pauline, LCSW at 08/17/16 1609

Author: Padrul, Pauline, LCSW | Service: Social Services | Author Type: Licensed Clinical Social Worker
Filed: 08/17/16 1637 | Note Time: 08/17/16 1609 | Status: Addendum
Editor: Padrul, Pauline, LCSW (Licensed Clinical Social Worker)
Related Notes: Original Note by Padrul, Pauline, LCSW (Licensed Clinical Social Worker) filed at 08/17/16 1619

LCSW met with patient to discuss discharge planning. Patient feels treatment team at Oakland Community Support has not been responsive to his needs; he is looking for psychiatric providers elsewhere. Discussed PHP; patient expresses much interest and is willing to make daily commitment. Patient is especially motivated for treatment given memories of molest that recently resurfaced; he will continue to engage in weekly therapy after conclusion of PHP. Patient is amenable to referral to Herrick and La Cheim PHPs. LCSW spoke with Herrick PHP intake staff; patient may be evaluated for transition day on Friday pending program has space and accepts medi/medi. Also LM for La Cheim PHP with plan to fax referral documents. Faxed initial H+P, ER notes, medicine consult and current medication regimen to David Beckerman at 510-596-8707.

Signed by Padrul, Pauline, LCSW at 08/17/16 1611
Signed by Padrul, Pauline, LCSW at 08/17/16 1619
Signed by Padrul, Pauline, LCSW at 08/17/16 1637

Behavioral Health Note by McCullough, Elizabeth Ann, RN at 08/17/16 2327

Author: McCullough, Elizabeth Ann, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/17/16 2328 | Note Time: 08/17/16 2327 | Status: Signed
Editor: McCullough, Elizabeth Ann, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☒PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
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ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	2	3.5	2

Signed by McCullough, Elizabeth Ann, RN at 08/17/16 2328

ED Notes (continued)

Behavioral Health Note by McCullough, Elizabeth Ann, RN at 08/17/16 2327 (continued)

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/18/16 1100

Author: Marin, Lisa Nicole, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/18/16 1311 | Note Time: 08/18/16 1100 | Status: Addendum
Editor: Marin, Lisa Nicole, RN (Registered Nurse)
Related Notes: Original Note by Marin, Lisa Nicole, RN (Registered Nurse) filed at 08/18/16 1311

EVALYSIS

☒Day Shift ☐PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
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Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	1	2.5	2

Signed by Marin, Lisa Nicole, RN at 08/18/16 1311
Signed by Marin, Lisa Nicole, RN at 08/18/16 1311

Behavioral Health Note by Abend, Marquel Marie, RN at 08/19/16 0100

Author: Abend, Marquel Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/19/16 0100 | Note Time: 08/19/16 0100 | Status: Signed
Editor: Abend, Marquel Marie, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☒PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	

ED Notes (continued)

Behavioral Health Note by Abend, Marquel Marie, RN at 08/19/16 0100 (continued)

ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	2	2.5	2

Signed by Abend, Marquel Marie, RN at 08/19/16 0100

Behavioral Health Note by Abend, Marquel Marie, RN at 08/19/16 0516

Author: Abend, Marquel Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/19/16 0516 | Note Time: 08/19/16 0516 | Status: Signed
Editor: Abend, Marquel Marie, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☐PM Shift ☒Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	2	2.5	2

Signed by Abend, Marquel Marie, RN at 08/19/16 0516

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/19/16 0954

Author: Marin, Lisa Nicole, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/19/16 0955 | Note Time: 08/19/16 0954 | Status: Signed
Editor: Marin, Lisa Nicole, RN (Registered Nurse)

ED Notes (continued)

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/19/16 0954 (continued)

EVALYSIS

☒Day Shift ☐PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	1	2.5	1

Signed by Marin, Lisa Nicole, RN at 08/19/16 0955

Behavioral Health Note by McCullough, Elizabeth Ann, RN at 08/19/16 1851

Author: McCullough, Elizabeth Ann, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/19/16 1853 | Note Time: 08/19/16 1851 | Status: Signed
Editor: McCullough, Elizabeth Ann, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☒PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐

ED Notes (continued)

Behavioral Health Note by McCullough, Elizabeth Ann, RN at 08/19/16 1851 (continued)

Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	0	1	3.5	2

Signed by McCullough, Elizabeth Ann, RN at 08/19/16 1853

Behavioral Health Note by Hima, Issaka, RN at 08/19/16 2353

Author: Hima, Issaka, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/19/16 2353 | Note Time: 08/19/16 2353 | Status: Signed
Editor: Hima, Issaka, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☐PM Shift ☒Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY**				
↓	☐1	☒2	☐3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	2	1.5	1

Signed by Hima, Issaka, RN at 08/19/16 2353

Behavioral Health Note by Yerby, Derrick J, RN at 08/20/16 0948

Author: Yerby, Derrick J, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/20/16 0949 | Note Time: 08/20/16 0948 | Status: Signed
Editor: Yerby, Derrick J, RN (Registered Nurse)

EVALYSIS

☒Day Shift ☐PM Shift ☐Noc Shift

PATIENT CARE INDICATORS	
CARE INDICATORS → **ACUITY**	

ED Notes (continued)

Behavioral Health Note by Yerby, Derrick J, RN at 08/20/16 0948 (continued)

↓	☐1	☐2	☒3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	3	3.5	2

Signed by Yerby, Derrick J, RN at 08/20/16 0949

Behavioral Health Note by Yerby, Derrick J, RN at 08/20/16 0949

Author: Yerby, Derrick J, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/20/16 1512 | Note Time: 08/20/16 0949 | Status: Signed
Editor: Yerby, Derrick J, RN (Registered Nurse)

Pt c/o of being very tired this morning because he had a difficult night last night. He reported that his troubles began late last evening when he started feeling extremely anxious, depressed, overwhelmed, and suicidal. He took two doses of Zyprexa last night which he states, "saved my life. It helped stop the negative thoughts, but I couldn't sleep and I'm tired today." He slept for the majority of the day today, he did not get up for breakfast or lunch, he only drank the juice that I brought him. He is med compliant. He did not go to any groups today, which is unusual for him. He offered no other complaints and continues resting/sleeping in his room. He appears in NAD.

Signed by Yerby, Derrick J, RN at 08/20/16 1512

Behavioral Health Note by Edwards, Sarah C, RN at 08/22/16 1002

Author: Edwards, Sarah C, RN | Service: Adolescent Mental Health | Author Type: Registered Nurse
Filed: 08/22/16 1003 | Note Time: 08/22/16 1002 | Status: Signed
Editor: Edwards, Sarah C, RN (Registered Nurse)

EVALYSIS

☒Day Shift ☐PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY**				
↓	☐1	☐2	☒3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐

ED Notes (continued)

Behavioral Health Note by Edwards, Sarah C, RN at 08/22/16 1002 (continued)

Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	2	3.5	2

Signed by Edwards, Sarah C, RN at 08/22/16 1003

Behavioral Health Note by Abend, Marquel Marie, RN at 08/22/16 2118

Author: Abend, Marquel Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/22/16 2119 | Note Time: 08/22/16 2118 | Status: Signed
Editor: Abend, Marquel Marie, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☒PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☐3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	2	2.5	2

Signed by Abend, Marquel Marie, RN at 08/22/16 2119

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/23/16 1100

Author: Marin, Lisa Nicole, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/23/16 1238 | Note Time: 08/23/16 1100 | Status: Signed
Editor: Marin, Lisa Nicole, RN (Registered Nurse)

ED Notes (continued)

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/23/16 1100 (continued)

EVALYSIS

☒Day Shift ☐PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	1	2.5	2

Signed by Marin, Lisa Nicole, RN at 08/23/16 1238

Behavioral Health Note by Senior, Adolfo A, RN at 08/23/16 1658

Author: Senior, Adolfo A, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/23/16 1700 | Note Time: 08/23/16 1658 | Status: Signed
Editor: Senior, Adolfo A, RN (Registered Nurse)

EVALYSIS

PATIENT CARE INDICATORS				
CARE INDICATORS → ACUITY ↓	☐1	☒2	☐3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0

ED Notes (continued)

Behavioral Health Note by Senior, Adolfo A, RN at 08/23/16 1658 (continued)

Total	2	2	1.5	1

Signed by Senior, Adolfo A, RN at 08/23/16 1700

Behavioral Health Note by Richardson, Cleo, RN at 08/24/16 0226

Author: Richardson, Cleo, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/24/16 0227 | Note Time: 08/24/16 0226 | Status: Signed
Editor: Richardson, Cleo, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☐PM Shift ☒Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☒2	☐3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	2	1.5	1

Signed by Richardson, Cleo, RN at 08/24/16 0227

Behavioral Health Note by Edwards, Sarah C, RN at 08/24/16 1029

Author: Edwards, Sarah C, RN | Service: Adolescent Mental Health | Author Type: Registered Nurse
Filed: 08/24/16 1031 | Note Time: 08/24/16 1029 | Status: Signed
Editor: Edwards, Sarah C, RN (Registered Nurse)

EVALYSIS

☒Day Shift ☐PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4

ED Notes (continued)

Behavioral Health Note by Edwards, Sarah C, RN at 08/24/16 1029 (continued)

ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	2	2.5	1

Signed by Edwards, Sarah C, RN at 08/24/16 1031

Behavioral Health Note by Walter, Willa, MFT at 08/24/16 1546

Author: Walter, Willa, MFT | Service: Mental Health | Author Type: Marriage and Family Therapist
Filed: 08/24/16 1550 | Note Time: 08/24/16 1546 | Status: Signed
Editor: Walter, Willa, MFT (Marriage and Family Therapist)

PHP Assessment
Reviewed chart, spoke with staff and met with patient per Dr. Cruz's request. Reviewed Insurance benefit information with patient.

Provided schedule and answered any questions patient had about PHP. Pt shared that he feels that he has been stable in his mood for the past two days and feels ready to try a transition day in the next day or two. Pt shared that he would like to work on managing his emotions around recent and historical traumas in his life. Pt denied SI, intent or plan.

Assessment: Patient is appropriate for PHP transition day. **Pt will transition on Friday rather then tomorrow because there is not room in ADH tomorrow for another transition.**

Plan: Patient will transition on FRIDAY to the ADH program, room J.
Patient will attend group from 9-11:45am, come to the unit for lunch and return for groups from 12:30-3:30pm.

Patient has agreed to stay within the physical boundaries of the 3rd Floor PHP Program during their transition day. He/she will not leave the premises of the program without being attended by staff. He/she will let the group leader know if he/she needs to return to the unit for any reason.

Before discharge from hospital, patient should have been given PHP admission paperwork to take home and fill out.
Patient should arrive at 8:30 and proceed to Admitting Office on first floor. After registering for PHP at Admitting Office, take elevator B to PHP Intake Office on 3rd Floor, Room 3388.

Signed by Walter, Willa, MFT at 08/24/16 1550

Behavioral Health Note by Richardson, Cleo, RN at 08/25/16 0042

ED Notes (continued)

Behavioral Health Note by Richardson, Cleo, RN at 08/25/16 0042 (continued)

Author: Richardson, Cleo, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/25/16 0043 | Note Time: 08/25/16 0042 | Status: Signed
Editor: Richardson, Cleo, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☐PM Shift ☒Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☒2	☐3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	2	1.5	1

Signed by Richardson, Cleo, RN at 08/25/16 0043

Behavioral Health Note by Edwards, Sarah C, RN at 08/25/16 1033

Author: Edwards, Sarah C, RN | Service: Adolescent Mental Health | Author Type: Registered Nurse
Filed: 08/25/16 1034 | Note Time: 08/25/16 1033 | Status: Signed
Editor: Edwards, Sarah C, RN (Registered Nurse)

EVALYSIS

☒Day Shift ☐PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☒2	☐3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐

ED Notes (continued)

Behavioral Health Note by Edwards, Sarah C, RN at 08/25/16 1033 (continued)

Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	2	1.5	0

Signed by Edwards, Sarah C, RN at 08/25/16 1034

Behavioral Health Note by McCullough, Elizabeth Ann, RN at 08/25/16 1637

Author: McCullough, Elizabeth Ann, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/25/16 1638 | Note Time: 08/25/16 1637 | Status: Signed
Editor: McCullough, Elizabeth Ann, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☒PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☒2	☐3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	3	2.5	1

Signed by McCullough, Elizabeth Ann, RN at 08/25/16 1638

Behavioral Health Note by Richardson, Cleo, RN at 08/26/16 0124

Author: Richardson, Cleo, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/26/16 0126 | Note Time: 08/26/16 0124 | Status: Signed
Editor: Richardson, Cleo, RN (Registered Nurse)

EVALYSIS

ED Notes (continued)

Behavioral Health Note by Richardson, Cleo, RN at 08/26/16 0124 (continued)

☐Day Shift ☐PM Shift ☒Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☐3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	3	2.5	1

Signed by Richardson, Cleo, RN at 08/26/16 0126

Behavioral Health Note by Harris, Stephanie, RN at 08/26/16 0959

Author: Harris, Stephanie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/26/16 0959 | Note Time: 08/26/16 0959 | Status: Signed
Editor: Harris, Stephanie, RN (Registered Nurse)

	08/26/16 0900
Legal Status	
Legal status	1 - voluntary
Pain Assessment: Number Scale (0-10)	
Pain Rating (0-10): Rest	0
Pain Rating (0-10): Activity	0
Comfort/Acceptable Pain Level	3
Skin WDL	
Skin WDL	WDL
Precautions/Isolation	
Precautions (displays in banner)	1
Precautions Interventions	
Interventions	yes

ED Notes (continued)

Behavioral Health Note by Harris, Stephanie, RN at 08/26/16 0959 (continued)

Performed	
Level of Observation	every 30 minutes
Activities of Daily Living	
ADL's (WDL)	WDL
Mental Status	
Orientation	oriented x 4
Level Of Consciousness	alert
General Appearance WDL	ex
General Appearance	body odor;unkempt
Mood	anxious;hopeful
Mood/Behavior/ Affect WDL	WDL
Behavior (WDL)	WDL
Mood/Behavior	appropriate
Speech	WDL
Speech	clear
Judgment and Insight	insight appropriate to situation
Insight	fair
Concentration	fair
Memory Deficit	intact
Thought (WDL)	WDL
Coping/Psychosocial Response	
Observed Emotional State	accepting;anxious;cooperative;hopeful
Verbalized Emotional State	acceptance;anxiety;hopefulness
Coping/Psychosocial Response Interventions	
Family/Support System Care	self-care encouraged
Plan Of Care Reviewed With	patient
Supportive Measures	decision-making supported
Psychiatric Symptoms	
Anxiety Symptoms (WDL)	Ex
Anxiety	generalized

ED Notes (continued)

Behavioral Health Note by Harris, Stephanie, RN at 08/26/16 0959 (continued)

Symptoms	
Manic Symptoms (WDL)	WDL
Psychotic symptoms (WDL)	WDL
Danger to Self	
Danger to Self (WDL)	WDL
Danger to Others	
Danger to Others (WDL)	WDL

Signed by Harris, Stephanie, RN at 08/26/16 0959

Behavioral Health Note by Harris, Stephanie, RN at 08/26/16 1401

Author: Harris, Stephanie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/26/16 1402 | Note Time: 08/26/16 1401 | Status: Signed
Editor: Harris, Stephanie, RN (Registered Nurse)

	08/26/16 1300
Assessment Type	
Assessment timing	Discharge
Suicide Risk Assessment- Mood	
Agitation	None
Anxiety or Fearfulness	None
Loss of Pleasure or Interest	None
Depression or Sadness	None
Suicide Plan for Today	None
Hopeless or Overwhelmed	None
Suicide Risk Assessment - Thinking	
Sleep Disturbances	None
Cognition Problems	None
Psychotic	None

ED Notes (continued)

Behavioral Health Note by Harris, Stephanie, RN at 08/26/16 1401 (continued)

Symptoms	
Suicide Risk Assessment-Behavior	
Withholding Information	None
Resistance to Treatment	None
Impulsivity	None
Aggressive towards self/others	None
Suicide Risk Assessment- Health	
Pain, real or perceived	Moderate
Perceived Loss of Health	Moderate
Suicide Risk Assessment-Discharge (for hospitalized patients only)	
Suicide Plan outside of Hospital	None
Lack of Support if Discharged	None
Pessimism if Discharged	None
Suicidal Inquiry	
Suicide Ideation for Today	None
Behavior congruent with Verbal and Non-Verbal	Yes
Assessment of Current Suicide Risk	
Assessment of Current Suicide Risk	Low

Signed by Harris, Stephanie, RN at 08/26/16 1402

Behavioral Health Note by Weber, Scott A, LCSW at 08/26/16 1704

ED Notes (continued)

Behavioral Health Note by Weber, Scott A, LCSW at 08/26/16 1704 (continued)

Author: Weber, Scott A, LCSW | Service: Mental Health | Author Type: Licensed Clinical Social Worker
Filed: 08/26/16 1706 | Note Time: 08/26/16 1704 | Status: Signed
Editor: Weber, Scott A, LCSW (Licensed Clinical Social Worker)

BEHAVIORAL HEALTH HAND OFF COMMUNICATION TOOL (PHP)

☐ UNIT 3EA ☐ UNIT 3EB ☒ UNIT 4EA ☐ UNIT 4EB ☐ OTHER _____

S = SITUATION

Patient attended groups in PHP for transition day.

B = BACKGROUND

Special Needs: ☐Vision ☐Hearing ☐Language(specify):

Mobility: ☐With Assistance ☒Without Assistance ☐Total Assistance Needed
Type of assistive device used:

Abnormal / significant lab or test results:

Abnormal / significant vital signs:

Infection control: ☐ Contact ☐ Airborne ☐ Droplet ☐ Other(Specify):

A = ASSESSMENT: *Assessment about the patient situation.*

Current mental status: Oriented X4

Current Behavior: Pt. Participated well in groups throughout the day. He appropriately asked about what to do if feeling triggered in the group. Focused on triggers and past traumatic events.

Active Medical Problems:

Skin:

Restraints: N/A

Has the client been searched? ☐ Yes ☒ No

Medication received: None

Pain status / intensity (1 – 10):
Location:
Last pain med given at:: N/A
Name of med: N/A

R = RECOMMENDATION

ED Notes (continued)

Behavioral Health Note by Weber, Scott A, LCSW at 08/26/16 1704 (continued)

Comments:

☒ Patient is appropriate for PHP.
☐ Second transition day recommended.
☐ Patient is not appropriate for PHP and Doctor notified.
Comments:

Signed by Weber, Scott A, LCSW at 08/26/16 1706

ED Vitals

ED Vitals

Date and Time	Temp	Pulse	Resp	BP	SpO2	Weight	Who
08/26/16 0824	97.5 °F (36.4 °C)	80	16	(!) 153/95 mmHg	98 %	--	FRS

ED Diagnoses

ED Diagnoses

- **Psoriasis**
- **Chronic pelvic pain in male**
- **Bipolar I disorder, most recent episode depressed (HCC) (Chronic)**
- **Gastroesophageal reflux disease without esophagitis**

ED Medications

Historical Medications Entered This Encounter

This print group is not available in inpatient encounters. Please contact a system administrator.

Allergies

Allergy History as of 09/22/16

No Known Allergies

Problem List

Problem List

Problem	Entered	Chronic
Fibromyalgia	8/10/2016 by Cruz, John Michael de Vera, MD	
Psoriasis	8/10/2016 by Cruz, John Michael de Vera, MD	
Chronic pelvic pain in male	8/10/2016 by Cruz, John Michael de Vera, MD	
Bipolar I disorder, most recent episode depressed (HCC)	8/10/2016 by Cruz, John Michael de Vera, MD	Yes
Acid reflux disease	8/22/2016 by Cruz, John Michael de Vera, MD	
Generalized anxiety disorder	8/29/2016 by Engwall, Bradley J, MD	

Cancer Staging Summary for Ho, Vincent

None

Problem List (continued)

History and Physical

H&P by Cruz, John Michael de Vera, MD at 08/10/16 0827

Author: Cruz, John Michael de Vera, MD | Service: Psychiatry | Author Type: Physician
Filed: 08/10/16 1918 | Note Time: 08/10/16 0827 | Status: Signed
Editor: Cruz, John Michael de Vera, MD (Physician)

INFORMANTS: Patient, Medical Records
CHIEF CONCERN: "I wanted to jump out of the window."
RELIABILITY OF INFORMANTS: Patient - Good, Past Medical Records - Good

HISTORY OF PRESENT ILLNESS
Vincent Ho is a 47 year old male with a history of bipolar disorder without psychotic features who presents with wanting to jump out of his apartment window in the setting of restarting his Paroxetine.

He has a history of a mood disorder for many years. He has a history of depressed mood, does not feel interested in coaching and just stays home, does not have a pleasure in teaching customers, has walked out of a coaching session when he normally enjoys coaching, would not touch a musical instrument for two or three months even though he enjoys playing music, will only eat a liquid because he does not feel like eating solid foods and finds no joy from eating, has recently lost 16 pounds in the space of two weeks, has no difficulties falling asleep but does tend to wake up earlier and earlier and will sleep only five hours and still feel rested, has a hard time reading and watching movies, does not care about making simple decisions like what to eat or what to wear or where to go, and has guilt about cheating on his ex-girlfriend. He denies any psychomotor agitation, fatigue, worthlessness, feelings of guilt, self harming thoughts, thoughts about death, suicidal ideation.

He also has a history of having tons of creativity, feeling extremely "hopeful", taking a series of tests to learn how to get certified in learning how to use a Baton, Handcuffing, Tasering, and has passed tests for six hand guns all within two weeks, would often be too demanding to his singers and to his musicians, want to buy one motorcycle and another then motorcycle and spend lots of money, be able to play the organ non stop for 12 hours at night, would go for 36 hours non-stop practicing music and not need to sleep, being told by people that he is speaking so fast that they cannot understand him, have five or six musical programs floating in his head and not able to choose which one and instead of doing more research he would buy the scores, would pace back and forth to the point where colleagues told him not to do so, buy musical scores and motor cycles that he does not need. He has no history of explosive irritability or anger, inflated self esteem, distractibility.

In the events leading up to this hospitalization, he was weaned off of Paroxetine slowly from 20 mg to 0 mg between October 2015 to April 2016 because his psychiatric nurse practictioner said that his depression was cured. He was doing well for the next month or so up until his home was invaded. Since then his depressive symptoms have been worsening. He was having headaches, dizziness, brain zaps, panic attacks, suicidal thoughts, feelings of depression, akathisia, trembling of his hands, chest pain and dyspnea. In addition, two weekends ago, he went to a meditation workshop where he uncovered that he was abused as a child in Hong Kong by his paternal grandfather's concubine who has been dead for the past 20 years. He spoke to his boss who is the US National Head Coach for rifalry and resigned from his job because he did not feel safe teaching students, two of which are training for the Junior Olympics. In addition, he started himself back on Paroxetine 5 mg PO at bedtime. On the Saturday prior to his admission, his suicidal thoughts became too intense. He called up a child molestation organization and when they could not help him, he "lost it." He opened up the window to his apartment and thought of jumping. He took an old Olanzapine ODT which he knew would make him collapse. He then called his best friend and asked her to help him. He resolved that whatever happened first would be what was "destined" for him to do. If his suicidal thoughts became too intense before his best

friend or the Olanzapine ODT worked, he would jump out of his window. Thankfully, his friend arrived before he jumped out of the window. He went to his psychiatrist on Monday who said that he needs to come to the hospital.

Past Psychiatric History:
He has a history of having spontaneous anxiety, dyspnea, dizziness, heart palpitations, faintness, nausea, fear of dying.

He has a history of having a recent home invasion and for the first two weeks, he woke up in the middle of the night that someone was going to shoot him to death. This home invasion occurred on May 27, 2016.

He denies any auditory or visual hallucinations or paranoid delusions.

He denies any fears of social interaction, public performance of wanting to spend time only with familiar people.

He denies any excessive worries or inability to control worries.

He denies any obsessions or compulsions.

FURTHER PAST PSYCHIATRIC HISTORY:
He has never engaged in self-harming behaviors.

He has never attempted suicide.

He has been psychiatrically hospitalized three times. The first time, they diagnosed him with major depressive disorder. The second time, they diagnosed him with major depressive disorder and started him on Paroxetine. The third time, they diagnosed him with bipolar disorder and started him on Divalproex and felt better. He ended up taking Lamotrigine though.
He does have access to fire arms.

He has never had in-home services.

He has never had an EEG.

He has never had neuroimaging.

His past medication trials not including his current medications include:

Anti-Depressants:
* Paroxetine up to 40 mg PO at bedtime --> effective
* Fluoxetine (unclear dosage) --> somnolence
* Bupropion XL --> constipation
* Amitriptyline --> ineffective
* Citalopram --> ineffective
* Sertraline --> ineffective
* Venlafaxine --> ineffective
* Doxepin --> somnolence
* He has never been on Escitalopram, Remeron, Duloxetine,

Mood Stabilizers:
* Valproic Acid (unclear dosage) --> effective
* Lamotrigine as high as 400 mg --> effective
* He has never been on Lithium

Neuroleptics:
* Quetiapine up to 400 mg PO at bedtime --> effective
* Olanzapine 10 mg --> effective for panic attack
* He has never been on Risperidone, Aripiprazole, Ziprasidone, Haloperidol, Lurasidone, Paliperidone, Iloperidone, and Asenapine.

Anxiolytics:
* Diazepam
* He has never been on Alprazolam or Clonazepam

FAMILY HISTORY:
Mother:
The patient's mother is 71 years old. She has psychiatric issues. She has anxiety and takes Alprazolam. She has no substance abuse issues. She has never tried to commit suicide. She and the patient have a close relationship. The last time that they spoke was four days prior to admission.

Father:
The patient's father is 73 years old. He has no psychiatric issues. It is unclear if he has any substance abuse issues. He has never tried to commit suicide. He and the patient have a distant relationship. They finally resolved their relationship where he physically abused the patient.

Siblings:
The patient has two sisters. The patient's sister is 7 years younger than the patient is. She has psychiatric issues. She has an eating disorder. It is unclear if she has any substance abuse issues. She has never tried to commit suicide.

His second sister does not have any psychiatric issues.

Extended Maternal History:
In the extended maternal family, there is psychiatric history. His grandmother has anxiety and takes Alprazolam. His grandfather abuses alcohol. His aunt abuses alcohol. His maternal great-grandfather was locked up in an asylum. There are also substance abuse problems. Many relatives abuse alcohol. There are no known history of suicide attempts and no known history of suicide completions.

Extended Paternal History:
In the extended paternal family, there is psychiatric history. His uncle has paranoid schizophrenia. There are also no substance abuse problems. There are no known history of suicide attempts and no known history of suicide completions.

BIRTH AND EARLY DEVELOPMENT:
The patient was born in Hong Kong and raised in Hong Kong. He came to the US at the age of 14 years old. He did meet his developmental milestones. He has a history of physical abuse by his father. He has a history

of sexual abuse by memory. He was abused by his paternal grandfather's concubine who was responsible for raising him. He has no history of neglect. There was no history of domestic violence. There was no DSS involvement. There was no CPS involvement. There was no DJS involvement. When he is feeling well, he enjoys teaching kids, giving his customers a good time and feel very safe, and empowering women.

EDUCATION HISTORY:
The patient's highest education level is two Master's Degree. One of them is in music from San Francisco State University. The second is in Business Adminstration from San Francscio State University.

EMPLOYMENT HISTORY:
The patient is unemployed. The last time he worked was in mid July 2016.

MILITARY SERVICE HISTORY:
The patient has never served in the military.

FINANCES:
The patient's SSDI provides $1100 per month for chronic pelvic pain syndrome.

RELATIONSHIP HISTORY:
The patient is currently not in a relationship.

CHILDREN:
The patient does not have children.

SEXUAL HISTORY:
He has a history of sexual abuse which he most recently recalled in July 2016.

LIVING SITUATION:
He currently lives by himself in the city of Oakland, CA.

SUBSTANCE ABUSE HISTORY:
He denies any substance abuse issues.

SUBSTANCE ABUSE TREATMENT PROGRAM: He has never been in a substance abuse treatment program.

RELIGION/ CULTURAL:
He is religious.

LEGAL HISTORY:
He has never been arrested.

PAST MEDICAL HISTORY:
Fibromyalgia
Psoriasis
Chronic Pelvic Pain Syndrome
No history of seizures

PAST SURGICAL HISTORY:

Appendectomy - Childhood

PRIMARY CARE PHYSICIAN:
Dr. Mark Robinson - Lifelong Medical Care - 510-430-8740

PSYCHIATRIST:
Dr. James Hinson - last saw him on August 8, 2016

THERAPIST:
Temporary Therapist - John R. Edwards - near Alta Bates in Oakland, CA - 510-213-9284 (had one session)

SPECIALISTS:
Dermatologist - Dr. Bill Littman - near Alta Bates in Oakland, CA
Highland Pain Clinic - 510-437-8552 - Amy Smith - 510-437-8377

PHARMACY:
Wellspring - Piedmont, CA

ALLERGIES:
None

MEDICATIONS:
* Methotrexate 7.5 mg PO at bedtime q7d (Mondays)/ 5 mg PO qam q7d (Tuesdays) - prescribed by Dr. Littman
* Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7d (Mondays) - prescribed by Highland Pain Clinic - Amy Smith - 510-437-8377
* PRN Buprenorphine 2 mg x 60 tablets per month
* PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg x 30 mg per month
* PRN Phenazopyridine 200 mg q8h for pelvic pain
* Lactulose PO at bedtime
* Folic Acid 1 mg PO daily

LABORATORY VALUES:
CBC:
Recent Labs

Lab	08/09/16 1025
WBC	2.2 L
HGB	13.3 L
HCT	40.2
PLT	233

CMP:
Recent Labs

Lab	08/09/16 1025
NA	144

K	4.0
CL	106
CO2	32
CA	9.1
BUN	18
CREATININE	0.93
GLU	100 H
TBILI	0.8
AST	39 H

UA:No results for input(s): UAWBC, UARBC, UAEPI, UAMUC in the last 72 hours.

THYROID FUNCTION TESTS:

Recent Labs

Lab	08/09/16 1025
TSH	0.67

HEMOGLOBINA1C:No results for input(s): A1CP in the last 72 hours.

URINE TOXICOLOGY:

Recent Labs

Lab	08/09/16 1100
UAMPHET	Neg
UBARBITURATE	Neg
UBENZODIAZ	Pos A
UCOC	Neg
UPCP	Neg
UTHC	Neg
UOPIATES	Neg
UMETHADONE	Neg

FASTING LIPID PANEL:No results for input(s): CHOLTOTAL, TRIG, HDL, LDL, VLDL in the last 72 hours.

MENTAL STATUS EXAM:

He had fair grooming, was dressed in hospital clothing , did look disheveled. He walked with a steady gait. He had good eye contact. He had no evidence of psychomotor agitation, had no evidence of psychomotor retardation, and had no abnormal involuntary movements. He had normal speech rate, normal rhythm, and normal volume. He was not dysarthric, was not able to engage in spontaneous speech, was not pressured, could be interrupted, and was not able to socially reciprocate. His thought process was goal-directed and linear. He had no loosening of associations. He had no abnormal thought content. He had no hallucinations. He had no delusions. His mood was " depressed " and he appeared "desperate." He had poor vital sense and poor self-esteem, and did feel hopeful about the future. He did not have passive death wish. He did not have suicidal ideations, intent or plans. He did not have homicidal ideations, intent or plans. He was alert. He was

oriented to person, place and time. He appeared to have intact fund of knowledge. His language was appropriate for his age. His recent memory was intact. His remote memory was intact. He had intact attention and concentration. He had good judgment as evidenced by taking his medications as prescribed and good insight as evidenced by knowing that he has Bipolar Disorder Type I without Psychotic Features. AIMS: 0.

VITAL SIGNS:
BP 113/77 | Pulse 95 | Temp (Src) 99.5 °F (37.5 °C) (Oral) | Resp 14 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 98%

PHYSICIAN SUICIDE RISK ASSESSMENT AND ATTESTATION:
1. Emotional and/or physical pain: **None**
2. Withdrawal /inability to talk about feelings/ lack of participation: **None**
3. Current stress/losses/difficult life situation: **High**
4. Hopelessness/inability to think the future could be bright: **Low**
5. Current thoughts of suicide, intent, plan: **None**
6. History of self-harm, especially in hospital or other healthcare facility: **None**
7. Estimated suicide risk in hospital: **Low**
8. Estimated suicide risk if discharged: **High**

In reaching this opinion, I have considered the risks including the above, as well as protective factors.
1. Nursing Suicide Assessment Reviewed in Doc Flowsheet: **Yes**
2. Nursing Notes Reviewed: **Yes**
3. My assessment was discussed with RN: **Yes**

Additional Comments:
No additional comments

Suicide Precautions:
No

FORMULATION:
Vincent Ho is a 47 year old male with a history of Generalized Anxiety Disorder, panic attacks and Bipolar Disorder Type I without psychotic features who presents with worsening suicidal thoughts in the setting of reinitiation of Paroxetine. He was referred her by the emergency room. His family history is significant for a mother with anxiety, a younger sister with an eating disorder, a maternal grandmother with anxiety and grandfather who abuses alcohol, a paternal uncle with paranoid schizophrenia. His birth and developmental history is significant for being raised in Hong Kong. His personal history is significant for recently quitting his job, being physically abused by his father as a child, and having recalled sexual abuse by his paternal grandfather's concubine who raised him. His educational history is significant for having two master's degree. His substance abuse history is significant for not abusing any substances. His medical history is significant for Fibromyalgia, Psoriasis, Chronic Pelvic Pain Syndrome. His past psychiatric history is significant for having multiple psychiatric hospitalizations and being tried on a number of anti-depressants. Upon admission, his mental status exam was significant for being in a good mood, not having any suicidal or homicidal thoughts, appearing "desperate," and having linear goal directed thoughts.

There are a number of possible diagnoses for this patient. His current presentation is most suggestive of Bipolar Disorder Type I without Psychotic Features. In favor of this diagnosis is that he has experienced not needing to sleep for 36 hours, having inflated self-esteem, talking so fast that his friends cannot understand

him, having a many musical scores floating around in his head, being distractible, buying numerous motorcycles and musical scores. In addition, he has also experienced having depressed mood, not being interested in teaching, not feeling like eating solid foods, losing significant amounts of weight, having difficulties staying asleep, and having thoughts about jumping out of his apartment window.

Another possible diagnosis is that he has Post Traumatic Stress Disorder. In favor of this diagnosis is that he has experienced his home being invaded and having recurrent nightmares about the abuse.

Another possible diagnosis is that he has Panic Attacks. In favor of this diagnosis is that he has has experienced spontaneous episodes of anxiety, dyspnea and dizziness.

PLAN:
 # Bipolar Disorder Type I without Psychotic Features:
- started Divalproex ER 1500 mg PO at bedtime since it is less renally metabolized than Lithium as the patient is taking Methotrexate for his psoriasis
- f/ Valproic Acid trough level on Saturday night, goal level between 50 - 125
- started PRN Olanzapine ODT 2.5 mg PO at bedtime, may repeat x 1

 # Post Traumatic Stress Disorder
- started PRN Gabapentin 300 mg PO q4h for anxiety
- f/u with outpatient therapy

 # Panic Attacks:
- started PRN Gabapentin 300 mg PO q4h for anxiety

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- PHP vs. Outpatient Psychiatrist

 # Estimated Length of Stay
- ~ 6 - 9 days

History and Physical (continued)

H&P by Cruz, John Michael de Vera, MD at 08/10/16 0827 (continued)

ATTENDING PHYSICIAN:
John M Cruz, MD

Signed by Cruz, John Michael de Vera, MD at 08/10/16 1918

Consults

Consults signed by Sharma, Kanika, MD at 08/11/16 1230

Author: Sharma, Kanika, MD | Service: Hospitalist Medicine | Author Type: Physician
Filed: 08/11/16 1230 | Note Time: 08/10/16 2139 | Status: Signed
Editor: Sharma, Kanika, MD (Physician)

Location: Alta Bates Summit Medical Center- Alta Bates Campus
PATIENT: HO, VINCENT
MRN: 50553672
Account: 820425781
DOB: 11/06/1968
Visit Start Date: 08/09/2016
Service Date: 08/10/2016
Author: Kanika Sharma, MD

Consultation

REQUESTING PHYSICIAN: John Cruz, MD

REASON FOR CONSULTATION: Medical management of the patient.

HISTORY OF PRESENT ILLNESS: This is a 47-year-old male who states he was diagnosed with bipolar affective disorder and PTSD in 2007. His last psychiatric admission was in 2007 in New Mexico. The patient states he had been on Lamictal, Seroquel and Paxil for a very long time. He says that he had not had any psychiatric issues for about the last 5 or 6 years. He was being followed by a psych nurse practitioner who told him that since he had not any problems, he was fine and started tapering him off of the psychiatric medications. He had stopped the Lamictal and Seroquel by the end of 2015, he said that went fine. He then tapered down Paxil. He states over the course of 6 months he went from 20 down to 0. He believes that it was too fast.

About a month and half after he was off of Paxil completely he says he had withdrawal symptoms, which included electric zaps in his brain, inability to concentrate, worsening migraines worsening depression, associated anxiety and panic attacks, chills and shortness of breath. The patient says that last week he saw his prior psychiatrist who says that he should restart Paxil. He restarted it at 5 mg a day but there was no improvement in his psychiatric symptoms. He had suicidal ideations, the first time this happened in about 11 years. He then had a panic attack and thought he was losing his mind. He had

an old Zyprexa tablet and took that. He was also contemplating jumping off a second story building; however, he called a friend, and the friend came just in time, and locked him into his room so that he could not hurt himself.

The next morning, the patient called the psychiatrist who recommended that he come to the hospital for evaluation.

In the Emergency Room, the patient did not require any medications. He was placed on a 5150 and transferred to Herrick for ongoing psychiatric care.

PAST MEDICAL HISTORY:
1. Chronic pelvic pain syndrome diagnosed in Stanford. The patient is currently on disability from that, this was diagnosed in 2003.
2. Fibromyalgia diagnosed in 2009. The patient states that his pain both for his pelvic pain syndrome and fibromyalgia are controlled with Butrans patch and Norco.
3. Psoriasis, for which he is on methotrexate 2.5, five tablets once a week. He usually takes them on Mondays.

PAST SURGICAL HISTORY: Appendectomy.

ALLERGIES: NONE.

MEDICATIONS: As an outpatient:
Subutex 2 mg sublingually q. 6 hours p.r.n.
Norco 10/325 one q. 24 hours p.r.n.
Lactulose 20 g at bedtime
Methotrexate 2.5 mg tablets 5 tablets q. Monday.
Pyridium 200 mg 3 times a day as needed for urinary pain.
Butrans patch 10 mcg patch q. 7 days.
Valium 10 mg as needed.
Paxil 5 mg at bedtime.

FAMILY HISTORY: Negative. The patient states that everyone in his family lives until they are 90.

SOCIAL HISTORY: The patient lives alone. He is currently on disability. The patient says he was working until about a week and a half ago when he walked off his job. The patient works with firearms and he felt that something was just not right with him and he should not be around firearms. He walked off the job and sold all of his guns. The patient states that he is an Olympic rifle coach for the National Junior level. He also is a private firearm instructor and a range safety officer.

HABITS: The patient denies any tobacco, alcohol or illicit drug use.

REVIEW OF SYSTEMS: A full 10-point review of systems was done. The patient complains of chronic pain secondary to his pelvic pain syndrome and

Consults (continued)

Consults signed by Sharma, Kanika, MD at 08/11/16 1230 (continued)

fibromyalgia. He goes to a pain management clinic at Highland General Hospital. He states that he also has pelvic floor dysfunction which affects his bladder, prostate, urethra and kidney. He states that the Pyridium helps him with those issues. He is also complaining of constipation. All other systems reviewed are negative.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 98.1, heart rate 77, blood pressure 117/70, respiratory rate is 16, sats 98% on room air, height is 170.2 cm, weight is 58.5 kg, BMI is 20.25.
GENERAL: The patient is awake, alert, appears comfortable.
HEENT: Pupils are round. Clear conjunctivae. Nares normal. No oral lesions appreciated.
NECK: Supple.
PULMONARY: Clear to auscultation bilaterally with no dyspnea.
CARDIOVASCULAR: Regular rate and rhythm, no murmur. Peripheral pulses intact. There is no peripheral edema.
GASTROINTESTINAL AND ABDOMEN: No hepatosplenomegaly. Abdomen is soft, nontender, nondistended, positive bowel sounds.
MUSCULOSKELETAL: Muscle strength and tone is normal. There is no muscle atrophy.
SKIN: No rashes or ulcerations are noted. The patient has hyperpigmented patches on his bilateral thighs and knees.
NEUROLOGIC: The patient is awake. Cranial nerves are intact. Motor function is intact. Gait is normal.
PSYCHIATRIC: The patient was awake, alert, calm, cooperative and answered questions appropriately.

Chart is reviewed.

LABORATORY DATA: CMP shows an elevated AST at 39, ALT elevated at 61. Glucose is 100. TSH is normal. Alcohol level less than 3. White count is low at 2.2. Hemoglobin is low at 13.3, platelets are normal at 233. Urine toxicology screen is positive for benzodiazepines, otherwise negative.

ASSESSMENT AND PLAN:
1. Chronic pain syndrome with chronic pelvic pain and fibromyalgia. The patient is followed by the Highland General Hospital Pain Clinic, will be continued on his Butrans patch, Subutex, Neurontin and Pyridium.
2. Psoriasis. Continue Methotrexate.
3. Bipolar affective disorder and posttraumatic stress disorder with associated suicidal ideations. The patient is medically cleared for inpatient psychiatric care.

DD: 08/10/2016 21:39:32; DT: 08/10/2016 22:45:52; ; D# 7105059ES; C# 1870285

cc: John Cruz MD

Consults (continued)

Consults signed by Sharma, Kanika, MD at 08/11/16 1230 (continued)

Signed by Sharma, Kanika, MD at 08/11/16 1230

General Script Information

ALL ORDERS AND RESULTS

The orders printed below will display the cosigner if there is one. If the order has not yet been cosigned and requires cosignature, then the order will have a status of "cosignature pending." If the order does not require cosignature, it will not display this status.

Order **(Order)**

All Orders Excluded (08/26/16 - 08/09/16)

DISCHARGE PATIENT

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/26/16 0951** Status: **Active**
Ordering user: Cruz, John Michael de Vera, MD 08/26/16 0951 Ordering provider: Cruz, John Michael de Vera, MD

DISCHARGE PATIENT

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/26/16 0951** Status: **Active**
Ordering user: Cruz, John Michael de Vera, MD 08/26/16 0951 Ordering provider: Cruz, John Michael de Vera, MD

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/25/16 0944** Status: **Active**
Ordering user: Cruz, John Michael de Vera, MD 08/25/16 0944 Ordering provider: Cruz, John Michael de Vera, MD

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/25/16 0944** Status: **Active**
Ordering user: Cruz, John Michael de Vera, MD 08/25/16 0944 Ordering provider: Cruz, John Michael de Vera, MD

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/23/16 1540** Status: **Active**
Ordering user: Cruz, John Michael de Vera, MD 08/23/16 1540 Ordering provider: Cruz, John Michael de Vera, MD

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/23/16 1540** Status: **Active**
Ordering user: Cruz, John Michael de Vera, MD 08/23/16 1540 Ordering provider: Cruz, John Michael de Vera, MD

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/22/16 1644** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/22/16 1644 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/24/16 1843 [Cancelled by MD]

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/22/16 1644** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/22/16 1644 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/24/16 1843 [Cancelled by MD]

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/22/16 1643** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/22/16 1643 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/22/16 1644

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/22/16 1643** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/22/16 1643 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/22/16 1644

NURSING COMMUNICATION

Electronically signed by: **Hirschtritt, Matthew E, MD on 08/21/16 0906** Status: **Discontinued**
Ordering user: Hirschtritt, Matthew E, MD 08/21/16 0906 Ordering provider: Hirschtritt, Matthew E, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/23/16 1540 [Cancelled by

All Orders Excluded (08/26/16 - 08/09/16) (continued)

NURSING COMMUNICATION (continued)

MD]

NURSING COMMUNICATION

Electronically signed by: **Hirschtritt, Matthew E, MD on 08/21/16 0906** Status: **Discontinued**
Ordering user: Hirschtritt, Matthew E, MD 08/21/16 0906 Ordering provider: Hirschtritt, Matthew E, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/23/16 1540 [Cancelled by MD]

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/19/16 1341** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/19/16 1341 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/22/16 1343 [Cancelled by MD]

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/19/16 1341** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/19/16 1341 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/22/16 1343 [Cancelled by MD]

NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/19/16 1114** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/19/16 1114 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/22/16 1343 [Cancelled by MD]

NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/19/16 1114** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/19/16 1114 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/22/16 1343 [Cancelled by MD]

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/19/16 1114** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/19/16 1114 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/22/16 1343 [Cancelled by MD]

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/19/16 1114** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/19/16 1114 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/22/16 1343 [Cancelled by MD]

NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/19/16 1112** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/19/16 1112 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/19/16 1114

NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/19/16 1112** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/19/16 1112 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/19/16 1114

NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 1646** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/15/16 1646 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/19/16 1112

NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 1646** Status: **Discontinued**

All Orders Excluded (08/26/16 - 08/09/16) (continued)

NURSING COMMUNICATION (continued)

Ordering user: Cruz, John Michael de Vera, MD 08/15/16 1646 — Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/19/16 1112

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 1133** — Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/15/16 1133 — Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1645 [Cancelled by MD]

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 1119** — Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/15/16 1119 — Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1128 [Cancelled by MD]

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 1119** — Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/15/16 1119 — Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1128 [Cancelled by MD]

GENERAL NURSING COMMUNICATION

Electronically signed by: **Schumm, Derek Daniel, MD on 08/14/16 1550** — Status: **Discontinued**
Ordering user: Schumm, Derek Daniel, MD 08/14/16 1550 — Ordering provider: Schumm, Derek Daniel, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1119 [Cancelled by MD]

GENERAL NURSING COMMUNICATION

Electronically signed by: **Schumm, Derek Daniel, MD on 08/14/16 1550** — Status: **Discontinued**
Ordering user: Schumm, Derek Daniel, MD 08/14/16 1550 — Ordering provider: Schumm, Derek Daniel, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1119 [Cancelled by MD]

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/12/16 2031** — Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/12/16 2031 — Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 0914 [Cancelled by MD]

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/12/16 2031** — Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/12/16 2031 — Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 0914 [Cancelled by MD]

OCCUPATIONAL THERAPY PLAN OF CARE

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/12/16 0907** — Status: **Active**
Mode: Ordering in Telephone mode — Communicated by: Elliott, Harold Edward, OT
Ordering user: Elliott, Harold Edward, OT 08/11/16 1706 — Ordering provider: Cruz, John Michael de Vera, MD

OCCUPATIONAL THERAPY PLAN OF CARE

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/12/16 0907** — Status: **Active**
Mode: Ordering in Telephone mode — Communicated by: Elliott, Harold Edward, OT
Ordering user: Elliott, Harold Edward, OT 08/11/16 1706 — Ordering provider: Cruz, John Michael de Vera, MD

PRIVILEGES (BEHAVIORAL HEALTH)

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/11/16 1547** — Status: **Active**
Ordering user: Cruz, John Michael de Vera, MD 08/11/16 1547 — Ordering provider: Cruz, John Michael de Vera, MD

MH PRECAUTIONS/LEVEL OF OBSERVATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/11/16 1547** — Status: **Active**

All Orders Excluded (08/26/16 - 08/09/16) (continued)

MH PRECAUTIONS/LEVEL OF OBSERVATION (continued)

Ordering user: Cruz, John Michael de Vera, MD 08/11/16 1547 Ordering provider: Cruz, John Michael de Vera, MD

PRIVILEGES (BEHAVIORAL HEALTH)

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/11/16 1547** Status: **Active**
Ordering user: Cruz, John Michael de Vera, MD 08/11/16 1547 Ordering provider: Cruz, John Michael de Vera, MD

MH PRECAUTIONS/LEVEL OF OBSERVATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/11/16 1547** Status: **Active**
Ordering user: Cruz, John Michael de Vera, MD 08/11/16 1547 Ordering provider: Cruz, John Michael de Vera, MD

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/11/16 0824** Status: **Active**
Ordering user: Cruz, John Michael de Vera, MD 08/11/16 0824 Ordering provider: Cruz, John Michael de Vera, MD

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/11/16 0824** Status: **Active**
Ordering user: Cruz, John Michael de Vera, MD 08/11/16 0824 Ordering provider: Cruz, John Michael de Vera, MD

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 1641** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 1641 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/11/16 0839 [Cancelled by MD]

GENERAL NURSING COMMUNICATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 1641** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 1641 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/11/16 0839 [Cancelled by MD]

VOLUNTARY: LEGAL STATUS

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 1636** Status: **Active**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 1636 Ordering provider: Cruz, John Michael de Vera, MD

VOLUNTARY: LEGAL STATUS

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 1636** Status: **Active**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 1636 Ordering provider: Cruz, John Michael de Vera, MD

MH PRECAUTIONS/LEVEL OF OBSERVATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 1629** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 1629 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/11/16 1547

MH PRECAUTIONS/LEVEL OF OBSERVATION

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 1629** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 1629 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/11/16 1547

FORMULA - ADULT

Electronically signed by: **Iwamura, Scott, RD on 08/10/16 0901** Status: **Active**
Ordering user: Iwamura, Scott, RD 08/10/16 0901 Ordering provider: Cruz, John Michael de Vera, MD

FORMULA - ADULT

Electronically signed by: **Iwamura, Scott, RD on 08/10/16 0901** Status: **Active**
Ordering user: Iwamura, Scott, RD 08/10/16 0901 Ordering provider: Cruz, John Michael de Vera, MD

INVOLUNTARY:LEGAL STATUS

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Discontinued**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN

All Orders Excluded (08/26/16 - 08/09/16) (continued)

INVOLUNTARY:LEGAL STATUS (continued)

Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/10/16 1636

PRIVILEGES (BEHAVIORAL HEALTH)

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Discontinued**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/11/16 1547

FULL (BY DEFAULT)

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Discontinued**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD
Discontinued by: Discharge Provider, Automatic 08/26/16 1953 [Patient Discharge]

VITAL SIGNS

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Active**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

WEIGHT

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Active**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

MEASURE HEIGHT / LENGTH

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Completed**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

MH PRECAUTIONS/LEVEL OF OBSERVATION

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Discontinued**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/10/16 1629

PATIENT ACTIVITY

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Active**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

CONSULT TO INTERNAL MEDICINE

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Active**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

OT EVALUATE AND TREAT

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Active**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

ADMIT TO INPATIENT (FROM HOSPITAL)

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Completed**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

DIET

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Active**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

All Orders Excluded (08/26/16 - 08/09/16) (continued)

DIET (continued)

INVOLUNTARY:LEGAL STATUS

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Discontinued**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/10/16 1636

PRIVILEGES (BEHAVIORAL HEALTH)

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Discontinued**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/11/16 1547

FULL (BY DEFAULT)

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Discontinued**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD
Discontinued by: Discharge Provider, Automatic 08/26/16 1953 [Patient Discharge]

VITAL SIGNS

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Active**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

WEIGHT

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Active**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

MEASURE HEIGHT / LENGTH

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Completed**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

MH PRECAUTIONS/LEVEL OF OBSERVATION

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Discontinued**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/10/16 1629

PATIENT ACTIVITY

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Active**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

CONSULT TO INTERNAL MEDICINE

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Active**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

OT EVALUATE AND TREAT

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Active**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

ADMIT TO INPATIENT (FROM HOSPITAL)

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Completed**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

All Orders Excluded (08/26/16 - 08/09/16) (continued)

DIET

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Active**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

CONSULT TO NUTRITION

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Completed**
Mode: Ordering in Telephone mode Communicated by: Silver, Amy E, RN
Ordering user: Silver, Amy E, RN 08/09/16 2224 Ordering provider: Michel, Christopher S, MD

CONSULT TO NUTRITION

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Completed**
Mode: Ordering in Telephone mode Communicated by: Silver, Amy E, RN
Ordering user: Silver, Amy E, RN 08/09/16 2224 Ordering provider: Michel, Christopher S, MD

Lab Orders and Results (08/09/16 - 08/23/16)

THYROID STIMULATING HORMONE (TSH)

Electronically signed by: **Ifc, Ehr Eb Ip Sq Lab Results In on 08/09/16 1025** Status: **Completed**
Ordering user: Ifc, Ehr Eb Ip Sq Lab Results In 08/09/16 1025 Ordering provider: Michel, Christopher S, MD

THYROID STIMULATING HORMONE (TSH)

Electronically signed by: **Ifc, Ehr Eb Ip Sq Lab Results In on 08/09/16 1025** Status: **Completed**
Ordering user: Ifc, Ehr Eb Ip Sq Lab Results In 08/09/16 1025 Ordering provider: Michel, Christopher S, MD

Final result

Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
TSH	0.67 uIU/mL	

RPR

Electronically signed by: **Ifc, Ehr Eb Ip Sq Lab Results In on 08/09/16 1025** Status: **Completed**
Ordering user: Ifc, Ehr Eb Ip Sq Lab Results In 08/09/16 1025 Ordering provider: Stanger, Michael Terence, MD

RPR

Electronically signed by: **Ifc, Ehr Eb Ip Sq Lab Results In on 08/09/16 1025** Status: **Completed**
Ordering user: Ifc, Ehr Eb Ip Sq Lab Results In 08/09/16 1025 Ordering provider: Stanger, Michael Terence, MD

Final result

Resulting lab: SUTTER HEALTH SHARED LABORATORY

Components

	Value	Flag
RPR	Non Reactive	

ADD ON LAB TEST

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Completed**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

LIPID PROFILE

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Completed**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

Lab Orders and Results (08/09/16 - 08/23/16) (continued)

HEMOGLOBIN A1C

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Completed**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

URINALYSIS, MACRO W/ MICRO IF INDICATED

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Discontinued**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/10/16 1636 [Cancelled by MD]

ADD ON LAB TEST

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Completed**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD

URINALYSIS, MACRO W/ MICRO IF INDICATED

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Discontinued**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/10/16 1636 [Cancelled by MD]

MAGNESIUM

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 0901** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 0901 Ordering provider: Cruz, John Michael de Vera, MD

PHOSPHORUS

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 0901** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 0901 Ordering provider: Cruz, John Michael de Vera, MD

VITAMIN B12

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 0901** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 0901 Ordering provider: Cruz, John Michael de Vera, MD

FOLATE (FOLIC ACID)

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 0901** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 0901 Ordering provider: Cruz, John Michael de Vera, MD

HIV 1 & 2 AB AG SCREEN W/ REFLEXES

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 0907** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 0907 Ordering provider: Cruz, John Michael de Vera, MD

CBC WITH AUTOMATED DIFFERENTIAL

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 1631** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 1631 Ordering provider: Cruz, John Michael de Vera, MD

URINALYSIS & CULT IF INDICATED

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 1636** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 1636 Ordering provider: Cruz, John Michael de Vera, MD

URINALYSIS & CULT IF INDICATED

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 1636** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 1636 Ordering provider: Cruz, John Michael de Vera, MD
Final result **(Abnormal)**

Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
Urine Color	Yellow	
Urine Appearance	Clear	

Lab Orders and Results (08/09/16 - 08/23/16) (continued)

URINALYSIS & CULT IF INDICATED (continued)

Urine Specific Gravity	1.016	
Urine pH	6.5	
Urine Leukocyte Esterase	Neg	
Urine Nitrites	Neg	
Urine Protein	Neg	
Urine Glucose	Neg	
Urine Ketones	1+	A
Urine Blood	Neg	
Urine Comments	Urine microscopic and culture not done, not indicated	

VALPROIC ACID

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 1637** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 1637 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/12/16 0854

HIV 1 & 2 AB AG SCREEN W/ REFLEXES

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 0907** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 0907 Ordering provider: Cruz, John Michael de Vera, MD
Final result
Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
HIV1/HIV2 SEPARATE REPORT	Non Reactive	

LIPID PROFILE

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Completed**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD
Final result **(Abnormal)**
Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
Total cholesterol	185 mg/dL	
Triglyceride	190 mg/dL	H
HDL cholesterol	60 mg/dL	
LDL Calculated	87 mg/dL	
VLDL (Calculated)	38 mg/dL	H

HEMOGLOBIN A1C

Electronically signed by: **Michel, Christopher S, MD on 08/11/16 1718** Status: **Completed**
Mode: Ordering in Telephone mode Communicated by: Piper, Mark E, RN
Ordering user: Piper, Mark E, RN 08/10/16 0019 Ordering provider: Michel, Christopher S, MD
Final result
Resulting lab: SUTTER HEALTH SHARED LABORATORY

Components

	Value	Flag
Hemoglobin A1c	5.1 %	
Average Glucose	100 mg/dL	

MAGNESIUM

Lab Orders and Results (08/09/16 - 08/23/16) (continued)

MAGNESIUM (continued)

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 0901** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 0901 Ordering provider: Cruz, John Michael de Vera, MD
Final result **(Abnormal)**
Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
Magnesium	2.5 mg/dL	H

PHOSPHORUS

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 0901** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 0901 Ordering provider: Cruz, John Michael de Vera, MD
Final result
Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
Phosphorus	2.9 mg/dL	

VITAMIN B12

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 0901** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 0901 Ordering provider: Cruz, John Michael de Vera, MD
Final result
Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
Vitamin B12	545 pg/mL	

FOLATE (FOLIC ACID)

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 0901** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 0901 Ordering provider: Cruz, John Michael de Vera, MD
Final result **(Abnormal)**
Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
Folate	>20.0 ng/mL	H

CBC WITH AUTOMATED DIFFERENTIAL

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/10/16 1631** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/10/16 1631 Ordering provider: Cruz, John Michael de Vera, MD
Final result **(Abnormal)**
Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
White Blood Cell Count	3.3 K/uL	L
Red Blood Cell Count	4.50 M/uL	
Hemoglobin	13.8 g/dL	
Hematocrit	41.1 %	
MCV	91 fL	
MCH	30.7 pg	
MCHC	33.6 g/dL	
RDW	13.7 %	
Platelet Count	224 K/uL	

Lab Orders and Results (08/09/16 - 08/23/16) (continued)

CBC WITH AUTOMATED DIFFERENTIAL (continued)

Differential Type	Automated
Neutrophil %	59 %
Lymphocyte %	29 %
Monocyte %	9 %
Eosinophil %	2 %
Basophil %	1 %
Abs. Neutrophil	2.0 K/uL
Abs. Lymphocyte	1.0 K/uL
Abs. Monocyte	0.3 K/uL
Abs. Eosinophil	0.1 K/uL
Abs. Basophil	0.0 K/uL
NUCLEATED RBC AUTO	0.0 /100 WBC

VALPROIC ACID

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/12/16 0854** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/12/16 0854 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1118 [Cancelled by MD]

CBC WITH AUTOMATED DIFFERENTIAL

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 0926** Status: **Completed**
Mode: Ordering in Telephone mode Communicated by: Ellison, Ricky, RN
Ordering user: Ellison, Ricky, RN 08/13/16 1023 Ordering provider: Cruz, John Michael de Vera, MD

CBC WITH AUTOMATED DIFFERENTIAL

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 0926** Status: **Completed**
Mode: Ordering in Telephone mode Communicated by: Ellison, Ricky, RN
Ordering user: Ellison, Ricky, RN 08/13/16 1023 Ordering provider: Cruz, John Michael de Vera, MD
Final result **(Abnormal)**
Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
White Blood Cell Count	3.8 K/uL	L
Red Blood Cell Count	4.80 M/uL	
Hemoglobin	14.6 g/dL	
Hematocrit	43.7 %	
MCV	91 fL	
MCH	30.4 pg	
MCHC	33.4 g/dL	
RDW	13.8 %	
Platelet Count	229 K/uL	
Differential Type	Automated	
Neutrophil %	47 %	L
Lymphocyte %	41 %	
Monocyte %	9 %	
Eosinophil %	2 %	
Basophil %	1 %	
Abs. Neutrophil	1.8 K/uL	L
Abs. Lymphocyte	1.6 K/uL	
Abs. Monocyte	0.4 K/uL	
Abs. Eosinophil	0.1 K/uL	
Abs. Basophil	0.0 K/uL	
NUCLEATED RBC AUTO	0.0 /100 WBC	

COMPREHENSIVE METABOLIC PANEL W GFR

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 0926** Status: **Completed**
Mode: Ordering in Telephone mode Communicated by: Ellison, Ricky, RN
Ordering user: Ellison, Ricky, RN 08/13/16 1025 Ordering provider: Cruz, John Michael de Vera, MD

COMPREHENSIVE METABOLIC PANEL W GFR

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 0926** Status: **Completed**

Lab Orders and Results (08/09/16 - 08/23/16) (continued)

COMPREHENSIVE METABOLIC PANEL W GFR (continued)

Mode: Ordering in Telephone mode
Communicated by: Ellison, Ricky, RN
Ordering user: Ellison, Ricky, RN 08/13/16 1025
Ordering provider: Cruz, John Michael de Vera, MD
Final result **(Abnormal)**
Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
Sodium	142 mmol/L	
Potassium	4.1 mmol/L	
Chloride	102 mmol/L	
CO2 (Bicarbonate)	34 mmol/L	H
Anion Gap	10.1 mmol/L	
Glucose	107 mg/dL	H
BUN	16 mg/dL	
Creatinine	0.98 mg/dL	
GFR Est-Other	91 See Cmnt	
GFR Est-African American	106 See Cmnt	
Calcium	9.1 mg/dL	
Total Protein	7.8 g/dL	
Albumin	4.0 g/dL	
Total Bilirubin	0.3 mg/dL	
Alkaline Phosphatase	103 U/L	
AST	62 U/L	H
ALT	126 U/L	H
Ionized Calcium Calc	0.97 mmol/L	
Osmolality Calc,Serum	285 mOsm/kg	

LIPASE

Electronically signed by: **Fitzpatrick, Matthew S, MD on 08/13/16 1029**
Status: **Completed**
Ordering user: Fitzpatrick, Matthew S, MD 08/13/16 1029
Ordering provider: Fitzpatrick, Matthew S, MD

LIPASE

Electronically signed by: **Fitzpatrick, Matthew S, MD on 08/13/16 1029**
Status: **Completed**
Ordering user: Fitzpatrick, Matthew S, MD 08/13/16 1029
Ordering provider: Fitzpatrick, Matthew S, MD
Final result
Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
Lipase	143 U/L	

VALPROIC ACID

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/12/16 0854**
Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/12/16 0854
Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1118 [Cancelled by MD]

CBC WITH AUTOMATED DIFFERENTIAL

Electronically signed by: **Sharma, Kanika, MD on 08/14/16 0816**
Status: **Discontinued**
Ordering user: Sharma, Kanika, MD 08/14/16 0816
Ordering provider: Sharma, Kanika, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1128 [Cancelled by MD]

MAGNESIUM

Electronically signed by: **Sharma, Kanika, MD on 08/14/16 0816**
Status: **Discontinued**
Ordering user: Sharma, Kanika, MD 08/14/16 0816
Ordering provider: Sharma, Kanika, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1645

COMPREHENSIVE METABOLIC PANEL W GFR

Electronically signed by: **Sharma, Kanika, MD on 08/14/16 0816**
Status: **Discontinued**

Lab Orders and Results (08/09/16 - 08/23/16) (continued)

COMPREHENSIVE METABOLIC PANEL W GFR (continued)

Ordering user: Sharma, Kanika, MD 08/14/16 0816 Ordering provider: Sharma, Kanika, MD

Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1128 [Cancelled by MD]

PHOSPHORUS

Electronically signed by: **Sharma, Kanika, MD on 08/14/16 0816** Status: **Discontinued**

Ordering user: Sharma, Kanika, MD 08/14/16 0816 Ordering provider: Sharma, Kanika, MD

Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1645

HEPATITIS ACUTE PANEL

Electronically signed by: **Sharma, Kanika, MD on 08/14/16 0816** Status: **Discontinued**

Ordering user: Sharma, Kanika, MD 08/14/16 0816 Ordering provider: Sharma, Kanika, MD

Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1133 [Cancelled by MD]

VALPROIC ACID

Electronically signed by: **Sharma, Kanika, MD on 08/14/16 0816** Status: **Completed**

Ordering user: Sharma, Kanika, MD 08/14/16 0816 Ordering provider: Sharma, Kanika, MD

MAGNESIUM

Electronically signed by: **Sharma, Kanika, MD on 08/14/16 0816** Status: **Discontinued**

Ordering user: Sharma, Kanika, MD 08/14/16 0816 Ordering provider: Sharma, Kanika, MD

Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1645

COMPREHENSIVE METABOLIC PANEL W GFR

Electronically signed by: **Sharma, Kanika, MD on 08/14/16 0816** Status: **Discontinued**

Ordering user: Sharma, Kanika, MD 08/14/16 0816 Ordering provider: Sharma, Kanika, MD

Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1128 [Cancelled by MD]

PHOSPHORUS

Electronically signed by: **Sharma, Kanika, MD on 08/14/16 0816** Status: **Discontinued**

Ordering user: Sharma, Kanika, MD 08/14/16 0816 Ordering provider: Sharma, Kanika, MD

Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1645

HEPATITIS ACUTE PANEL

Electronically signed by: **Sharma, Kanika, MD on 08/14/16 0816** Status: **Discontinued**

Ordering user: Sharma, Kanika, MD 08/14/16 0816 Ordering provider: Sharma, Kanika, MD

Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1133 [Cancelled by MD]

VALPROIC ACID

Electronically signed by: **Sharma, Kanika, MD on 08/14/16 0816** Status: **Completed**

Ordering user: Sharma, Kanika, MD 08/14/16 0816 Ordering provider: Sharma, Kanika, MD

Final result

Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
Valproic Acid	75.0 ug/mL	

CBC WITH AUTOMATED DIFFERENTIAL

Electronically signed by: **Sharma, Kanika, MD on 08/14/16 0816** Status: **Discontinued**

Ordering user: Sharma, Kanika, MD 08/14/16 0816 Ordering provider: Sharma, Kanika, MD

Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1128 [Cancelled by MD]

VALPROIC ACID

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 1118** Status: **Discontinued**

Lab Orders and Results (08/09/16 - 08/23/16) (continued)

VALPROIC ACID (continued)

Ordering user: Cruz, John Michael de Vera, MD 08/15/16 1118 Ordering provider: Cruz, John Michael de Vera, MD

Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1128 [Cancelled by MD]

VALPROIC ACID

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 1133** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/15/16 1133 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1645

CBC WITH AUTOMATED DIFFERENTIAL

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 1133** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/15/16 1133 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1645

COMPREHENSIVE METABOLIC PANEL W GFR

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 1133** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/15/16 1133 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1645

HEPATITIS ACUTE PANEL

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 1133** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/15/16 1133 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 1645

CBC WITH AUTOMATED DIFFERENTIAL

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 1645** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/15/16 1645 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/19/16 1113 [Cancelled by MD]

COMPREHENSIVE METABOLIC PANEL W GFR

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 1645** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/15/16 1645 Ordering provider: Cruz, John Michael de Vera, MD

HEPATITIS ACUTE PANEL

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 1645** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/15/16 1645 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/15/16 2045

VALPROIC ACID

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 1645** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/15/16 1645 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/18/16 1849

MAGNESIUM

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 1645** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/15/16 1645 Ordering provider: Cruz, John Michael de Vera, MD

PHOSPHORUS

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 1645** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/15/16 1645 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/18/16 1842

HEPATITIS ACUTE PANEL

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 2045** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/15/16 2045 Ordering provider: Cruz, John Michael de Vera, MD

PHOSPHORUS

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/18/16 1842** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/18/16 1842 Ordering provider: Cruz, John Michael de Vera, MD

Lab Orders and Results (08/09/16 - 08/23/16) (continued)

PHOSPHORUS (continued)

Discontinued by: Cruz, John Michael de Vera, MD 08/18/16 1910

CBC WITH AUTOMATED DIFFERENTIAL

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/20/16 2127** Status: **Discontinued**
Mode: Ordering in Verbal mode Communicated by: Abend, Marquel Marie, RN
Ordering user: Abend, Marquel Marie, RN 08/18/16 1846 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/18/16 1910 [Cancelled by MD]

CBC WITH AUTOMATED DIFFERENTIAL

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/20/16 2127** Status: **Discontinued**
Mode: Ordering in Verbal mode Communicated by: Abend, Marquel Marie, RN
Ordering user: Abend, Marquel Marie, RN 08/18/16 1846 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/18/16 1910 [Cancelled by MD]

VALPROIC ACID

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/18/16 1849** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/18/16 1849 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/18/16 1850

VALPROIC ACID

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/18/16 1850** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/18/16 1850 Ordering provider: Cruz, John Michael de Vera, MD
Additional signing events:
Cruz, John Michael de Vera, MD 08/20/16 2127, for Discontinuing in Telephone mode, Communicator - Abend, Marquel Marie, RN
Discontinued by: Abend, Marquel Marie, RN 08/18/16 1853

VALPROIC ACID

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/20/16 2127** Status: **Discontinued**
Mode: Ordering in Telephone mode Communicated by: Abend, Marquel Marie, RN
Ordering user: Abend, Marquel Marie, RN 08/18/16 1853 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/18/16 1856

VALPROIC ACID

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/18/16 1856** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/18/16 1856 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/18/16 1900

VALPROIC ACID

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/18/16 1900** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/18/16 1900 Ordering provider: Cruz, John Michael de Vera, MD

CBC WITH AUTOMATED DIFFERENTIAL

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 1645** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/15/16 1645 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/19/16 1113 [Cancelled by MD]

COMPREHENSIVE METABOLIC PANEL W GFR

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 1645** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/15/16 1645 Ordering provider: Cruz, John Michael de Vera, MD
Final result **(Abnormal)**
Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
Sodium	144 mmol/L	
Potassium	4.6 mmol/L	
Chloride	108 mmol/L	
CO2 (Bicarbonate)	29 mmol/L	
Anion Gap	11.6 mmol/L	
Glucose	75 mg/dL	

Lab Orders and Results (08/09/16 - 08/23/16) (continued)

COMPREHENSIVE METABOLIC PANEL W GFR (continued)

BUN	18 mg/dL	
Creatinine	0.83 mg/dL	
GFR Est-Other	105 See Cmnt	
GFR Est-African American	121 See Cmnt	
Calcium	8.7 mg/dL	
Total Protein	6.5 g/dL	
Albumin	3.3 g/dL	
Total Bilirubin	0.3 mg/dL	
Alkaline Phosphatase	85 U/L	
AST	30 U/L	
ALT	72 U/L	H
Ionized Calcium Calc	0.98 mmol/L	
Osmolality Calc,Serum	287 mOsm/kg	

MAGNESIUM

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 1645** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/15/16 1645 Ordering provider: Cruz, John Michael de Vera, MD

Final result

Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
Magnesium	2.4 mg/dL	

HEPATITIS ACUTE PANEL

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/15/16 2045** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/15/16 2045 Ordering provider: Cruz, John Michael de Vera, MD

Final result

Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
Hepatitis A IgM Antibody	Non Reactive	
Hepatitis B Core IgM	Non Reactive	
Hep B Surface Antigen	Non Reactive	
Hepatitis C Antibody	Non Reactive	

PHOSPHORUS

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/18/16 1842** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/18/16 1842 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/18/16 1910

VALPROIC ACID

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/18/16 1900** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/18/16 1900 Ordering provider: Cruz, John Michael de Vera, MD

Final result **(Abnormal)**

Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
Valproic Acid	123.3 ug/mL	H

PHOSPHORUS

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/18/16 1910** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/18/16 1910 Ordering provider: Cruz, John Michael de Vera, MD

Lab Orders and Results (08/09/16 - 08/23/16) (continued)

PHOSPHORUS (continued)

Discontinued by: Cruz, John Michael de Vera, MD 08/19/16 1113 [Cancelled by MD]

PHOSPHORUS

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/18/16 1910** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/18/16 1910 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/19/16 1113 [Cancelled by MD]

VALPROIC ACID

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/19/16 1115** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/19/16 1115 Ordering provider: Cruz, John Michael de Vera, MD

PHOSPHORUS

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/19/16 1116** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/19/16 1116 Ordering provider: Cruz, John Michael de Vera, MD

CBC WITH AUTOMATED DIFFERENTIAL

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/19/16 1826** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/19/16 1826 Ordering provider: Cruz, John Michael de Vera, MD

VALPROIC ACID

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/19/16 1115** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/19/16 1115 Ordering provider: Cruz, John Michael de Vera, MD
Final result
Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
Valproic Acid	89.4 ug/mL	

PHOSPHORUS

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/19/16 1116** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/19/16 1116 Ordering provider: Cruz, John Michael de Vera, MD
Final result
Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
Phosphorus	3.6 mg/dL	

CBC WITH AUTOMATED DIFFERENTIAL

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/19/16 1826** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/19/16 1826 Ordering provider: Cruz, John Michael de Vera, MD
Final result **(Abnormal)**
Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
White Blood Cell Count	4.3 K/uL	
Red Blood Cell Count	4.25 M/uL	L
Hemoglobin	12.7 g/dL	L
Hematocrit	39.0 %	L
MCV	92 fL	
MCH	29.9 pg	
MCHC	32.6 g/dL	
RDW	13.6 %	
Platelet Count	143 K/uL	L
Differential Type	Automated	

Lab Orders and Results (08/09/16 - 08/23/16) (continued)

CBC WITH AUTOMATED DIFFERENTIAL (continued)

Neutrophil %	64 %	
Lymphocyte %	23 %	L
Monocyte %	8 %	
Eosinophil %	4 %	
Basophil %	1 %	
Abs. Neutrophil	2.8 K/uL	
Abs. Lymphocyte	1.0 K/uL	
Abs. Monocyte	0.3 K/uL	
Abs. Eosinophil	0.2 K/uL	
Abs. Basophil	0.0 K/uL	
NUCLEATED RBC AUTO	0.0 /100 WBC	

VALPROIC ACID

Electronically signed by: **Hirschtritt, Matthew E, MD on 08/20/16 1417** Status: **Discontinued**
Ordering user: Hirschtritt, Matthew E, MD 08/20/16 1417 Ordering provider: Hirschtritt, Matthew E, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/22/16 1343

VALPROIC ACID

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/22/16 1343** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/22/16 1343 Ordering provider: Cruz, John Michael de Vera, MD

CBC WITH AUTOMATED DIFFERENTIAL

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/22/16 1343** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/22/16 1343 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/23/16 2027 [Cancelled by MD]

COMPREHENSIVE METABOLIC PANEL W GFR

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/22/16 1343** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/22/16 1343 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/23/16 2027 [Cancelled by MD]

VALPROIC ACID

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/22/16 1343** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/22/16 1343 Ordering provider: Cruz, John Michael de Vera, MD
Final result
Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
Valproic Acid	97.8 ug/mL	

CBC WITH AUTOMATED DIFFERENTIAL

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/22/16 1343** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/22/16 1343 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/23/16 2027 [Cancelled by MD]

COMPREHENSIVE METABOLIC PANEL W GFR

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/22/16 1343** Status: **Discontinued**
Ordering user: Cruz, John Michael de Vera, MD 08/22/16 1343 Ordering provider: Cruz, John Michael de Vera, MD
Discontinued by: Cruz, John Michael de Vera, MD 08/23/16 2027 [Cancelled by MD]

CBC WITH AUTOMATED DIFFERENTIAL

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/23/16 2028** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/23/16 2028 Ordering provider: Cruz, John Michael de Vera, MD

Lab Orders and Results (08/09/16 - 08/23/16) (continued)

CBC WITH AUTOMATED DIFFERENTIAL (continued)

COMPREHENSIVE METABOLIC PANEL W GFR

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/23/16 2028** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/23/16 2028 Ordering provider: Cruz, John Michael de Vera, MD

CBC WITH AUTOMATED DIFFERENTIAL

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/23/16 2028** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/23/16 2028 Ordering provider: Cruz, John Michael de Vera, MD

Final result **(Abnormal)**

Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
White Blood Cell Count	3.9 K/uL	L
Red Blood Cell Count	4.07 M/uL	L
Hemoglobin	12.5 g/dL	L
Hematocrit	38.4 %	L
MCV	94 fL	
MCH	30.7 pg	
MCHC	32.6 g/dL	
RDW	13.6 %	
Platelet Count	100 K/uL	L
Differential Type	Automated	
Neutrophil %	51 %	
Lymphocyte %	34 %	
Monocyte %	11 %	
Eosinophil %	3 %	
Basophil %	1 %	
Abs. Neutrophil	2.1 K/uL	
Abs. Lymphocyte	1.4 K/uL	
Abs. Monocyte	0.4 K/uL	
Abs. Eosinophil	0.1 K/uL	
Abs. Basophil	0.0 K/uL	
NUCLEATED RBC AUTO	0.0 /100 WBC	

COMPREHENSIVE METABOLIC PANEL W GFR

Electronically signed by: **Cruz, John Michael de Vera, MD on 08/23/16 2028** Status: **Completed**
Ordering user: Cruz, John Michael de Vera, MD 08/23/16 2028 Ordering provider: Cruz, John Michael de Vera, MD

Final result **(Abnormal)**

Resulting lab: ALTA BATES CAMPUS LABORATORY

Components

	Value	Flag
Sodium	146 mmol/L	H
Potassium	4.6 mmol/L	
Chloride	108 mmol/L	H
CO2 (Bicarbonate)	33 mmol/L	H
Anion Gap	9.6 mmol/L	L
Glucose	69 mg/dL	L
BUN	21 mg/dL	
Creatinine	1.06 mg/dL	
GFR Est-Other	83 See Cmnt	
GFR Est-African American	96 See Cmnt	
Calcium	8.6 mg/dL	
Total Protein	6.9 g/dL	
Albumin	3.4 g/dL	
Total Bilirubin	0.3 mg/dL	
Alkaline Phosphatase	90 U/L	
AST	26 U/L	
ALT	75 U/L	H
Ionized Calcium Calc	0.96 mmol/L	
Osmolality Calc,Serum	292 mOsm/kg	H

All Flowsheet Data (08/24/16 0000--08/26/16 2359)

MAR MINI-FLOWSHEET DATA

	08/26/16 1600	08/26/16 1028	08/26/16 0900	08/26/16 0824	08/26/16 0200
Pain					
Pain Rating (0-10): Rest	0 -MA	4 -SH	0 -SH	0 -FS	0 -CR
Pain Rating (0-10): Activity	0 -MA	4 -SH	0 -SH		
Cognitive/Neuro/Behavioral					
(POSS) Pasero Opioid-Induced Sed Scale		1 - Awake and alert -SH			
	08/25/16 1600	08/25/16 1234	08/25/16 0000	08/24/16 1652	08/24/16 0900
Pain					
Pain Rating (0-10): Rest	0 -EM	0 -SE	0 -CR	0 -FSA	0 -PK
Pain Rating (0-10): Activity	0 -EM	0 -SE		0 -FSA	0 -PK
	08/24/16 0200				
Pain					
Pain Rating (0-10): Rest	0 -CR				

CARE PLAN MINI-FLOWSHEET DATA

	08/26/16 1650	08/26/16 1600	08/26/16 1007	08/26/16 0900	08/25/16 1641
Depression (Adult,Obstetrics,Pediatric)					
Establish/Maintain Self-Care Routine			making progress toward outcome -SH		
Improved/Stable Mood			making progress toward outcome -SH		
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -MA	patient -MA		patient -SH	patient -EM
Plan of Care Review					
Progress					improving -EM
Fall Risk (Adult)					
Absence of Falls			making progress toward outcome -SH		
Constipation (Adult)					
Effective Bowel Elimination			making progress toward outcome -SH		
Comfort			making progress toward outcome -SH		
	08/25/16 1600	08/25/16 1358	08/25/16 1234	08/24/16 2200	08/24/16 1452
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -EM	patient -SE	patient -SE	patient -FSA	patient -SE

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

CARE PLAN MINI-FLOWSHEET DATA (continued)

	08/25/16 1600	08/25/16 1358	08/25/16 1234	08/24/16 2200	08/24/16 1452
Plan of Care Review					
Progress		progress towards functional goals is fair -SE			progress toward functional goals as expected -SE

	08/24/16 1329
Coping/Psychosocial Response Interventions	
Plan Of Care Reviewed With	patient -SE

LACE/LACE+ Score

	08/26/16 1653
OTHER	
LACE+ Score	64 -MA
LACE Score	11 -MA

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	08/26/16 1600	08/26/16 1128	08/26/16 1028	08/26/16 0900	08/26/16 0824
Vital Signs					
Temp					97.5 °F (36.4 °C) -FS
Temp src					Oral -FS
Pulse					80 -FS
BP					**(!)** 153/95 mmHg -FS
Patient Position					Sitting -FS
BP Location					Left arm -FS
BP Method					Automatic -FS
Resp					16 -FS
Skin					
Skin WDL	WDL -MA			WDL -SH	
Pain/Comfort, Non Labor					
Pain Rating (0-10): Rest	0 -MA		4 -SH	0 -SH	0 -FS
Pain Rating (0-10): Activity	0 -MA		4 -SH	0 -SH	
Comfort/Acceptable Pain Level				3 -SH	
Pain Quality			aching -SH		
Post Anesthesia					
Orientation	oriented x 4 -MA			oriented x 4 -SH	
Pain Assessment					
Pain Management Interventions			single medication modality -SH		
Pain Body Location			back -SH		
Oxygen Therapy during Labor					
SpO2					98 % -FS

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

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	08/26/16 1600	08/26/16 1128	08/26/16 1028	08/26/16 0900	08/26/16 0824
O2 Device					room air -FS
Pain Assessment: Number Scale (0-10) (OB - Non Labor)					
Response to Interventions		relief -SH			
Cognitive					
Memory Deficit	intact -MA			intact -SH	
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy -MA				
Fall Risk Score	3 -MA				
Danger to Self					
Danger to Self (WDL)	WDL -MA			WDL -SH	
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -MA			-- -SH	
Self-Injurious Behavior				-- -SH	
Self-injury Description				-- -SH	
Agreement not to Harm Self				-- -SH	
Danger to Others					
Danger to Others (WDL)	WDL -MA			WDL -SH	
Precautions/Isolation					
Precautions (displays in banner)	None -MA			None -SH	

	08/26/16 0200	08/25/16 1600	08/25/16 1533	08/25/16 1234	08/25/16 0800
Vital Signs					
Temp			98.6 °F (37 °C) -AS		98.2 °F (36.8 °C) -AP
Pulse			85 -AS		66 -AP
BP			134/74 mmHg -AS		96/51 mmHg -AP
Patient Position			Sitting -AS		
BP Location			Right arm -AS		
Resp			16 -AS		17 -AP
Skin					
Skin WDL	WDL -CR	WDL -EM		WDL -SE	
Pain/Comfort, Non Labor					
Pain Rating (0-10): Rest	0 -CR	0 -EM		0 -SE	
Pain Rating (0-10): Activity		0 -EM		0 -SE	
Comfort/Accept		3 -EM			

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/26/16 0200	08/25/16 1600	08/25/16 1533	08/25/16 1234	08/25/16 0800
able Pain Level					
Post Anesthesia					
Orientation		oriented x 4 -EM		oriented x 4 -SE	
Oxygen Therapy during Labor					
SpO2					98 % -AP
Patient Observation					
Observations	q30 -CR	q30 -EM		q30 -SE	
Cognitive					
Memory Deficit		intact -EM		intact -SE	
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy -CR	3-->polypharmacy -EM		3-->polypharmacy -SE	
Fall Risk Score	3 -CR	3 -EM		3 -SE	
Danger to Self					
Danger to Self (WDL)	WDL -CR	WDL -EM		WDL -SE	
Danger to Self		no suicidal ideation or behavior indicators observed or expressed -EM		no suicidal ideation or behavior indicators observed or expressed -SE	
Keeps Self Safe		yes (describe) -EM		yes (describe) -SE	
Description of Suicide Plan		Denied -EM			
Self-Injurious Behavior		no self-injurious ideation or behavior indicators observed or expressed -EM		no self-injurious ideation or behavior indicators observed or expressed -SE	
Self-injury Description		Denied -EM			
Agreement not to Harm Self		yes (describe) -EM		yes (describe) -SE	
Description of Agreement		verbal -EM			
Danger to Others					
Danger to Others (WDL)	WDL -CR	WDL -EM		WDL -SE	
Precautions/Isolation					
Precautions (displays in banner)	None -CR	None -EM		None -SE	

	08/25/16 0000	08/24/16 2200	08/24/16 1652	08/24/16 1329	08/24/16 1100
Vital Signs					
Temp			98.1 °F (36.7 °C) -FSA		
Temp src			Oral -FSA		
Pulse			83 -FSA		
BP			123/73 mmHg -FSA		

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/25/16 0000	08/24/16 2200	08/24/16 1652	08/24/16 1329	08/24/16 1100
Patient Position			Sitting -FSA		
BP Location			Right arm -FSA		
BP Method			Automatic -FSA		
Resp			17 -FSA		
Skin					
Skin WDL	WDL -CR		WDL -FSA		WDL -SE
Pain/Comfort, Non Labor					
Pain Rating (0-10): Rest	0 -CR		0 -FSA		
Pain Rating (0-10): Activity			0 -FSA		
Post Anesthesia					
Orientation			oriented x 4 -FSA		oriented x 4 -SE
Oxygen Therapy during Labor					
SpO2			98 % -FSA		
O2 Device			room air -FSA		
Patient Observation					
Observations	q30 -CR		q30 -FSA		q30 -SE
Cognitive					
Memory Deficit			intact -FSA	intact -SE	
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy -CR		3-->polypharmacy -FSA		3-->polypharmacy -SE
Fall Risk Score	3 -CR		3 -FSA		3 -SE
Danger to Self					
Danger to Self (WDL)	WDL -CR	WDL -FSA		WDL -SE	
Danger to Self				no suicidal ideation or behavior indicators observed or expressed -SE	
Keeps Self Safe				yes (describe) -SE	
Self-Injurious Behavior				no self-injurious ideation or behavior indicators observed or expressed -SE	
Agreement not to Harm Self				yes (describe) -SE	
Danger to Others					
Danger to Others (WDL)	WDL -CR			WDL -SE	
Precautions/Isolation					
Precautions (displays in banner)	None -CR		None -FSA		None -SE

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/24/16 0900	08/24/16 0200
Vital Signs		
Temp	98.2 °F (36.8 °C) -PK	
Temp src	Oral -PK	
Pulse	87 -PK	
BP	132/87 mmHg -PK	
Patient Position	Sitting -PK	
BP Location	Left arm -PK	
BP Method	Automatic -PK	
Resp	16 -PK	
Skin		
Skin WDL		WDL -CR
Pain/Comfort, Non Labor		
Pain Rating (0-10): Rest	0 -PK	0 -CR
Pain Rating (0-10): Activity	0 -PK	
Comfort/Acceptable Pain Level	0 -PK	
Oxygen Therapy during Labor		
SpO2	95 % -PK	
O2 Device	room air -PK	
Patient Observation		
Observations		q30 -CR
Fall Risk Assessment		
Fall Risk Indicators		3-->polypharmacy -CR
Fall Risk Score		3 -CR
Danger to Self		
Danger to Self (WDL)		WDL -CR
Danger to Others		
Danger to Others (WDL)		WDL -CR
Precautions/Isolation		
Precautions (displays in banner)		None -CR

BH PS Main

	08/26/16 1600	08/26/16 1300	08/26/16 0900	08/26/16 0200	08/25/16 1600
Legal Status					
Legal status	voluntary -MA		voluntary -SH	voluntary -CR	voluntary -EM
Risk Assessment					
Danger to Self (WDL)	WDL -MA		WDL -SH	WDL -CR	WDL -EM
Danger to Self	no suicidal ideation or behavior indicators		-- -SH		no suicidal ideation or behavior

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH PS Main (continued)

	08/26/16 1600	08/26/16 1300	08/26/16 0900	08/26/16 0200	08/25/16 1600
	observed or expressed -MA				indicators observed or expressed -EM
Keeps Self Safe					yes (describe) -EM
Description of Suicide Plan					Denied -EM
Self-Injurious Behavior			-- -SH		no self-injurious ideation or behavior indicators observed or expressed -EM
Self-injury Description			-- -SH		Denied -EM
Agreement not to Harm Self			-- -SH		yes (describe) -EM
Description of Agreement					verbal -EM
Assessment timing	Discharge -MA	Discharge -SH			Shift -EM
Assessment of Risk Factors					Deficits in social, decision, and coping skills -EM
Assessment of Protective Factors					Good access to health care/therapy -EM
Agitation	None -MA	None -SH			
Anxiety or Fearfulness	Low -MA	None -SH			
Loss of Pleasure or Interest	None -MA	None -SH			
Depression or Sadness	Low -MA	None -SH			
Suicide Plan for Today	None -MA	None -SH			
Hopeless or Overwhelmed	None -MA	None -SH			
Sleep Disturbances	None -MA	None -SH			
Cognition Problems	None -MA	None -SH			
Psychotic Symptoms	None -MA	None -SH			
Withholding Information	None -MA	None -SH			
Resistance to Treatment	None -MA	None -SH			

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH PS Main (continued)

	08/26/16 1600	08/26/16 1300	08/26/16 0900	08/26/16 0200	08/25/16 1600
Impulsivity	None -MA	None -SH			
Aggressive towards self/others	None -MA	None -SH			
Pain, real or perceived	Low -MA	Moderate -SH			
Perceived Loss of Health	Low -MA	Moderate -SH			
Suicide Plan outside of Hospital	Moderate -MA	None -SH			
Lack of Support if Discharged	None -MA	None -SH			
Pessimism if Discharged	None -MA	None -SH			
Suicide Ideation for Today	None -MA	None -SH			
Behavior congruent with Verbal and Non-Verbal		Yes -SH			
Assessment of Current Suicide Risk	Low -MA	Low -SH			
Protective Factors to Strengthen	A healthy fear of risky behaviors and pain -MA				
Danger to Others (WDL)	WDL -MA		WDL -SH	WDL -CR	WDL -EM
	08/25/16 1234	08/25/16 0000	08/24/16 2200	08/24/16 1652	08/24/16 1329
Legal Status					
Legal status	voluntary -SE	voluntary -CR		voluntary -FSA	
Risk Assessment					
Danger to Self (WDL)	WDL -SE	WDL -CR	WDL -FSA		WDL -SE
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -SE				no suicidal ideation or behavior indicators observed or expressed -SE
Keeps Self Safe	yes (describe) -SE				yes (describe) -SE
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -SE				no self-injurious ideation or behavior indicators observed or expressed -SE
Agreement not	yes (describe) -SE				yes (describe) -

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH PS Main (continued)

	08/25/16 1234	08/25/16 0000	08/24/16 2200	08/24/16 1652	08/24/16 1329
to Harm Self					SE
Danger to Others (WDL)	WDL -SE	WDL -CR			WDL -SE
	08/24/16 1100	08/24/16 0200			
Legal Status					
Legal status	voluntary -SE	voluntary -CR			
Risk Assessment					
Danger to Self (WDL)		WDL -CR			
Danger to Others (WDL)		WDL -CR			

BH Tx Plan MH IP

	08/26/16 1000	08/24/16 1000
Patient Assets/Stressors		
Patient Assets	general fund of knowledge;average or above intelligence;motivation for treatment/growth;capable of independent living;supportive family/friends;work skills;physical health;ability for insight;communication skills -DY	general fund of knowledge;average or above intelligence;motivation for treatment/growth;capable of independent living;supportive family/friends;work skills;physical health;ability for insight;communication skills -PK
Patient Stressors	medication change or non-compliance -DY	medication change or non-compliance -PK
Discharge Planning		
Discharge Criteria	improved stabilization in mood, thinking and/or behavior;verbal commitment to aftercare and medication compliance -DY	improved stabilization in mood, thinking and/or behavior;verbal commitment to aftercare and medication compliance -PK
Recommended Discharge Plan	return to previous living environment;medication management with psychiatrist or other physician -DY	return to previous living environment;medication management with psychiatrist or other physician -PK
Pt's Acceptance	yes -DY	yes -PK

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Tx Plan MH IP (continued)

	08/26/16 1000	08/24/16 1000
of Discharge Plan		
Why Continues to Need Hospitalization	severe impairment of level of functioning;danger to self or others;medication stabilization -DY	severe impairment of level of functioning;danger to self or others;medication stabilization -PK
Estimated Length of Stay	3-5 days -DY	3-5 days -PK
Provisional DSM 5 Diagnoses		
Problem Being Addressed	refer to problem list -DY	refer to problem list -PK
Goal: Will work with social worker/treatment coordinator to develop safe discharge plan		
Goal Status	goal initiated -DY	goal initiated -PK
Goal: Will attend Occupational Therapy groups up to seven days weekly as tolerated		
Objectives	increase coping skills -DY	increase coping skills -PK
Goal Status	progress made toward outcome -DY	progress made toward outcome -PK
Treatment Plan Reviewed by		
Physician	Cruz, Schumm -DY	Cruz, Schumm -PK
Psychiatric Social Worker	Himot -DY	Himot -PK
Registered Nurse	yerby -DY	Kader -PK
Occupational Therapist	Edward -DY	Edward -PK

VS Simple

	08/26/16 1600	08/26/16 1128	08/26/16 1028	08/26/16 0900	08/26/16 0824
Vital Signs					
Temp					97.5 °F (36.4 °C) -FS
Temp src					Oral -FS
Pulse					80 -FS
BP					**(!)** 153/95 mmHg -FS
Patient Position					Sitting -FS
BP Location					Left arm -FS
BP Method					Automatic -FS
Resp					16 -FS
Oxygen Therapy					
SpO2					98 % -FS
O2 Device					room air -FS
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale)				

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

VS Simple (continued)

	08/26/16 1600	08/26/16 1128	08/26/16 1028	08/26/16 0900	08/26/16 0824
	-MA				
(POSS) Pasero Opioid-Induced Sed Scale			1 - Awake and alert -SH		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -MA		4 -SH	0 -SH	0 -FS
Pain Rating (0-10): Activity	0 -MA		4 -SH	0 -SH	
Comfort/Acceptable Pain Level				3 -SH	
Pain Body Location			back -SH		
Pain Quality			aching -SH		
Pain Management Interventions			single medication modality -SH		
Response to Interventions		relief -SH			

	08/26/16 0200	08/25/16 1600	08/25/16 1533	08/25/16 1234	08/25/16 0800
Vital Signs					
Temp			98.6 °F (37 °C) -AS		98.2 °F (36.8 °C) -AP
Pulse			85 -AS		66 -AP
BP			134/74 mmHg -AS		96/51 mmHg -AP
Patient Position			Sitting -AS		
BP Location			Right arm -AS		
Resp			16 -AS		17 -AP
Oxygen Therapy					
SpO2					98 % -AP
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -CR	number (Numeric Rating Pain Scale) -EM		number (Numeric Rating Pain Scale) -SE	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -CR	0 -EM		0 -SE	
Pain Rating (0-10): Activity		0 -EM		0 -SE	
Comfort/Acceptable Pain Level		3 -EM			
Patient Observation					
Observations	q30 -CR	q30 -EM		q30 -SE	

	08/25/16 0000	08/24/16 1652	08/24/16 1100	08/24/16 0900	08/24/16 0200
Vital Signs					
Temp		98.1 °F (36.7 °C) -FSA		98.2 °F (36.8 °C) -PK	
Temp src		Oral -FSA		Oral -PK	

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

VS Simple (continued)

	08/25/16 0000	08/24/16 1652	08/24/16 1100	08/24/16 0900	08/24/16 0200
Pulse		83 -FSA		87 -PK	
Pulse Source		Oximetry;Right;Brachial -FSA		Brachial -PK	
BP		123/73 mmHg -FSA		132/87 mmHg -PK	
Patient Position		Sitting -FSA		Sitting -PK	
BP Location		Right arm -FSA		Left arm -PK	
BP Method		Automatic -FSA		Automatic -PK	
Resp		17 -FSA		16 -PK	
Orthostatic BP Ordered?				No -PK	
Oxygen Therapy					
SpO2		98 % -FSA		95 % -PK	
O2 Device		room air -FSA		room air -PK	
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -CR	number (Numeric Rating Pain Scale) -FSA		number (Numeric Rating Pain Scale) -PK	number (Numeric Rating Pain Scale) -CR
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -CR	0 -FSA		0 -PK	0 -CR
Pain Rating (0-10): Activity		0 -FSA		0 -PK	
Comfort/Acceptable Pain Level				0 -PK	
Patient Observation					
Observations	q30 -CR	q30 -FSA	q30 -SE		q30 -CR

VS Simple

	08/26/16 1600	08/26/16 1128	08/26/16 1028	08/26/16 0900	08/26/16 0824
Vital Signs					
Temp					97.5 °F (36.4 °C) -FS
Temp src					Oral -FS
Pulse					80 -FS
BP					**(!)** 153/95 mmHg -FS
Patient Position					Sitting -FS
BP Location					Left arm -FS
BP Method					Automatic -FS
Resp					16 -FS
Oxygen Therapy					
SpO2					98 % -FS
O2 Device					room air -FS
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -MA				
Pain Assessment: Number Scale (0-10)					

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

VS Simple (continued)

	08/26/16 1600	08/26/16 1128	08/26/16 1028	08/26/16 0900	08/26/16 0824
Pain Rating (0-10): Rest	0 -MA		4 -SH	0 -SH	0 -FS
Pain Rating (0-10): Activity	0 -MA		4 -SH	0 -SH	
Comfort/Acceptable Pain Level				3 -SH	
Pain Body Location			back -SH		
Pain Quality			aching -SH		
Pain Management Interventions			single medication modality -SH		
Response to Interventions		relief -SH			
	08/26/16 0200	08/25/16 1600	08/25/16 1533	08/25/16 1234	08/25/16 0800
Vital Signs					
Temp			98.6 °F (37 °C) -AS		98.2 °F (36.8 °C) -AP
Pulse			85 -AS		66 -AP
BP			134/74 mmHg -AS		96/51 mmHg -AP
Patient Position			Sitting -AS		
BP Location			Right arm -AS		
Resp			16 -AS		17 -AP
Oxygen Therapy					
SpO2					98 % -AP
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -CR	number (Numeric Rating Pain Scale) -EM		number (Numeric Rating Pain Scale) -SE	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -CR	0 -EM		0 -SE	
Pain Rating (0-10): Activity		0 -EM		0 -SE	
Comfort/Acceptable Pain Level		3 -EM			
Patient Observation					
Observations	q30 -CR	q30 -EM		q30 -SE	
	08/25/16 0000	08/24/16 1652	08/24/16 1100	08/24/16 0900	08/24/16 0200
Vital Signs					
Temp		98.1 °F (36.7 °C) -FSA		98.2 °F (36.8 °C) -PK	
Temp src		Oral -FSA		Oral -PK	
Pulse		83 -FSA		87 -PK	
Pulse Source		Oximetry;Right;Brachial -FSA		Brachial -PK	
BP		123/73 mmHg -FSA		132/87 mmHg -PK	
Patient Position		Sitting -FSA		Sitting -PK	

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

VS Simple (continued)

	08/25/16 0000	08/24/16 1652	08/24/16 1100	08/24/16 0900	08/24/16 0200
BP Location		Right arm -FSA		Left arm -PK	
BP Method		Automatic -FSA		Automatic -PK	
Resp		17 -FSA		16 -PK	
Orthostatic BP Ordered?				No -PK	
Oxygen Therapy					
SpO2		98 % -FSA		95 % -PK	
O2 Device		room air -FSA		room air -PK	
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -CR	number (Numeric Rating Pain Scale) -FSA		number (Numeric Rating Pain Scale) -PK	number (Numeric Rating Pain Scale) -CR
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -CR	0 -FSA		0 -PK	0 -CR
Pain Rating (0-10): Activity		0 -FSA		0 -PK	
Comfort/Acceptable Pain Level				0 -PK	
Patient Observation					
Observations	q30 -CR	q30 -FSA	q30 -SE		q30 -CR

Pain Scales

	08/26/16 1600	08/26/16 1128	08/26/16 1028	08/26/16 0900	08/26/16 0824
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -MA				
(POSS) Pasero Opioid-Induced Sed Scale			1 - Awake and alert -SH		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -MA		4 -SH	0 -SH	0 -FS
Pain Rating (0-10): Activity	0 -MA		4 -SH	0 -SH	
Comfort/Acceptable Pain Level				3 -SH	
Pain Body Location			back -SH		
Pain Quality			aching -SH		
Pain Management Interventions			single medication modality -SH		
Response to Interventions		relief -SH			

	08/26/16 0200	08/25/16 1600	08/25/16 1234	08/25/16 0000	08/24/16 1652
Pain/Comfort/Sleep					
Preferred Pain	number (Numeric	number (Numeric	number (Numeric	number (Numeric	number

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

Pain Scales (continued)

	08/26/16 0200	08/25/16 1600	08/25/16 1234	08/25/16 0000	08/24/16 1652
Scale	Rating Pain Scale) -CR	Rating Pain Scale) -EM	Rating Pain Scale) -SE	Rating Pain Scale) -CR	(Numeric Rating Pain Scale) -FSA
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -CR	0 -EM	0 -SE	0 -CR	0 -FSA
Pain Rating (0-10): Activity		0 -EM	0 -SE		0 -FSA
Comfort/Acceptable Pain Level		3 -EM			

	08/24/16 0900	08/24/16 0200
Pain/Comfort/Sleep		
Preferred Pain Scale	number (Numeric Rating Pain Scale) -PK	number (Numeric Rating Pain Scale) -CR
Pain Assessment: Number Scale (0-10)		
Pain Rating (0-10): Rest	0 -PK	0 -CR
Pain Rating (0-10): Activity	0 -PK	
Comfort/Acceptable Pain Level	0 -PK	

Pain Reassessment

	08/26/16 1600	08/26/16 1128	08/26/16 1028	08/26/16 0900	08/26/16 0824
Pain/Comfort/Sleep					
(POSS) Pasero Opioid-Induced Sed Scale			1 - Awake and alert -SH		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -MA		4 -SH	0 -SH	0 -FS
Pain Rating (0-10): Activity	0 -MA		4 -SH	0 -SH	
Comfort/Acceptable Pain Level				3 -SH	
Pain Body Location			back -SH		
Pain Quality			aching -SH		
Pain Management Interventions			single medication modality -SH		
Response to Interventions		relief -SH			
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -MA				

	08/26/16 0200	08/25/16 1600	08/25/16 1234	08/25/16 0000	08/24/16 1652
Pain Assessment: Number Scale (0-10)					

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

Pain Reassessment (continued)

	08/26/16 0200	08/25/16 1600	08/25/16 1234	08/25/16 0000	08/24/16 1652
Pain Rating (0-10): Rest	0 -CR	0 -EM	0 -SE	0 -CR	0 -FSA
Pain Rating (0-10): Activity		0 -EM	0 -SE		0 -FSA
Comfort/Acceptable Pain Level		3 -EM			
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -CR	number (Numeric Rating Pain Scale) -EM	number (Numeric Rating Pain Scale) -SE	number (Numeric Rating Pain Scale) -CR	number (Numeric Rating Pain Scale) -FSA

	08/24/16 0900	08/24/16 0200
Pain Assessment: Number Scale (0-10)		
Pain Rating (0-10): Rest	0 -PK	0 -CR
Pain Rating (0-10): Activity	0 -PK	
Comfort/Acceptable Pain Level	0 -PK	
Pain/Comfort		
Preferred Pain Scale	number (Numeric Rating Pain Scale) -PK	number (Numeric Rating Pain Scale) -CR

BH Daily Assess

	08/26/16 1650	08/26/16 1600	08/26/16 1300	08/26/16 1128	08/26/16 1028
Legal Status					
Legal status		voluntary -MA			
Pain/Comfort					
Preferred Pain Scale		number (Numeric Rating Pain Scale) -MA			
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -MA			4 -SH
Pain Rating (0-10): Activity		0 -MA			4 -SH
Pain Body Location					back -SH
Pain Quality					aching -SH
Pain Management Interventions					single medication modality -SH
Response to Interventions				relief -SH	
Skin WDL					
Skin WDL		WDL -MA			
HEENT					
HEENT WDL		WDL -MA			
Fall Risk Assessment					

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Daily Assess (continued)

	08/26/16 1650	08/26/16 1600	08/26/16 1300	08/26/16 1128	08/26/16 1028
Fall Risk Indicators		3-->polypharmacy -MA			
Fall Risk Score		3 -MA			
Patient Rights Denials					
Rights Denied or Restrictions Imposed		no -MA			
Precautions/Isolation					
Precautions (displays in banner)		None -MA			
Precautions Interventions					
Interventions Performed		yes -MA			
Level of Observation		every 30 minutes -MA			
Activities of Daily Living					
ADL's (WDL)		WDL -MA			
Daily Sleep					
Daily Sleep (WDL)		WDL -MA			
Daily Nutrition					
Daily Nutrition (WDL)		WDL -MA			
Mental Status					
Orientation		oriented x 4 -MA			
Level Of Consciousness		alert -MA			
General Appearance WDL		WDL except -MA			
General Appearance		body odor;unkempt -MA			
Mood		anxious;hopeful -MA			
Mood/Behavior/ Affect WDL		WDL -MA			
Behavior (WDL)		WDL -MA			
Mood/Behavior		appropriate -MA			
Speech		WDL -MA			
Speech		clear -MA			
Judgment and Insight		insight appropriate to situation -MA			
Insight		fair -MA			
Concentration		fair -MA			
Memory Deficit		intact -MA			
Thought (WDL)		WDL -MA			
Coping/Psychosocial Response					
Observed		accepting;anxious;			

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Daily Assess (continued)

	08/26/16 1650	08/26/16 1600	08/26/16 1300	08/26/16 1128	08/26/16 1028
Emotional State		cooperative;hopeful -MA			
Verbalized Emotional State		acceptance;anxiety;hopefulness -MA			
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -MA	patient -MA			
Psychiatric Symptoms					
Anxiety Symptoms (WDL)		WDL except -MA			
Anxiety Symptoms		generalized -MA			
Manic Symptoms (WDL)		WDL -MA			
Psychotic symptoms (WDL)		WDL -MA			
Danger to Self					
Danger to Self (WDL)		WDL -MA			
Danger to Self		no suicidal ideation or behavior indicators observed or expressed -MA			
Assessment Type					
Assessment timing		Discharge -MA	Discharge -SH		
Suicide Risk Assessment- Mood					
Agitation		None -MA	None -SH		
Anxiety or Fearfulness		Low -MA	None -SH		
Loss of Pleasure or Interest		None -MA	None -SH		
Depression or Sadness		Low -MA	None -SH		
Suicide Plan for Today		None -MA	None -SH		
Hopeless or Overwhelmed		None -MA	None -SH		
Suicide Risk Assessment - Thinking					
Sleep Disturbances		None -MA	None -SH		
Cognition Problems		None -MA	None -SH		
Psychotic		None -MA	None -SH		

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Daily Assess (continued)

	08/26/16 1650	08/26/16 1600	08/26/16 1300	08/26/16 1128	08/26/16 1028
Symptoms					
Suicide Risk Assessment- Behavior					
Withholding Information		None -MA	None -SH		
Resistance to Treatment		None -MA	None -SH		
Impulsivity		None -MA	None -SH		
Aggressive towards self/others		None -MA	None -SH		
Suicide Risk Assessment- Health					
Pain, real or perceived		Low -MA	Moderate -SH		
Perceived Loss of Health		Low -MA	Moderate -SH		
Suicide Risk Assessment- Discharge (for hospitalized patients only)					
Suicide Plan outside of Hospital		Moderate -MA	None -SH		
Lack of Support if Discharged		None -MA	None -SH		
Pessimism if Discharged		None -MA	None -SH		
Suicidal Inquiry					
Suicide Ideation for Today		None -MA	None -SH		
Behavior congruent with Verbal and Non-Verbal			Yes -SH		
Assessment of Current Suicide Risk					
Assessment of Current Suicide Risk		Low -MA	Low -SH		
Tentative Treatment Plan					
Protective Factors to Strengthen		A healthy fear of risky behaviors and pain -MA			
Danger to Others					
Danger to Others (WDL)		WDL -MA			

	08/26/16 0900	08/26/16 0824	08/26/16 0600	08/26/16 0200	08/25/16 1641
Legal Status					
Legal status	voluntary -SH			voluntary -CR	
Vital Signs					
Temp		97.5 °F (36.4 °C) -FS			
Temp src		Oral -FS			
Pulse		80 -FS			

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Daily Assess (continued)

	08/26/16 0900	08/26/16 0824	08/26/16 0600	08/26/16 0200	08/25/16 1641
BP		**(!)** 153/95 mmHg -FS			
Patient Position		Sitting -FS			
BP Location		Left arm -FS			
BP Method		Automatic -FS			
Resp		16 -FS			
Patient Observation					
Observations				q30 -CR	
Oxygen Therapy					
SpO2		98 % -FS			
O2 Device		room air -FS			
Pain/Comfort					
Preferred Pain Scale				number (Numeric Rating Pain Scale) -CR	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -SH	0 -FS		0 -CR	
Pain Rating (0-10): Activity	0 -SH				
Comfort/Acceptable Pain Level	3 -SH				
Skin WDL					
Skin WDL	WDL -SH			WDL -CR	
Fall Risk Assessment					
Fall Risk Indicators				3-->polypharmacy -CR	
Fall Risk Score				3 -CR	
Patient Rights Denials					
Rights Denied or Restrictions Imposed	no -SH			no -CR	
Precautions/Isolation					
Precautions (displays in banner)	None -SH			None -CR	
Precautions Interventions					
Interventions Performed	yes -SH			yes -CR	
Level of Observation	every 30 minutes -SH			every 30 minutes -CR	
Activities of Daily Living					
ADL's (WDL)	WDL -SH				
Daily Sleep					
Daily Hours of Sleep			7.0 -CR		
Mental Status					
Orientation	oriented x 4 -SH				
Level Of	alert -SH			asleep -CR	

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Daily Assess (continued)

	08/26/16 0900	08/26/16 0824	08/26/16 0600	08/26/16 0200	08/25/16 1641
Consciousness					
General Appearance WDL	WDL except -SH				
General Appearance	body odor;unkempt -SH				
Mood	anxious;hopeful -SH				
Mood/Behavior/ Affect WDL	WDL -SH				
Behavior (WDL)	WDL -SH				
Mood/Behavior	appropriate -SH				
Speech	WDL -SH				
Speech	clear -SH				
Judgment and Insight	insight appropriate to situation -SH				
Insight	fair -SH				
Concentration	fair -SH				
Memory Deficit	intact -SH				
Thought (WDL)	WDL -SH				
Coping/Psychosocial Response					
Observed Emotional State	accepting;anxious; cooperative;hopeful -SH				
Verbalized Emotional State	acceptance;anxiety;hopefulness -SH				
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -SH				patient -EM
Supportive Measures	decision-making supported -SH				
Family/Support System Care	self-care encouraged -SH				
Psychiatric Symptoms					
Anxiety Symptoms (WDL)	WDL except -SH				
Anxiety Symptoms	generalized -SH				
Manic Symptoms (WDL)	WDL -SH				
Psychotic symptoms (WDL)	WDL -SH				
Danger to Self					
Danger to Self (WDL)	WDL -SH			WDL -CR	
Danger to Self	-- -SH				

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Daily Assess (continued)

	08/26/16 0900	08/26/16 0824	08/26/16 0600	08/26/16 0200	08/25/16 1641
Self-Injurious Behavior	-- -SH				
Self-injury Description	-- -SH				
Agreement not to Harm Self	-- -SH				
Danger to Others					
Danger to Others (WDL)	WDL -SH			WDL -CR	
	08/25/16 1600	08/25/16 1533	08/25/16 1358	08/25/16 1234	08/25/16 0800
Legal Status					
Legal status	voluntary -EM			voluntary -SE	
Vital Signs					
Temp		98.6 °F (37 °C) -AS			98.2 °F (36.8 °C) -AP
Pulse		85 -AS			66 -AP
BP		134/74 mmHg -AS			96/51 mmHg -AP
Patient Position		Sitting -AS			
BP Location		Right arm -AS			
Resp		16 -AS			17 -AP
Patient Observation					
Observations	q30 -EM			q30 -SE	
Oxygen Therapy					
SpO2					98 % -AP
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -EM			number (Numeric Rating Pain Scale) -SE	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -EM			0 -SE	
Pain Rating (0-10): Activity	0 -EM			0 -SE	
Comfort/Acceptable Pain Level	3 -EM				
Skin WDL					
Skin WDL	WDL -EM			WDL -SE	
HEENT					
HEENT WDL	WDL -EM				
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy -EM			3-->polypharmacy -SE	
Fall Risk Score	3 -EM			3 -SE	
Patient Rights Denials					
Rights Denied or Restrictions Imposed	no -EM				

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Daily Assess (continued)

	08/25/16 1600	08/25/16 1533	08/25/16 1358	08/25/16 1234	08/25/16 0800
Precautions/Isolation					
Precautions (displays in banner)	None -EM			None -SE	
Precautions Interventions					
Interventions Performed	yes -EM				
Level of Observation	every 30 minutes -EM			every 30 minutes -SE	
Activities of Daily Living					
ADL's (WDL)	WDL -EM			WDL -SE	
Daily Sleep					
Daily Sleep (WDL)	WDL -EM			WDL -SE	
Daily Nutrition					
Daily Nutrition (WDL)	WDL -EM			WDL -SE	
Mental Status					
Orientation	oriented x 4 -EM			oriented x 4 -SE	
Level Of Consciousness	alert -EM			alert -SE	
General Appearance WDL	WDL except -EM			WDL except -SE	
General Appearance	body odor;unkempt -EM			unkempt;body odor -SE	
Mood	anxious;hopeful -EM			calm;hopeful -SE	
Mood/Behavior/ Affect WDL	WDL except -EM			WDL except -SE	
Affect	restricted -EM			restricted -SE	
Behavior (WDL)	WDL except -EM			WDL except -SE	
Mood/Behavior	anxious;cooperative;restless -EM			distant/aloof -SE	
Speech	WDL -EM			WDL -SE	
Speech	clear -EM			clear -SE	
Judgment and Insight	insight appropriate to situation -EM			insight appropriate to situation -SE	
Insight	fair -EM			fair -SE	
Concentration	fair -EM			fair -SE	
Memory Deficit	intact -EM			intact -SE	
Thought (WDL)	WDL -EM			WDL -SE	
Coping/Psychosocial Response					
Observed Emotional State	accepting;anxious;cooperative;hopeful -EM			calm;hopeful -SE	
Verbalized Emotional State	acceptance;anxiety;hopefulness -EM			hopefulness -SE	
Coping/Psychosocial Response Interventions					

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Daily Assess (continued)

	08/25/16 1600	08/25/16 1533	08/25/16 1358	08/25/16 1234	08/25/16 0800
Plan Of Care Reviewed With	patient -EM		patient -SE	patient -SE	
Supportive Measures	decision-making supported -EM			self-care encouraged -SE	
Family/Support System Care	self-care encouraged -EM			self-care encouraged -SE	
Psychiatric Symptoms					
Anxiety Symptoms (WDL)	WDL except -EM			WDL -SE	
Anxiety Symptoms	generalized -EM				
Manic Symptoms (WDL)	WDL -EM			WDL -SE	
Psychotic symptoms (WDL)	WDL -EM			WDL -SE	
Danger to Self					
Danger to Self (WDL)	WDL -EM			WDL -SE	
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -EM			no suicidal ideation or behavior indicators observed or expressed -SE	
Keeps Self Safe	yes (describe) -EM			yes (describe) -SE	
Description of Suicide Plan	Denied -EM				
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -EM			no self-injurious ideation or behavior indicators observed or expressed -SE	
Self-injury Description	Denied -EM				
Agreement not to Harm Self	yes (describe) -EM			yes (describe) -SE	
Description of Agreement	verbal -EM				
Assessment Type					
Assessment timing	Shift -EM				
Assessment of contributing factors					
Assessment of Risk Factors	Deficits in social, decision, and coping skills -EM				
Assessment of Protective	Good access to health				

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Daily Assess (continued)

	08/25/16 1600	08/25/16 1533	08/25/16 1358	08/25/16 1234	08/25/16 0800
Factors	care/therapy -EM				
Danger to Others					
Danger to Others (WDL)	WDL -EM			WDL -SE	
	08/25/16 0600	08/25/16 0000	08/24/16 2200	08/24/16 1652	08/24/16 1452
Legal Status					
Legal status		voluntary -CR		voluntary -FSA	
Vital Signs					
Temp				98.1 °F (36.7 °C) -FSA	
Temp src				Oral -FSA	
Pulse				83 -FSA	
Pulse Source				Oximetry;Right;Brachial -FSA	
BP				123/73 mmHg -FSA	
Patient Position				Sitting -FSA	
BP Location				Right arm -FSA	
BP Method				Automatic -FSA	
Resp				17 -FSA	
Patient Observation					
Observations		q30 -CR		q30 -FSA	
Oxygen Therapy					
SpO2				98 % -FSA	
O2 Device				room air -FSA	
Pain/Comfort					
Preferred Pain Scale		number (Numeric Rating Pain Scale) -CR		number (Numeric Rating Pain Scale) -FSA	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -CR		0 -FSA	
Pain Rating (0-10): Activity				0 -FSA	
Skin WDL					
Skin WDL		WDL -CR		WDL -FSA	
Fall Risk Assessment					
Fall Risk Indicators		3-->polypharmacy -CR		3-->polypharmacy -FSA	
Fall Risk Score		3 -CR		3 -FSA	
Patient Rights Denials					
Rights Denied or Restrictions Imposed		no -CR		no -FSA	
Precautions/Isolation					
Precautions (displays in banner)		None -CR		None -FSA	
Precautions Interventions					

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Daily Assess (continued)

	08/25/16 0600	08/25/16 0000	08/24/16 2200	08/24/16 1652	08/24/16 1452
Interventions Performed		yes -CR		yes -FSA	
Level of Observation		every 30 minutes -CR		every 30 minutes -FSA	
Activities of Daily Living					
ADL's (WDL)				WDL -FSA	
Daily Sleep					
Daily Sleep (WDL)				WDL -FSA	
Daily Hours of Sleep	7.5 -CR				
Daily Nutrition					
Daily Nutrition (WDL)				WDL -FSA	
Mental Status					
Orientation				oriented x 4 -FSA	
Level Of Consciousness		asleep -CR		alert -FSA	
General Appearance WDL				WDL -FSA	
Mood				calm;hopeful -FSA	
Mood/Behavior/ Affect WDL				WDL except;affect -FSA	
Affect				flat -FSA	
Behavior (WDL)				WDL -FSA	
Mood/Behavior				alert;calm;cooperative -FSA	
Speech				WDL -FSA	
Speech				clear -FSA	
Judgment and Insight				insight appropriate to situation -FSA	
Insight				fair -FSA	
Concentration				fair -FSA	
Memory Deficit				intact -FSA	
Thought (WDL)				WDL -FSA	
Coping/Psychosocial Response					
Observed Emotional State			accepting;hopeful -FSA		
Verbalized Emotional State			hopefulness -FSA		
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With			patient -FSA		patient -SE
Supportive Measures			self-care encouraged -FSA		
Family/Support System Care			self-care encouraged -FSA		

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Daily Assess (continued)

	08/25/16 0600	08/25/16 0000	08/24/16 2200	08/24/16 1652	08/24/16 1452
Psychiatric Symptoms					
Anxiety Symptoms (WDL)			WDL -FSA		
Manic Symptoms (WDL)			WDL -FSA		
Psychotic symptoms (WDL)			WDL -FSA		
Danger to Self					
Danger to Self (WDL)		WDL -CR	WDL -FSA		
Danger to Others					
Danger to Others (WDL)		WDL -CR			

	08/24/16 1329	08/24/16 1100	08/24/16 0900	08/24/16 0700	08/24/16 0200
Legal Status					
Legal status		voluntary -SE			voluntary -CR
Vital Signs					
Temp			98.2 °F (36.8 °C) -PK		
Temp src			Oral -PK		
Pulse			87 -PK		
Pulse Source			Brachial -PK		
BP			132/87 mmHg -PK		
Patient Position			Sitting -PK		
BP Location			Left arm -PK		
BP Method			Automatic -PK		
Resp			16 -PK		
Orthostatic BP Ordered?			No -PK		
Patient Observation					
Observations		q30 -SE			q30 -CR
Oxygen Therapy					
SpO2			95 % -PK		
O2 Device			room air -PK		
Pain/Comfort					
Preferred Pain Scale			number (Numeric Rating Pain Scale) -PK		number (Numeric Rating Pain Scale) -CR
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest			0 -PK		0 -CR
Pain Rating (0-10): Activity			0 -PK		
Comfort/Acceptable Pain Level			0 -PK		

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Daily Assess (continued)

	08/24/16 1329	08/24/16 1100	08/24/16 0900	08/24/16 0700	08/24/16 0200
Skin WDL					
Skin WDL		WDL -SE			WDL -CR
Fall Risk Assessment					
Fall Risk Indicators		3-->polypharmacy -SE			3-->polypharmacy -CR
Fall Risk Score		3 -SE			3 -CR
Patient Rights Denials					
Rights Denied or Restrictions Imposed					no -CR
Precautions/Isolation					
Precautions (displays in banner)		None -SE			None -CR
Precautions Interventions					
Interventions Performed					yes -CR
Level of Observation		every 30 minutes -SE			every 30 minutes -CR
Self Harm Precautions		check for contraband -SE			
Activities of Daily Living					
ADL's (WDL)		WDL -SE			
Daily Sleep					
Daily Sleep (WDL)		WDL -SE			
Daily Hours of Sleep				7.5 -CR	
Daily Nutrition					
Daily Nutrition (WDL)		WDL -SE			
Mental Status					
Orientation		oriented x 4 -SE			
Level Of Consciousness		alert -SE			asleep -CR
General Appearance WDL		WDL except -SE			
General Appearance		unkempt -SE			
Mood	hopeful;isolative -SE				
Mood/Behavior/ Affect WDL	WDL except -SE				
Affect	restricted -SE				
Behavior (WDL)	WDL except -SE				
Mood/Behavior	anxious -SE				
Speech	WDL -SE				

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Daily Assess (continued)

	08/24/16 1329	08/24/16 1100	08/24/16 0900	08/24/16 0700	08/24/16 0200
Speech	clear -SE				
Judgment and Insight	insight appropriate to situation -SE				
Insight	fair -SE				
Concentration	fair -SE				
Memory Deficit	intact -SE				
Thought (WDL)	WDL -SE				
Coping/Psychosocial Response					
Observed Emotional State	hopeful -SE				
Verbalized Emotional State	hopefulness -SE				
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -SE				
Supportive Measures	self-care encouraged -SE				
Family/Support System Care	self-care encouraged -SE				
Psychiatric Symptoms					
Anxiety Symptoms (WDL)	WDL -SE				
Manic Symptoms (WDL)	WDL -SE				
Psychotic symptoms (WDL)	WDL -SE				
Danger to Self					
Danger to Self (WDL)	WDL -SE				WDL -CR
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -SE				
Keeps Self Safe	yes (describe) -SE				
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -SE				
Agreement not to Harm Self	yes (describe) -SE				
Danger to Others					
Danger to Others (WDL)	WDL -SE				WDL -CR

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

Risk Screening

	08/26/16 1600	08/26/16 0900	08/26/16 0200	08/25/16 1600	08/25/16 1234
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy -MA		3-->polypharmacy -CR	3-->polypharmacy -EM	3-->polypharmacy -SE
Fall Risk Score	3 -MA		3 -CR	3 -EM	3 -SE
Danger to Self					
Danger to Self (WDL)	WDL -MA	WDL -SH	WDL -CR	WDL -EM	WDL -SE
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -MA	-- -SH		no suicidal ideation or behavior indicators observed or expressed -EM	no suicidal ideation or behavior indicators observed or expressed -SE
Keeps Self Safe				yes (describe) -EM	yes (describe) -SE
Description of Suicide Plan				Denied -EM	
Self-Injurious Behavior		-- -SH		no self-injurious ideation or behavior indicators observed or expressed -EM	no self-injurious ideation or behavior indicators observed or expressed -SE
Self-injury Description		-- -SH		Denied -EM	
Agreement not to Harm Self		-- -SH		yes (describe) -EM	yes (describe) -SE
Description of Agreement				verbal -EM	
Danger to Others					
Danger to Others (WDL)	WDL -MA	WDL -SH	WDL -CR	WDL -EM	WDL -SE

	08/25/16 0000	08/24/16 2200	08/24/16 1652	08/24/16 1329	08/24/16 1100
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy -CR		3-->polypharmacy -FSA		3-->polypharmacy -SE
Fall Risk Score	3 -CR		3 -FSA		3 -SE
Danger to Self					
Danger to Self (WDL)	WDL -CR	WDL -FSA		WDL -SE	
Danger to Self				no suicidal ideation or behavior indicators observed or expressed -SE	
Keeps Self Safe				yes (describe) -SE	
Self-Injurious Behavior				no self-injurious ideation or	

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

Risk Screening (continued)

	08/25/16 0000	08/24/16 2200	08/24/16 1652	08/24/16 1329	08/24/16 1100
				behavior indicators observed or expressed -SE	
Agreement not to Harm Self				yes (describe) -SE	
Danger to Others					
Danger to Others (WDL)	WDL -CR			WDL -SE	

	08/24/16 0200
Fall Risk Assessment	
Fall Risk Indicators	3-->polypharmacy -CR
Fall Risk Score	3 -CR
Danger to Self	
Danger to Self (WDL)	WDL -CR
Danger to Others	
Danger to Others (WDL)	WDL -CR

BH Initial Eval

	08/26/16 1600	08/26/16 1300	08/26/16 1128	08/26/16 1028	08/26/16 0900
Legal Status					
Legal status	voluntary -MA				voluntary -SH
Evidence of Mood Disorders					
Manic Symptoms (WDL)	WDL -MA				WDL -SH
Evidence of Anxiety Disorders					
Anxiety Symptoms (WDL)	WDL except -MA				WDL except -SH
Anxiety Symptoms	generalized -MA				generalized -SH
Danger to Self					
Danger to Self (WDL)	WDL -MA				WDL -SH
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -MA				-- -SH
Self-Injurious Behavior					-- -SH
Self-injury Description					-- -SH
Agreement not to Harm Self					-- -SH
Assessment Type					

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Initial Eval (continued)

	08/26/16 1600	08/26/16 1300	08/26/16 1128	08/26/16 1028	08/26/16 0900
Assessment timing	Discharge -MA	Discharge -SH			
Suicide Risk Assessment- Mood					
Agitation	None -MA	None -SH			
Anxiety or Fearfulness	Low -MA	None -SH			
Loss of Pleasure or Interest	None -MA	None -SH			
Depression or Sadness	Low -MA	None -SH			
Suicide Plan for Today	None -MA	None -SH			
Hopeless or Overwhelmed	None -MA	None -SH			
Suicide Risk Assessment - Thinking					
Sleep Disturbances	None -MA	None -SH			
Cognition Problems	None -MA	None -SH			
Psychotic Symptoms	None -MA	None -SH			
Suicide Risk Assessment- Behavior					
Withholding Information	None -MA	None -SH			
Resistance to Treatment	None -MA	None -SH			
Impulsivity	None -MA	None -SH			
Aggressive towards self/others	None -MA	None -SH			
Suicide Risk Assessment- Health					
Pain, real or perceived	Low -MA	Moderate -SH			
Perceived Loss of Health	Low -MA	Moderate -SH			
Suicide Risk Assessment- Discharge (for hospitalized patients only)					
Suicide Plan outside of Hospital	Moderate -MA	None -SH			
Lack of Support if Discharged	None -MA	None -SH			
Pessimism if Discharged	None -MA	None -SH			
Suicidal Inquiry					
Suicide Ideation for Today	None -MA	None -SH			
Behavior congruent with		Yes -SH			

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Initial Eval (continued)

	08/26/16 1600	08/26/16 1300	08/26/16 1128	08/26/16 1028	08/26/16 0900
Verbal and Non-Verbal					
Assessment of Current Suicide Risk					
Assessment of Current Suicide Risk	Low -MA	Low -SH			
Tentative Treatment Plan					
Protective Factors to Strengthen	A healthy fear of risky behaviors and pain -MA				
Danger to Others					
Danger to Others (WDL)	WDL -MA				WDL -SH
Mental Status					
Level Of Consciousness	alert -MA				alert -SH
Orientation	oriented x 4 -MA				oriented x 4 -SH
General Appearance WDL	WDL except -MA				WDL except -SH
General Appearance	body odor;unkempt -MA				body odor;unkempt -SH
Mood/Behavior/ Affect WDL	WDL -MA				WDL -SH
Mood/Behavior	appropriate -MA				appropriate -SH
Speech	WDL -MA				WDL -SH
Speech	clear -MA				clear -SH
Judgment and Insight	insight appropriate to situation -MA				insight appropriate to situation -SH
Insight	fair -MA				fair -SH
Concentration	fair -MA				fair -SH
Memory Deficit	intact -MA				intact -SH
Behavior (WDL)	WDL -MA				WDL -SH
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -MA				
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -MA			4 -SH	0 -SH
Pain Rating (0-10): Activity	0 -MA			4 -SH	0 -SH
Comfort/Acceptable Pain Level					3 -SH
Pain Body Location				back -SH	
Pain Quality				aching -SH	

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Initial Eval (continued)

	08/26/16 1600	08/26/16 1300	08/26/16 1128	08/26/16 1028	08/26/16 0900
Pain Management Interventions				single medication modality -SH	
Response to Interventions			relief -SH		
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy -MA				
Fall Risk Score	3 -MA				
	08/26/16 0824	08/26/16 0600	08/26/16 0200	08/25/16 1600	08/25/16 1533
Legal Status					
Legal status			voluntary -CR	voluntary -EM	
Evidence of Mood Disorders					
Manic Symptoms (WDL)				WDL -EM	
Evidence of Anxiety Disorders					
Anxiety Symptoms (WDL)				WDL except -EM	
Anxiety Symptoms				generalized -EM	
Danger to Self					
Danger to Self (WDL)			WDL -CR	WDL -EM	
Danger to Self				no suicidal ideation or behavior indicators observed or expressed -EM	
Keeps Self Safe				yes (describe) -EM	
Description of Suicide Plan				Denied -EM	
Self-Injurious Behavior				no self-injurious ideation or behavior indicators observed or expressed -EM	
Self-injury Description				Denied -EM	
Agreement not to Harm Self				yes (describe) -EM	
Description of Agreement				verbal -EM	
Assessment Type					
Assessment timing				Shift -EM	
Assessment of contributing factors					
Assessment of				Deficits in social,	

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Initial Eval (continued)

	08/26/16 0824	08/26/16 0600	08/26/16 0200	08/25/16 1600	08/25/16 1533
Risk Factors				decision, and coping skills -EM	
Assessment of Protective Factors				Good access to health care/therapy -EM	
Danger to Others					
Danger to Others (WDL)			WDL -CR	WDL -EM	
Mental Status					
Level Of Consciousness			asleep -CR	alert -EM	
Orientation				oriented x 4 -EM	
General Appearance WDL				WDL except -EM	
General Appearance				body odor;unkempt -EM	
Mood/Behavior/ Affect WDL				WDL except -EM	
Affect				restricted -EM	
Mood/Behavior				anxious;cooperative;restless -EM	
Speech				WDL -EM	
Speech				clear -EM	
Judgment and Insight				insight appropriate to situation -EM	
Insight				fair -EM	
Concentration				fair -EM	
Memory Deficit				intact -EM	
Behavior (WDL)				WDL except -EM	
Sleep/Rest/Relaxation					
Daily Hours of Sleep		7.0 -CR			
Vital Signs					
Temp	97.5 °F (36.4 °C) -FS				98.6 °F (37 °C) -AS
Pulse	80 -FS				85 -AS
BP	**(!)** 153/95 mmHg -FS				134/74 mmHg -AS
Patient Position	Sitting -FS				Sitting -AS
Resp	16 -FS				16 -AS
Pain/Comfort					
Preferred Pain Scale			number (Numeric Rating Pain Scale) -CR	number (Numeric Rating Pain Scale) -EM	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -FS		0 -CR	0 -EM	
Pain Rating (0-				0 -EM	

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Initial Eval (continued)

	08/26/16 0824	08/26/16 0600	08/26/16 0200	08/25/16 1600	08/25/16 1533
10): Activity					
Comfort/Acceptable Pain Level				3 -EM	
Fall Risk Assessment					
Fall Risk Indicators			3-->polypharmacy -CR	3-->polypharmacy -EM	
Fall Risk Score			3 -CR	3 -EM	
	08/25/16 1234	08/25/16 0800	08/25/16 0600	08/25/16 0000	08/24/16 2200
Legal Status					
Legal status	voluntary -SE			voluntary -CR	
Evidence of Mood Disorders					
Manic Symptoms (WDL)	WDL -SE				WDL -FSA
Evidence of Anxiety Disorders					
Anxiety Symptoms (WDL)	WDL -SE				WDL -FSA
Danger to Self					
Danger to Self (WDL)	WDL -SE			WDL -CR	WDL -FSA
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -SE				
Keeps Self Safe	yes (describe) -SE				
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -SE				
Agreement not to Harm Self	yes (describe) -SE				
Danger to Others					
Danger to Others (WDL)	WDL -SE			WDL -CR	
Mental Status					
Level Of Consciousness	alert -SE			asleep -CR	
Orientation	oriented x 4 -SE				
General Appearance WDL	WDL except -SE				
General Appearance	unkempt;body odor -SE				
Mood/Behavior/Affect WDL	WDL except -SE				
Affect	restricted -SE				

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Initial Eval (continued)

	08/25/16 1234	08/25/16 0800	08/25/16 0600	08/25/16 0000	08/24/16 2200
Mood/Behavior	distant/aloof -SE				
Speech	WDL -SE				
Speech	clear -SE				
Judgment and Insight	insight appropriate to situation -SE				
Insight	fair -SE				
Concentration	fair -SE				
Memory Deficit	intact -SE				
Behavior (WDL)	WDL except -SE				
Sleep/Rest/Relaxation					
Daily Hours of Sleep			7.5 -CR		
Vital Signs					
Temp		98.2 °F (36.8 °C) -AP			
Pulse		66 -AP			
BP		96/51 mmHg -AP			
Resp		17 -AP			
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -SE			number (Numeric Rating Pain Scale) -CR	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -SE			0 -CR	
Pain Rating (0-10): Activity	0 -SE				
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy -SE			3-->polypharmacy -CR	
Fall Risk Score	3 -SE			3 -CR	

	08/24/16 1652	08/24/16 1329	08/24/16 1100	08/24/16 0900	08/24/16 0700
Legal Status					
Legal status	voluntary -FSA		voluntary -SE		
Evidence of Mood Disorders					
Manic Symptoms (WDL)		WDL -SE			
Evidence of Anxiety Disorders					
Anxiety Symptoms (WDL)		WDL -SE			
Danger to Self					
Danger to Self (WDL)		WDL -SE			
Danger to Self		no suicidal ideation or behavior indicators observed or			

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Initial Eval (continued)

	08/24/16 1652	08/24/16 1329	08/24/16 1100	08/24/16 0900	08/24/16 0700
		expressed -SE			
Keeps Self Safe		yes (describe) -SE			
Self-Injurious Behavior		no self-injurious ideation or behavior indicators observed or expressed -SE			
Agreement not to Harm Self		yes (describe) -SE			
Danger to Others					
Danger to Others (WDL)		WDL -SE			
Mental Status					
Level Of Consciousness	alert -FSA		alert -SE		
Orientation	oriented x 4 -FSA		oriented x 4 -SE		
General Appearance WDL	WDL -FSA		WDL except -SE		
General Appearance			unkempt -SE		
Mood/Behavior/ Affect WDL	WDL except;affect -FSA	WDL except -SE			
Affect	flat -FSA	restricted -SE			
Mood/Behavior	alert;calm;cooperative -FSA	anxious -SE			
Speech	WDL -FSA	WDL -SE			
Speech	clear -FSA	clear -SE			
Judgment and Insight	insight appropriate to situation -FSA	insight appropriate to situation -SE			
Insight	fair -FSA	fair -SE			
Concentration	fair -FSA	fair -SE			
Memory Deficit	intact -FSA	intact -SE			
Behavior (WDL)	WDL -FSA	WDL except -SE			
Sleep/Rest/Relaxation					
Daily Hours of Sleep					7.5 -CR
Vital Signs					
Temp	98.1 °F (36.7 °C) -FSA			98.2 °F (36.8 °C) -PK	
Pulse	83 -FSA			87 -PK	
BP	123/73 mmHg -FSA			132/87 mmHg -PK	
Patient Position	Sitting -FSA			Sitting -PK	
Resp	17 -FSA			16 -PK	
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -FSA			number (Numeric Rating Pain Scale) -PK	
Pain Assessment: Number Scale (0-10)					

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH Initial Eval (continued)

	08/24/16 1652	08/24/16 1329	08/24/16 1100	08/24/16 0900	08/24/16 0700
Pain Rating (0-10): Rest	0 -FSA			0 -PK	
Pain Rating (0-10): Activity	0 -FSA			0 -PK	
Comfort/Acceptable Pain Level				0 -PK	
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy -FSA		3-->polypharmacy -SE		
Fall Risk Score	3 -FSA		3 -SE		

	08/24/16 0200
Legal Status	
Legal status	voluntary -CR
Danger to Self	
Danger to Self (WDL)	WDL -CR
Danger to Others	
Danger to Others (WDL)	WDL -CR
Mental Status	
Level Of Consciousness	asleep -CR
Pain/Comfort	
Preferred Pain Scale	number (Numeric Rating Pain Scale) -CR
Pain Assessment: Number Scale (0-10)	
Pain Rating (0-10): Rest	0 -CR
Fall Risk Assessment	
Fall Risk Indicators	3-->polypharmacy -CR
Fall Risk Score	3 -CR

BH OT Observations NAV IP

	08/26/16 1600	08/26/16 0900	08/25/16 1600	08/25/16 1234	08/24/16 1652
General Observations					
Mood/Behavior/Affect WDL	WDL -MA	WDL -SH	WDL except -EM	WDL except -SE	WDL except;affect -FSA
Affect			restricted -EM	restricted -SE	flat -FSA
Mood	anxious;hopeful -MA	anxious;hopeful -SH	anxious;hopeful -EM	calm;hopeful -SE	calm;hopeful -FSA
Orientation	oriented x 4 -MA	oriented x 4 -SH	oriented x 4 -EM	oriented x 4 -SE	oriented x 4 -FSA
Speech	clear -MA	clear -SH	clear -EM	clear -SE	clear -FSA
General Appearance WDL	WDL except -MA	WDL except -SH	WDL except -EM	WDL except -SE	WDL -FSA
General	body	body	body	unkempt;body	

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

BH OT Observations NAV IP (continued)

	08/26/16 1600	08/26/16 0900	08/25/16 1600	08/25/16 1234	08/24/16 1652
Appearance	odor;unkempt -MA	odor;unkempt -SH	odor;unkempt -EM	odor -SE	
	08/24/16 1329	08/24/16 1100			
General Observations					
Mood/Behavior/Affect WDL	WDL except -SE				
Affect	restricted -SE				
Mood	hopeful;isolative -SE				
Orientation		oriented x 4 -SE			
Speech	clear -SE				
General Appearance WDL		WDL except -SE			
General Appearance		unkempt -SE			

Adult Care Sum F14

	08/26/16 1650	08/26/16 1600	08/26/16 1128	08/26/16 1028	08/26/16 0900
Plan of Care Review					
Plan Of Care Reviewed With	patient -MA	patient -MA			patient -SH
Pain/Comfort/Sleep					
Preferred Pain Scale		number (Numeric Rating Pain Scale) -MA			
(POSS) Pasero Opioid-Induced Sed Scale				1 - Awake and alert -SH	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -MA		4 -SH	0 -SH
Pain Rating (0-10): Activity		0 -MA		4 -SH	0 -SH
Comfort/Acceptable Pain Level					3 -SH
Pain Body Location				back -SH	
Pain Quality				aching -SH	
Pain Management Interventions				single medication modality -SH	
Response to Interventions			relief -SH		
Coping/Psychosocial					
Observed Emotional State		accepting;anxious;cooperative;hopeful -MA			accepting;anxious;cooperative;hopeful -SH
Verbalized Emotional State		acceptance;anxiety;hopefulness -MA			acceptance;anxiety;hopefulness

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/26/16 1650	08/26/16 1600	08/26/16 1128	08/26/16 1028	08/26/16 0900
Coping Strategies					
Supportive Measures					decision-making supported -SH
Family/Support System Care					self-care encouraged -SH
HEENT					
HEENT WDL		WDL -MA			
Cognitive					
Memory Deficit		intact -MA			intact -SH
Neuro					
Level Of Consciousness		alert -MA			alert -SH
Orientation		oriented x 4 -MA			oriented x 4 -SH
General Appearance					
General Appearance WDL		WDL except -MA			WDL except -SH
General Appearance		body odor;unkempt -MA			body odor;unkempt -SH
Mood/Behavior/Affect					
Mood/Behavior/ Affect WDL		WDL -MA			WDL -SH
Mood/Behavior		appropriate -MA			appropriate -SH
Speech					
Speech		WDL -MA			WDL -SH
Speech		clear -MA			clear -SH
Thought Process					
Judgment and Insight		insight appropriate to situation -MA			insight appropriate to situation -SH
Skin					
Skin WDL		WDL -MA			WDL -SH
Safety Interventions					
Precautions (displays in banner)		None -MA			None -SH
Fall Risk Indicators		3-->polypharmacy -MA			
Fall Risk Score		3 -MA			

	08/26/16 0824	08/26/16 0600	08/26/16 0200	08/25/16 1641	08/25/16 1600
Plan of Care Review					
Plan Of Care Reviewed With				patient -EM	patient -EM
Pain/Comfort/Sleep					
Preferred Pain Scale			number (Numeric Rating Pain Scale) -CR		number (Numeric Rating Pain Scale) -EM

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/26/16 0824	08/26/16 0600	08/26/16 0200	08/25/16 1641	08/25/16 1600
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -FS		0 -CR		0 -EM
Pain Rating (0-10): Activity					0 -EM
Comfort/Acceptable Pain Level					3 -EM
Sleep/Rest/Relaxation					
Daily Hours of Sleep		7.0 -CR			
Coping/Psychosocial					
Observed Emotional State					accepting;anxious;cooperative;hopeful -EM
Verbalized Emotional State					acceptance;anxiety;hopefulness -EM
Coping Strategies					
Supportive Measures					decision-making supported -EM
Family/Support System Care					self-care encouraged -EM
HEENT					
HEENT WDL					WDL -EM
Cognitive					
Memory Deficit					intact -EM
Neuro					
Level Of Consciousness			asleep -CR		alert -EM
Orientation					oriented x 4 -EM
General Appearance					
General Appearance WDL					WDL except -EM
General Appearance					body odor;unkempt -EM
Mood/Behavior/Affect					
Mood/Behavior/Affect WDL					WDL except -EM
Affect					restricted -EM
Mood/Behavior					anxious;cooperative;restless -EM
Speech					
Speech					WDL -EM
Speech					clear -EM
Thought Process					
Judgment and Insight					insight appropriate to

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/26/16 0824	08/26/16 0600	08/26/16 0200	08/25/16 1641	08/25/16 1600
					situation -EM
Oxygen Therapy					
SpO2	98 % -FS				
O2 Device	room air -FS				
Skin					
Skin WDL			WDL -CR		WDL -EM
Safety Interventions					
Precautions (displays in banner)			None -CR		None -EM
Fall Risk Indicators			3-->polypharmacy -CR		3-->polypharmacy -EM
Fall Risk Score			3 -CR		3 -EM

	08/25/16 1358	08/25/16 1234	08/25/16 0800	08/25/16 0600	08/25/16 0000
Plan of Care Review					
Plan Of Care Reviewed With	patient -SE	patient -SE			
Pain/Comfort/Sleep					
Preferred Pain Scale		number (Numeric Rating Pain Scale) -SE			number (Numeric Rating Pain Scale) -CR
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -SE			0 -CR
Pain Rating (0-10): Activity		0 -SE			
Sleep/Rest/Relaxation					
Daily Hours of Sleep				7.5 -CR	
Coping/Psychosocial					
Observed Emotional State		calm;hopeful -SE			
Verbalized Emotional State		hopefulness -SE			
Coping Strategies					
Supportive Measures		self-care encouraged -SE			
Family/Support System Care		self-care encouraged -SE			
Cognitive					
Memory Deficit		intact -SE			
Neuro					
Level Of Consciousness		alert -SE			asleep -CR
Orientation		oriented x 4 -SE			
General Appearance					
General		WDL except -SE			

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/25/16 1358	08/25/16 1234	08/25/16 0800	08/25/16 0600	08/25/16 0000
Appearance WDL					
General Appearance		unkempt;body odor -SE			
Mood/Behavior/Affect					
Mood/Behavior/ Affect WDL		WDL except -SE			
Affect		restricted -SE			
Mood/Behavior		distant/aloof -SE			
Speech					
Speech		WDL -SE			
Speech		clear -SE			
Thought Process					
Judgment and Insight		insight appropriate to situation -SE			
Oxygen Therapy					
SpO2			98 % -AP		
Skin					
Skin WDL		WDL -SE			WDL -CR
Safety Interventions					
Precautions (displays in banner)		None -SE			None -CR
Fall Risk Indicators		3-->polypharmacy -SE			3-->polypharmacy -CR
Fall Risk Score		3 -SE			3 -CR
	08/24/16 2200	08/24/16 1652	08/24/16 1452	08/24/16 1329	08/24/16 1100
Plan of Care Review					
Plan Of Care Reviewed With	patient -FSA		patient -SE	patient -SE	
Pain/Comfort/Sleep					
Preferred Pain Scale		number (Numeric Rating Pain Scale) -FSA			
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -FSA			
Pain Rating (0-10): Activity		0 -FSA			
Coping/Psychosocial					
Observed Emotional State	accepting;hopeful -FSA			hopeful -SE	
Verbalized Emotional State	hopefulness -FSA			hopefulness -SE	
Coping Strategies					
Supportive Measures	self-care encouraged -FSA			self-care encouraged -SE	
Family/Support	self-care			self-care	

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/24/16 2200	08/24/16 1652	08/24/16 1452	08/24/16 1329	08/24/16 1100
System Care	encouraged -FSA			encouraged -SE	
Cognitive					
Memory Deficit		intact -FSA		intact -SE	
Neuro					
Level Of Consciousness		alert -FSA			alert -SE
Orientation		oriented x 4 -FSA			oriented x 4 -SE
General Appearance					
General Appearance WDL		WDL -FSA			WDL except -SE
General Appearance					unkempt -SE
Mood/Behavior/Affect					
Mood/Behavior/ Affect WDL		WDL except;affect -FSA		WDL except -SE	
Affect		flat -FSA		restricted -SE	
Mood/Behavior		alert;calm;cooperative -FSA		anxious -SE	
Speech					
Speech		WDL -FSA		WDL -SE	
Speech		clear -FSA		clear -SE	
Thought Process					
Judgment and Insight		insight appropriate to situation -FSA		insight appropriate to situation -SE	
Oxygen Therapy					
SpO2		98 % -FSA			
O2 Device		room air -FSA			
Skin					
Skin WDL		WDL -FSA			WDL -SE
Safety Interventions					
Precautions (displays in banner)		None -FSA			None -SE
Fall Risk Indicators		3-->polypharmacy -FSA			3-->polypharmacy -SE
Fall Risk Score		3 -FSA			3 -SE

	08/24/16 0900	08/24/16 0700	08/24/16 0200
Pain/Comfort/Sleep			
Preferred Pain Scale	number (Numeric Rating Pain Scale) -PK		number (Numeric Rating Pain Scale) -CR
Pain Assessment: Number Scale (0-10)			
Pain Rating (0-10): Rest	0 -PK		0 -CR
Pain Rating (0-10): Activity	0 -PK		
Comfort/Accept	0 -PK		

All Flowsheet Data (08/24/16 0000--08/26/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/24/16 0900	08/24/16 0700	08/24/16 0200
able Pain Level			
Sleep/Rest/Relaxation			
Daily Hours of Sleep		7.5 -CR	
Neuro			
Level Of Consciousness			asleep -CR
Oxygen Therapy			
SpO2	95 % -PK		
O2 Device	room air -PK		
Skin			
Skin WDL			WDL -CR
Safety Interventions			
Precautions (displays in banner)			None -CR
Fall Risk Indicators			3-->polypharmacy -CR
Fall Risk Score			3 -CR

Social Work Assessment

	08/26/16 0900	08/25/16 1600	08/25/16 1234	08/24/16 1329
Suicide Risk				
Self-Injurious Behavior	-- -SH	no self-injurious ideation or behavior indicators observed or expressed -EM	no self-injurious ideation or behavior indicators observed or expressed -SE	no self-injurious ideation or behavior indicators observed or expressed -SE
Self-injury Description	-- -SH	Denied -EM		

(r) = User Recd, (t) = User Taken, (c) = User Cosigned

User Key

Initials	Name	Effective Dates
EM	McCullough, Elizabeth Ann, RN	04/15/15 -
MA	Abend, Marquel Marie, RN	11/10/15 -
SE	Edwards, Sarah C, RN	02/05/15 -
PK	Kader, Paz T, RN	02/02/15 -
AP	Parrish, Alan	03/31/16 -
CR	Richardson, Cleo, RN	02/05/15 -
FSA	Scurry-Scott, Frazier M, RN	02/05/15 -
FS	Sepulveda, Francis R	04/06/16 -
AS	Smith, Arthur L, CNA	07/02/15 -
DY	Yerby, Derrick J, RN	04/22/16 -
SH	Harris, Stephanie, RN	07/02/15 -

All Flowsheet Data (08/21/16 0000--08/23/16 2359)

MAR MINI-FLOWSHEET DATA

	08/23/16 1745	08/23/16 0830	08/23/16 0825	08/23/16 0222	08/22/16 1700
Pain					
Pain Rating (0-10): Rest	0 -AS	0 -LM	0 -FS	0 Appears to be sleeping soundly, no c/o pain or discomfort. -HS	0 -MA
Pain Rating (0-10): Activity	0 -AS	0 -LM		0 -HS	0 -MA
	08/22/16 1357	08/22/16 0827	08/21/16 1919	08/21/16 0942	08/21/16 0800
Pain					
Pain Rating (0-10): Rest	0 -SE	0 -FS	0 -KR	-- -JB	0 -JB
Pain Rating (0-10): Activity	0 -SE		0 -KR	-- -JB	0 -JB
	08/21/16 0014				
Pain					
Pain Rating (0-10): Rest	0 -FSA				
Pain Rating (0-10): Activity	0 -FSA				

CARE PLAN MINI-FLOWSHEET DATA

	08/23/16 2014	08/23/16 1406	08/23/16 1240	08/23/16 0830	08/22/16 2120
Depression (Adult,Obstetrics,Pediatric)					
Establish/Maintain Self-Care Routine			making progress toward outcome -LM		
Improved/Stable Mood			making progress toward outcome -LM		
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -AS	patient -ASA (r) LM (t)		patient -LM	patient -MA
Plan of Care Review					
Progress	improving -AS	**(p) progress toward functional goals is gradual** -LM			progress toward functional goals is gradual -MA
Fall Risk (Adult)					
Absence of Falls			making progress toward outcome -LM		
Constipation (Adult)					
Effective Bowel Elimination			making progress toward outcome -LM		
Comfort			making progress toward outcome -LM		
	08/22/16 1700	08/22/16 1411	08/22/16 1357	08/21/16 2306	08/21/16 1919
Coping/Psychosocial Response Interventions					

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

CARE PLAN MINI-FLOWSHEET DATA (continued)

	08/22/16 1700	08/22/16 1411	08/22/16 1357	08/21/16 2306	08/21/16 1919
Plan Of Care Reviewed With	patient -MA	patient -SE	patient -SE	patient -KR	patient -KR
Plan of Care Review					
Progress		progress towards functional goals is fair -SE		progress toward functional goals as expected -KR	
	08/21/16 1652	08/21/16 1651	08/21/16 1129	08/21/16 0942	08/21/16 0014
Depression (Adult,Obstetrics,Pediatric)					
Establish/Maintain Self-Care Routine		making progress toward outcome -KR	making progress toward outcome -JB		
Improved/Stable Mood			making progress toward outcome -JB		
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With			patient -JB	patient -JB	patient -FSA
Plan of Care Review					
Progress			progress toward functional goals is gradual -JB		
Fall Risk (Adult)					
Absence of Falls		making progress toward outcome -KR	making progress toward outcome -JB		
Constipation (Adult)					
Effective Bowel Elimination			making progress toward outcome -JB		
Comfort	making progress toward outcome -KR		making progress toward outcome -JB		

DO NOT DELETE - Nav Reporting Template

	08/23/16 1745	08/23/16 1532	08/23/16 0830	08/23/16 0825	08/23/16 0222
Vital Signs					
Temp		98.4 °F (36.9 °C) -ASA		97.6 °F (36.4 °C) -FS	
Temp src				Oral -FS	
Pulse		79 -ASA		79 -FS	
BP		119/64 mmHg -ASA		112/79 mmHg -FS	
Patient Position		Sitting -ASA		Sitting -FS	
BP Location		Right arm -ASA		Left arm -FS	
BP Method				Automatic -FS	
Resp		16 -ASA		16 -FS	
Skin					
Skin WDL	WDL -AS		WDL -LM		WDL -HS
Pain/Comfort, Non Labor					
Pain Rating (0-	0 -AS		0 -LM	0 -FS	0

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/23/16 1745	08/23/16 1532	08/23/16 0830	08/23/16 0825	08/23/16 0222
10): Rest					Appears to be sleeping soundly, no c/o pain or discomfort. -HS
Pain Rating (0-10): Activity	0 -AS		0 -LM		0 -HS
Comfort/Acceptable Pain Level	0 -AS				
Post Anesthesia					
Orientation	oriented x 4 -AS		oriented x 4 -LM		
Oxygen Therapy during Labor					
SpO2				100 % -FS	
O2 Device				room air -FS	
Patient Observation					
Observations	q30 -AS		Q 30 mins -LM		Q 30 mins -HS
Cognitive					
Memory Deficit	intact -AS		intact -LM		
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy -AS		3-->central nervous system/psychotropic medication;2-->depression;1-->male non-skid footwear; clutter-free environment -LM		3-->polypharmacy;3-->central nervous system/psychotropic medication;2-->depression;1-->male -HS
Fall Risk Score	3 -AS		6 -LM		9 -HS
Danger to Self					
Danger to Self (WDL)	WDL -AS		WDL -LM		WDL -HS
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -AS		no suicidal ideation or behavior indicators observed or expressed -LM		no suicidal ideation or behavior indicators observed or expressed -HS
Keeps Self Safe	yes (describe) -AS				
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -AS				
Agreement not to Harm Self	yes (describe) -AS				
Danger to Others					
Danger to Others (WDL)			WDL -LM		WDL -HS
Precautions/Isolation					
Precautions	None -AS		None -LM		None -HS

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/23/16 1745	08/23/16 1532	08/23/16 0830	08/23/16 0825	08/23/16 0222
(displays in banner)					
	08/22/16 1700	08/22/16 1357	08/22/16 0827	08/21/16 2345	08/21/16 1919
Vital Signs					
Temp			97.8 °F (36.6 °C) -FS		98.1 °F (36.7 °C) -KR
Temp src			Oral -FS		
Pulse			86 -FS		86 -KR
BP			128/71 mmHg -FS		115/63 mmHg -KR
Patient Position			Sitting -FS		
BP Location			Left arm -FS		
BP Method			Automatic -FS		
Resp			16 -FS		16 -KR
Skin					
Skin WDL	WDL -MA	WDL -SE		WDL -FSA	WDL -KR
Pain/Comfort, Non Labor					
Pain Rating (0-10): Rest	0 -MA	0 -SE	0 -FS		0 -KR
Pain Rating (0-10): Activity	0 -MA	0 -SE			0 -KR
FACES Pain Rating: Rest				0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA	
FACES Pain Rating: Activity				0-->no hurt -FSA	
Post Anesthesia					
Orientation	oriented x 4 -MA	oriented x 4 -SE			oriented x 4 -KR
Oxygen Therapy during Labor					
SpO2			100 % -FS		100 % -KR
O2 Device			room air -FS		room air -KR
Patient Observation					
Observations	Q30 -MA	Q30 -SE		Q30 -FSA	Q30 -KR
Cognitive					
Memory Deficit	intact -MA	intact -SE			intact -KR
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy;3-->central nervous system/psychotropic medication;2-->depression;1-->male -MA	3-->polypharmacy -SE		3-->polypharmacy;3-->central nervous system/psychotropic medication;2-->depression;1-->male -FSA	3-->polypharmacy;3-->central nervous system/psychotropic medication;2-->depression;1-->male -KR
Fall Risk Score	9 -MA	3 -SE		9 -FSA	9 -KR
Danger to Self					

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/22/16 1700	08/22/16 1357	08/22/16 0827	08/21/16 2345	08/21/16 1919
Danger to Self (WDL)	WDL -MA	WDL -SE		-- Asleep -FSA	WDL -KR
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -MA	no suicidal ideation or behavior indicators observed or expressed -SE		no suicidal ideation or behavior indicators observed or expressed -FSA	no suicidal ideation or behavior indicators observed or expressed -KR
Keeps Self Safe		yes (describe) -SE			yes (describe) -KR
Self-Injurious Behavior		no self-injurious ideation or behavior indicators observed or expressed -SE		no self-injurious ideation or behavior indicators observed or expressed -FSA	no self-injurious ideation or behavior indicators observed or expressed -KR
Self-injury Description					Denied -KR
Agreement not to Harm Self		yes (describe) -SE			yes (describe) -KR
Description of Agreement					verbal -KR
Danger to Others					
Danger to Others (WDL)		WDL -SE		-- Asleep -FSA	WDL -KR
Precautions/Isolation					
Precautions (displays in banner)	None -MA	None -SE		Fall -FSA	Fall -KR

	08/21/16 0942	08/21/16 0800	08/21/16 0014
Vital Signs			
Temp		97.9 °F (36.6 °C) -AP	
Pulse		74 -AP	
BP		103/76 mmHg -AP	
Patient Position	-- -JB		
BP Location	-- -JB		
BP Method	-- -JB		
Resp		17 -AP	
Skin			
Skin WDL	WDL -JB		WDL -FSA
Pain/Comfort, Non Labor			
Pain Rating (0-10): Rest	-- -JB	0 -JB	0 -FSA
Pain Rating (0-10): Activity	-- -JB	0 -JB	0 -FSA
Post Anesthesia			
Orientation	oriented x 4 -JB		oriented x 4 -FSA
Oxygen Therapy during Labor			

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/21/16 0942	08/21/16 0800	08/21/16 0014
SpO2		99 % -AP	
O2 Device	-- -JB		
Patient Observation			
Observations	Q30 -JB		Q30 -FSA
Cognitive			
Memory Deficit	intact -JB		intact -FSA
Fall Risk Assessment			
Fall Risk Indicators	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -JB		3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -FSA
Fall Risk Score	9 -JB		9 -FSA
Danger to Self			
Danger to Self (WDL)	WDL -JB		WDL -FSA
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -JB		no suicidal ideation or behavior indicators observed or expressed -FSA
Keeps Self Safe	yes (describe) -JB		
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -JB		no self-injurious ideation or behavior indicators observed or expressed -FSA
Self-injury Description	Denied -JB		
Agreement not to Harm Self	yes (describe) -JB		
Description of Agreement	verbal -JB		
Danger to Others			
Danger to Others (WDL)	WDL -JB		WDL -FSA
Precautions/Isolation			
Precautions (displays in banner)	Fall -JB		Fall -FSA

BH PS Main

	08/23/16 1745	08/23/16 0830	08/23/16 0222	08/22/16 1700	08/22/16 1600
Legal Status					
Legal status	voluntary -AS	voluntary -LM	voluntary -HS	voluntary -MA	voluntary -MA
Risk Assessment					
Danger to Self	WDL -AS	WDL -LM	WDL -HS	WDL -MA	

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH PS Main (continued)

	08/23/16 1745	08/23/16 0830	08/23/16 0222	08/22/16 1700	08/22/16 1600
(WDL)					
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -AS	no suicidal ideation or behavior indicators observed or expressed -LM	no suicidal ideation or behavior indicators observed or expressed -HS	no suicidal ideation or behavior indicators observed or expressed -MA	
Keeps Self Safe	yes (describe) -AS				
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -AS				
Agreement not to Harm Self	yes (describe) -AS				
Assessment timing				Shift -MA	
Danger to Others (WDL)		WDL -LM	WDL -HS		
	08/22/16 1357	08/21/16 2345	08/21/16 1919	08/21/16 0942	08/21/16 0014
Legal Status					
Legal status	voluntary -SE	voluntary -FSA	voluntary -KR	voluntary -JB	voluntary -FSA
Risk Assessment					
Danger to Self (WDL)	WDL -SE	-- Asleep -FSA	WDL -KR	WDL -JB	WDL -FSA
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -SE	no suicidal ideation or behavior indicators observed or expressed -FSA	no suicidal ideation or behavior indicators observed or expressed -KR	no suicidal ideation or behavior indicators observed or expressed -JB	no suicidal ideation or behavior indicators observed or expressed -FSA
Keeps Self Safe	yes (describe) -SE		yes (describe) -KR	yes (describe) -JB	
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -SE	no self-injurious ideation or behavior indicators observed or expressed -FSA	no self-injurious ideation or behavior indicators observed or expressed -KR	no self-injurious ideation or behavior indicators observed or expressed -JB	no self-injurious ideation or behavior indicators observed or expressed -FSA
Self-injury Description			Denied -KR	Denied -JB	
Agreement not to Harm Self	yes (describe) -SE		yes (describe) -KR	yes (describe) -JB	
Description of Agreement			verbal -KR	verbal -JB	
Assessment timing				-- -JB	
Suicide Ideation for Today			None -KR		
Danger to Others (WDL)	WDL -SE	-- Asleep -FSA	WDL -KR	WDL -JB	WDL -FSA

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Tx Plan MH IP

	08/22/16 0929
Patient Assets/Stressors	
Patient Assets	general fund of knowledge;average or above intelligence;motivation for treatment/growth;capable of independent living;supportive family/friends;work skills;physical health;ability for insight;communication skills -RE
Patient Stressors	medication change or non-compliance -RE
Discharge Planning	
Discharge Criteria	improved stabilization in mood, thinking and/or behavior;verbal commitment to aftercare and medication compliance -RE
Recommended Discharge Plan	return to previous living environment;medication management with psychiatrist or other physician -RE
Pt's Acceptance of Discharge Plan	yes -RE
Why Continues to Need Hospitalization	severe impairment of level of functioning;danger to self or others;medication stabilization -RE
Estimated Length of Stay	3-5 days -RE
Provisional DSM 5 Diagnoses	
Problem Being Addressed	refer to problem list -RE
Goal: Will work with social worker/treatment coordinator to develop safe discharge plan	

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Tx Plan MH IP (continued)

	08/22/16 0929
Goal Status	goal initiated -RE
Goal: Will attend Occupational Therapy groups up to seven days weekly as tolerated	
Objectives	increase coping skills -RE
Goal Status	progress made toward outcome -RE
Treatment Plan Reviewed by	
Physician	Cruz, Schumm -RE
Psychiatric Social Worker	Bathick -RE
Registered Nurse	Ellison -RE
Nurse Manager	Han -RE
Occupational Therapist	Peter -RE
Other	Silverman -RE

VS Simple

	08/23/16 1745	08/23/16 1532	08/23/16 0830	08/23/16 0825	08/23/16 0222
Vital Signs					
Temp		98.4 °F (36.9 °C) -ASA		97.6 °F (36.4 °C) -FS	
Temp src				Oral -FS	
Pulse		79 -ASA		79 -FS	
BP		119/64 mmHg -ASA		112/79 mmHg -FS	
Patient Position		Sitting -ASA		Sitting -FS	
BP Location		Right arm -ASA		Left arm -FS	
BP Method				Automatic -FS	
Resp		16 -ASA		16 -FS	
Oxygen Therapy					
SpO2				100 % -FS	
O2 Device				room air -FS	
Pain/Comfort/Sleep					
Preferred Pain Scale					number (Numeric Rating Pain Scale) -HS
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -AS		0 -LM	0 -FS	0 Appears to be sleeping soundly, no c/o pain or discomfort. -HS
Pain Rating (0-10): Activity	0 -AS		0 -LM		0 -HS
Comfort/Acceptable Pain Level	0 -AS				
Patient Observation					
Observations	q30 -AS		Q 30 mins -LM		Q 30 mins -HS

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

VS Simple (continued)

	08/22/16 1700	08/22/16 1357	08/22/16 0827	08/21/16 2345	08/21/16 1919
Vital Signs					
Temp			97.8 °F (36.6 °C) -FS		98.1 °F (36.7 °C) -KR
Temp src			Oral -FS		
Pulse			86 -FS		86 -KR
BP			128/71 mmHg -FS		115/63 mmHg -KR
Patient Position			Sitting -FS		
BP Location			Left arm -FS		
BP Method			Automatic -FS		
Resp			16 -FS		16 -KR
Oxygen Therapy					
SpO2			100 % -FS		100 % -KR
O2 Device			room air -FS		room air -KR
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -MA	number (Numeric Rating Pain Scale) -SE		FACES (Wong-Baker FACES Pain Rating Scale) -FSA	number (Numeric Rating Pain Scale) -KR
Sleep/Rest/Relaxation	difficulty falling asleep -MA			appears asleep -FSA	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -MA	0 -SE	0 -FS		0 -KR
Pain Rating (0-10): Activity	0 -MA	0 -SE			0 -KR
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest				0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA	
FACES Pain Rating: Activity				0-->no hurt -FSA	
Patient Observation					
Observations	Q30 -MA	Q30 -SE		Q30 -FSA	Q30 -KR

	08/21/16 0942	08/21/16 0800	08/21/16 0014
Vital Signs			
Temp		97.9 °F (36.6 °C) -AP	
Pulse		74 -AP	
Pulse Source	-- -JB		
BP		103/76 mmHg -AP	
Patient Position	-- -JB		
BP Location	-- -JB		
BP Method	-- -JB		
Resp		17 -AP	
Oxygen Therapy			
SpO2		99 % -AP	

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

VS Simple (continued)

	08/21/16 0942	08/21/16 0800	08/21/16 0014
O2 Device	-- -JB		
Pain/Comfort/Sleep			
Preferred Pain Scale			number (Numeric Rating Pain Scale) -FSA
Sleep/Rest/Relaxation	-- -JB		other (see comments) Roommate's talking in sleep keeping awake. Will use earplugs -FSA
Pain Assessment: Number Scale (0-10)			
Pain Rating (0-10): Rest	-- -JB	0 -JB	0 -FSA
Pain Rating (0-10): Activity	-- -JB	0 -JB	0 -FSA
Patient Observation			
Observations	Q30 -JB		Q30 -FSA

VS Simple

	08/23/16 1745	08/23/16 1532	08/23/16 0830	08/23/16 0825	08/23/16 0222
Vital Signs					
Temp		98.4 °F (36.9 °C) -ASA		97.6 °F (36.4 °C) -FS	
Temp src				Oral -FS	
Pulse		79 -ASA		79 -FS	
BP		119/64 mmHg -ASA		112/79 mmHg -FS	
Patient Position		Sitting -ASA		Sitting -FS	
BP Location		Right arm -ASA		Left arm -FS	
BP Method				Automatic -FS	
Resp		16 -ASA		16 -FS	
Oxygen Therapy					
SpO2				100 % -FS	
O2 Device				room air -FS	
Pain/Comfort					
Preferred Pain Scale					number (Numeric Rating Pain Scale) -HS
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -AS		0 -LM	0 -FS	0 Appears to be sleeping soundly, no c/o pain or discomfort. -HS
Pain Rating (0-10): Activity	0 -AS		0 -LM		0 -HS
Comfort/Acceptable Pain Level	0 -AS				
Patient Observation					
Observations	q30 -AS		Q 30 mins -LM		Q 30 mins -HS

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

VS Simple (continued)

	08/22/16 1700	08/22/16 1357	08/22/16 0827	08/21/16 2345	08/21/16 1919
Vital Signs					
Temp			97.8 °F (36.6 °C) -FS		98.1 °F (36.7 °C) -KR
Temp src			Oral -FS		
Pulse			86 -FS		86 -KR
BP			128/71 mmHg -FS		115/63 mmHg -KR
Patient Position			Sitting -FS		
BP Location			Left arm -FS		
BP Method			Automatic -FS		
Resp			16 -FS		16 -KR
Oxygen Therapy					
SpO2			100 % -FS		100 % -KR
O2 Device			room air -FS		room air -KR
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -MA	number (Numeric Rating Pain Scale) -SE		FACES (Wong-Baker FACES Pain Rating Scale) -FSA	number (Numeric Rating Pain Scale) -KR
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -MA	0 -SE	0 -FS		0 -KR
Pain Rating (0-10): Activity	0 -MA	0 -SE			0 -KR
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest				0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA	
FACES Pain Rating: Activity				0-->no hurt -FSA	
Patient Observation					
Observations	Q30 -MA	Q30 -SE		Q30 -FSA	Q30 -KR

	08/21/16 0942	08/21/16 0800	08/21/16 0014
Vital Signs			
Temp		97.9 °F (36.6 °C) -AP	
Pulse		74 -AP	
Pulse Source	-- -JB		
BP		103/76 mmHg -AP	
Patient Position	-- -JB		
BP Location	-- -JB		
BP Method	-- -JB		
Resp		17 -AP	
Oxygen Therapy			
SpO2		99 % -AP	
O2 Device	-- -JB		
Pain/Comfort			

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

VS Simple (continued)

	08/21/16 0942	08/21/16 0800	08/21/16 0014
Preferred Pain Scale			number (Numeric Rating Pain Scale) -FSA
Pain Assessment: Number Scale (0-10)			
Pain Rating (0-10): Rest	-- -JB	0 -JB	0 -FSA
Pain Rating (0-10): Activity	-- -JB	0 -JB	0 -FSA
Patient Observation			
Observations	Q30 -JB		Q30 -FSA

Pain Scales

	08/23/16 1745	08/23/16 0830	08/23/16 0825	08/23/16 0222	08/22/16 1700
Pain/Comfort/Sleep					
Preferred Pain Scale				number (Numeric Rating Pain Scale) -HS	number (Numeric Rating Pain Scale) -MA
Sleep/Rest/Relaxation					difficulty falling asleep -MA
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -AS	0 -LM	0 -FS	0 Appears to be sleeping soundly, no c/o pain or discomfort. -HS	0 -MA
Pain Rating (0-10): Activity	0 -AS	0 -LM		0 -HS	0 -MA
Comfort/Acceptable Pain Level	0 -AS				

	08/22/16 1357	08/22/16 0827	08/21/16 2345	08/21/16 1919	08/21/16 0942
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -SE		FACES (Wong-Baker FACES Pain Rating Scale) -FSA	number (Numeric Rating Pain Scale) -KR	
Sleep/Rest/Relaxation			appears asleep -FSA		-- -JB
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -SE	0 -FS		0 -KR	-- -JB
Pain Rating (0-10): Activity	0 -SE			0 -KR	-- -JB
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest			0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA		
FACES Pain Rating: Activity			0-->no hurt -FSA		

	08/21/16 0800	08/21/16 0014
Pain/Comfort/Sleep		

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

Pain Scales (continued)

	08/21/16 0800	08/21/16 0014
Preferred Pain Scale		number (Numeric Rating Pain Scale) -FSA
Sleep/Rest/Relaxation		other (see comments) Roommate's talking in sleep keeping awake. Will use earplugs -FSA
Pain Assessment: Number Scale (0-10)		
Pain Rating (0-10): Rest	0 -JB	0 -FSA
Pain Rating (0-10): Activity	0 -JB	0 -FSA

Pain Reassessment

	08/23/16 1745	08/23/16 0830	08/23/16 0825	08/23/16 0222	08/22/16 1700
Pain/Comfort/Sleep					
Sleep/Rest/Relaxation					difficulty falling asleep -MA
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -AS	0 -LM	0 -FS	0 Appears to be sleeping soundly, no c/o pain or discomfort. -HS	0 -MA
Pain Rating (0-10): Activity	0 -AS	0 -LM		0 -HS	0 -MA
Comfort/Acceptable Pain Level	0 -AS				
Pain/Comfort					
Preferred Pain Scale				number (Numeric Rating Pain Scale) -HS	number (Numeric Rating Pain Scale) -MA

	08/22/16 1357	08/22/16 0827	08/21/16 2345	08/21/16 1919	08/21/16 0942
Pain/Comfort/Sleep					
Sleep/Rest/Relaxation			appears asleep -FSA		-- -JB
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -SE	0 -FS		0 -KR	-- -JB
Pain Rating (0-10): Activity	0 -SE			0 -KR	-- -JB
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest			0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA		
FACES Pain Rating: Activity			0-->no hurt -FSA		
Pain/Comfort					
Preferred Pain	number (Numeric		FACES (Wong-	number (Numeric	

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

Pain Reassessment (continued)

	08/22/16 1357	08/22/16 0827	08/21/16 2345	08/21/16 1919	08/21/16 0942
Scale	Rating Pain Scale) -SE		Baker FACES Pain Rating Scale) -FSA	Rating Pain Scale) -KR	
	08/21/16 0800	08/21/16 0014			
Pain/Comfort/Sleep					
Sleep/Rest/Relaxation		other (see comments) Roommate's talking in sleep keeping awake. Will use earplugs -FSA			
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -JB	0 -FSA			
Pain Rating (0-10): Activity	0 -JB	0 -FSA			
Pain/Comfort					
Preferred Pain Scale		number (Numeric Rating Pain Scale) -FSA			

BH Daily Assess

	08/23/16 2014	08/23/16 1745	08/23/16 1532	08/23/16 1406	08/23/16 0830
Legal Status					
Legal status		voluntary -AS			voluntary -LM
Vital Signs					
Temp			98.4 °F (36.9 °C) -ASA		
Pulse			79 -ASA		
BP			119/64 mmHg -ASA		
Patient Position			Sitting -ASA		
BP Location			Right arm -ASA		
Resp			16 -ASA		
Patient Observation					
Observations		q30 -AS			Q 30 mins -LM
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -AS			0 -LM
Pain Rating (0-10): Activity		0 -AS			0 -LM
Comfort/Acceptable Pain Level		0 -AS			
Skin WDL					
Skin WDL		WDL -AS			WDL -LM
HEENT					
HEENT WDL		WDL -AS			WDL -LM
Fall Risk Assessment					
Fall Risk Indicators		3-->polypharmacy -AS			3-->central nervous system/psychotr

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Daily Assess (continued)

	08/23/16 2014	08/23/16 1745	08/23/16 1532	08/23/16 1406	08/23/16 0830
					opic medication;2-->depression;1-->male non-skid footwear; clutter-free environment -LM
Fall Risk Score		3 -AS			6 -LM
Patient Rights Denials					
Rights Denied or Restrictions Imposed		no -AS			no -LM
Precautions/Isolation					
Precautions (displays in banner)		None -AS			None -LM
Precautions Interventions					
Interventions Performed		yes -AS			yes -LM
Level of Observation		every 30 minutes -AS			every 30 minutes -LM
Activities of Daily Living					
ADL's (WDL)		WDL -AS			WDL -LM
Daily Nutrition					
Daily Nutrition (WDL)		WDL -AS			WDL -LM
Mental Status					
Orientation		oriented x 4 -AS			oriented x 4 -LM
Level Of Consciousness		alert -AS			alert -LM
General Appearance WDL		WDL except -AS			WDL except -LM
General Appearance		unkempt -AS			unkempt -LM
Mood		depressed but less today -AS			mood shifts;anxious;sad;isolative -LM
Mood/Behavior/ Affect WDL		WDL except -AS			WDL except -LM
Affect		flat -AS			restricted -LM
Behavior (WDL)		WDL -AS			WDL except -LM
Mood/Behavior					anxious;sad;isolative -LM
Speech		WDL -AS			WDL -LM
Speech		clear -AS			clear -LM
Judgment and Insight		insight not appropriate to situation -AS			insight not appropriate to situation;judgme

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Daily Assess (continued)

	08/23/16 2014	08/23/16 1745	08/23/16 1532	08/23/16 1406	08/23/16 0830
					nt not appropriate to situation -LM
Insight		fair -AS			fair -LM
Concentration		fair -AS			fair -LM
Memory Deficit		intact -AS			intact -LM
Thought (WDL)		WDL -AS			WDL -LM
Coping/Psychosocial Response					
Observed Emotional State		accepting -AS			anxious;withdrawn;sad -LM
Verbalized Emotional State		hopefulness -AS			anxiety;depression;hopefulness -LM
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -AS			patient -ASA (r) LM (t)	patient -LM
Supportive Measures		goal setting facilitated -AS			self-care encouraged;active listening utilized -LM
Family/Support System Care					self-care encouraged -LM
Behavior Management					behavioral plan reviewed -LM
Psychiatric Symptoms					
Anxiety Symptoms (WDL)		WDL except -AS			WDL except -LM
Anxiety Symptoms		generalized -AS			fatigue;generalized -LM
Manic Symptoms (WDL)		WDL -AS			WDL -LM
Manic Symptoms		no problems reported or observed. -AS			
Psychotic symptoms (WDL)		WDL -AS			WDL -LM
Danger to Self					
Danger to Self (WDL)		WDL -AS			WDL -LM
Danger to Self		no suicidal ideation or behavior indicators observed or expressed -AS			no suicidal ideation or behavior indicators observed or expressed -LM
Keeps Self Safe		yes (describe) -AS			

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Daily Assess (continued)

	08/23/16 2014	08/23/16 1745	08/23/16 1532	08/23/16 1406	08/23/16 0830
Self-Injurious Behavior		no self-injurious ideation or behavior indicators observed or expressed -AS			
Agreement not to Harm Self		yes (describe) -AS			
Danger to Others					
Danger to Others (WDL)					WDL -LM
	08/23/16 0825	08/23/16 0700	08/23/16 0222	08/22/16 2120	08/22/16 1700
Legal Status					
Legal status			voluntary -HS		voluntary -MA
Vital Signs					
Temp	97.6 °F (36.4 °C) -FS				
Temp src	Oral -FS				
Pulse	79 -FS				
BP	112/79 mmHg -FS				
Patient Position	Sitting -FS				
BP Location	Left arm -FS				
BP Method	Automatic -FS				
Resp	16 -FS				
Patient Observation					
Observations			Q 30 mins -HS		Q30 -MA
Oxygen Therapy					
SpO2	100 % -FS				
O2 Device	room air -FS				
Pain/Comfort					
Preferred Pain Scale			number (Numeric Rating Pain Scale) -HS		number (Numeric Rating Pain Scale) -MA
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -FS		0 Appears to be sleeping soundly, no c/o pain or discomfort. -HS		0 -MA
Pain Rating (0-10): Activity			0 -HS		0 -MA
Skin WDL					
Skin WDL			WDL -HS		WDL -MA
HEENT					
HEENT WDL					WDL -MA
Fall Risk Assessment					
Fall Risk Indicators			3-->polypharmacy;3-->central nervous system/psychotropic medication;2--		3-->polypharmacy;3-->central nervous system/psychotr

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Daily Assess (continued)

	08/23/16 0825	08/23/16 0700	08/23/16 0222	08/22/16 2120	08/22/16 1700
			>depression;1-->male -HS		opic medication;2-->depression;1-->male -MA
Fall Risk Score			9 -HS		9 -MA
Patient Rights Denials					
Rights Denied or Restrictions Imposed			no -HS		
Precautions/Isolation					
Precautions (displays in banner)			None -HS		None -MA
Precautions Interventions					
Interventions Performed			yes -HS		yes -MA
Level of Observation			every 30 minutes -HS		every 30 minutes -MA
Activities of Daily Living					
ADL's (WDL)					WDL -MA
Daily Sleep					
Daily Sleep (WDL)		WDL -EG	WDL -HS		WDL Except -MA
Sleep/Rest/Relaxation					difficulty falling asleep -MA
Daily Hours of Sleep		7.0 -EG			
Daily Nutrition					
Daily Nutrition (WDL)					WDL -MA
Mental Status					
Orientation					oriented x 4 -MA
Level Of Consciousness			asleep -HS		alert -MA
General Appearance WDL					WDL except -MA
General Appearance					unkempt -MA
Mood					isolative;depressed;worried -MA
Mood/Behavior/Affect WDL					WDL except -MA
Affect					restricted -MA
Mood/Behavior					anxious -MA
Speech					WDL -MA
Speech					clear -MA
Judgment and Insight					insight not appropriate to

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Daily Assess (continued)

	08/23/16 0825	08/23/16 0700	08/23/16 0222	08/22/16 2120	08/22/16 1700
					situation;judgment not appropriate to situation -MA
Insight					fair -MA
Concentration					fair -MA
Memory Deficit					intact -MA
Thought (WDL)					WDL -MA
Thought Process					concrete -MA
Coping/Psychosocial Response					
Observed Emotional State					anxious -MA
Verbalized Emotional State					anxiety -MA
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With				patient -MA	patient -MA
Psychiatric Symptoms					
Anxiety Symptoms (WDL)					WDL except -MA
Anxiety Symptoms					hot flashes -MA
Manic Symptoms (WDL)			WDL -HS		WDL -MA
Psychotic symptoms (WDL)			WDL -HS		WDL -MA
Danger to Self					
Danger to Self (WDL)			WDL -HS		WDL -MA
Danger to Self			no suicidal ideation or behavior indicators observed or expressed -HS		no suicidal ideation or behavior indicators observed or expressed -MA
Assessment Type					
Assessment timing					Shift -MA
Danger to Others					
Danger to Others (WDL)			WDL -HS		
	08/22/16 1600	08/22/16 1411	08/22/16 1357	08/22/16 0827	08/22/16 0600
Legal Status					
Legal status	voluntary -MA		voluntary -SE		
Vital Signs					

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Daily Assess (continued)

	08/22/16 1600	08/22/16 1411	08/22/16 1357	08/22/16 0827	08/22/16 0600
Temp				97.8 °F (36.6 °C) -FS	
Temp src				Oral -FS	
Pulse				86 -FS	
BP				128/71 mmHg -FS	
Patient Position				Sitting -FS	
BP Location				Left arm -FS	
BP Method				Automatic -FS	
Resp				16 -FS	
Patient Observation					
Observations			Q30 -SE		
Oxygen Therapy					
SpO2				100 % -FS	
O2 Device				room air -FS	
Pain/Comfort					
Preferred Pain Scale			number (Numeric Rating Pain Scale) -SE		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest			0 -SE	0 -FS	
Pain Rating (0-10): Activity			0 -SE		
Skin WDL					
Skin WDL			WDL -SE		
Fall Risk Assessment					
Fall Risk Indicators			3-->polypharmacy -SE		
Fall Risk Score			3 -SE		
Precautions/Isolation					
Precautions (displays in banner)			None -SE		
Precautions Interventions					
Level of Observation			every 30 minutes -SE		
Self Harm Precautions			check for contraband -SE		
Activities of Daily Living					
ADL's (WDL)			WDL -SE		
Daily Sleep					
Daily Sleep (WDL)			WDL -SE		
Daily Hours of Sleep					7.5 -CR
Daily Nutrition					
Daily Nutrition (WDL)			WDL -SE		

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Daily Assess (continued)

	08/22/16 1600	08/22/16 1411	08/22/16 1357	08/22/16 0827	08/22/16 0600
Mental Status					
Orientation			oriented x 4 -SE		
Level Of Consciousness			alert -SE		
General Appearance WDL			WDL except -SE		
General Appearance			unkempt -SE		
Mood			hopeful;isolative -SE		
Mood/Behavior/ Affect WDL			WDL except -SE		
Affect			restricted -SE		
Behavior (WDL)			WDL except -SE		
Mood/Behavior			anxious;distant/aloof;isolative -SE		
Speech			WDL -SE		
Speech			clear -SE		
Judgment and Insight			insight appropriate to situation -SE		
Insight			fair -SE		
Concentration			fair -SE		
Memory Deficit			intact -SE		
Thought (WDL)			WDL -SE		
Coping/Psychosocial Response					
Observed Emotional State			calm;hopeful -SE		
Verbalized Emotional State			hopefulness;relief -SE		
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With		patient -SE	patient -SE		
Psychiatric Symptoms					
Anxiety Symptoms (WDL)			WDL except -SE		
Anxiety Symptoms			generalized -SE		
Manic Symptoms (WDL)			WDL -SE		
Psychotic symptoms (WDL)			WDL -SE		
Danger to Self					
Danger to Self (WDL)			WDL -SE		
Danger to Self			no suicidal		

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Daily Assess (continued)

	08/22/16 1600	08/22/16 1411	08/22/16 1357	08/22/16 0827	08/22/16 0600
			ideation or behavior indicators observed or expressed -SE		
Keeps Self Safe			yes (describe) -SE		
Self-Injurious Behavior			no self-injurious ideation or behavior indicators observed or expressed -SE		
Agreement not to Harm Self			yes (describe) -SE		
Danger to Others					
Danger to Others (WDL)			WDL -SE		
	08/21/16 2345	08/21/16 2306	08/21/16 1919	08/21/16 1129	08/21/16 0942
Legal Status					
Legal status	voluntary -FSA		voluntary -KR		voluntary -JB
Vital Signs					
Temp			98.1 °F (36.7 °C) -KR		
Pulse			86 -KR		
Pulse Source					-- -JB
BP			115/63 mmHg -KR		
Patient Position					-- -JB
BP Location					-- -JB
BP Method					-- -JB
Resp			16 -KR		
Patient Observation					
Observations	Q30 -FSA		Q30 -KR		Q30 -JB
Oxygen Therapy					
SpO2			100 % -KR		
O2 Device			room air -KR		-- -JB
Pain/Comfort					
Preferred Pain Scale	FACES (Wong-Baker FACES Pain Rating Scale) -FSA		number (Numeric Rating Pain Scale) -KR		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest			0 -KR		-- -JB
Pain Rating (0-10): Activity			0 -KR		-- -JB
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest	0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA				
FACES Pain	0-->no hurt -FSA				

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Daily Assess (continued)

	08/21/16 2345	08/21/16 2306	08/21/16 1919	08/21/16 1129	08/21/16 0942
Rating: Activity					
Skin WDL					
Skin WDL	WDL -FSA		WDL -KR		WDL -JB
HEENT					
HEENT WDL			WDL -KR		WDL -JB
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy;3-->central nervous system/psychotropic medication;2-->depression;1-->male -FSA		3-->polypharmacy;3-->central nervous system/psychotropic medication;2-->depression;1-->male -KR		3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -JB
Fall Risk Score	9 -FSA		9 -KR		9 -JB
Patient Rights Denials					
Rights Denied or Restrictions Imposed	no -FSA		no -KR		no -JB
Precautions/Isolation					
Precautions (displays in banner)	Fall -FSA		Fall -KR		Fall -JB
Precautions Interventions					
Interventions Performed	yes -FSA		yes -KR		yes -JB
Level of Observation	every 30 minutes -FSA		every 30 minutes -KR		every 30 minutes -JB
Activities of Daily Living					
ADL's (WDL)			WDL -KR		WDL -JB
Daily Sleep					
Daily Sleep (WDL)			WDL -KR		WDL -JB
Sleep/Rest/Relaxation	appears asleep -FSA				-- -JB
Daily Nutrition					
Daily Nutrition (WDL)			WDL except -KR		WDL except -JB
Appetite Change			decreased -KR		decreased -JB
Mental Status					
Orientation			oriented x 4 -KR		oriented x 4 -JB
Level Of Consciousness	asleep -FSA		alert -KR		alert -JB
General Appearance WDL			WDL except -KR		WDL except -JB
General			unkempt -KR		unkempt -JB

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Daily Assess (continued)

	08/21/16 2345	08/21/16 2306	08/21/16 1919	08/21/16 1129	08/21/16 0942
Appearance					
Mood			anxious -KR		anxious -JB
Mood/Behavior/ Affect WDL			WDL except -KR		WDL except -JB
Affect			restricted -KR		blunted -JB
Behavior (WDL)			WDL except -KR		WDL except -JB
Mood/Behavior			anxious;isolative -KR		anxious;isolative -JB
Somatic Symptoms			-- -KR		akathisia -JB
Speech			WDL -KR		WDL -JB
Speech			clear -KR		clear -JB
Judgment and Insight			judgment appropriate to situation -KR		judgment not appropriate to situation -JB
Insight			fair -KR		fair -JB
Concentration			fair -KR		fair -JB
Memory Deficit			intact -KR		intact -JB
Thought (WDL)			WDL -KR		WDL -JB
Thought Process			concrete -KR		
Coping/Psychosocial Response					
Observed Emotional State			calm;quiet;restless -KR		withdrawn;calm -JB
Verbalized Emotional State			anxiety;depression -KR		depression -JB
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With		patient -KR	patient -KR	patient -JB	patient -JB
Psychiatric Symptoms					
Anxiety Symptoms (WDL)	-- Asleep -FSA		WDL except -KR		WDL except -JB
Anxiety Symptoms			difficulty controlling anxiety or worry -KR		generalized -JB
Manic Symptoms (WDL)			WDL -KR		WDL -JB
Psychotic symptoms (WDL)			WDL -KR		WDL -JB
Danger to Self					
Danger to Self (WDL)	-- Asleep -FSA		WDL -KR		WDL -JB
Danger to Self	no suicidal ideation or behavior indicators observed or		no suicidal ideation or behavior indicators observed or		no suicidal ideation or behavior indicators

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Daily Assess (continued)

	08/21/16 2345	08/21/16 2306	08/21/16 1919	08/21/16 1129	08/21/16 0942
	expressed -FSA		expressed -KR		observed or expressed -JB
Keeps Self Safe			yes (describe) -KR		yes (describe) -JB
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -FSA		no self-injurious ideation or behavior indicators observed or expressed -KR		no self-injurious ideation or behavior indicators observed or expressed -JB
Self-injury Description			Denied -KR		Denied -JB
Agreement not to Harm Self			yes (describe) -KR		yes (describe) -JB
Description of Agreement			verbal -KR		verbal -JB
Assessment Type					
Assessment timing					-- -JB
Suicidal Inquiry					
Suicide Ideation for Today			None -KR		
Danger to Others					
Danger to Others (WDL)	-- Asleep -FSA		WDL -KR		WDL -JB
	08/21/16 0800	08/21/16 0600	08/21/16 0014		
Legal Status					
Legal status			voluntary -FSA		
Vital Signs					
Temp	97.9 °F (36.6 °C) -AP				
Pulse	74 -AP				
BP	103/76 mmHg -AP				
Resp	17 -AP				
Patient Observation					
Observations			Q30 -FSA		
Oxygen Therapy					
SpO2	99 % -AP				
Pain/Comfort					
Preferred Pain Scale			number (Numeric Rating Pain Scale) -FSA		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -JB		0 -FSA		
Pain Rating (0-10): Activity	0 -JB		0 -FSA		
Skin WDL					
Skin WDL			WDL -FSA		

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Daily Assess (continued)

	08/21/16 0800	08/21/16 0600	08/21/16 0014
Fall Risk Assessment			
Fall Risk Indicators			3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -FSA
Fall Risk Score			9 -FSA
Patient Rights Denials			
Rights Denied or Restrictions Imposed			no -FSA
Precautions/Isolation			
Precautions (displays in banner)			Fall -FSA
Precautions Interventions			
Interventions Performed			yes -FSA
Level of Observation			every 30 minutes -FSA
Daily Sleep			
Daily Sleep (WDL)			WDL Except -FSA
Sleep/Rest/Relaxation			other (see comments) Roommate's talking in sleep keeping awake. Will use earplugs -FSA
Daily Hours of Sleep		7.0 -CR	
Mental Status			
Orientation			oriented x 4 -FSA
Level Of Consciousness			alert -FSA
General Appearance WDL			WDL except -FSA
General Appearance			unkempt -FSA
Mood			anxious -FSA
Mood/Behavior/ Affect WDL			WDL except -FSA
Affect			blunted -FSA
Behavior (WDL)			WDL except -FSA
Mood/Behavior			angry;restless -FSA
Speech			WDL -FSA
Judgment and			judgment not

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Daily Assess (continued)

	08/21/16 0800	08/21/16 0600	08/21/16 0014
Insight			appropriate to situation -FSA
Insight			fair -FSA
Concentration			fair -FSA
Memory Deficit			intact -FSA
Thought (WDL)			WDL -FSA
Coping/Psychosocial Response			
Observed Emotional State			frustrated -FSA
Verbalized Emotional State			anxiety;frustration -FSA
Coping/Psychosocial Response Interventions			
Plan Of Care Reviewed With			patient -FSA
Psychiatric Symptoms			
Anxiety Symptoms (WDL)			WDL except -FSA
Anxiety Symptoms			generalized -FSA
Manic Symptoms (WDL)			WDL -FSA
Psychotic symptoms (WDL)			WDL -FSA
Danger to Self			
Danger to Self (WDL)			WDL -FSA
Danger to Self			no suicidal ideation or behavior indicators observed or expressed -FSA
Self-Injurious Behavior			no self-injurious ideation or behavior indicators observed or expressed -FSA
Danger to Others			
Danger to Others (WDL)			WDL -FSA

Risk Screening

	08/23/16 1745	08/23/16 0830	08/23/16 0222	08/22/16 1700	08/22/16 1357
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy -AS	3-->central nervous system/psychotrop	3-->polypharmacy;3-->central nervous	3-->polypharmacy;3-->central nervous	3-->polypharmacy -SE

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

Risk Screening (continued)

	08/23/16 1745	08/23/16 0830	08/23/16 0222	08/22/16 1700	08/22/16 1357
		ic medication;2-->depression;1-->male non-skid footwear; clutter-free environment -LM	system/psychotropic medication;2-->depression;1-->male -HS	system/psychotropic medication;2-->depression;1-->male -MA	
Fall Risk Score	3 -AS	6 -LM	9 -HS	9 -MA	3 -SE
Danger to Self					
Danger to Self (WDL)	WDL -AS	WDL -LM	WDL -HS	WDL -MA	WDL -SE
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -AS	no suicidal ideation or behavior indicators observed or expressed -LM	no suicidal ideation or behavior indicators observed or expressed -HS	no suicidal ideation or behavior indicators observed or expressed -MA	no suicidal ideation or behavior indicators observed or expressed -SE
Keeps Self Safe	yes (describe) -AS				yes (describe) -SE
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -AS				no self-injurious ideation or behavior indicators observed or expressed -SE
Agreement not to Harm Self	yes (describe) -AS				yes (describe) -SE
Danger to Others					
Danger to Others (WDL)		WDL -LM	WDL -HS		WDL -SE
	08/21/16 2345	08/21/16 1919	08/21/16 0942	08/21/16 0014	
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy;3-->central nervous system/psychotropic medication;2-->depression;1-->male -FSA	3-->polypharmacy;3-->central nervous system/psychotropic medication;2-->depression;1-->male -KR	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -JB	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -FSA	
Fall Risk Score	9 -FSA	9 -KR	9 -JB	9 -FSA	
Danger to Self					
Danger to Self (WDL)	-- Asleep -FSA	WDL -KR	WDL -JB	WDL -FSA	
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -FSA	no suicidal ideation or behavior indicators observed or expressed -KR	no suicidal ideation or behavior indicators observed or expressed -JB	no suicidal ideation or behavior indicators observed or expressed -FSA	
Keeps Self Safe		yes (describe) -KR	yes (describe) -JB		
Self-Injurious Behavior	no self-injurious ideation or	no self-injurious ideation or	no self-injurious ideation or	no self-injurious ideation or	

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

Risk Screening (continued)

	08/21/16 2345	08/21/16 1919	08/21/16 0942	08/21/16 0014
	behavior indicators observed or expressed -FSA	behavior indicators observed or expressed -KR	behavior indicators observed or expressed -JB	behavior indicators observed or expressed -FSA
Self-injury Description		Denied -KR	Denied -JB	
Agreement not to Harm Self		yes (describe) -KR	yes (describe) -JB	
Description of Agreement		verbal -KR	verbal -JB	
Danger to Others				
Danger to Others (WDL)	-- Asleep -FSA	WDL -KR	WDL -JB	WDL -FSA

BH Initial Eval

	08/23/16 1745	08/23/16 1532	08/23/16 0830	08/23/16 0825	08/23/16 0700
Legal Status					
Legal status	voluntary -AS		voluntary -LM		
Evidence of Mood Disorders					
Manic Symptoms (WDL)	WDL -AS		WDL -LM		
Manic Symptoms	no problems reported or observed. -AS				
Evidence of Anxiety Disorders					
Anxiety Symptoms (WDL)	WDL except -AS		WDL except -LM		
Anxiety Symptoms	generalized -AS		fatigue;generalized -LM		
Danger to Self					
Danger to Self (WDL)	WDL -AS		WDL -LM		
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -AS		no suicidal ideation or behavior indicators observed or expressed -LM		
Keeps Self Safe	yes (describe) -AS				
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -AS				
Agreement not to Harm Self	yes (describe) -AS				
Danger to Others					
Danger to Others (WDL)			WDL -LM		

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Initial Eval (continued)

	08/23/16 1745	08/23/16 1532	08/23/16 0830	08/23/16 0825	08/23/16 0700
Mental Status					
Level Of Consciousness	alert -AS		alert -LM		
Orientation	oriented x 4 -AS		oriented x 4 -LM		
General Appearance WDL	WDL except -AS		WDL except -LM		
General Appearance	unkempt -AS		unkempt -LM		
Mood/Behavior/ Affect WDL	WDL except -AS		WDL except -LM		
Affect	flat -AS		restricted -LM		
Mood/Behavior			anxious;sad;isolative -LM		
Speech	WDL -AS		WDL -LM		
Speech	clear -AS		clear -LM		
Judgment and Insight	insight not appropriate to situation -AS		insight not appropriate to situation;judgment not appropriate to situation -LM		
Insight	fair -AS		fair -LM		
Concentration	fair -AS		fair -LM		
Memory Deficit	intact -AS		intact -LM		
Behavior (WDL)	WDL -AS		WDL except -LM		
Sleep/Rest/Relaxation					
Daily Hours of Sleep					7.0 -EG
Vital Signs					
Temp		98.4 °F (36.9 °C) -ASA		97.6 °F (36.4 °C) -FS	
Pulse		79 -ASA		79 -FS	
BP		119/64 mmHg -ASA		112/79 mmHg -FS	
Patient Position		Sitting -ASA		Sitting -FS	
Resp		16 -ASA		16 -FS	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -AS		0 -LM	0 -FS	
Pain Rating (0-10): Activity	0 -AS		0 -LM		
Comfort/Acceptable Pain Level	0 -AS				
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy -AS		3-->central nervous system/psychotropic medication;2-->depression;1--		

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Initial Eval (continued)

	08/23/16 1745	08/23/16 1532	08/23/16 0830	08/23/16 0825	08/23/16 0700
			>male non-skid footwear; clutter-free environment -LM		
Fall Risk Score	3 -AS		6 -LM		
	08/23/16 0222	08/22/16 1700	08/22/16 1600	08/22/16 1357	08/22/16 0827
Legal Status					
Legal status	voluntary -HS	voluntary -MA	voluntary -MA	voluntary -SE	
Evidence of Mood Disorders					
Manic Symptoms (WDL)	WDL -HS	WDL -MA		WDL -SE	
Evidence of Anxiety Disorders					
Anxiety Symptoms (WDL)		WDL except -MA		WDL except -SE	
Anxiety Symptoms		hot flashes -MA		generalized -SE	
Danger to Self					
Danger to Self (WDL)	WDL -HS	WDL -MA		WDL -SE	
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -HS	no suicidal ideation or behavior indicators observed or expressed -MA		no suicidal ideation or behavior indicators observed or expressed -SE	
Keeps Self Safe				yes (describe) -SE	
Self-Injurious Behavior				no self-injurious ideation or behavior indicators observed or expressed -SE	
Agreement not to Harm Self				yes (describe) -SE	
Assessment Type					
Assessment timing		Shift -MA			
Danger to Others					
Danger to Others (WDL)	WDL -HS			WDL -SE	
Mental Status					
Level Of Consciousness	asleep -HS	alert -MA		alert -SE	
Orientation		oriented x 4 -MA		oriented x 4 -SE	
General Appearance WDL		WDL except -MA		WDL except -SE	
General Appearance		unkempt -MA		unkempt -SE	
Mood/Behavior/		WDL except -MA		WDL except -SE	

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Initial Eval (continued)

	08/23/16 0222	08/22/16 1700	08/22/16 1600	08/22/16 1357	08/22/16 0827
Affect WDL					
Affect		restricted -MA		restricted -SE	
Mood/Behavior		anxious -MA		anxious;distant/aloof;isolative -SE	
Speech		WDL -MA		WDL -SE	
Speech		clear -MA		clear -SE	
Judgment and Insight		insight not appropriate to situation;judgment not appropriate to situation -MA		insight appropriate to situation -SE	
Insight		fair -MA		fair -SE	
Concentration		fair -MA		fair -SE	
Memory Deficit		intact -MA		intact -SE	
Thought Process		concrete -MA			
Behavior (WDL)				WDL except -SE	
Sleep/Rest/Relaxation					
Sleep/Rest/Relaxation		difficulty falling asleep -MA			
Vital Signs					
Temp					97.8 °F (36.6 °C) -FS
Pulse					86 -FS
BP					128/71 mmHg -FS
Patient Position					Sitting -FS
Resp					16 -FS
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -HS	number (Numeric Rating Pain Scale) -MA		number (Numeric Rating Pain Scale) -SE	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 Appears to be sleeping soundly, no c/o pain or discomfort. -HS	0 -MA		0 -SE	0 -FS
Pain Rating (0-10): Activity	0 -HS	0 -MA		0 -SE	
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy;3-->central nervous system/psychotropic medication;2-->depression;1-->male -HS	3-->polypharmacy;3-->central nervous system/psychotropic medication;2-->depression;1-->male -MA		3-->polypharmacy -SE	
Fall Risk Score	9 -HS	9 -MA		3 -SE	
	08/22/16 0600	08/21/16 2345	08/21/16 1919	08/21/16 0942	08/21/16 0800
Legal Status					

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Initial Eval (continued)

	08/22/16 0600	08/21/16 2345	08/21/16 1919	08/21/16 0942	08/21/16 0800
Legal status		voluntary -FSA	voluntary -KR	voluntary -JB	
Evidence of Mood Disorders					
Manic Symptoms (WDL)			WDL -KR	WDL -JB	
Evidence of Anxiety Disorders					
Anxiety Symptoms (WDL)		-- Asleep -FSA	WDL except -KR	WDL except -JB	
Anxiety Symptoms			difficulty controlling anxiety or worry -KR	generalized -JB	
Danger to Self					
Danger to Self (WDL)		-- Asleep -FSA	WDL -KR	WDL -JB	
Danger to Self		no suicidal ideation or behavior indicators observed or expressed -FSA	no suicidal ideation or behavior indicators observed or expressed -KR	no suicidal ideation or behavior indicators observed or expressed -JB	
Keeps Self Safe			yes (describe) -KR	yes (describe) -JB	
Self-Injurious Behavior		no self-injurious ideation or behavior indicators observed or expressed -FSA	no self-injurious ideation or behavior indicators observed or expressed -KR	no self-injurious ideation or behavior indicators observed or expressed -JB	
Self-injury Description			Denied -KR	Denied -JB	
Agreement not to Harm Self			yes (describe) -KR	yes (describe) -JB	
Description of Agreement			verbal -KR	verbal -JB	
Assessment Type					
Assessment timing				-- -JB	
Suicidal Inquiry					
Suicide Ideation for Today			None -KR		
Danger to Others					
Danger to Others (WDL)		-- Asleep -FSA	WDL -KR	WDL -JB	
Mental Status					
Level Of Consciousness		asleep -FSA	alert -KR	alert -JB	
Orientation			oriented x 4 -KR	oriented x 4 -JB	
General Appearance WDL			WDL except -KR	WDL except -JB	
General			unkempt -KR	unkempt -JB	

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Initial Eval (continued)

	08/22/16 0600	08/21/16 2345	08/21/16 1919	08/21/16 0942	08/21/16 0800
Appearance					
Mood/Behavior/ Affect WDL			WDL except -KR	WDL except -JB	
Affect			restricted -KR	blunted -JB	
Mood/Behavior			anxious;isolative -KR	anxious;isolative -JB	
Speech			WDL -KR	WDL -JB	
Speech			clear -KR	clear -JB	
Judgment and Insight			judgment appropriate to situation -KR	judgment not appropriate to situation -JB	
Insight			fair -KR	fair -JB	
Concentration			fair -KR	fair -JB	
Memory Deficit			intact -KR	intact -JB	
Thought Process			concrete -KR		
Behavior (WDL)			WDL except -KR	WDL except -JB	
Sleep/Rest/Relaxation					
Sleep/Rest/Relaxation		appears asleep -FSA		-- -JB	
Daily Hours of Sleep	7.5 -CR				
Vital Signs					
Temp			98.1 °F (36.7 °C) -KR		97.9 °F (36.6 °C) -AP
Pulse			86 -KR		74 -AP
BP			115/63 mmHg -KR		103/76 mmHg -AP
Patient Position				-- -JB	
Resp			16 -KR		17 -AP
Pain/Comfort					
Preferred Pain Scale		FACES (Wong-Baker FACES Pain Rating Scale) -FSA	number (Numeric Rating Pain Scale) -KR		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest			0 -KR	-- -JB	0 -JB
Pain Rating (0-10): Activity			0 -KR	-- -JB	0 -JB
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest		0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA			
FACES Pain Rating: Activity		0-->no hurt -FSA			
Fall Risk Assessment					
Fall Risk		3--	3--	3-->central	

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Initial Eval (continued)

	08/22/16 0600	08/21/16 2345	08/21/16 1919	08/21/16 0942	08/21/16 0800
Indicators		>polypharmacy;3-->central nervous system/psychotropic medication;2-->depression;1-->male -FSA	>polypharmacy;3-->central nervous system/psychotropic medication;2-->depression;1-->male -KR	nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -JB	
Fall Risk Score		9 -FSA	9 -KR	9 -JB	

	08/21/16 0600	08/21/16 0014
Legal Status		
Legal status		voluntary -FSA
Evidence of Mood Disorders		
Manic Symptoms (WDL)		WDL -FSA
Evidence of Anxiety Disorders		
Anxiety Symptoms (WDL)		WDL except -FSA
Anxiety Symptoms		generalized -FSA
Danger to Self		
Danger to Self (WDL)		WDL -FSA
Danger to Self		no suicidal ideation or behavior indicators observed or expressed -FSA
Self-Injurious Behavior		no self-injurious ideation or behavior indicators observed or expressed -FSA
Danger to Others		
Danger to Others (WDL)		WDL -FSA
Mental Status		
Level Of Consciousness		alert -FSA
Orientation		oriented x 4 -FSA
General Appearance WDL		WDL except -FSA
General Appearance		unkempt -FSA
Mood/Behavior/ Affect WDL		WDL except -FSA
Affect		blunted -FSA
Mood/Behavior		angry;restless -FSA

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH Initial Eval (continued)

	08/21/16 0600	08/21/16 0014
Speech		WDL -FSA
Judgment and Insight		judgment not appropriate to situation -FSA
Insight		fair -FSA
Concentration		fair -FSA
Memory Deficit		intact -FSA
Behavior (WDL)		WDL except -FSA
Sleep/Rest/Relaxation		
Sleep/Rest/Relaxation		other (see comments) Roommate's talking in sleep keeping awake. Will use earplugs -FSA
Daily Hours of Sleep	7.0 -CR	
Pain/Comfort		
Preferred Pain Scale		number (Numeric Rating Pain Scale) -FSA
Pain Assessment: Number Scale (0-10)		
Pain Rating (0-10): Rest		0 -FSA
Pain Rating (0-10): Activity		0 -FSA
Fall Risk Assessment		
Fall Risk Indicators		3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -FSA
Fall Risk Score		9 -FSA

BH OT Observations NAV IP

	08/23/16 1745	08/23/16 0830	08/22/16 1700	08/22/16 1357	08/21/16 1919
General Observations					
Mood/Behavior/Affect WDL	WDL except -AS	WDL except -LM	WDL except -MA	WDL except -SE	WDL except -KR
Affect	flat -AS	restricted -LM	restricted -MA	restricted -SE	restricted -KR
Mood	depressed but less today -AS	mood shifts;anxious;sad;isolative -LM	isolative;depressed;worried -MA	hopeful;isolative -SE	anxious -KR
Orientation	oriented x 4 -AS	oriented x 4 -LM	oriented x 4 -MA	oriented x 4 -SE	oriented x 4 -KR
Thought Process			concrete -MA		concrete -KR
Speech	clear -AS	clear -LM	clear -MA	clear -SE	clear -KR
General Appearance	WDL except -AS	WDL except -LM	WDL except -MA	WDL except -SE	WDL except -KR

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

BH OT Observations NAV IP (continued)

	08/23/16 1745	08/23/16 0830	08/22/16 1700	08/22/16 1357	08/21/16 1919
WDL					
General Appearance	unkempt -AS	unkempt -LM	unkempt -MA	unkempt -SE	unkempt -KR

	08/21/16 0942	08/21/16 0014
General Observations		
Mood/Behavior/Affect WDL	WDL except -JB	WDL except -FSA
Affect	blunted -JB	blunted -FSA
Mood	anxious -JB	anxious -FSA
Orientation	oriented x 4 -JB	oriented x 4 -FSA
Speech	clear -JB	
General Appearance WDL	WDL except -JB	WDL except -FSA
General Appearance	unkempt -JB	unkempt -FSA

Adult Care Sum F14

	08/23/16 2014	08/23/16 1745	08/23/16 1406	08/23/16 0830	08/23/16 0825
Plan of Care Review					
Plan Of Care Reviewed With	patient -AS		patient -ASA (r) LM (t)	patient -LM	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -AS		0 -LM	0 -FS
Pain Rating (0-10): Activity		0 -AS		0 -LM	
Comfort/Acceptable Pain Level		0 -AS			
Coping/Psychosocial					
Observed Emotional State		accepting -AS		anxious;withdrawn;sad -LM	
Verbalized Emotional State		hopefulness -AS		anxiety;depression;hopefulness -LM	
Coping Strategies					
Supportive Measures		goal setting facilitated -AS		self-care encouraged;active listening utilized -LM	
Family/Support System Care				self-care encouraged -LM	
Coping/Psychosocial Interventions					
Behavior Management				behavioral plan reviewed -LM	
HEENT					
HEENT WDL		WDL -AS		WDL -LM	
Cognitive					
Memory Deficit		intact -AS		intact -LM	
Neuro					

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/23/16 2014	08/23/16 1745	08/23/16 1406	08/23/16 0830	08/23/16 0825
Level Of Consciousness		alert -AS		alert -LM	
Orientation		oriented x 4 -AS		oriented x 4 -LM	
General Appearance					
General Appearance WDL		WDL except -AS		WDL except -LM	
General Appearance		unkempt -AS		unkempt -LM	
Mood/Behavior/Affect					
Mood/Behavior/ Affect WDL		WDL except -AS		WDL except -LM	
Affect		flat -AS		restricted -LM	
Mood/Behavior				anxious;sad;isolative -LM	
Speech					
Speech		WDL -AS		WDL -LM	
Speech		clear -AS		clear -LM	
Thought Process					
Judgment and Insight		insight not appropriate to situation -AS		insight not appropriate to situation;judgment not appropriate to situation -LM	
Oxygen Therapy					
SpO2					100 % -FS
O2 Device					room air -FS
Skin					
Skin WDL		WDL -AS		WDL -LM	
Safety Interventions					
Precautions (displays in banner)		None -AS		None -LM	
Fall Risk Indicators		3-->polypharmacy -AS		3-->central nervous system/psychotropic medication;2-->depression;1-->male non-skid footwear; clutter-free environment -LM	
Fall Risk Score		3 -AS		6 -LM	
	08/23/16 0700	08/23/16 0222	08/22/16 2120	08/22/16 1700	08/22/16 1411
Plan of Care Review					
Plan Of Care Reviewed With			patient -MA	patient -MA	patient -SE
Pain/Comfort/Sleep					
Preferred Pain		number (Numeric		number (Numeric	

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/23/16 0700	08/23/16 0222	08/22/16 2120	08/22/16 1700	08/22/16 1411
Scale		Rating Pain Scale) -HS		Rating Pain Scale) -MA	
Sleep/Rest/Relaxation				difficulty falling asleep -MA	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 Appears to be sleeping soundly, no c/o pain or discomfort. -HS		0 -MA	
Pain Rating (0-10): Activity		0 -HS		0 -MA	
Sleep/Rest/Relaxation					
Daily Hours of Sleep	7.0 -EG				
Coping/Psychosocial					
Observed Emotional State				anxious -MA	
Verbalized Emotional State				anxiety -MA	
HEENT					
HEENT WDL				WDL -MA	
Cognitive					
Memory Deficit				intact -MA	
Neuro					
Level Of Consciousness		asleep -HS		alert -MA	
Orientation				oriented x 4 -MA	
General Appearance					
General Appearance WDL				WDL except -MA	
General Appearance				unkempt -MA	
Mood/Behavior/Affect					
Mood/Behavior/Affect WDL				WDL except -MA	
Affect				restricted -MA	
Mood/Behavior				anxious -MA	
Speech					
Speech				WDL -MA	
Speech				clear -MA	
Thought Process					
Judgment and Insight				insight not appropriate to situation;judgment not appropriate to situation -MA	
Thought Process				concrete -MA	

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/23/16 0700	08/23/16 0222	08/22/16 2120	08/22/16 1700	08/22/16 1411
Skin					
Skin WDL		WDL -HS		WDL -MA	
Safety Interventions					
Precautions (displays in banner)		None -HS		None -MA	
Fall Risk Indicators		3-->polypharmacy;3-->central nervous system/psychotropic medication;2-->depression;1-->male -HS		3-->polypharmacy;3-->central nervous system/psychotropic medication;2-->depression;1-->male -MA	
Fall Risk Score		9 -HS		9 -MA	
	08/22/16 1357	**08/22/16 0827**	**08/22/16 0600**	**08/21/16 2345**	**08/21/16 2306**
Plan of Care Review					
Plan Of Care Reviewed With	patient -SE				patient -KR
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -SE			FACES (Wong-Baker FACES Pain Rating Scale) -FSA	
Sleep/Rest/Relaxation				appears asleep -FSA	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -SE	0 -FS			
Pain Rating (0-10): Activity	0 -SE				
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest				0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA	
FACES Pain Rating: Activity				0-->no hurt -FSA	
Sleep/Rest/Relaxation					
Daily Hours of Sleep			7.5 -CR		
Coping/Psychosocial					
Observed Emotional State	calm;hopeful -SE				
Verbalized Emotional State	hopefulness;relief -SE				
Cognitive					
Memory Deficit	intact -SE				
Neuro					
Level Of	alert -SE			asleep -FSA	

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/22/16 1357	08/22/16 0827	08/22/16 0600	08/21/16 2345	08/21/16 2306
Consciousness					
Orientation	oriented x 4 -SE				
General Appearance					
General Appearance WDL	WDL except -SE				
General Appearance	unkempt -SE				
Mood/Behavior/Affect					
Mood/Behavior/ Affect WDL	WDL except -SE				
Affect	restricted -SE				
Mood/Behavior	anxious;distant/aloof;isolative -SE				
Speech					
Speech	WDL -SE				
Speech	clear -SE				
Thought Process					
Judgment and Insight	insight appropriate to situation -SE				
Oxygen Therapy					
SpO2		100 % -FS			
O2 Device		room air -FS			
Skin					
Skin WDL	WDL -SE			WDL -FSA	
Safety Interventions					
Precautions (displays in banner)	None -SE			Fall -FSA	
Fall Risk Indicators	3-->polypharmacy -SE			3-->polypharmacy;3-->central nervous system/psychotropic medication;2-->depression;1-->male -FSA	
Fall Risk Score	3 -SE			9 -FSA	

	08/21/16 1919	08/21/16 1129	08/21/16 0942	08/21/16 0800	08/21/16 0600
Plan of Care Review					
Plan Of Care Reviewed With	patient -KR	patient -JB	patient -JB		
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -KR				
Sleep/Rest/Relaxation			-- -JB		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-	0 -KR		-- -JB	0 -JB	

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/21/16 1919	08/21/16 1129	08/21/16 0942	08/21/16 0800	08/21/16 0600
10): Rest					
Pain Rating (0-10): Activity	0 -KR		-- -JB	0 -JB	
Sleep/Rest/Relaxation					
Daily Hours of Sleep					7.0 -CR
Coping/Psychosocial					
Observed Emotional State	calm;quiet;restless -KR		withdrawn;calm -JB		
Verbalized Emotional State	anxiety;depression -KR		depression -JB		
HEENT					
HEENT WDL	WDL -KR		WDL -JB		
Cognitive					
Memory Deficit	intact -KR		intact -JB		
Neuro					
Level Of Consciousness	alert -KR		alert -JB		
Orientation	oriented x 4 -KR		oriented x 4 -JB		
General Appearance					
General Appearance WDL	WDL except -KR		WDL except -JB		
General Appearance	unkempt -KR		unkempt -JB		
Mood/Behavior/Affect					
Mood/Behavior/ Affect WDL	WDL except -KR		WDL except -JB		
Affect	restricted -KR		blunted -JB		
Mood/Behavior	anxious;isolative -KR		anxious;isolative -JB		
Speech					
Speech	WDL -KR		WDL -JB		
Speech	clear -KR		clear -JB		
Thought Process					
Judgment and Insight	judgment appropriate to situation -KR		judgment not appropriate to situation -JB		
Thought Process	concrete -KR				
Oxygen Therapy					
SpO2	100 % -KR			99 % -AP	
O2 Device	room air -KR		-- -JB		
Skin					
Skin WDL	WDL -KR		WDL -JB		
Safety Interventions					
Precautions (displays in	Fall -KR		Fall -JB		

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/21/16 1919	08/21/16 1129	08/21/16 0942	08/21/16 0800	08/21/16 0600
banner)					
Fall Risk Indicators	3-->polypharmacy;3-->central nervous system/psychotropic medication;2-->depression;1-->male -KR		3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -JB		
Fall Risk Score	9 -KR		9 -JB		

	08/21/16 0014
Plan of Care Review	
Plan Of Care Reviewed With	patient -FSA
Pain/Comfort/Sleep	
Preferred Pain Scale	number (Numeric Rating Pain Scale) -FSA
Sleep/Rest/Relaxation	other (see comments) Roommate's talking in sleep keeping awake. Will use earplugs -FSA
Pain Assessment: Number Scale (0-10)	
Pain Rating (0-10): Rest	0 -FSA
Pain Rating (0-10): Activity	0 -FSA
Coping/Psychosocial	
Observed Emotional State	frustrated -FSA
Verbalized Emotional State	anxiety;frustration -FSA
Cognitive	
Memory Deficit	intact -FSA
Neuro	
Level Of Consciousness	alert -FSA
Orientation	oriented x 4 -FSA
General Appearance	
General Appearance WDL	WDL except -FSA
General Appearance	unkempt -FSA
Mood/Behavior/Affect	
Mood/Behavior/Affect WDL	WDL except -FSA
Affect	blunted -FSA
Mood/Behavior	angry;restless -FSA

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/21/16 0014
Speech	
Speech	WDL -FSA
Thought Process	
Judgment and Insight	judgment not appropriate to situation -FSA
Skin	
Skin WDL	WDL -FSA
Safety Interventions	
Precautions (displays in banner)	Fall -FSA
Fall Risk Indicators	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -FSA
Fall Risk Score	9 -FSA

Social Work Assessment

	08/23/16 1745	08/22/16 1357	08/21/16 2345	08/21/16 1919	08/21/16 0942
Suicide Risk					
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -AS	no self-injurious ideation or behavior indicators observed or expressed -SE	no self-injurious ideation or behavior indicators observed or expressed -FSA	no self-injurious ideation or behavior indicators observed or expressed -KR	no self-injurious ideation or behavior indicators observed or expressed -JB
Self-injury Description				Denied -KR	Denied -JB

	08/21/16 0014
Suicide Risk	
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -FSA

(r) = User Recd, (t) = User Taken, (c) = User Cosigned

User Key

Initials	Name	Effective Dates
JB	Britt, Julia Anna, RN	03/12/15 -
LM	Marin, Lisa Nicole, RN	05/20/15 -
MA	Abend, Marquel Marie, RN	11/10/15 -
SE	Edwards, Sarah C, RN	02/05/15 -
RE	Ellison, Ricky, RN	02/05/15 -
EG	Garza, Efren A, RN	02/05/15 -

All Flowsheet Data (08/21/16 0000--08/23/16 2359) (continued)

(r) = User Recd, (t) = User Taken, (c) = User Cosigned

User Key (continued)

Initials	Name	Effective Dates
AP	Parrish, Alan	03/31/16 -
CR	Richardson, Cleo, RN	02/05/15 -
FSA	Scurry-Scott, Frazier M, RN	02/05/15 -
AS	Senior, Adolfo A, RN	02/05/15 -
FS	Sepulveda, Francis R	04/06/16 -
ASA	Smith, Arthur L, CNA	07/02/15 -
HS	Smith, Hilda, RN	02/05/15 -
KR	Rowny, Katharine Lynne, RN	04/09/15 -

All Flowsheet Data (08/18/16 0000--08/20/16 2359)

MAR MINI-FLOWSHEET DATA

	08/20/16 1700	08/20/16 1300	08/20/16 0200	08/19/16 1613	08/19/16 0900
Pain					
Pain Rating (0-10): Rest	0 -MA	0 -DY	0 -IH	0 -EM	0 -LM
Pain Rating (0-10): Activity	0 -MA	0 -DY	0 -IH	0 -EM	0 -LM

	08/19/16 0802	08/18/16 1900	08/18/16 1000	08/18/16 0820	
Pain					
Pain Rating (0-10): Rest	0 -FS	0 -MA	0 -LM	0 -FS	
Pain Rating (0-10): Activity		0 -MA	0 -LM		

CARE PLAN MINI-FLOWSHEET DATA

	08/20/16 1742	08/20/16 1700	08/20/16 1339	08/20/16 1300	08/20/16 0239
Depression (Adult,Obstetrics,Pediatric)					
Establish/Maintain Self-Care Routine					making progress toward outcome -IH
Improved/Stable Mood			making progress toward outcome -DY		making progress toward outcome -IH
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -FSA (r) MA (t)	patient -MA	patient -DY	patient -DY	patient -IH
Plan of Care Review					
Progress	**(p) progress toward functional goals is gradual** -MA		improving -DY		
Fall Risk (Adult)					
Absence of Falls			making progress toward outcome -DY		making progress toward outcome -IH
Constipation (Adult)					
Effective Bowel Elimination			making progress toward outcome -DY		
Comfort			making progress toward outcome -DY		

	08/20/16 0200	08/19/16 1902	08/19/16 1613	08/19/16 1442	08/19/16 0958
Depression (Adult,Obstetrics,Pediatric)					
Establish/Maintain Self-Care Routine					unable to achieve outcome -LM
Improved/Stable Mood					unable to achieve outcome -LM
Coping/Psychosocial Response Interventions					

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

CARE PLAN MINI-FLOWSHEET DATA (continued)

	08/20/16 0200	08/19/16 1902	08/19/16 1613	08/19/16 1442	08/19/16 0958
Plan Of Care Reviewed With	patient -IH	patient -EM	patient -EM	patient -LM	
Plan of Care Review					
Progress		improving -EM		progress toward functional goals is gradual -LM	
Fall Risk (Adult)					
Absence of Falls					making progress toward outcome -LM
Constipation (Adult)					
Effective Bowel Elimination					making progress toward outcome -LM
Comfort					making progress toward outcome -LM

	08/19/16 0900	08/19/16 0511	08/19/16 0006	08/18/16 1900	08/18/16 1425
Depression (Adult,Obstetrics,Pediatric)					
Establish/Maintain Self-Care Routine					making progress toward outcome -LM
Improved/Stable Mood					making progress toward outcome -LM
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -LM	patient -MA	patient -MA	patient -MA	patient -LM
Plan of Care Review					
Progress		progress towards functional goals is fair -MA	progress toward functional goals is gradual -MA		progress toward functional goals is gradual -LM
Fall Risk (Adult)					
Absence of Falls					making progress toward outcome -LM
Constipation (Adult)					
Effective Bowel Elimination					making progress toward outcome -LM
Comfort					making progress toward outcome -LM

	08/18/16 1000
Coping/Psychosocial Response Interventions	
Plan Of Care Reviewed With	patient -LM

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All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/20/16 1700	08/20/16 1300	08/20/16 0800	08/20/16 0200	08/19/16 1613
Vital Signs					
Temp	98.1 °F (36.7 °C) -MA		98 °F (36.7 °C) -AP		98 °F (36.7 °C) -AS
Pulse	92 -MA		64 -AP		79 -AS
BP	118/70 mmHg -MA		101/70 mmHg -AP		141/79 mmHg -AS
Patient Position	Sitting -MA				Sitting -AS
BP Location	Left arm -MA				Right arm -AS
BP Method	Automatic -MA				
Resp	16 -MA		17 -AP		16 -AS
Skin					
Skin WDL	WDL -MA			WDL except -IH	WDL except -EM
Skin Integrity					other (see comments) psoriasis -EM
Pain/Comfort, Non Labor					
Pain Rating (0-10): Rest	0 -MA	0 -DY		0 -IH	0 -EM
Pain Rating (0-10): Activity	0 -MA	0 -DY		0 -IH	0 -EM
Comfort/Acceptable Pain Level					3 -EM
Postpartum Interventions					
Bathing/Skin Care		patient refused -DY		patient refused -IH	patient refused -EM
Post Anesthesia					
Orientation	oriented x 4 -MA	oriented x 4 -DY		oriented x 4 -IH	oriented x 4 -EM
Oxygen Therapy during Labor					
SpO2	100 % -MA		99 % -AP		
O2 Device	room air -MA				
Patient Observation					
Observations	Q30 -MA	Q30 -DY		Q30 -IH	Q30 -EM
Cognitive					
Memory Deficit	intact -MA	intact -DY		intact -IH	intact -EM
Fall Risk Assessment					
Fall Risk Indicators	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -MA	3-->polypharmacy;1-->male;2-->depression;3-->central nervous system/psychotropic medication -DY		3-->polypharmacy;1-->male;2-->depression;3-->central nervous system/psychotropic medication -IH	3-->polypharmacy;1-->male;2-->depression;3-->central nervous system/psychotropic medication -EM
Fall Risk Score	9 -MA	9 -DY		9 -IH	9 -EM
Danger to Self					
Danger to Self (WDL)	WDL -MA	WDL -DY		WDL -IH	WDL -EM

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/20/16 1700	08/20/16 1300	08/20/16 0800	08/20/16 0200	08/19/16 1613
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -MA	no suicidal ideation or behavior indicators observed or expressed -DY		no suicidal ideation or behavior indicators observed or expressed -IH	no suicidal ideation or behavior indicators observed or expressed -EM
Keeps Self Safe				yes (describe) -IH	yes (describe) -EM
Description of Suicide Plan					Denied -EM
Self-Injurious Behavior		no self-injurious ideation or behavior indicators observed or expressed -DY		no self-injurious ideation or behavior indicators observed or expressed -IH	no self-injurious ideation or behavior indicators observed or expressed -EM
Self-injury Description		Denied -DY		Denied -IH	Denied -EM
Agreement not to Harm Self		yes (describe) -DY		yes (describe) -IH	yes (describe) -EM
Description of Agreement					verbal -EM
Pain/Comfort/Sleep Interventions					
Sleep/Rest Enhancement		-- -DY		awakenings minimized;regular sleep/rest pattern promoted -IH	awakenings minimized;regular sleep/rest pattern promoted -EM
Danger to Others					
Danger to Others (WDL)	WDL -MA	WDL -DY		WDL -IH	WDL -EM
Precautions/Isolation					
Precautions (displays in banner)	Fall -MA	Fall -DY		Fall -IH	Fall -EM

	08/19/16 0900	08/19/16 0802	08/19/16 0031	08/18/16 1900	08/18/16 1542
Vital Signs					
Temp		97.8 °F (36.6 °C) -FS			98.1 °F (36.7 °C) -AS
Temp src		Oral -FS			
Pulse		81 -FS			79 -AS
BP		136/83 mmHg -FS			128/71 mmHg -AS
Patient Position		Sitting -FS			Sitting -AS
BP Location		Left arm -FS			Right arm -AS
BP Method		Automatic -FS			
Resp		16 -FS			16 -AS
Skin					
Skin WDL	WDL except -LM		WDL except -MA	WDL -MA	

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/19/16 0900	08/19/16 0802	08/19/16 0031	08/18/16 1900	08/18/16 1542
Skin Integrity	other (see comments) psoriasis -LM		bruise(s) from blood draws -MA		
Pain/Comfort, Non Labor					
Pain Rating (0-10): Rest	0 -LM	0 -FS		0 -MA	
Pain Rating (0-10): Activity	0 -LM			0 -MA	
FACES Pain Rating: Rest			0-->no hurt -MA		
FACES Pain Rating: Activity			0-->no hurt -MA		
Post Anesthesia					
Orientation	oriented x 4 -LM			oriented x 4 -MA	
Oxygen Therapy during Labor					
SpO2		100 % -FS			
O2 Device		room air -FS			
Patient Observation					
Observations	Q30 -LM		Q30 -MA	Q30 -MA	
Cognitive					
Memory Deficit	intact -LM			intact -MA	
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication non-skid footwear; clutter-free environment -LM		3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -MA	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -MA	
Fall Risk Score	9 -LM		9 -MA	9 -MA	
Danger to Self					
Danger to Self (WDL)	WDL -LM		WDL pt appears asleep -MA	WDL -MA	
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -LM			no suicidal ideation or behavior indicators observed or expressed -MA	
Agreement not to Harm Self	yes (describe) -LM				
Danger to Others					
Danger to Others (WDL)	WDL -LM		WDL pt appears asleep -MA	WDL -MA	
Precautions/Isolation					
Precautions (displays in banner)	None -LM		None -MA	None -MA	

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/18/16 1000	08/18/16 0820	08/18/16 0050
Vital Signs			
Temp		97.7 °F (36.5 °C) -FS	
Temp src		Oral -FS	
Pulse		98 -FS	
BP		131/86 mmHg -FS	
Patient Position		Sitting -FS	
BP Location		Left arm -FS	
BP Method		Automatic -FS	
Resp		17 -FS	
Skin			
Skin WDL	WDL except -LM		WDL except;all;color -FSA
Skin Integrity	other (see comments) psoriasis -LM		
Pain/Comfort, Non Labor			
Pain Rating (0-10): Rest	0 -LM	0 -FS	
Pain Rating (0-10): Activity	0 -LM		
FACES Pain Rating: Rest			0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA
FACES Pain Rating: Activity			0-->no hurt -FSA
Post Anesthesia			
Orientation	oriented x 4 -LM		
Oxygen Therapy during Labor			
SpO2		98 % -FS	
O2 Device		room air -FS	
Patient Observation			
Observations	Q30 -LM		Q30 -FSA
Cognitive			
Memory Deficit	intact -LM		
Fall Risk Assessment			
Fall Risk Indicators	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication non-skid footwear; clutter-free environment -LM		3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -FSA
Fall Risk Score	9 -LM		9 -FSA
Danger to Self			

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/18/16 1000	08/18/16 0820	08/18/16 0050
Danger to Self (WDL)	WDL -LM		-- Asleep -FSA
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -LM		
Keeps Self Safe	yes (describe) -LM		
Description of Suicide Plan	Pt denies current SI -LM		
Agreement not to Harm Self	yes (describe) -LM		
Description of Agreement	verbal; will come to staff -LM		
Danger to Others			
Danger to Others (WDL)	WDL -LM		-- Asleep -FSA
Precautions/Isolation			
Precautions (displays in banner)	None -LM		None -FSA

BH PS Main

	08/20/16 1700	08/20/16 1300	08/20/16 0200	08/19/16 1613	08/19/16 0900
Legal Status					
Legal status	voluntary -MA	voluntary -DY	voluntary -IH	voluntary -EM	voluntary -LM
Risk Assessment					
Danger to Self (WDL)	WDL -MA	WDL -DY	WDL -IH	WDL -EM	WDL -LM
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -MA	no suicidal ideation or behavior indicators observed or expressed -DY	no suicidal ideation or behavior indicators observed or expressed -IH	no suicidal ideation or behavior indicators observed or expressed -EM	no suicidal ideation or behavior indicators observed or expressed -LM
Keeps Self Safe			yes (describe) -IH	yes (describe) -EM	
Description of Suicide Plan				Denied -EM	
Self-Injurious Behavior		no self-injurious ideation or behavior indicators observed or expressed -DY	no self-injurious ideation or behavior indicators observed or expressed -IH	no self-injurious ideation or behavior indicators observed or expressed -EM	
Self-injury Description		Denied -DY	Denied -IH	Denied -EM	
Agreement not to Harm Self		yes (describe) -DY	yes (describe) -IH	yes (describe) -EM	yes (describe) -LM
Description of Agreement				verbal -EM	

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH PS Main (continued)

	08/20/16 1700	08/20/16 1300	08/20/16 0200	08/19/16 1613	08/19/16 0900
Assessment timing	Shift -MA			Shift -EM	
Assessment of Risk Factors				Deficits in social, decision, and coping skills;Prior suicide attempts -EM	
Assessment of Protective Factors				Good access to health care/therapy -EM	
Danger to Others (WDL)	WDL -MA	WDL -DY	WDL -IH	WDL -EM	WDL -LM
	08/19/16 0031	08/18/16 1900	08/18/16 1000	08/18/16 0050	
Legal Status					
Legal status	voluntary -MA	voluntary -MA	voluntary -LM	voluntary -FSA	
Risk Assessment					
Danger to Self (WDL)	WDL pt appears asleep -MA	WDL -MA	WDL -LM	-- Asleep -FSA	
Danger to Self		no suicidal ideation or behavior indicators observed or expressed -MA	no suicidal ideation or behavior indicators observed or expressed -LM		
Keeps Self Safe			yes (describe) -LM		
Description of Suicide Plan			Pt denies current SI -LM		
Agreement not to Harm Self			yes (describe) -LM		
Description of Agreement			verbal; will come to staff -LM		
Assessment timing	Shift -MA	Shift -MA			
Danger to Others (WDL)	WDL pt appears asleep -MA	WDL -MA	WDL -LM	-- Asleep -FSA	

BH Tx Plan MH IP

	08/19/16 1000
Patient Assets/Stressors	
Patient Assets	general fund of knowledge;average or above intelligence;motivation for treatment/growth;capable of independent living;supportive family/friends;work skills;physical health;ability for

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Tx Plan MH IP (continued)

	08/19/16 1000
	insight;communication skills -PK
Patient Stressors	medication change or non-compliance -PK
Discharge Planning	
Discharge Criteria	improved stabilization in mood, thinking and/or behavior;verbal commitment to aftercare and medication compliance -PK
Recommended Discharge Plan	return to previous living environment;medication management with psychiatrist or other physician -PK
Pt's Acceptance of Discharge Plan	yes -PK
Why Continues to Need Hospitalization	severe impairment of level of functioning;danger to self or others;medication stabilization -PK
Estimated Length of Stay	3-5 days -PK
Provisional DSM 5 Diagnoses	
Problem Being Addressed	refer to problem list -PK
Goal: Will work with social worker/treatment coordinator to develop safe discharge plan	
Goal Status	goal initiated -PK
Goal: Will attend Occupational Therapy groups up to seven days weekly as tolerated	
Objectives	increase coping skills -PK
Goal Status	progress made toward outcome -PK
Treatment Plan Reviewed by	
Psychiatric Social Worker	Guerian -PK
Registered Nurse	Kader -PK
Nurse Manager	Han -PK

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Tx Plan MH IP (continued)

	08/19/16 1000
Occupational Therapist	Clare -PK
Other	Leveton -PK

VS Simple

	08/20/16 1700	08/20/16 1300	08/20/16 0800	08/20/16 0200	08/19/16 1613
Vital Signs					
Temp	98.1 °F (36.7 °C) -MA		98 °F (36.7 °C) -AP		98 °F (36.7 °C) -AS
Pulse	92 -MA		64 -AP		79 -AS
Pulse Source	Brachial -MA				
BP	118/70 mmHg -MA		101/70 mmHg -AP		141/79 mmHg -AS
Patient Position	Sitting -MA				Sitting -AS
BP Location	Left arm -MA				Right arm -AS
BP Method	Automatic -MA				
Resp	16 -MA		17 -AP		16 -AS
Oxygen Therapy					
SpO2	100 % -MA		99 % -AP		
O2 Device	room air -MA				
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -MA			number (Numeric Rating Pain Scale) -IH	number (Numeric Rating Pain Scale) -EM
Sleep/Rest/Relaxation	sleeping between care -MA	-- -DY		unable to go back to sleep;sleep interrupted -IH	unable to go back to sleep;sleep interrupted -EM
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -MA	0 -DY		0 -IH	0 -EM
Pain Rating (0-10): Activity	0 -MA	0 -DY		0 -IH	0 -EM
Comfort/Acceptable Pain Level					3 -EM
Patient Observation					
Observations	Q30 -MA	Q30 -DY		Q30 -IH	Q30 -EM

	08/19/16 0900	08/19/16 0802	08/19/16 0031	08/18/16 1900	08/18/16 1542
Vital Signs					
Temp		97.8 °F (36.6 °C) -FS			98.1 °F (36.7 °C) -AS
Temp src		Oral -FS			
Pulse		81 -FS			79 -AS
BP		136/83 mmHg -FS			128/71 mmHg -AS
Patient Position		Sitting -FS			Sitting -AS
BP Location		Left arm -FS			Right arm -AS
BP Method		Automatic -FS			
Resp		16 -FS			16 -AS

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

VS Simple (continued)

	08/19/16 0900	08/19/16 0802	08/19/16 0031	08/18/16 1900	08/18/16 1542
Oxygen Therapy					
SpO2		100 % -FS			
O2 Device		room air -FS			
Pain/Comfort/Sleep					
Preferred Pain Scale				number (Numeric Rating Pain Scale) -MA	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -LM	0 -FS		0 -MA	
Pain Rating (0-10): Activity	0 -LM			0 -MA	
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest			0-->no hurt -MA		
FACES Pain Rating: Activity			0-->no hurt -MA		
Patient Observation					
Observations	Q30 -LM		Q30 -MA	Q30 -MA	

	08/18/16 1000	08/18/16 0820	08/18/16 0050
Vital Signs			
Temp		97.7 °F (36.5 °C) -FS	
Temp src		Oral -FS	
Pulse		98 -FS	
BP		131/86 mmHg -FS	
Patient Position		Sitting -FS	
BP Location		Left arm -FS	
BP Method		Automatic -FS	
Resp		17 -FS	
Oxygen Therapy			
SpO2		98 % -FS	
O2 Device		room air -FS	
Pain/Comfort/Sleep			
Preferred Pain Scale			FACES (Wong-Baker FACES Pain Rating Scale) -FSA
Sleep/Rest/Relaxation			appears asleep -FSA
Pain Assessment: Number Scale (0-10)			
Pain Rating (0-10): Rest	0 -LM	0 -FS	
Pain Rating (0-10): Activity	0 -LM		
Pain Assessment: FACES Scale			
FACES Pain Rating: Rest			0-->no hurt Appears asleep with no signs/sx of

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

VS Simple (continued)

	08/18/16 1000	08/18/16 0820	08/18/16 0050
			pain/discomfort observed -FSA
FACES Pain Rating: Activity			0-->no hurt -FSA
Patient Observation			
Observations	Q30 -LM		Q30 -FSA

VS Simple

	08/20/16 1700	08/20/16 1300	08/20/16 0800	08/20/16 0200	08/19/16 1613
Vital Signs					
Temp	98.1 °F (36.7 °C) -MA		98 °F (36.7 °C) -AP		98 °F (36.7 °C) -AS
Pulse	92 -MA		64 -AP		79 -AS
Pulse Source	Brachial -MA				
BP	118/70 mmHg -MA		101/70 mmHg -AP		141/79 mmHg -AS
Patient Position	Sitting -MA				Sitting -AS
BP Location	Left arm -MA				Right arm -AS
BP Method	Automatic -MA				
Resp	16 -MA		17 -AP		16 -AS
Oxygen Therapy					
SpO2	100 % -MA		99 % -AP		
O2 Device	room air -MA				
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -MA			number (Numeric Rating Pain Scale) -IH	number (Numeric Rating Pain Scale) -EM
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -MA	0 -DY		0 -IH	0 -EM
Pain Rating (0-10): Activity	0 -MA	0 -DY		0 -IH	0 -EM
Comfort/Acceptable Pain Level					3 -EM
Patient Observation					
Observations	Q30 -MA	Q30 -DY		Q30 -IH	Q30 -EM

	08/19/16 0900	08/19/16 0802	08/19/16 0031	08/18/16 1900	08/18/16 1542
Vital Signs					
Temp		97.8 °F (36.6 °C) -FS			98.1 °F (36.7 °C) -AS
Temp src		Oral -FS			
Pulse		81 -FS			79 -AS
BP		136/83 mmHg -FS			128/71 mmHg -AS
Patient Position		Sitting -FS			Sitting -AS
BP Location		Left arm -FS			Right arm -AS
BP Method		Automatic -FS			
Resp		16 -FS			16 -AS
Oxygen Therapy					

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

VS Simple (continued)

	08/19/16 0900	08/19/16 0802	08/19/16 0031	08/18/16 1900	08/18/16 1542
SpO2		100 % -FS			
O2 Device		room air -FS			
Pain/Comfort					
Preferred Pain Scale				number (Numeric Rating Pain Scale) -MA	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -LM	0 -FS		0 -MA	
Pain Rating (0-10): Activity	0 -LM			0 -MA	
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest			0-->no hurt -MA		
FACES Pain Rating: Activity			0-->no hurt -MA		
Patient Observation					
Observations	Q30 -LM		Q30 -MA	Q30 -MA	

	08/18/16 1000	08/18/16 0820	08/18/16 0050
Vital Signs			
Temp		97.7 °F (36.5 °C) -FS	
Temp src		Oral -FS	
Pulse		98 -FS	
BP		131/86 mmHg -FS	
Patient Position		Sitting -FS	
BP Location		Left arm -FS	
BP Method		Automatic -FS	
Resp		17 -FS	
Oxygen Therapy			
SpO2		98 % -FS	
O2 Device		room air -FS	
Pain/Comfort			
Preferred Pain Scale			FACES (Wong-Baker FACES Pain Rating Scale) -FSA
Pain Assessment: Number Scale (0-10)			
Pain Rating (0-10): Rest	0 -LM	0 -FS	
Pain Rating (0-10): Activity	0 -LM		
Pain Assessment: FACES Scale			
FACES Pain Rating: Rest			0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA
FACES Pain Rating: Activity			0-->no hurt -FSA

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

VS Simple (continued)

	08/18/16 1000	08/18/16 0820	08/18/16 0050
Patient Observation			
Observations	Q30 -LM		Q30 -FSA

Pain Scales

	08/20/16 1700	08/20/16 1300	08/20/16 0200	08/19/16 1613	08/19/16 0900
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -MA		number (Numeric Rating Pain Scale) -IH	number (Numeric Rating Pain Scale) -EM	
Sleep/Rest/Relaxation	sleeping between care -MA	-- -DY	unable to go back to sleep;sleep interrupted -IH	unable to go back to sleep;sleep interrupted -EM	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -MA	0 -DY	0 -IH	0 -EM	0 -LM
Pain Rating (0-10): Activity	0 -MA	0 -DY	0 -IH	0 -EM	0 -LM
Comfort/Acceptable Pain Level				3 -EM	

	08/19/16 0802	08/19/16 0031	08/18/16 1900	08/18/16 1000	08/18/16 0820
Pain/Comfort/Sleep					
Preferred Pain Scale			number (Numeric Rating Pain Scale) -MA		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -FS		0 -MA	0 -LM	0 -FS
Pain Rating (0-10): Activity			0 -MA	0 -LM	
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest		0-->no hurt -MA			
FACES Pain Rating: Activity		0-->no hurt -MA			

	08/18/16 0050
Pain/Comfort/Sleep	
Preferred Pain Scale	FACES (Wong-Baker FACES Pain Rating Scale) -FSA
Sleep/Rest/Relaxation	appears asleep -FSA
Pain Assessment: FACES Scale	
FACES Pain Rating: Rest	0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA
FACES Pain Rating: Activity	0-->no hurt -FSA

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

Pain Reassessment

	08/20/16 1700	08/20/16 1300	08/20/16 0200	08/19/16 1613	08/19/16 0900
Pain/Comfort/Sleep					
Sleep/Rest/Relaxation	sleeping between care -MA	-- -DY	unable to go back to sleep;sleep interrupted -IH	unable to go back to sleep;sleep interrupted -EM	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -MA	0 -DY	0 -IH	0 -EM	0 -LM
Pain Rating (0-10): Activity	0 -MA	0 -DY	0 -IH	0 -EM	0 -LM
Comfort/Acceptable Pain Level				3 -EM	
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -MA		number (Numeric Rating Pain Scale) -IH	number (Numeric Rating Pain Scale) -EM	

	08/19/16 0802	08/19/16 0031	08/18/16 1900	08/18/16 1000	08/18/16 0820
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -FS		0 -MA	0 -LM	0 -FS
Pain Rating (0-10): Activity			0 -MA	0 -LM	
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest		0-->no hurt -MA			
FACES Pain Rating: Activity		0-->no hurt -MA			
Pain/Comfort					
Preferred Pain Scale			number (Numeric Rating Pain Scale) -MA		

	08/18/16 0050
Pain/Comfort/Sleep	
Sleep/Rest/Relaxation	appears asleep -FSA
Pain Assessment: FACES Scale	
FACES Pain Rating: Rest	0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA
FACES Pain Rating: Activity	0-->no hurt -FSA
Pain/Comfort	
Preferred Pain Scale	FACES (Wong-Baker FACES Pain Rating Scale) -FSA

BH Daily Assess

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Daily Assess (continued)

	08/20/16 1742	08/20/16 1700	08/20/16 1339	08/20/16 1300	08/20/16 0800
Legal Status					
Legal status		voluntary -MA		voluntary -DY	
Vital Signs					
Temp		98.1 °F (36.7 °C) -MA			98 °F (36.7 °C) -AP
Pulse		92 -MA			64 -AP
Pulse Source		Brachial -MA			
BP		118/70 mmHg -MA			101/70 mmHg -AP
Patient Position		Sitting -MA			
BP Location		Left arm -MA			
BP Method		Automatic -MA			
Resp		16 -MA			17 -AP
Patient Observation					
Observations		Q30 -MA		Q30 -DY	
Oxygen Therapy					
SpO2		100 % -MA			99 % -AP
O2 Device		room air -MA			
Pain/Comfort					
Preferred Pain Scale		number (Numeric Rating Pain Scale) -MA			
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -MA		0 -DY	
Pain Rating (0-10): Activity		0 -MA		0 -DY	
Skin WDL					
Skin WDL		WDL -MA			
HEENT					
HEENT WDL		WDL -MA			
Fall Risk Assessment					
Fall Risk Indicators		3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -MA		3-->polypharmacy;1-->male;2-->depression;3-->central nervous system/psychotropic medication -DY	
Fall Risk Score		9 -MA		9 -DY	
Patient Rights Denials					
Rights Denied or Restrictions Imposed		no -MA		no -DY	
Precautions/Isolation					
Precautions (displays in banner)		Fall -MA		Fall -DY	
Precautions Interventions					

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Daily Assess (continued)

	08/20/16 1742	08/20/16 1700	08/20/16 1339	08/20/16 1300	08/20/16 0800
Interventions Performed		yes -MA		yes -DY	
Level of Observation		every 30 minutes -MA		every 30 minutes -DY	
Activities of Daily Living					
ADL's (WDL)		WDL -MA		WDL Except -DY	
Bathing/Skin Care				patient refused -DY	
Daily Sleep					
Daily Sleep (WDL)		WDL Except -MA		-- -DY	
Sleep/Rest/Relaxation		sleeping between care -MA		-- -DY	
Sleep/Rest Enhancement				-- -DY	
Nutritional Intake					
Lunch (%)		0 % -MA			
Daily Nutrition					
Daily Nutrition (WDL)		WDL except -MA		WDL -DY	
Appetite Change		decreased -MA		decreased -DY	
Mental Status					
Orientation		oriented x 4 -MA		oriented x 4 -DY	
Level Of Consciousness		lethargic -MA		alert -DY	
General Appearance WDL		WDL except -MA		WDL except -DY	
General Appearance		unkempt -MA		unkempt -DY	
Mood		depressed;calm -MA		anxious;mood shifts;withdrawn -DY	
Mood/Behavior/ Affect WDL		WDL except -MA		WDL except -DY	
Affect		blunted -MA		blunted -DY	
Behavior (WDL)		WDL except -MA		WDL except -DY	
Mood/Behavior		anxious;isolative -MA		anxious;isolative -DY	
Somatic Symptoms				nausea -DY	
Speech		WDL -MA		WDL except -DY	
Speech				pressured -DY	
Judgment and Insight		judgment not appropriate to situation -MA		judgment appropriate to situation -DY	
Insight		fair -MA		fair -DY	
Concentration		fair -MA		fair -DY	

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Daily Assess (continued)

	08/20/16 1742	08/20/16 1700	08/20/16 1339	08/20/16 1300	08/20/16 0800
Memory Deficit		intact -MA		intact -DY	
Thought (WDL)		WDL -MA		WDL -DY	
Thought Process				circumstantial thought -DY	
Coping/Psychosocial Response					
Observed Emotional State		withdrawn;calm -MA		anxious;withdrawn -DY	
Verbalized Emotional State		depression -MA		anxiety -DY	
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -FSA (r) MA (t)	patient -MA	patient -DY	patient -DY	
Supportive Measures				active listening utilized;verbalization of feelings encouraged -DY	
Family/Support System Care				self-care encouraged -DY	
Behavior Management				behavioral plan reviewed -DY	
Psychiatric Symptoms					
Anxiety Symptoms (WDL)		WDL except -MA		WDL except -DY	
Anxiety Symptoms		generalized -MA		generalized -DY	
Manic Symptoms (WDL)		WDL -MA		WDL -DY	
Psychotic symptoms (WDL)		WDL -MA		WDL -DY	
Danger to Self					
Danger to Self (WDL)		WDL -MA		WDL -DY	
Danger to Self		no suicidal ideation or behavior indicators observed or expressed -MA		no suicidal ideation or behavior indicators observed or expressed -DY	
Self-Injurious Behavior				no self-injurious ideation or behavior indicators observed or expressed -DY	
Self-injury Description				Denied -DY	
Agreement not to Harm Self				yes (describe) -DY	

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Daily Assess (continued)

	08/20/16 1742	08/20/16 1700	08/20/16 1339	08/20/16 1300	08/20/16 0800
Assessment Type					
Assessment timing		Shift -MA			
Danger to Others					
Danger to Others (WDL)		WDL -MA		WDL -DY	
	08/20/16 0703	**08/20/16 0239**	**08/20/16 0200**	**08/19/16 1902**	**08/19/16 1613**
Legal Status					
Legal status			voluntary -IH		voluntary -EM
Vital Signs					
Temp					98 °F (36.7 °C) -AS
Pulse					79 -AS
BP					141/79 mmHg -AS
Patient Position					Sitting -AS
BP Location					Right arm -AS
Resp					16 -AS
Patient Observation					
Observations			Q30 -IH		Q30 -EM
Pain/Comfort					
Preferred Pain Scale			number (Numeric Rating Pain Scale) -IH		number (Numeric Rating Pain Scale) -EM
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest			0 -IH		0 -EM
Pain Rating (0-10): Activity			0 -IH		0 -EM
Comfort/Acceptable Pain Level					3 -EM
Skin WDL					
Skin WDL			WDL except -IH		WDL except -EM
Skin Integrity					other (see comments) psoriasis -EM
HEENT					
HEENT WDL			WDL -IH		WDL -EM
Fall Risk Assessment					
Fall Risk Indicators			3-->polypharmacy;1-->male;2-->depression;3-->central nervous system/psychotropic medication -IH		3-->polypharmacy;1-->male;2-->depression;3-->central nervous system/psychotropic medication -EM

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Daily Assess (continued)

	08/20/16 0703	08/20/16 0239	08/20/16 0200	08/19/16 1902	08/19/16 1613
Fall Risk Score			9 -IH		9 -EM
Patient Rights Denials					
Rights Denied or Restrictions Imposed			no -IH		no -EM
Precautions/Isolation					
Precautions (displays in banner)			Fall -IH		Fall -EM
Precautions Interventions					
Interventions Performed			yes -IH		yes -EM
Level of Observation			every 30 minutes -IH		every 30 minutes -EM
Activities of Daily Living					
ADL's (WDL)			WDL Except -IH		WDL Except -EM
Bathing/Skin Care			patient refused -IH		patient refused -EM
Daily Sleep					
Daily Sleep (WDL)			WDL Except -IH		WDL Except -EM
Sleep/Rest/Relaxation			unable to go back to sleep;sleep interrupted -IH		unable to go back to sleep;sleep interrupted -EM
Sleep/Rest Enhancement			awakenings minimized;regular sleep/rest pattern promoted -IH		awakenings minimized;regular sleep/rest pattern promoted -EM
Daily Hours of Sleep	7.5 -EA				
Nutritional Intake					
Dinner (%)					80 % -EM
Daily Nutrition					
Daily Nutrition (WDL)			WDL -IH		WDL -EM
Appetite Change			decreased -IH		
Mental Status					
Orientation			oriented x 4 -IH		oriented x 4 -EM
Level Of Consciousness			alert -IH		alert -EM
General Appearance WDL			WDL except -IH		WDL except -EM
General Appearance			unkempt -IH		unkempt -EM

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Daily Assess (continued)

	08/20/16 0703	08/20/16 0239	08/20/16 0200	08/19/16 1902	08/19/16 1613
Mood			anxious;mood shifts;withdrawn -IH		anxious;mood shifts;withdrawn -EM
Mood/Behavior/ Affect WDL			WDL except -IH		WDL except -EM
Affect			blunted -IH		blunted -EM
Behavior (WDL)			WDL except -IH		WDL except -EM
Mood/Behavior			anxious;isolative -IH		anxious;isolative -EM
Somatic Symptoms			nausea -IH		
Speech			WDL except -IH		WDL except -EM
Speech			pressured -IH		pressured -EM
Judgment and Insight			judgment appropriate to situation -IH		judgment appropriate to situation -EM
Insight			fair -IH		fair -EM
Concentration			fair -IH		fair -EM
Memory Deficit			intact -IH		intact -EM
Thought (WDL)			WDL -IH		WDL -EM
Thought Process			circumstantial thought -IH		
Coping/Psychosocial Response					
Observed Emotional State			anxious;withdrawn -IH		anxious;withdrawn -EM
Verbalized Emotional State			anxiety -IH		anxiety -EM
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With		patient -IH	patient -IH	patient -EM	patient -EM
Supportive Measures			active listening utilized;verbalization of feelings encouraged -IH		active listening utilized;verbalization of feelings encouraged -EM
Family/Support System Care			self-care encouraged -IH		self-care encouraged -EM
Behavior Management			behavioral plan reviewed -IH		behavioral plan reviewed -EM
Psychiatric Symptoms					
Anxiety Symptoms (WDL)			WDL except -IH		WDL except -EM
Anxiety Symptoms			generalized -IH		generalized -EM
Manic Symptoms (WDL)			WDL -IH		WDL -EM
Psychotic			WDL -IH		WDL -EM

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Daily Assess (continued)

	08/20/16 0703	08/20/16 0239	08/20/16 0200	08/19/16 1902	08/19/16 1613
symptoms (WDL)					
Danger to Self					
Danger to Self (WDL)			WDL -IH		WDL -EM
Danger to Self			no suicidal ideation or behavior indicators observed or expressed -IH		no suicidal ideation or behavior indicators observed or expressed -EM
Keeps Self Safe			yes (describe) -IH		yes (describe) -EM
Description of Suicide Plan					Denied -EM
Self-Injurious Behavior			no self-injurious ideation or behavior indicators observed or expressed -IH		no self-injurious ideation or behavior indicators observed or expressed -EM
Self-injury Description			Denied -IH		Denied -EM
Agreement not to Harm Self			yes (describe) -IH		yes (describe) -EM
Description of Agreement					verbal -EM
Assessment Type					
Assessment timing					Shift -EM
Assessment of contributing factors					
Assessment of Risk Factors					Deficits in social, decision, and coping skills;Prior suicide attempts -EM
Assessment of Protective Factors					Good access to health care/therapy -EM
Danger to Others					
Danger to Others (WDL)			WDL -IH		WDL -EM

	08/19/16 1442	08/19/16 0900	08/19/16 0802	08/19/16 0641	08/19/16 0511
Legal Status					
Legal status		voluntary -LM			
Vital Signs					
Temp			97.8 °F (36.6 °C) -FS		
Temp src			Oral -FS		

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Daily Assess (continued)

	08/19/16 1442	08/19/16 0900	08/19/16 0802	08/19/16 0641	08/19/16 0511
Pulse			81 -FS		
BP			136/83 mmHg -FS		
Patient Position			Sitting -FS		
BP Location			Left arm -FS		
BP Method			Automatic -FS		
Resp			16 -FS		
Patient Observation					
Observations		Q30 -LM			
Oxygen Therapy					
SpO2			100 % -FS		
O2 Device			room air -FS		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -LM	0 -FS		
Pain Rating (0-10): Activity		0 -LM			
Skin WDL					
Skin WDL		WDL except -LM			
Skin Integrity		other (see comments) psoriasis -LM			
HEENT					
HEENT WDL		WDL -LM			
Fall Risk Assessment					
Fall Risk Indicators		3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication non-skid footwear; clutter-free environment -LM			
Fall Risk Score		9 -LM			
Patient Rights Denials					
Rights Denied or Restrictions Imposed		no -LM			
Precautions/Isolation					
Precautions (displays in banner)		None -LM			
Precautions Interventions					
Interventions Performed		yes -LM			
Level of Observation		every 30 minutes -LM			
Activities of Daily Living					

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Daily Assess (continued)

	08/19/16 1442	08/19/16 0900	08/19/16 0802	08/19/16 0641	08/19/16 0511
ADL's (WDL)		WDL Except -LM			
Daily Sleep					
Daily Hours of Sleep				7.5 -EA	
Daily Nutrition					
Daily Nutrition (WDL)		WDL -LM			
Mental Status					
Orientation		oriented x 4 -LM			
Level Of Consciousness		alert -LM			
General Appearance WDL		WDL except -LM			
General Appearance		unkempt -LM			
Mood		anxious;depressed -LM			
Mood/Behavior/ Affect WDL		WDL except -LM			
Affect		blunted -LM			
Behavior (WDL)		WDL except -LM			
Mood/Behavior		anxious;sad -LM			
Speech		WDL except -LM			
Speech		pressured -LM			
Judgment and Insight		judgment appropriate to situation;insight not appropriate to situation -LM			
Insight		poor -LM			
Concentration		fair -LM			
Memory Deficit		intact -LM			
Thought (WDL)		WDL -LM			
Coping/Psychosocial Response					
Observed Emotional State		anxious;sad -LM			
Verbalized Emotional State		anxiety;frustration; depression -LM			
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -LM	patient -LM			patient -MA
Supportive Measures		active listening utilized;verbalization of feelings encouraged -LM			
Family/Support System Care		self-care encouraged -LM			
Behavior		behavioral plan			

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Daily Assess (continued)

	08/19/16 1442	08/19/16 0900	08/19/16 0802	08/19/16 0641	08/19/16 0511
Management		reviewed -LM			
Psychiatric Symptoms					
Anxiety Symptoms (WDL)		WDL except -LM			
Anxiety Symptoms		generalized -LM			
Manic Symptoms (WDL)		WDL -LM			
Psychotic symptoms (WDL)		WDL -LM			
Danger to Self					
Danger to Self (WDL)		WDL -LM			
Danger to Self		no suicidal ideation or behavior indicators observed or expressed -LM			
Agreement not to Harm Self		yes (describe) -LM			
Danger to Others					
Danger to Others (WDL)		WDL -LM			

	08/19/16 0031	08/19/16 0006	08/18/16 1900	08/18/16 1542	08/18/16 1425
Legal Status					
Legal status	voluntary -MA		voluntary -MA		
Vital Signs					
Temp				98.1 °F (36.7 °C) -AS	
Pulse				79 -AS	
BP				128/71 mmHg -AS	
Patient Position				Sitting -AS	
BP Location				Right arm -AS	
Resp				16 -AS	
Patient Observation					
Observations	Q30 -MA		Q30 -MA		
Pain/Comfort					
Preferred Pain Scale			number (Numeric Rating Pain Scale) -MA		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest			0 -MA		
Pain Rating (0-10): Activity			0 -MA		
Pain Assessment: FACES Scale					

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Daily Assess (continued)

	08/19/16 0031	08/19/16 0006	08/18/16 1900	08/18/16 1542	08/18/16 1425
FACES Pain Rating: Rest	0-->no hurt -MA				
FACES Pain Rating: Activity	0-->no hurt -MA				
Skin WDL					
Skin WDL	WDL except -MA		WDL -MA		
Skin Integrity	bruise(s) from blood draws -MA				
HEENT					
HEENT WDL	WDL -MA		WDL -MA		
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -MA		3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -MA		
Fall Risk Score	9 -MA		9 -MA		
Patient Rights Denials					
Rights Denied or Restrictions Imposed	no -MA		no -MA		
Precautions/Isolation					
Precautions (displays in banner)	None -MA		None -MA		
Precautions Interventions					
Interventions Performed	yes -MA		yes -MA		
Level of Observation	every 30 minutes -MA		every 30 minutes -MA		
Activities of Daily Living					
ADL's (WDL)	WDL -MA		WDL -MA		
Daily Sleep					
Daily Sleep (WDL)	WDL -MA		WDL -MA		
Daily Nutrition					
Daily Nutrition (WDL)	WDL -MA		WDL -MA		
Mental Status					
Orientation			oriented x 4 -MA		
Level Of Consciousness	asleep -MA		alert -MA		
General Appearance			unkempt -MA		
Mood			euthymic -MA		
Mood/Behavior/ Affect WDL			WDL -MA		

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Daily Assess (continued)

	08/19/16 0031	08/19/16 0006	08/18/16 1900	08/18/16 1542	08/18/16 1425
Behavior (WDL)			WDL -MA		
Speech			WDL -MA		
Judgment and Insight			judgment not appropriate to situation -MA		
Insight			fair -MA		
Concentration			fair -MA		
Memory Deficit			intact -MA		
Thought (WDL)			WDL -MA		
Coping/Psychosocial Response					
Observed Emotional State			calm -MA		
Verbalized Emotional State			acceptance -MA		
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With		patient -MA	patient -MA		patient -LM
Supportive Measures			active listening utilized;verbalization of feelings encouraged -MA		
Family/Support System Care			self-care encouraged -MA		
Behavior Management			behavioral plan reviewed -MA		
Psychiatric Symptoms					
Anxiety Symptoms (WDL)			WDL except -MA		
Anxiety Symptoms			generalized -MA		
Manic Symptoms (WDL)			WDL -MA		
Psychotic symptoms (WDL)			WDL -MA		
Danger to Self					
Danger to Self (WDL)	WDL pt appears asleep -MA		WDL -MA		
Danger to Self			no suicidal ideation or behavior indicators observed or expressed -MA		
Assessment Type					
Assessment timing	Shift -MA		Shift -MA		
Danger to Others					

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Daily Assess (continued)

	08/19/16 0031	08/19/16 0006	08/18/16 1900	08/18/16 1542	08/18/16 1425
Danger to Others (WDL)	WDL pt appears asleep -MA		WDL -MA		
	08/18/16 1000	08/18/16 0820	08/18/16 0652	08/18/16 0050	
Legal Status					
Legal status	voluntary -LM			voluntary -FSA	
Vital Signs					
Temp		97.7 °F (36.5 °C) -FS			
Temp src		Oral -FS			
Pulse		98 -FS			
BP		131/86 mmHg -FS			
Patient Position		Sitting -FS			
BP Location		Left arm -FS			
BP Method		Automatic -FS			
Resp		17 -FS			
Patient Observation					
Observations	Q30 -LM			Q30 -FSA	
Oxygen Therapy					
SpO2		98 % -FS			
O2 Device		room air -FS			
Pain/Comfort					
Preferred Pain Scale				FACES (Wong-Baker FACES Pain Rating Scale) -FSA	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -LM	0 -FS			
Pain Rating (0-10): Activity	0 -LM				
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest				0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA	
FACES Pain Rating: Activity				0-->no hurt -FSA	
Skin WDL					
Skin WDL	WDL except -LM			WDL except;all;color -FSA	
Skin Integrity	other (see comments) psoriasis -LM				
HEENT					
HEENT WDL	WDL -LM				
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy;2--			3-->polypharmacy;2--	

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Daily Assess (continued)

	08/18/16 1000	08/18/16 0820	08/18/16 0652	08/18/16 0050
	>depression;1-->male;3-->central nervous system/psychotropic medication non-skid footwear; clutter-free environment -LM			>depression;1-->male;3-->central nervous system/psychotropic medication -FSA
Fall Risk Score	9 -LM			9 -FSA
Patient Rights Denials				
Rights Denied or Restrictions Imposed	no -LM			no -FSA
Precautions/Isolation				
Precautions (displays in banner)	None -LM			None -FSA
Precautions Interventions				
Interventions Performed	yes -LM			yes -FSA
Level of Observation	every 30 minutes -LM			every 30 minutes -FSA
Activities of Daily Living				
ADL's (WDL)	WDL Except -LM			
Daily Sleep				
Sleep/Rest/Relaxation				appears asleep -FSA
Daily Hours of Sleep			7.5 -EA	
Daily Nutrition				
Daily Nutrition (WDL)	WDL -LM			
Mental Status				
Orientation	oriented x 4 -LM			
Level Of Consciousness	alert -LM			asleep -FSA
General Appearance WDL	WDL except -LM			
General Appearance	unkempt -LM			
Mood	anxious;angry;depressed -LM			
Mood/Behavior/Affect WDL	WDL except -LM			
Affect	blunted -LM			
Behavior (WDL)	WDL except -LM			
Mood/Behavior	anxious;angry;sad -LM			
Speech	WDL except -LM			

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Daily Assess (continued)

	08/18/16 1000	08/18/16 0820	08/18/16 0652	08/18/16 0050
Speech	pressured -LM			
Judgment and Insight	judgment appropriate to situation -LM			
Insight	fair -LM			
Concentration	fair -LM			
Memory Deficit	intact -LM			
Thought (WDL)	WDL -LM			
Coping/Psychosocial Response				
Observed Emotional State	anxious;angry;sad -LM			
Verbalized Emotional State	anxiety;frustration; depression -LM			
Coping/Psychosocial Response Interventions				
Plan Of Care Reviewed With	patient -LM			
Supportive Measures	active listening utilized;verbalization of feelings encouraged -LM			
Family/Support System Care	self-care encouraged -LM			
Behavior Management	behavioral plan reviewed -LM			
Psychiatric Symptoms				
Anxiety Symptoms (WDL)	WDL except -LM			-- Asleep -FSA
Anxiety Symptoms	generalized -LM			
Manic Symptoms (WDL)	WDL -LM			
Psychotic symptoms (WDL)	WDL -LM			
Danger to Self				
Danger to Self (WDL)	WDL -LM			-- Asleep -FSA
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -LM			
Keeps Self Safe	yes (describe) -LM			
Description of Suicide Plan	Pt denies current SI -LM			
Agreement not to Harm Self	yes (describe) -LM			

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Daily Assess (continued)

	08/18/16 1000	08/18/16 0820	08/18/16 0652	08/18/16 0050	
Description of Agreement	verbal; will come to staff -LM				
Danger to Others					
Danger to Others (WDL)	WDL -LM			-- Asleep -FSA	

Risk Screening

	08/20/16 1700	08/20/16 1300	08/20/16 0200	08/19/16 1613	08/19/16 0900
Fall Risk Assessment					
Fall Risk Indicators	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -MA	3-->polypharmacy;1-->male;2-->depression;3-->central nervous system/psychotropic medication -DY	3-->polypharmacy;1-->male;2-->depression;3-->central nervous system/psychotropic medication -IH	3-->polypharmacy;1-->male;2-->depression;3-->central nervous system/psychotropic medication -EM	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication non-skid footwear; clutter-free environment -LM
Fall Risk Score	9 -MA	9 -DY	9 -IH	9 -EM	9 -LM
Danger to Self					
Danger to Self (WDL)	WDL -MA	WDL -DY	WDL -IH	WDL -EM	WDL -LM
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -MA	no suicidal ideation or behavior indicators observed or expressed -DY	no suicidal ideation or behavior indicators observed or expressed -IH	no suicidal ideation or behavior indicators observed or expressed -EM	no suicidal ideation or behavior indicators observed or expressed -LM
Keeps Self Safe			yes (describe) -IH	yes (describe) -EM	
Description of Suicide Plan				Denied -EM	
Self-Injurious Behavior		no self-injurious ideation or behavior indicators observed or expressed -DY	no self-injurious ideation or behavior indicators observed or expressed -IH	no self-injurious ideation or behavior indicators observed or expressed -EM	
Self-injury Description		Denied -DY	Denied -IH	Denied -EM	
Agreement not to Harm Self		yes (describe) -DY	yes (describe) -IH	yes (describe) -EM	yes (describe) -LM
Description of Agreement				verbal -EM	
Danger to Others					
Danger to Others (WDL)	WDL -MA	WDL -DY	WDL -IH	WDL -EM	WDL -LM

	08/19/16 0031	08/18/16 1900	08/18/16 1000	08/18/16 0050	
Fall Risk Assessment					

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

Risk Screening (continued)

	08/19/16 0031	08/18/16 1900	08/18/16 1000	08/18/16 0050
Fall Risk Indicators	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -MA	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -MA	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication non-skid footwear; clutter-free environment -LM	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -FSA
Fall Risk Score	9 -MA	9 -MA	9 -LM	9 -FSA
Danger to Self				
Danger to Self (WDL)	WDL pt appears asleep -MA	WDL -MA	WDL -LM	-- Asleep -FSA
Danger to Self		no suicidal ideation or behavior indicators observed or expressed -MA	no suicidal ideation or behavior indicators observed or expressed -LM	
Keeps Self Safe			yes (describe) -LM	
Description of Suicide Plan			Pt denies current SI -LM	
Agreement not to Harm Self			yes (describe) -LM	
Description of Agreement			verbal; will come to staff -LM	
Danger to Others				
Danger to Others (WDL)	WDL pt appears asleep -MA	WDL -MA	WDL -LM	-- Asleep -FSA

BH Initial Eval

	08/20/16 1700	08/20/16 1300	08/20/16 0800	08/20/16 0703	08/20/16 0200
Legal Status					
Legal status	voluntary -MA	voluntary -DY			voluntary -IH
Evidence of Mood Disorders					
Manic Symptoms (WDL)	WDL -MA	WDL -DY			WDL -IH
Evidence of Anxiety Disorders					
Anxiety Symptoms (WDL)	WDL except -MA	WDL except -DY			WDL except -IH
Anxiety Symptoms	generalized -MA	generalized -DY			generalized -IH
Danger to Self					
Danger to Self (WDL)	WDL -MA	WDL -DY			WDL -IH
Danger to Self	no suicidal ideation or behavior indicators	no suicidal ideation or behavior indicators			no suicidal ideation or behavior

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Initial Eval (continued)

	08/20/16 1700	08/20/16 1300	08/20/16 0800	08/20/16 0703	08/20/16 0200
	observed or expressed -MA	observed or expressed -DY			indicators observed or expressed -IH
Keeps Self Safe					yes (describe) -IH
Self-Injurious Behavior		no self-injurious ideation or behavior indicators observed or expressed -DY			no self-injurious ideation or behavior indicators observed or expressed -IH
Self-injury Description		Denied -DY			Denied -IH
Agreement not to Harm Self		yes (describe) -DY			yes (describe) -IH
Assessment Type					
Assessment timing	Shift -MA				
Danger to Others					
Danger to Others (WDL)	WDL -MA	WDL -DY			WDL -IH
Mental Status					
Level Of Consciousness	lethargic -MA	alert -DY			alert -IH
Orientation	oriented x 4 -MA	oriented x 4 -DY			oriented x 4 -IH
General Appearance WDL	WDL except -MA	WDL except -DY			WDL except -IH
General Appearance	unkempt -MA	unkempt -DY			unkempt -IH
Mood/Behavior/ Affect WDL	WDL except -MA	WDL except -DY			WDL except -IH
Affect	blunted -MA	blunted -DY			blunted -IH
Mood/Behavior	anxious;isolative -MA	anxious;isolative -DY			anxious;isolative -IH
Speech	WDL -MA	WDL except -DY			WDL except -IH
Speech		pressured -DY			pressured -IH
Judgment and Insight	judgment not appropriate to situation -MA	judgment appropriate to situation -DY			judgment appropriate to situation -IH
Insight	fair -MA	fair -DY			fair -IH
Concentration	fair -MA	fair -DY			fair -IH
Memory Deficit	intact -MA	intact -DY			intact -IH
Thought Process		circumstantial thought -DY			circumstantial thought -IH
Behavior (WDL)	WDL except -MA	WDL except -DY			WDL except -IH
Sleep/Rest/Relaxation					
Sleep/Rest/Relaxation	sleeping between care -MA	-- -DY			unable to go back to

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Initial Eval (continued)

	08/20/16 1700	08/20/16 1300	08/20/16 0800	08/20/16 0703	08/20/16 0200
					sleep;sleep interrupted -IH
Daily Hours of Sleep				7.5 -EA	
Vital Signs					
Temp	98.1 °F (36.7 °C) -MA		98 °F (36.7 °C) -AP		
Pulse	92 -MA		64 -AP		
BP	118/70 mmHg -MA		101/70 mmHg -AP		
Patient Position	Sitting -MA				
Resp	16 -MA		17 -AP		
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -MA				number (Numeric Rating Pain Scale) -IH
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -MA	0 -DY			0 -IH
Pain Rating (0-10): Activity	0 -MA	0 -DY			0 -IH
Fall Risk Assessment					
Fall Risk Indicators	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -MA	3-->polypharmacy;1-->male;2-->depression;3-->central nervous system/psychotropic medication -DY			3-->polypharmacy;1-->male;2-->depression;3-->central nervous system/psychotropic medication -IH
Fall Risk Score	9 -MA	9 -DY			9 -IH
	08/19/16 1613	08/19/16 0900	08/19/16 0802	08/19/16 0641	08/19/16 0031
Legal Status					
Legal status	voluntary -EM	voluntary -LM			voluntary -MA
Evidence of Mood Disorders					
Manic Symptoms (WDL)	WDL -EM	WDL -LM			
Evidence of Anxiety Disorders					
Anxiety Symptoms (WDL)	WDL except -EM	WDL except -LM			
Anxiety Symptoms	generalized -EM	generalized -LM			
Danger to Self					
Danger to Self (WDL)	WDL -EM	WDL -LM			WDL pt appears asleep -MA
Danger to Self	no suicidal ideation or	no suicidal ideation or			

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Initial Eval (continued)

	08/19/16 1613	08/19/16 0900	08/19/16 0802	08/19/16 0641	08/19/16 0031
	behavior indicators observed or expressed -EM	behavior indicators observed or expressed -LM			
Keeps Self Safe	yes (describe) -EM				
Description of Suicide Plan	Denied -EM				
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -EM				
Self-injury Description	Denied -EM				
Agreement not to Harm Self	yes (describe) -EM	yes (describe) -LM			
Description of Agreement	verbal -EM				
Assessment Type					
Assessment timing	Shift -EM				Shift -MA
Assessment of contributing factors					
Assessment of Risk Factors	Deficits in social, decision, and coping skills;Prior suicide attempts -EM				
Assessment of Protective Factors	Good access to health care/therapy -EM				
Danger to Others					
Danger to Others (WDL)	WDL -EM	WDL -LM			WDL pt appears asleep -MA
Mental Status					
Level Of Consciousness	alert -EM	alert -LM			asleep -MA
Orientation	oriented x 4 -EM	oriented x 4 -LM			
General Appearance WDL	WDL except -EM	WDL except -LM			
General Appearance	unkempt -EM	unkempt -LM			
Mood/Behavior/ Affect WDL	WDL except -EM	WDL except -LM			
Affect	blunted -EM	blunted -LM			
Mood/Behavior	anxious;isolative -EM	anxious;sad -LM			
Speech	WDL except -EM	WDL except -LM			
Speech	pressured -EM	pressured -LM			
Judgment and	judgment	judgment			

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Initial Eval (continued)

	08/19/16 1613	08/19/16 0900	08/19/16 0802	08/19/16 0641	08/19/16 0031
Insight	appropriate to situation -EM	appropriate to situation;insight not appropriate to situation -LM			
Insight	fair -EM	poor -LM			
Concentration	fair -EM	fair -LM			
Memory Deficit	intact -EM	intact -LM			
Behavior (WDL)	WDL except -EM	WDL except -LM			
Sleep/Rest/Relaxation					
Sleep/Rest/Relaxation	unable to go back to sleep;sleep interrupted -EM				
Daily Hours of Sleep				7.5 -EA	
Vital Signs					
Temp	98 °F (36.7 °C) -AS		97.8 °F (36.6 °C) -FS		
Pulse	79 -AS		81 -FS		
BP	141/79 mmHg -AS		136/83 mmHg -FS		
Patient Position	Sitting -AS		Sitting -FS		
Resp	16 -AS		16 -FS		
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -EM				
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -EM	0 -LM	0 -FS		
Pain Rating (0-10): Activity	0 -EM	0 -LM			
Comfort/Acceptable Pain Level	3 -EM				
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest					0-->no hurt -MA
FACES Pain Rating: Activity					0-->no hurt -MA
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy;1-->male;2-->depression;3-->central nervous system/psychotropic medication -EM	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication non-skid footwear; clutter-free environment -LM			3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -MA
Fall Risk Score	9 -EM	9 -LM			9 -MA

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Initial Eval (continued)

	08/18/16 1900	08/18/16 1542	08/18/16 1000	08/18/16 0820	08/18/16 0652
Legal Status					
Legal status	voluntary -MA		voluntary -LM		
Evidence of Mood Disorders					
Manic Symptoms (WDL)	WDL -MA		WDL -LM		
Evidence of Anxiety Disorders					
Anxiety Symptoms (WDL)	WDL except -MA		WDL except -LM		
Anxiety Symptoms	generalized -MA		generalized -LM		
Danger to Self					
Danger to Self (WDL)	WDL -MA		WDL -LM		
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -MA		no suicidal ideation or behavior indicators observed or expressed -LM		
Keeps Self Safe			yes (describe) -LM		
Description of Suicide Plan			Pt denies current SI -LM		
Agreement not to Harm Self			yes (describe) -LM		
Description of Agreement			verbal; will come to staff -LM		
Assessment Type					
Assessment timing	Shift -MA				
Danger to Others					
Danger to Others (WDL)	WDL -MA		WDL -LM		
Mental Status					
Level Of Consciousness	alert -MA		alert -LM		
Orientation	oriented x 4 -MA		oriented x 4 -LM		
General Appearance WDL			WDL except -LM		
General Appearance	unkempt -MA		unkempt -LM		
Mood/Behavior/ Affect WDL	WDL -MA		WDL except -LM		
Affect			blunted -LM		
Mood/Behavior			anxious;angry;sad -LM		
Speech	WDL -MA		WDL except -LM		
Speech			pressured -LM		

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Initial Eval (continued)

	08/18/16 1900	08/18/16 1542	08/18/16 1000	08/18/16 0820	08/18/16 0652
Judgment and Insight	judgment not appropriate to situation -MA		judgment appropriate to situation -LM		
Insight	fair -MA		fair -LM		
Concentration	fair -MA		fair -LM		
Memory Deficit	intact -MA		intact -LM		
Behavior (WDL)	WDL -MA		WDL except -LM		
Sleep/Rest/Relaxation					
Daily Hours of Sleep					7.5 -EA
Vital Signs					
Temp		98.1 °F (36.7 °C) -AS		97.7 °F (36.5 °C) -FS	
Pulse		79 -AS		98 -FS	
BP		128/71 mmHg -AS		131/86 mmHg -FS	
Patient Position		Sitting -AS		Sitting -FS	
Resp		16 -AS		17 -FS	
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -MA				
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -MA		0 -LM	0 -FS	
Pain Rating (0-10): Activity	0 -MA		0 -LM		
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -MA		3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication non-skid footwear; clutter-free environment -LM		
Fall Risk Score	9 -MA		9 -LM		

	08/18/16 0050
Legal Status	
Legal status	voluntary -FSA
Evidence of Anxiety Disorders	
Anxiety Symptoms (WDL)	-- Asleep -FSA
Danger to Self	
Danger to Self (WDL)	-- Asleep -FSA
Danger to Others	
Danger to	--

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH Initial Eval (continued)

	08/18/16 0050
Others (WDL)	Asleep -FSA
Mental Status	
Level Of Consciousness	asleep -FSA
Sleep/Rest/Relaxation	
Sleep/Rest/Relaxation	appears asleep -FSA
Pain/Comfort	
Preferred Pain Scale	FACES (Wong-Baker FACES Pain Rating Scale) -FSA
Pain Assessment: FACES Scale	
FACES Pain Rating: Rest	0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA
FACES Pain Rating: Activity	0-->no hurt -FSA
Fall Risk Assessment	
Fall Risk Indicators	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -FSA
Fall Risk Score	9 -FSA

BH OT Observations NAV IP

	08/20/16 1700	08/20/16 1300	08/20/16 0200	08/19/16 1613	08/19/16 0900
General Observations					
Mood/Behavior/Affect WDL	WDL except -MA	WDL except -DY	WDL except -IH	WDL except -EM	WDL except -LM
Affect	blunted -MA	blunted -DY	blunted -IH	blunted -EM	blunted -LM
Mood	depressed;calm -MA	anxious;mood shifts;withdrawn -DY	anxious;mood shifts;withdrawn -IH	anxious;mood shifts;withdrawn -EM	anxious;depressed -LM
Orientation	oriented x 4 -MA	oriented x 4 -DY	oriented x 4 -IH	oriented x 4 -EM	oriented x 4 -LM
Thought Process		circumstantial thought -DY	circumstantial thought -IH		
Speech		pressured -DY	pressured -IH	pressured -EM	pressured -LM
General Appearance WDL	WDL except -MA	WDL except -DY	WDL except -IH	WDL except -EM	WDL except -LM
General Appearance	unkempt -MA	unkempt -DY	unkempt -IH	unkempt -EM	unkempt -LM

	08/18/16 1900	08/18/16 1000
General Observations		

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

BH OT Observations NAV IP (continued)

	08/18/16 1900	08/18/16 1000
Mood/Behavior/ Affect WDL	WDL -MA	WDL except -LM
Affect		blunted -LM
Mood	euthymic -MA	anxious;angry;depressed -LM
Orientation	oriented x 4 -MA	oriented x 4 -LM
Speech		pressured -LM
General Appearance WDL		WDL except -LM
General Appearance	unkempt -MA	unkempt -LM

Adult Nutrition Assessment

	08/18/16 1100
Nutrition Risk	
Level Of Risk - Acuity	low -DP
Follow Up Date	08/25/16 f/u vs rescreen -DP

Adult Care Sum F14

	08/20/16 1742	08/20/16 1700	08/20/16 1339	08/20/16 1300	08/20/16 0800
Plan of Care Review					
Plan Of Care Reviewed With	patient -FSA (r) MA (t)	patient -MA	patient -DY	patient -DY	
Pain/Comfort/Sleep					
Preferred Pain Scale		number (Numeric Rating Pain Scale) -MA			
Sleep/Rest/Relaxation		sleeping between care -MA		-- -DY	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -MA		0 -DY	
Pain Rating (0-10): Activity		0 -MA		0 -DY	
Pain/Comfort/Sleep Interventions					
Sleep/Rest Enhancement				-- -DY	
Coping/Psychosocial					
Observed Emotional State		withdrawn;calm -MA		anxious;withdrawn -DY	
Verbalized Emotional State		depression -MA		anxiety -DY	
Coping Strategies					
Supportive Measures				active listening utilized;verbalization of feelings	

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/20/16 1742	08/20/16 1700	08/20/16 1339	08/20/16 1300	08/20/16 0800
				encouraged -DY	
Family/Support System Care				self-care encouraged -DY	
Coping/Psychosocial Interventions					
Behavior Management				behavioral plan reviewed -DY	
HEENT					
HEENT WDL		WDL -MA			
Cognitive					
Memory Deficit		intact -MA		intact -DY	
Neuro					
Level Of Consciousness		lethargic -MA		alert -DY	
Orientation		oriented x 4 -MA		oriented x 4 -DY	
General Appearance					
General Appearance WDL		WDL except -MA		WDL except -DY	
General Appearance		unkempt -MA		unkempt -DY	
Mood/Behavior/Affect					
Mood/Behavior/ Affect WDL		WDL except -MA		WDL except -DY	
Affect		blunted -MA		blunted -DY	
Mood/Behavior		anxious;isolative -MA		anxious;isolative -DY	
Speech					
Speech		WDL -MA		WDL except -DY	
Speech				pressured -DY	
Thought Process					
Judgment and Insight		judgment not appropriate to situation -MA		judgment appropriate to situation -DY	
Thought Process				circumstantial thought -DY	
Oxygen Therapy					
SpO2		100 % -MA			99 % -AP
O2 Device		room air -MA			
Skin					
Skin WDL		WDL -MA			
Safety Interventions					
Precautions (displays in banner)		Fall -MA		Fall -DY	
Fall Risk Indicators		3-->central nervous system/psychotropic medication;3-->polypharmacy;2--		3-->polypharmacy;1-->male;2-->depression;3-->central nervous	

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/20/16 1742	08/20/16 1700	08/20/16 1339	08/20/16 1300	08/20/16 0800
		>depression;1-->male -MA		system/psychotropic medication -DY	
Fall Risk Score		9 -MA		9 -DY	
	08/20/16 0703	08/20/16 0239	08/20/16 0200	08/19/16 1902	08/19/16 1613
Plan of Care Review					
Plan Of Care Reviewed With		patient -IH	patient -IH	patient -EM	patient -EM
Pain/Comfort/Sleep					
Preferred Pain Scale			number (Numeric Rating Pain Scale) -IH		number (Numeric Rating Pain Scale) -EM
Sleep/Rest/Relaxation			unable to go back to sleep;sleep interrupted -IH		unable to go back to sleep;sleep interrupted -EM
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest			0 -IH		0 -EM
Pain Rating (0-10): Activity			0 -IH		0 -EM
Comfort/Acceptable Pain Level					3 -EM
Sleep/Rest/Relaxation					
Daily Hours of Sleep	7.5 -EA				
Pain/Comfort/Sleep Interventions					
Sleep/Rest Enhancement			awakenings minimized;regular sleep/rest pattern promoted -IH		awakenings minimized;regular sleep/rest pattern promoted -EM
Coping/Psychosocial					
Observed Emotional State			anxious;withdrawn -IH		anxious;withdrawn -EM
Verbalized Emotional State			anxiety -IH		anxiety -EM
Coping Strategies					
Supportive Measures			active listening utilized;verbalization of feelings encouraged -IH		active listening utilized;verbalization of feelings encouraged -EM
Family/Support System Care			self-care encouraged -IH		self-care encouraged -EM
Coping/Psychosocial Interventions					
Behavior Management			behavioral plan reviewed -IH		behavioral plan reviewed -EM
HEENT					
HEENT WDL			WDL -IH		WDL -EM
Cognitive					

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/20/16 0703	08/20/16 0239	08/20/16 0200	08/19/16 1902	08/19/16 1613
Memory Deficit			intact -IH		intact -EM
Neuro					
Level Of Consciousness			alert -IH		alert -EM
Orientation			oriented x 4 -IH		oriented x 4 -EM
General Appearance					
General Appearance WDL			WDL except -IH		WDL except -EM
General Appearance			unkempt -IH		unkempt -EM
Mood/Behavior/Affect					
Mood/Behavior/ Affect WDL			WDL except -IH		WDL except -EM
Affect			blunted -IH		blunted -EM
Mood/Behavior			anxious;isolative -IH		anxious;isolative -EM
Speech					
Speech			WDL except -IH		WDL except -EM
Speech			pressured -IH		pressured -EM
Thought Process					
Judgment and Insight			judgment appropriate to situation -IH		judgment appropriate to situation -EM
Thought Process			circumstantial thought -IH		
Skin					
Skin WDL			WDL except -IH		WDL except -EM
Skin Integrity					other (see comments) psoriasis -EM
Safety Interventions					
Precautions (displays in banner)			Fall -IH		Fall -EM
Fall Risk Indicators			3-->polypharmacy;1-->male;2-->depression;3-->central nervous system/psychotropic medication -IH		3-->polypharmacy;1-->male;2-->depression;3-->central nervous system/psychotropic medication -EM
Fall Risk Score			9 -IH		9 -EM
	08/19/16 1442	08/19/16 0900	08/19/16 0802	08/19/16 0641	08/19/16 0511
Plan of Care Review					
Plan Of Care	patient -LM	patient -LM			patient -MA

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/19/16 1442	08/19/16 0900	08/19/16 0802	08/19/16 0641	08/19/16 0511
Reviewed With					
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -LM	0 -FS		
Pain Rating (0-10): Activity		0 -LM			
Sleep/Rest/Relaxation					
Daily Hours of Sleep				7.5 -EA	
Coping/Psychosocial					
Observed Emotional State		anxious;sad -LM			
Verbalized Emotional State		anxiety;frustration; depression -LM			
Coping Strategies					
Supportive Measures		active listening utilized;verbalization of feelings encouraged -LM			
Family/Support System Care		self-care encouraged -LM			
Coping/Psychosocial Interventions					
Behavior Management		behavioral plan reviewed -LM			
HEENT					
HEENT WDL		WDL -LM			
Cognitive					
Memory Deficit		intact -LM			
Neuro					
Level Of Consciousness		alert -LM			
Orientation		oriented x 4 -LM			
General Appearance					
General Appearance WDL		WDL except -LM			
General Appearance		unkempt -LM			
Mood/Behavior/Affect					
Mood/Behavior/ Affect WDL		WDL except -LM			
Affect		blunted -LM			
Mood/Behavior		anxious;sad -LM			
Speech					
Speech		WDL except -LM			
Speech		pressured -LM			
Thought Process					
Judgment and		judgment			

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/19/16 1442	08/19/16 0900	08/19/16 0802	08/19/16 0641	08/19/16 0511
Insight		appropriate to situation;insight not appropriate to situation -LM			
Oxygen Therapy					
SpO2			100 % -FS		
O2 Device			room air -FS		
Skin					
Skin WDL		WDL except -LM			
Skin Integrity		other (see comments) psoriasis -LM			
Safety Interventions					
Precautions (displays in banner)		None -LM			
Fall Risk Indicators		3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication non-skid footwear; clutter-free environment -LM			
Fall Risk Score		9 -LM			
	08/19/16 0031	08/19/16 0006	08/18/16 1900	08/18/16 1425	08/18/16 1000
Plan of Care Review					
Plan Of Care Reviewed With		patient -MA	patient -MA	patient -LM	patient -LM
Pain/Comfort/Sleep					
Preferred Pain Scale			number (Numeric Rating Pain Scale) -MA		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest			0 -MA		0 -LM
Pain Rating (0-10): Activity			0 -MA		0 -LM
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest	0-->no hurt -MA				
FACES Pain Rating: Activity	0-->no hurt -MA				
Coping/Psychosocial					
Observed Emotional State			calm -MA		anxious;angry;sad -LM
Verbalized Emotional State			acceptance -MA		anxiety;frustration;depression -

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/19/16 0031	08/19/16 0006	08/18/16 1900	08/18/16 1425	08/18/16 1000
					LM
Coping Strategies					
Supportive Measures			active listening utilized;verbalization of feelings encouraged -MA		active listening utilized;verbalization of feelings encouraged -LM
Family/Support System Care			self-care encouraged -MA		self-care encouraged -LM
Coping/Psychosocial Interventions					
Behavior Management			behavioral plan reviewed -MA		behavioral plan reviewed -LM
HEENT					
HEENT WDL	WDL -MA		WDL -MA		WDL -LM
Cognitive					
Memory Deficit			intact -MA		intact -LM
Neuro					
Level Of Consciousness	asleep -MA		alert -MA		alert -LM
Orientation			oriented x 4 -MA		oriented x 4 -LM
General Appearance					
General Appearance WDL					WDL except -LM
General Appearance			unkempt -MA		unkempt -LM
Mood/Behavior/Affect					
Mood/Behavior/ Affect WDL			WDL -MA		WDL except -LM
Affect					blunted -LM
Mood/Behavior					anxious;angry;sad -LM
Speech					
Speech			WDL -MA		WDL except -LM
Speech					pressured -LM
Thought Process					
Judgment and Insight			judgment not appropriate to situation -MA		judgment appropriate to situation -LM
Skin					
Skin WDL	WDL except -MA		WDL -MA		WDL except -LM
Skin Integrity	bruise(s) from blood draws -MA				other (see comments) psoriasis -LM
Safety Interventions					
Precautions (displays in banner)	None -MA		None -MA		None -LM

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/19/16 0031	08/19/16 0006	08/18/16 1900	08/18/16 1425	08/18/16 1000
Fall Risk Indicators	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -MA		3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -MA		3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication non-skid footwear; clutter-free environment -LM
Fall Risk Score	9 -MA		9 -MA		9 -LM
	08/18/16 0820	08/18/16 0652	08/18/16 0050		
Pain/Comfort/Sleep					
Preferred Pain Scale			FACES (Wong-Baker FACES Pain Rating Scale) -FSA		
Sleep/Rest/Relaxation			appears asleep -FSA		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -FS				
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest			0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA		
FACES Pain Rating: Activity			0-->no hurt -FSA		
Sleep/Rest/Relaxation					
Daily Hours of Sleep		7.5 -EA			
Neuro					
Level Of Consciousness			asleep -FSA		
Oxygen Therapy					
SpO2	98 % -FS				
O2 Device	room air -FS				
Skin					
Skin WDL			WDL except;all;color -FSA		
Safety Interventions					
Precautions (displays in banner)			None -FSA		
Fall Risk Indicators			3-->polypharmacy;2--		

All Flowsheet Data (08/18/16 0000--08/20/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/18/16 0820	08/18/16 0652	08/18/16 0050
			>depression;1-->male;3-->central nervous system/psychotropic medication -FSA
Fall Risk Score			9 -FSA

Social Work Assessment

	08/20/16 1300	08/20/16 0200	08/19/16 1613
Suicide Risk			
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -DY	no self-injurious ideation or behavior indicators observed or expressed -IH	no self-injurious ideation or behavior indicators observed or expressed -EM
Self-injury Description	Denied -DY	Denied -IH	Denied -EM

(r) = User Recd, (t) = User Taken, (c) = User Cosigned

User Key

Initials	Name	Effective Dates
LM	Marin, Lisa Nicole, RN	05/20/15 -
EM	McCullough, Elizabeth Ann, RN	04/15/15 -
IH	Hima, Issaka, RN	05/20/15 -
MA	Abend, Marquel Marie, RN	11/10/15 -
EA	Angeles Pagtakhan, Edna R, RN	02/05/15 -
PK	Kader, Paz T, RN	02/02/15 -
DP	Parker, Dominique S, RD	07/02/15 -
AP	Parrish, Alan	03/31/16 -
FSA	Scurry-Scott, Frazier M, RN	02/05/15 -
FS	Sepulveda, Francis R	04/06/16 -
AS	Smith, Arthur L, CNA	07/02/15 -
DY	Yerby, Derrick J, RN	04/22/16 -

All Flowsheet Data (08/15/16 0000--08/17/16 2359)

MAR MINI-FLOWSHEET DATA

	08/17/16 1900	08/17/16 0822	08/16/16 1609	08/16/16 1008	08/16/16 0905
Pain					
Pain Rating (0-10): Rest	0 -EM	0 -FS	0 -EM	0 -JB	3 -JB
Pain Rating (0-10): Activity	0 -EM		0 -EM	0 -JB	3 -JB
	08/16/16 0800	08/15/16 2200	08/15/16 2044	08/15/16 1000	08/15/16 0851
Pain					
Pain Rating (0-10): Rest	0 -JB	0 -FG	0 -FG	0 -SH	0 -FS
Pain Rating (0-10): Activity	0 -JB	0 -FG	0 -FG	0 -SH	
	08/15/16 0100				
Pain					
Pain Rating (0-10): Rest	0 -CR				

CARE PLAN MINI-FLOWSHEET DATA

	08/17/16 2328	08/17/16 1900	08/17/16 1131	08/17/16 0822	08/16/16 2233
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -EM	patient -EM	patient -RE	patient -RE	patient -EM
Plan of Care Review					
Progress	no change -EM				improving -EM
	08/16/16 1609	08/16/16 1347	08/16/16 1100	08/15/16 1932	08/15/16 1630
Suicide Risk (Adult,Obstetrics,Pediatric)					
Strength-Based Wellness/Recovery		**(p) making progress toward outcome** -JB			
Physical Safety		**(p) making progress toward outcome** -JB			
Depression (Adult,Obstetrics,Pediatric)					
Establish/Maintain Self-Care Routine		**(p) making progress toward outcome** -JB			
Improved/Stable Mood		**(p) making progress toward outcome** -JB			
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -EM	patient -JT (r) JB (t)	patient -JB	patient -FG	patient -FG
Plan of Care Review					
Progress		**(p) progress toward functional goals is gradual** -JB		progress towards functional goals is fair -FG	
Fall Risk (Adult)					
Absence of		**(p) making**			

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

CARE PLAN MINI-FLOWSHEET DATA (continued)

	08/16/16 1609	08/16/16 1347	08/16/16 1100	08/15/16 1932	08/15/16 1630
Falls		**progress toward outcome** -JB			
	08/15/16 1434	08/15/16 1000			
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -SH	patient -SH			
Plan of Care Review					
Progress	progress toward functional goals is gradual -SH				

Custom Formula Data

	08/17/16 0822
Nutritional Screening Tool (modified PG-SGA) If Total: Calculated Risk Score for Cancer is 4 or greater, intervention by dietitian, in conjunction with nurse or physician, is strongly indicated.	
Percent weight Change	1.24 % -FS
Score For Calculated % weight Change Value	0 -FS
Healthy Eating	
Weight change (+/-)	0 -FS
OTHER	
Weight Change (%)	1.24 -FS
Length and Weight	
Weight change (gms)	0 -FS

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	08/17/16 1900	08/17/16 1540	08/17/16 0822	08/17/16 0100	08/16/16 1609
Vital Signs					
Temp		98 °F (36.7 °C) -AS	98.1 °F (36.7 °C) -FS		98.5 °F (36.9 °C) -JT
Temp src			Oral -FS		Oral -JT
Pulse		72 -AS	80 -FS		94 -JT
BP		128/74 mmHg -AS	111/88 mmHg -FS		120/74 mmHg -JT
Patient Position		Sitting -AS	Sitting -FS		Sitting -JT
BP Location		Right arm -AS	Left arm -FS		Left arm -JT
BP Method			Automatic -FS		Automatic -JT
Resp		16 -AS	16 -FS		16 -JT
Skin					
Skin WDL	WDL except;all;color -EM		WDL except -RE	WDL except;all;color -FSA	WDL except;all;color -EM
Skin Integrity	other (see				other (see

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/17/16 1900	08/17/16 1540	08/17/16 0822	08/17/16 0100	08/16/16 1609
	comments) psoriasis -EM				comments) psoriasis -EM
Pain/Comfort, Non Labor					
Pain Rating (0-10): Rest	0 -EM		0 -FS		0 -EM
Pain Rating (0-10): Activity	0 -EM				0 -EM
Comfort/Acceptable Pain Level	3 -EM				3 -EM
FACES Pain Rating: Rest				0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA	
FACES Pain Rating: Activity				0-->no hurt -FSA	
Postpartum Interventions					
Bathing/Skin Care	patient refused -EM				patient refused -EM
Post Anesthesia					
Orientation	oriented x 4 -EM		oriented x 4 -RE		oriented x 4 -EM
Oxygen Therapy during Labor					
SpO2			96 % -FS		95 % -JT
O2 Device			room air -FS		room air -JT
Patient Observation					
Observations	Q30 -EM			Q30 -FSA	Q30 -EM
Height and Weight					
Weight			59.24 kg (130 lb 9.6 oz) -FS		
Cognitive					
Memory Deficit	intact -EM		intact -RE		intact -EM
Length and Weight					
Weight change (gms)			0 -FS		
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -EM		3-->polypharmacy -RE	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -FSA	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -EM
Fall Risk Score	9 -EM		3 -RE	9 -FSA	9 -EM
Danger to Self					
Danger to Self (WDL)	WDL -EM		WDL -RE	-- Asleep -FSA	WDL -EM
Danger to Self	no suicidal		no suicidal		no suicidal

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/17/16 1900	08/17/16 1540	08/17/16 0822	08/17/16 0100	08/16/16 1609
	ideation or behavior indicators observed or expressed -EM		ideation or behavior indicators observed or expressed -RE		ideation or behavior indicators observed or expressed -EM
Keeps Self Safe	yes (describe) -EM		yes (describe) -RE		yes (describe) -EM
Description of Suicide Plan	Denied -EM				Denied -EM
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -EM		no self-injurious ideation or behavior indicators observed or expressed -RE		no self-injurious ideation or behavior indicators observed or expressed -EM
Self-injury Description	Denied -EM				Denied -EM
Agreement not to Harm Self	yes (describe) -EM		yes (describe) -RE		yes (describe) -EM
Description of Agreement	verbal -EM				verbal -EM
Pain/Comfort/Sleep Interventions					
Sleep/Rest Enhancement	awakenings minimized;regular sleep/rest pattern promoted -EM				awakenings minimized;regular sleep/rest pattern promoted -EM
Danger to Others					
Danger to Others (WDL)	WDL -EM		WDL -RE	-- Asleep -FSA	WDL -EM
Precautions/Isolation					
Precautions (displays in banner)	None -EM		None -RE	None -FSA	None -EM
	08/16/16 1100	08/16/16 1008	08/16/16 0905	08/16/16 0800	08/16/16 0200
Vital Signs					
Temp				98.4 °F (36.9 °C) -AP	
Pulse				84 -AP	
BP				134/72 mmHg -AP	
Resp				18 -AP	
Skin					
Skin WDL		WDL except;all;color -JB			
Skin Integrity		other (see comments) psoriasis -JB			
Pain/Comfort, Non Labor					
Pain Rating (0-10): Rest		0 -JB	3 -JB	0 -JB	

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/16/16 1100	08/16/16 1008	08/16/16 0905	08/16/16 0800	08/16/16 0200
Pain Rating (0-10): Activity		0 -JB	3 -JB	0 -JB	
Pain Quality			aching -JB		
Postpartum Interventions					
Bathing/Skin Care		-- needs encouragment -JB			
Post Anesthesia					
Orientation	oriented x 4 -JB				
Pain Assessment					
Pain Management Interventions			single medication modality -JB		
Pain Body Location - Side		Bilateral -JB	Bilateral -JB		
Pain Body Location - Orientation		-- pelvic pain -JB	other (see comments) pelvic -JB		
Pain Body Location		-- pelvic pain -JB	other (see comments) "pelvic pain" -JB		
Oxygen Therapy during Labor					
SpO2				99 % -AP	
Patient Observation					
Observations		Q30 -JB			Q30 -MB
Cognitive					
Memory Deficit	intact -JB				
Fall Risk Assessment					
Fall Risk Indicators		3-->central nervous system/psychotropic medication;2-->depression;1-->male;3-->polypharmacy -JB			
Fall Risk Score		9 -JB			
Danger to Self					
Danger to Self (WDL)	WDL -JB	-- -JB			WDL -MB
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -JB	-- -JB			no suicidal ideation or behavior indicators observed or expressed Pt asleep -MB
Keeps Self Safe	yes (describe) -JB				
Self-Injurious Behavior	no self-injurious ideation or behavior indicators				

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/16/16 1100	08/16/16 1008	08/16/16 0905	08/16/16 0800	08/16/16 0200
	observed or expressed -JB				
Agreement not to Harm Self	yes (describe) -JB				
Description of Agreement	verbal -JB				
Danger to Others					
Danger to Others (WDL)	WDL -JB	-- -JB			WDL Pt asleep -MB
Precautions/Isolation					
Precautions (displays in banner)		None -JB			None -MB
	08/15/16 2200	08/15/16 2044	08/15/16 1630	08/15/16 1544	08/15/16 1000
Vital Signs					
Temp				98.5 °F (36.9 °C) -AS	
Pulse				98 -AS	
BP				133/85 mmHg -AS	
Patient Position				Sitting -AS	
BP Location				Right arm -AS	
Resp				16 -AS	
Skin					
Skin WDL			WDL -FG		WDL -SH
Pain/Comfort, Non Labor					
Pain Rating (0-10): Rest	0 -FG	0 -FG			0 -SH
Pain Rating (0-10): Activity	0 -FG	0 -FG			0 -SH
Comfort/Acceptable Pain Level	0 -FG				0 -SH
Post Anesthesia					
Orientation			oriented x 4 -FG		oriented x 4 -SH
Patient Observation					
Observations			Q 30 mins -FG		
Cognitive					
Memory Deficit					intact -SH
Fall Risk Assessment					
Fall Risk Indicators			3-->central nervous system/psychotropic medication;2-->depression;1-->male;3-->polypharmacy -FG		3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -SH
Fall Risk Score			9 -FG		9 -SH
Danger to Self					

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/15/16 2200	08/15/16 2044	08/15/16 1630	08/15/16 1544	08/15/16 1000
Danger to Self (WDL)			WDL -FG		WDL -SH
Danger to Others					
Danger to Others (WDL)			WDL -FG		WDL -SH
Precautions/Isolation					
Precautions (displays in banner)			None -FG		None -SH

	08/15/16 0851	08/15/16 0100
Vital Signs		
Temp	97.5 °F (36.4 °C) -FS	
Temp src	Oral -FS	
Pulse	114 -FS	
BP	117/70 mmHg -FS	
Patient Position	Sitting -FS	
BP Location	Left arm -FS	
BP Method	Automatic -FS	
Resp	16 -FS	
Pain/Comfort, Non Labor		
Pain Rating (0-10): Rest	0 -FS	0 -CR
Oxygen Therapy during Labor		
SpO2	97 % -FS	
O2 Device	room air -FS	
Patient Observation		
Observations		Q 30 mins -CR
Fall Risk Assessment		
Fall Risk Indicators		3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -CR
Fall Risk Score		9 -CR
Danger to Self		
Danger to Self (WDL)		WDL -CR
Danger to Others		
Danger to Others (WDL)		WDL -CR
Precautions/Isolation		
Precautions (displays in banner)		None -CR

BH PS Main

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH PS Main (continued)

	08/17/16 1900	08/17/16 0822	08/17/16 0100	08/16/16 1609	08/16/16 1100
Legal Status					
Legal status	voluntary -EM	voluntary -RE	voluntary -FSA	voluntary -EM	
Risk Assessment					
Danger to Self (WDL)	WDL -EM	WDL -RE	-- Asleep -FSA	WDL -EM	WDL -JB
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -EM	no suicidal ideation or behavior indicators observed or expressed -RE		no suicidal ideation or behavior indicators observed or expressed -EM	no suicidal ideation or behavior indicators observed or expressed -JB
Keeps Self Safe	yes (describe) -EM	yes (describe) -RE		yes (describe) -EM	yes (describe) -JB
Description of Suicide Plan	Denied -EM			Denied -EM	
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -EM	no self-injurious ideation or behavior indicators observed or expressed -RE		no self-injurious ideation or behavior indicators observed or expressed -EM	no self-injurious ideation or behavior indicators observed or expressed -JB
Self-injury Description	Denied -EM			Denied -EM	
Agreement not to Harm Self	yes (describe) -EM	yes (describe) -RE		yes (describe) -EM	yes (describe) -JB
Description of Agreement	verbal -EM			verbal -EM	verbal -JB
Assessment timing	Shift -EM	Shift -RE		Shift -EM	
Assessment of Risk Factors	Prior suicide attempts;Deficits in social, decision, and coping skills;History of childhood physicial/sexual abuse -EM	Current drug or alcohol abuse -RE		Prior suicide attempts;Deficits in social, decision, and coping skills;History of childhood physicial/sexual abuse -EM	
Assessment of Protective Factors	Good access to health care/therapy -EM	Good access to health care/therapy -RE		Good access to health care/therapy -EM	
Agitation		Low -RE			
Anxiety or Fearfulness		None -RE			
Depression or Sadness		None -RE			
Danger to Others (WDL)	WDL -EM	WDL -RE	-- Asleep -FSA	WDL -EM	WDL -JB
	08/16/16 1008	08/16/16 0200	08/15/16 1630	08/15/16 1000	08/15/16 0100
Legal Status					
Legal status	voluntary -JB	voluntary -MB	voluntary -FG	voluntary -SH	voluntary -CR

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH PS Main (continued)

	08/16/16 1008	08/16/16 0200	08/15/16 1630	08/15/16 1000	08/15/16 0100
Risk Assessment					
Danger to Self (WDL)	-- -JB	WDL -MB	WDL -FG	WDL -SH	WDL -CR
Danger to Self	-- -JB	no suicidal ideation or behavior indicators observed or expressed Pt asleep -MB			
Danger to Others (WDL)	-- -JB	WDL Pt asleep -MB	WDL -FG	WDL -SH	WDL -CR

BH Tx Plan MH IP

	08/17/16 1021	08/15/16 1054
Patient Assets/Stressors		
Patient Assets	general fund of knowledge;average or above intelligence;motivation for treatment/growth;capable of independent living;supportive family/friends;work skills;physical health;ability for insight;communication skills -PK	general fund of knowledge;average or above intelligence;motivation for treatment/growth;capable of independent living;supportive family/friends;work skills;physical health;ability for insight;communication skills -LM
Patient Stressors	medication change or non-compliance -PK	medication change or non-compliance -LM
Discharge Planning		
Discharge Criteria	improved stabilization in mood, thinking and/or behavior;verbal commitment to aftercare and medication compliance -PK	improved stabilization in mood, thinking and/or behavior;verbal commitment to aftercare and medication compliance -LM
Recommended Discharge Plan	return to previous living environment;medication management with psychiatrist or other physician -PK	return to previous living environment;medication management with psychiatrist or other physician -LM
Pt's Acceptance of Discharge	yes -PK	yes -LM

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Tx Plan MH IP (continued)

	08/17/16 1021	08/15/16 1054
Plan		
Why Continues to Need Hospitalization	severe impairment of level of functioning;danger to self or others;medication stabilization -PK	severe impairment of level of functioning;danger to self or others;medication stabilization -LM
Estimated Length of Stay	3-5 days -PK	3-5 days -LM
Provisional DSM 5 Diagnoses		
Problem Being Addressed	refer to problem list -PK	refer to problem list -LM
Goal: Will work with social worker/treatment coordinator to develop safe discharge plan		
Goal Status	goal initiated -PK	goal initiated -LM
Goal: Will attend Occupational Therapy groups up to seven days weekly as tolerated		
Objectives	increase coping skills -PK	increase coping skills -LM
Goal Status	progress made toward outcome -PK	progress made toward outcome -LM
Treatment Plan Reviewed by		
Psychiatric Social Worker	Pauline -PK	Himot -LM
Registered Nurse	Kader -PK	Marin -LM
Nurse Manager	Han -PK	
Occupational Therapist	Edwards -PK	Bailey -LM
Other	Leveton -PK	Byrne -LM

VS Simple

	08/17/16 1900	08/17/16 1540	08/17/16 0822	08/17/16 0638	08/17/16 0100
Vital Signs					
Temp		98 °F (36.7 °C) -AS	98.1 °F (36.7 °C) -FS		
Temp src			Oral -FS		
Pulse		72 -AS	80 -FS		
BP		128/74 mmHg -AS	111/88 mmHg -FS		
Patient Position		Sitting -AS	Sitting -FS		
BP Location		Right arm -AS	Left arm -FS		
BP Method			Automatic -FS		
Resp		16 -AS	16 -FS		
Oxygen Therapy					
SpO2			96 % -FS		
O2 Device			room air -FS		
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -EM				FACES (Wong-Baker FACES Pain Rating

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

VS Simple (continued)

	08/17/16 1900	08/17/16 1540	08/17/16 0822	08/17/16 0638	08/17/16 0100
					Scale) -FSA
Sleep/Rest/Relaxation	sleep interrupted -EM			no problem identified -FSA	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -EM		0 -FS		
Pain Rating (0-10): Activity	0 -EM				
Comfort/Acceptable Pain Level	3 -EM				
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest					0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA
FACES Pain Rating: Activity					0-->no hurt -FSA
Height and Weight					
Weight			59.24 kg (130 lb 9.6 oz) -FS		
Patient Observation					
Observations	Q30 -EM				Q30 -FSA
	08/16/16 1609	08/16/16 1008	08/16/16 0905	08/16/16 0800	08/16/16 0200
Vital Signs					
Temp	98.5 °F (36.9 °C) -JT			98.4 °F (36.9 °C) -AP	
Temp src	Oral -JT				
Pulse	94 -JT			84 -AP	
Pulse Source	Brachial -JT				
BP	120/74 mmHg -JT			134/72 mmHg -AP	
Patient Position	Sitting -JT				
BP Location	Left arm -JT				
BP Method	Automatic -JT				
Resp	16 -JT			18 -AP	
Oxygen Therapy					
SpO2	95 % -JT			99 % -AP	
O2 Device	room air -JT				
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -EM				
Sleep/Rest/Relaxation	sleep interrupted -EM	-- -JB			no problem identified;appears asleep;limb movements periodically during sleep -MB
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-	0 -EM	0 -JB	3 -JB	0 -JB	

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

VS Simple (continued)

	08/16/16 1609	08/16/16 1008	08/16/16 0905	08/16/16 0800	08/16/16 0200
10): Rest					
Pain Rating (0-10): Activity	0 -EM	0 -JB	3 -JB	0 -JB	
Comfort/Acceptable Pain Level	3 -EM				
Pain Body Location - Side		Bilateral -JB	Bilateral -JB		
Pain Body Location - Orientation		-- pelvic pain -JB	other (see comments) pelvic -JB		
Pain Body Location		-- pelvic pain -JB	other (see comments) "pelvic pain" -JB		
Pain Quality			aching -JB		
Pain Management Interventions			single medication modality -JB		
Patient Observation					
Observations	Q30 -EM	Q30 -JB			Q30 -MB
	08/15/16 2200	08/15/16 2044	08/15/16 1630	08/15/16 1544	08/15/16 1000
Vital Signs					
Temp				98.5 °F (36.9 °C) -AS	
Pulse				98 -AS	
BP				133/85 mmHg -AS	
Patient Position				Sitting -AS	
BP Location				Right arm -AS	
Resp				16 -AS	
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -FG				
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -FG	0 -FG			0 -SH
Pain Rating (0-10): Activity	0 -FG	0 -FG			0 -SH
Comfort/Acceptable Pain Level	0 -FG				0 -SH
Patient Observation					
Observations			Q 30 mins -FG		
	08/15/16 0851	08/15/16 0100			
Vital Signs					
Temp	97.5 °F (36.4 °C) -FS				
Temp src	Oral -FS				
Pulse	114 -FS				
BP	117/70 mmHg -FS				
Patient Position	Sitting -FS				

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

VS Simple (continued)

	08/15/16 0851	08/15/16 0100
BP Location	Left arm -FS	
BP Method	Automatic -FS	
Resp	16 -FS	
Oxygen Therapy		
SpO2	97 % -FS	
O2 Device	room air -FS	
Pain/Comfort/Sleep		
Preferred Pain Scale		number (Numeric Rating Pain Scale) -CR
Pain Assessment: Number Scale (0-10)		
Pain Rating (0-10): Rest	0 -FS	0 -CR
Patient Observation		
Observations		Q 30 mins -CR

VS Simple

	08/17/16 1900	08/17/16 1540	08/17/16 0822	08/17/16 0100	08/16/16 1609
Height and Weight					
Weight			59.24 kg (130 lb 9.6 oz) -FS		
Vital Signs					
Temp		98 °F (36.7 °C) -AS	98.1 °F (36.7 °C) -FS		98.5 °F (36.9 °C) -JT
Temp src			Oral -FS		Oral -JT
Pulse		72 -AS	80 -FS		94 -JT
Pulse Source					Brachial -JT
BP		128/74 mmHg -AS	111/88 mmHg -FS		120/74 mmHg -JT
Patient Position		Sitting -AS	Sitting -FS		Sitting -JT
BP Location		Right arm -AS	Left arm -FS		Left arm -JT
BP Method			Automatic -FS		Automatic -JT
Resp		16 -AS	16 -FS		16 -JT
Oxygen Therapy					
SpO2			96 % -FS		95 % -JT
O2 Device			room air -FS		room air -JT
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -EM			FACES (Wong-Baker FACES Pain Rating Scale) -FSA	number (Numeric Rating Pain Scale) -EM
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -EM		0 -FS		0 -EM
Pain Rating (0-10): Activity	0 -EM				0 -EM
Comfort/Acceptable Pain Level	3 -EM				3 -EM
Pain Assessment: FACES Scale					

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

VS Simple (continued)

	08/17/16 1900	08/17/16 1540	08/17/16 0822	08/17/16 0100	08/16/16 1609
FACES Pain Rating: Rest				0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA	
FACES Pain Rating: Activity				0-->no hurt -FSA	
Patient Observation					
Observations	Q30 -EM			Q30 -FSA	Q30 -EM
	08/16/16 1008	08/16/16 0905	08/16/16 0800	08/16/16 0200	08/15/16 2200
Vital Signs					
Temp			98.4 °F (36.9 °C) -AP		
Pulse			84 -AP		
BP			134/72 mmHg -AP		
Resp			18 -AP		
Oxygen Therapy					
SpO2			99 % -AP		
Pain/Comfort					
Preferred Pain Scale					number (Numeric Rating Pain Scale) -FG
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -JB	3 -JB	0 -JB		0 -FG
Pain Rating (0-10): Activity	0 -JB	3 -JB	0 -JB		0 -FG
Comfort/Acceptable Pain Level					0 -FG
Pain Body Location - Side	Bilateral -JB	Bilateral -JB			
Pain Body Location - Orientation	-- pelvic pain -JB	other (see comments) pelvic -JB			
Pain Body Location	-- pelvic pain -JB	other (see comments) "pelvic pain" -JB			
Pain Quality		aching -JB			
Pain Management Interventions		single medication modality -JB			
Patient Observation					
Observations	Q30 -JB			Q30 -MB	
	08/15/16 2044	08/15/16 1630	08/15/16 1544	08/15/16 1000	08/15/16 0851
Vital Signs					
Temp			98.5 °F (36.9 °C) -AS		97.5 °F (36.4 °C) -FS
Temp src					Oral -FS
Pulse			98 -AS		114 -FS
BP			133/85 mmHg -AS		117/70 mmHg -

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

VS Simple (continued)

	08/15/16 2044	08/15/16 1630	08/15/16 1544	08/15/16 1000	08/15/16 0851
					FS
Patient Position			Sitting -AS		Sitting -FS
BP Location			Right arm -AS		Left arm -FS
BP Method					Automatic -FS
Resp			16 -AS		16 -FS
Oxygen Therapy					
SpO2					97 % -FS
O2 Device					room air -FS
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -FG			0 -SH	0 -FS
Pain Rating (0-10): Activity	0 -FG			0 -SH	
Comfort/Acceptable Pain Level				0 -SH	
Patient Observation					
Observations		Q 30 mins -FG			

	08/15/16 0100
Pain/Comfort	
Preferred Pain Scale	number (Numeric Rating Pain Scale) -CR
Pain Assessment: Number Scale (0-10)	
Pain Rating (0-10): Rest	0 -CR
Patient Observation	
Observations	Q 30 mins -CR

Pain Scales

	08/17/16 1900	08/17/16 0822	08/17/16 0638	08/17/16 0100	08/16/16 1609
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -EM			FACES (Wong-Baker FACES Pain Rating Scale) -FSA	number (Numeric Rating Pain Scale) -EM
Sleep/Rest/Relaxation	sleep interrupted -EM		no problem identified -FSA		sleep interrupted -EM
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -EM	0 -FS			0 -EM
Pain Rating (0-10): Activity	0 -EM				0 -EM
Comfort/Acceptable Pain Level	3 -EM				3 -EM
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest				0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA	

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

Pain Scales (continued)

	08/17/16 1900	08/17/16 0822	08/17/16 0638	08/17/16 0100	08/16/16 1609
FACES Pain Rating: Activity				0-->no hurt -FSA	
	08/16/16 1008	08/16/16 0905	08/16/16 0800	08/16/16 0200	08/15/16 2200
Pain/Comfort/Sleep					
Preferred Pain Scale					number (Numeric Rating Pain Scale) -FG
Sleep/Rest/Relaxation	-- -JB			no problem identified;appears asleep;limb movements periodically during sleep -MB	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -JB	3 -JB	0 -JB		0 -FG
Pain Rating (0-10): Activity	0 -JB	3 -JB	0 -JB		0 -FG
Comfort/Acceptable Pain Level					0 -FG
Pain Body Location - Side	Bilateral -JB	Bilateral -JB			
Pain Body Location - Orientation	-- pelvic pain -JB	other (see comments) pelvic -JB			
Pain Body Location	-- pelvic pain -JB	other (see comments) "pelvic pain" -JB			
Pain Quality		aching -JB			
Pain Management Interventions		single medication modality -JB			
	08/15/16 2044	08/15/16 1000	08/15/16 0851	08/15/16 0100	
Pain/Comfort/Sleep					
Preferred Pain Scale				number (Numeric Rating Pain Scale) -CR	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -FG	0 -SH	0 -FS	0 -CR	
Pain Rating (0-10): Activity	0 -FG	0 -SH			
Comfort/Acceptable Pain Level		0 -SH			

Pain Reassessment

	08/17/16 1900	08/17/16 0822	08/17/16 0638	08/17/16 0100	08/16/16 1609
Pain/Comfort/Sleep					
Sleep/Rest/Relaxation	sleep interrupted -EM		no problem identified -FSA		sleep interrupted -EM

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

Pain Reassessment (continued)

	08/17/16 1900	08/17/16 0822	08/17/16 0638	08/17/16 0100	08/16/16 1609
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -EM	0 -FS			0 -EM
Pain Rating (0-10): Activity	0 -EM				0 -EM
Comfort/Acceptable Pain Level	3 -EM				3 -EM
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest				0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA	
FACES Pain Rating: Activity				0-->no hurt -FSA	
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -EM			FACES (Wong-Baker FACES Pain Rating Scale) -FSA	number (Numeric Rating Pain Scale) -EM
	08/16/16 1008	08/16/16 0905	08/16/16 0800	08/16/16 0200	08/15/16 2200
Pain/Comfort/Sleep					
Sleep/Rest/Relaxation	-- -JB			no problem identified;appears asleep;limb movements periodically during sleep -MB	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -JB	3 -JB	0 -JB		0 -FG
Pain Rating (0-10): Activity	0 -JB	3 -JB	0 -JB		0 -FG
Comfort/Acceptable Pain Level					0 -FG
Pain Body Location - Side	Bilateral -JB	Bilateral -JB			
Pain Body Location - Orientation	-- pelvic pain -JB	other (see comments) pelvic -JB			
Pain Body Location	-- pelvic pain -JB	other (see comments) "pelvic pain" -JB			
Pain Quality		aching -JB			
Pain Management Interventions		single medication modality -JB			
Pain/Comfort					
Preferred Pain Scale					number (Numeric Rating

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

Pain Reassessment (continued)

	08/16/16 1008	08/16/16 0905	08/16/16 0800	08/16/16 0200	08/15/16 2200
					Pain Scale) -FG
	08/15/16 2044	08/15/16 1000	08/15/16 0851	08/15/16 0100	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -FG	0 -SH	0 -FS	0 -CR	
Pain Rating (0-10): Activity	0 -FG	0 -SH			
Comfort/Acceptable Pain Level		0 -SH			
Pain/Comfort					
Preferred Pain Scale				number (Numeric Rating Pain Scale) -CR	

BH Daily Assess

	08/17/16 2328	08/17/16 1900	08/17/16 1540	08/17/16 1131	08/17/16 0822
Legal Status					
Legal status		voluntary -EM			voluntary -RE
Vital Signs					
Temp			98 °F (36.7 °C) -AS		98.1 °F (36.7 °C) -FS
Temp src					Oral -FS
Pulse			72 -AS		80 -FS
BP			128/74 mmHg -AS		111/88 mmHg -FS
Patient Position			Sitting -AS		Sitting -FS
BP Location			Right arm -AS		Left arm -FS
BP Method					Automatic -FS
Resp			16 -AS		16 -FS
Patient Observation					
Observations		Q30 -EM			
Oxygen Therapy					
SpO2					96 % -FS
O2 Device					room air -FS
Height and Weight					
Weight					59.24 kg (130 lb 9.6 oz) -FS
Pain/Comfort					
Preferred Pain Scale		number (Numeric Rating Pain Scale) -EM			
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -EM			0 -FS
Pain Rating (0-10): Activity		0 -EM			
Comfort/Acceptable Pain Level		3 -EM			
Skin WDL					

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Daily Assess (continued)

	08/17/16 2328	08/17/16 1900	08/17/16 1540	08/17/16 1131	08/17/16 0822
Skin WDL		WDL except;all;color -EM			WDL except -RE
Skin Integrity		other (see comments) psoriasis -EM			
HEENT					
HEENT WDL		WDL -EM			WDL -RE
Fall Risk Assessment					
Fall Risk Indicators		3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -EM			3-->polypharmacy -RE
Fall Risk Score		9 -EM			3 -RE
Patient Rights Denials					
Rights Denied or Restrictions Imposed		no -EM			
Precautions/Isolation					
Precautions (displays in banner)		None -EM			None -RE
Precautions Interventions					
Interventions Performed		yes -EM			yes -RE
Level of Observation		every 30 minutes -EM			every 30 minutes -RE
Activities of Daily Living					
ADL's (WDL)		WDL Except -EM			WDL Except -RE
Bathing/Skin Care		patient refused -EM			
Daily Sleep					
Daily Sleep (WDL)		WDL Except -EM			WDL -RE
Sleep/Rest/Relaxation		sleep interrupted -EM			
Sleep/Rest Enhancement		awakenings minimized;regular sleep/rest pattern promoted -EM			
Nutritional Intake					
Dinner (%)		100 % -EM			
Snack #3 Intake (%)		100 % -EM			
Daily Nutrition					
Daily Nutrition		WDL -EM			WDL -RE

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Daily Assess (continued)

	08/17/16 2328	08/17/16 1900	08/17/16 1540	08/17/16 1131	08/17/16 0822
(WDL)					
Mental Status					
Orientation		oriented x 4 -EM			oriented x 4 -RE
Level Of Consciousness		alert -EM			alert -RE
General Appearance WDL		WDL except -EM			WDL except -RE
General Appearance		unkempt -EM			unkempt -RE
Mood		anxious;depressed -EM			anxious -RE
Mood/Behavior/ Affect WDL		WDL except;all;affect;mood/behavior -EM			WDL except -RE
Affect		blunted -EM			flat -RE
Behavior (WDL)		WDL except -EM			WDL except -RE
Mood/Behavior		anxious;cooperative -EM			anxious -RE
Speech		WDL -EM			WDL -RE
Speech					clear -RE
Judgment and Insight		judgment appropriate to situation -EM			judgment appropriate to situation -RE
Insight		fair -EM			fair -RE
Concentration		fair -EM			fair -RE
Memory Deficit		intact -EM			intact -RE
Thought (WDL)		WDL -EM			WDL -RE
Thought Process		circumstantial thought -EM			circumstantial thought -RE
Coping/Psychosocial Response					
Observed Emotional State		accepting;anxious;cooperative;restless -EM			accepting -RE
Verbalized Emotional State		anxiety;depression;acceptance -EM			anxiety -RE
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -EM	patient -EM		patient -RE	patient -RE
Supportive Measures		active listening utilized;verbalization of feelings encouraged -EM			active listening utilized;counseling provided -RE
Behavior Management		behavioral plan reviewed -EM			
Psychiatric Symptoms					
Anxiety Symptoms		WDL except -EM			WDL -RE

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Daily Assess (continued)

	08/17/16 2328	08/17/16 1900	08/17/16 1540	08/17/16 1131	08/17/16 0822
(WDL)					
Anxiety Symptoms		generalized -EM			generalized -RE
Manic Symptoms (WDL)		WDL -EM			WDL -RE
Psychotic symptoms (WDL)		WDL -EM			WDL -RE
Danger to Self					
Danger to Self (WDL)		WDL -EM			WDL -RE
Danger to Self		no suicidal ideation or behavior indicators observed or expressed -EM			no suicidal ideation or behavior indicators observed or expressed -RE
Keeps Self Safe		yes (describe) -EM			yes (describe) -RE
Description of Suicide Plan		Denied -EM			
Self-Injurious Behavior		no self-injurious ideation or behavior indicators observed or expressed -EM			no self-injurious ideation or behavior indicators observed or expressed -RE
Self-injury Description		Denied -EM			
Agreement not to Harm Self		yes (describe) -EM			yes (describe) -RE
Description of Agreement		verbal -EM			
Assessment Type					
Assessment timing		Shift -EM			Shift -RE
Assessment of contributing factors					
Assessment of Risk Factors		Prior suicide attempts;Deficits in social, decision, and coping skills;History of childhood physicial/sexual abuse -EM			Current drug or alcohol abuse -RE
Assessment of Protective Factors		Good access to health care/therapy -EM			Good access to health care/therapy -RE
Suicide Risk Assessment- Mood					

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Daily Assess (continued)

	08/17/16 2328	08/17/16 1900	08/17/16 1540	08/17/16 1131	08/17/16 0822
Agitation					Low -RE
Anxiety or Fearfulness					None -RE
Depression or Sadness					None -RE
Danger to Others					
Danger to Others (WDL)		WDL -EM			WDL -RE
	08/17/16 0638	08/17/16 0100	08/16/16 2233	08/16/16 1609	08/16/16 1347
Legal Status					
Legal status		voluntary -FSA		voluntary -EM	
Vital Signs					
Temp				98.5 °F (36.9 °C) -JT	
Temp src				Oral -JT	
Pulse				94 -JT	
Pulse Source				Brachial -JT	
BP				120/74 mmHg -JT	
Patient Position				Sitting -JT	
BP Location				Left arm -JT	
BP Method				Automatic -JT	
Resp				16 -JT	
Patient Observation					
Observations		Q30 -FSA		Q30 -EM	
Oxygen Therapy					
SpO2				95 % -JT	
O2 Device				room air -JT	
Pain/Comfort					
Preferred Pain Scale		FACES (Wong-Baker FACES Pain Rating Scale) -FSA		number (Numeric Rating Pain Scale) -EM	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest				0 -EM	
Pain Rating (0-10): Activity				0 -EM	
Comfort/Acceptable Pain Level				3 -EM	
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest		0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA			
FACES Pain Rating: Activity		0-->no hurt -FSA			
Skin WDL					
Skin WDL		WDL		WDL	

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Daily Assess (continued)

	08/17/16 0638	08/17/16 0100	08/16/16 2233	08/16/16 1609	08/16/16 1347
		except;all;color -FSA		except;all;color -EM	
Skin Integrity				other (see comments) psoriasis -EM	
HEENT					
HEENT WDL				WDL -EM	
Fall Risk Assessment					
Fall Risk Indicators		3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -FSA		3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -EM	
Fall Risk Score		9 -FSA		9 -EM	
Patient Rights Denials					
Rights Denied or Restrictions Imposed		no -FSA		no -EM	
Precautions/Isolation					
Precautions (displays in banner)		None -FSA		None -EM	
Precautions Interventions					
Interventions Performed		yes -FSA		yes -EM	
Level of Observation				every 30 minutes -EM	
Activities of Daily Living					
ADL's (WDL)				WDL Except -EM	
Bathing/Skin Care				patient refused -EM	
Daily Sleep					
Daily Sleep (WDL)	WDL -FSA			WDL Except -EM	
Sleep/Rest/Relaxation	no problem identified -FSA			sleep interrupted -EM	
Sleep/Rest Enhancement				awakenings minimized;regular sleep/rest pattern promoted -EM	
Daily Hours of Sleep	7.5 -EA				
Nutritional Intake					
Dinner (%)				75 % -EM	
Snack #3 Intake (%)				0 % -EM	
Daily Nutrition					

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Daily Assess (continued)

	08/17/16 0638	08/17/16 0100	08/16/16 2233	08/16/16 1609	08/16/16 1347
Daily Nutrition (WDL)				WDL -EM	
Mental Status					
Orientation				oriented x 4 -EM	
Level Of Consciousness				alert -EM	
General Appearance WDL				WDL except -EM	
General Appearance				unkempt -EM	
Mood				anxious;depressed -EM	
Mood/Behavior/ Affect WDL				WDL except;all;affect;mood/behavior -EM	
Affect				blunted -EM	
Behavior (WDL)				WDL except -EM	
Mood/Behavior				anxious;cooperative -EM	
Speech				WDL except -EM	
Speech				hyperverbal -EM	
Judgment and Insight				judgment appropriate to situation -EM	
Insight				fair -EM	
Concentration				fair -EM	
Memory Deficit				intact -EM	
Thought (WDL)				WDL Except -EM	
Thought Process				circumstantial thought -EM	
Coping/Psychosocial Response					
Observed Emotional State				accepting;anxious;cooperative;restless -EM	
Verbalized Emotional State				anxiety;depression;acceptance -EM	
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With			patient -EM	patient -EM	patient -JT (r) JB (t)
Supportive Measures				active listening utilized;verbalization of feelings encouraged -EM	
Behavior Management				behavioral plan reviewed -EM	
Psychiatric Symptoms					
Anxiety Symptoms		-- Asleep -FSA		WDL except -EM	

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Daily Assess (continued)

	08/17/16 0638	08/17/16 0100	08/16/16 2233	08/16/16 1609	08/16/16 1347
(WDL)					
Anxiety Symptoms				generalized -EM	
Manic Symptoms (WDL)				WDL -EM	
Psychotic symptoms (WDL)				WDL -EM	
Danger to Self					
Danger to Self (WDL)		-- Asleep -FSA		WDL -EM	
Danger to Self				no suicidal ideation or behavior indicators observed or expressed -EM	
Keeps Self Safe				yes (describe) -EM	
Description of Suicide Plan				Denied -EM	
Self-Injurious Behavior				no self-injurious ideation or behavior indicators observed or expressed -EM	
Self-injury Description				Denied -EM	
Agreement not to Harm Self				yes (describe) -EM	
Description of Agreement				verbal -EM	
Assessment Type					
Assessment timing				Shift -EM	
Assessment of contributing factors					
Assessment of Risk Factors				Prior suicide attempts;Deficits in social, decision, and coping skills;History of childhood physicial/sexual abuse -EM	
Assessment of Protective Factors				Good access to health care/therapy -EM	
Danger to Others					
Danger to Others (WDL)		-- Asleep -FSA		WDL -EM	

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Daily Assess (continued)

	08/16/16 1100	08/16/16 1008	08/16/16 0905	08/16/16 0800	08/16/16 0700
Legal Status					
Legal status		voluntary -JB			
Vital Signs					
Temp				98.4 °F (36.9 °C) -AP	
Pulse				84 -AP	
BP				134/72 mmHg -AP	
Resp				18 -AP	
Patient Observation					
Observations		Q30 -JB			
Oxygen Therapy					
SpO2				99 % -AP	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -JB	3 -JB	0 -JB	
Pain Rating (0-10): Activity		0 -JB	3 -JB	0 -JB	
Pain Body Location - Side		Bilateral -JB	Bilateral -JB		
Pain Body Location - Orientation		-- pelvic pain -JB	other (see comments) pelvic -JB		
Pain Body Location		-- pelvic pain -JB	other (see comments) "pelvic pain" -JB		
Pain Quality			aching -JB		
Pain Management Interventions			single medication modality -JB		
Skin WDL					
Skin WDL		WDL except;all;color -JB			
Skin Integrity		other (see comments) psoriasis -JB			
Additional Documentation		-- hx psoriasis -JB			
Fall Risk Assessment					
Fall Risk Indicators		3-->central nervous system/psychotropic medication;2-->depression;1-->male;3-->polypharmacy -JB			
Fall Risk Score		9 -JB			
Patient Rights Denials					
Rights Denied or Restrictions		no -JB			

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Daily Assess (continued)

	08/16/16 1100	08/16/16 1008	08/16/16 0905	08/16/16 0800	08/16/16 0700
Imposed					
Precautions/Isolation					
Precautions (displays in banner)		None -JB			
Activities of Daily Living					
ADL's (WDL)		WDL Except -JB			
Bathing/Skin Care		-- needs encouragment -JB			
Daily Sleep					
Daily Sleep (WDL)		WDL -JB			
Sleep/Rest/Relaxation		-- -JB			
Daily Hours of Sleep					8 -MB
Daily Nutrition					
Daily Nutrition (WDL)	WDL except -JB				
Appetite Change	decreased -JB				
Barriers to Nutrition	-- anxiety -JB				
Mental Status					
Orientation	oriented x 4 -JB				
Level Of Consciousness	alert -JB	-- -JB			
General Appearance WDL	WDL except;appearance -JB				
General Appearance	unkempt -JB				
Mood	anxious;depressed -JB				
Mood/Behavior/Affect WDL	WDL except;all;affect;mood/behavior -JB				
Affect	flat -JB				
Behavior (WDL)	WDL except -JB	-- -JB			
Mood/Behavior	anxious;cooperative;restless -JB				
Somatic Symptoms	-- pelvic pain -JB				
Speech	WDL -JB				
Speech	clear -JB				
Insight	fair -JB				
Concentration	fair -JB				
Memory Deficit	intact -JB				

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Daily Assess (continued)

	08/16/16 1100	08/16/16 1008	08/16/16 0905	08/16/16 0800	08/16/16 0700
Thought (WDL)	WDL -JB				
Thought Process	organized anxious but appears organized -JB				
Mental Status Comments	-- anxious -JB				
Coping/Psychosocial Response					
Observed Emotional State	withdrawn;quiet -JB				
Verbalized Emotional State	anxiety;depression -JB				
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -JB				
Psychiatric Symptoms					
Anxiety Symptoms (WDL)	WDL except -JB	-- -JB			
Anxiety Symptoms	generalized restless -JB				
Manic Symptoms (WDL)	WDL -JB	-- -JB			
Manic Symptoms		-- -JB			
Psychotic symptoms (WDL)	WDL -JB	-- -JB			
Danger to Self					
Danger to Self (WDL)	WDL -JB	-- -JB			
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -JB	-- -JB			
Keeps Self Safe	yes (describe) -JB				
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -JB				
Agreement not to Harm Self	yes (describe) -JB				
Description of Agreement	verbal -JB				
Danger to Others					
Danger to Others (WDL)	WDL -JB	-- -JB			

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Daily Assess (continued)

	08/16/16 0200	08/15/16 2200	08/15/16 2044	08/15/16 1932	08/15/16 1630
Legal Status					
Legal status	voluntary -MB				voluntary -FG
Patient Observation					
Observations	Q30 -MB				Q 30 mins -FG
Pain/Comfort					
Preferred Pain Scale		number (Numeric Rating Pain Scale) -FG			
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -FG	0 -FG		
Pain Rating (0-10): Activity		0 -FG	0 -FG		
Comfort/Acceptable Pain Level		0 -FG			
Skin WDL					
Skin WDL					WDL -FG
HEENT					
HEENT WDL					WDL -FG
Fall Risk Assessment					
Fall Risk Indicators					3-->central nervous system/psychotropic medication;2-->depression;1-->male;3-->polypharmacy -FG
Fall Risk Score					9 -FG
Patient Rights Denials					
Rights Denied or Restrictions Imposed					no -FG
Precautions/Isolation					
Precautions (displays in banner)	None -MB				None -FG
Precautions Interventions					
Interventions Performed					yes -FG
Level of Observation					every 30 minutes -FG
Daily Sleep					
Daily Sleep (WDL)	WDL -MB				
Sleep/Rest/Relaxation	no problem identified;appears asleep;limb				

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Daily Assess (continued)

	08/16/16 0200	08/15/16 2200	08/15/16 2044	08/15/16 1932	08/15/16 1630
	movements periodically during sleep -MB				
Mental Status					
Orientation					oriented x 4 -FG
Level Of Consciousness	asleep -MB				alert -FG
General Appearance WDL					WDL except;appearance -FG
General Appearance					unkempt;unclean -FG
Mood					depressed -FG
Mood/Behavior/ Affect WDL					WDL -FG
Affect					congruent -FG
Behavior (WDL)	WDL Pt asleep -MB				WDL except -FG
Mood/Behavior					cooperative;hyperactive -FG
Speech					WDL -FG
Speech					clear -FG
Judgment and Insight					judgment appropriate to situation -FG
Insight					fair -FG
Concentration					fair -FG
Coping/Psychosocial Response					
Observed Emotional State					withdrawn;quiet -FG
Verbalized Emotional State					depression;frustration -FG
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With				patient -FG	patient -FG
Supportive Measures					active listening utilized -FG
Family/Support System Care					self-care encouraged -FG
Psychiatric Symptoms					
Anxiety Symptoms (WDL)	WDL -MB				WDL except -FG
Anxiety Symptoms					generalized -FG
Manic Symptoms (WDL)	WDL -MB				WDL -FG
Manic	no problems				

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Daily Assess (continued)

	08/16/16 0200	08/15/16 2200	08/15/16 2044	08/15/16 1932	08/15/16 1630
Symptoms	reported or observed. -MB				
Psychotic symptoms (WDL)	WDL Pt asleep -MB				WDL -FG
Danger to Self					
Danger to Self (WDL)	WDL -MB				WDL -FG
Danger to Self	no suicidal ideation or behavior indicators observed or expressed Pt asleep -MB				
Danger to Others					
Danger to Others (WDL)	WDL Pt asleep -MB				WDL -FG
	08/15/16 1544	08/15/16 1434	08/15/16 1000	08/15/16 0851	08/15/16 0659
Legal Status					
Legal status			voluntary -SH		
Vital Signs					
Temp	98.5 °F (36.9 °C) -AS			97.5 °F (36.4 °C) -FS	
Temp src				Oral -FS	
Pulse	98 -AS			114 -FS	
BP	133/85 mmHg -AS			117/70 mmHg -FS	
Patient Position	Sitting -AS			Sitting -FS	
BP Location	Right arm -AS			Left arm -FS	
BP Method				Automatic -FS	
Resp	16 -AS			16 -FS	
Oxygen Therapy					
SpO2				97 % -FS	
O2 Device				room air -FS	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest			0 -SH	0 -FS	
Pain Rating (0-10): Activity			0 -SH		
Comfort/Acceptable Pain Level			0 -SH		
Skin WDL					
Skin WDL			WDL -SH		
Fall Risk Assessment					
Fall Risk Indicators			3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1--		

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Daily Assess (continued)

	08/15/16 1544	08/15/16 1434	08/15/16 1000	08/15/16 0851	08/15/16 0659
			>male -SH		
Fall Risk Score			9 -SH		
Precautions/Isolation					
Precautions (displays in banner)			None -SH		
Precautions Interventions					
Interventions Performed			yes -SH		
Level of Observation			every 30 minutes -SH		
Activities of Daily Living					
ADL's (WDL)			WDL -SH		
Daily Sleep					
Daily Sleep (WDL)			WDL -SH		
Daily Hours of Sleep					7.25 hrs. -KS
Daily Nutrition					
Daily Nutrition (WDL)			WDL except -SH		
Appetite Change			decreased -SH		
Barriers to Nutrition			constipation -SH		
Level of Assistance			needs encouragement -SH		
Mental Status					
Orientation			oriented x 4 -SH		
Level Of Consciousness			alert -SH		
General Appearance WDL			WDL except;appearance Does look dischelved -SH		
General Appearance			body odor -SH		
Mood			anxious;depressed;withdrawn -SH		
Mood/Behavior/ Affect WDL			WDL except;all -SH		
Affect			guarded;restricted -SH		
Behavior (WDL)			WDL except -SH		
Mood/Behavior			isolative -SH		
Speech			WDL -SH		
Speech			clear -SH		

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Daily Assess (continued)

	08/15/16 1544	08/15/16 1434	08/15/16 1000	08/15/16 0851	08/15/16 0659
Judgment and Insight			judgment not appropriate to situation;insight not appropriate to situation -SH		
Insight			fair -SH		
Concentration			fair -SH		
Memory Deficit			intact -SH		
Thought (WDL)			WDL -SH		
Coping/Psychosocial Response					
Observed Emotional State			anxious;withdrawn;withholds information;quiet -SH		
Verbalized Emotional State			anxiety;depression -SH		
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With		patient -SH	patient -SH		
Supportive Measures			active listening utilized -SH		
Psychiatric Symptoms					
Anxiety Symptoms (WDL)			WDL except -SH		
Anxiety Symptoms			generalized -SH		
Manic Symptoms (WDL)			WDL -SH		
Psychotic symptoms (WDL)			WDL -SH		
Danger to Self					
Danger to Self (WDL)			WDL -SH		
Danger to Others					
Danger to Others (WDL)			WDL -SH		

	08/15/16 0100
Legal Status	
Legal status	voluntary -CR
Patient Observation	
Observations	Q 30 mins -CR
Pain/Comfort	
Preferred Pain Scale	number (Numeric Rating Pain Scale) -CR
Pain Assessment: Number Scale (0-10)	

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Daily Assess (continued)

	08/15/16 0100
Pain Rating (0-10): Rest	0 -CR
Fall Risk Assessment	
Fall Risk Indicators	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -CR
Fall Risk Score	9 -CR
Patient Rights Denials	
Rights Denied or Restrictions Imposed	no -CR
Precautions/Isolation	
Precautions (displays in banner)	None -CR
Precautions Interventions	
Interventions Performed	yes -CR
Level of Observation	every 30 minutes -CR
Mental Status	
Level Of Consciousness	asleep -CR
Danger to Self	
Danger to Self (WDL)	WDL -CR
Danger to Others	
Danger to Others (WDL)	WDL -CR

Risk Screening

	08/17/16 1900	08/17/16 0822	08/17/16 0100	08/16/16 1609	08/16/16 1100
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -EM	3-->polypharmacy -RE	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -FSA	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -EM	
Fall Risk Score	9 -EM	3 -RE	9 -FSA	9 -EM	
Danger to Self					
Danger to Self (WDL)	WDL -EM	WDL -RE	-- Asleep -FSA	WDL -EM	WDL -JB
Danger to Self	no suicidal	no suicidal		no suicidal	no suicidal

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

Risk Screening (continued)

	08/17/16 1900	08/17/16 0822	08/17/16 0100	08/16/16 1609	08/16/16 1100
	ideation or behavior indicators observed or expressed -EM	ideation or behavior indicators observed or expressed -RE		ideation or behavior indicators observed or expressed -EM	ideation or behavior indicators observed or expressed -JB
Keeps Self Safe	yes (describe) -EM	yes (describe) -RE		yes (describe) -EM	yes (describe) -JB
Description of Suicide Plan	Denied -EM			Denied -EM	
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -EM	no self-injurious ideation or behavior indicators observed or expressed -RE		no self-injurious ideation or behavior indicators observed or expressed -EM	no self-injurious ideation or behavior indicators observed or expressed -JB
Self-injury Description	Denied -EM			Denied -EM	
Agreement not to Harm Self	yes (describe) -EM	yes (describe) -RE		yes (describe) -EM	yes (describe) -JB
Description of Agreement	verbal -EM			verbal -EM	verbal -JB
Danger to Others					
Danger to Others (WDL)	WDL -EM	WDL -RE	-- Asleep -FSA	WDL -EM	WDL -JB
	08/16/16 1008	08/16/16 0200	08/15/16 1630	08/15/16 1000	08/15/16 0100
Fall Risk Assessment					
Fall Risk Indicators	3-->central nervous system/psychotropic medication;2-->depression;1-->male;3-->polypharmacy -JB		3-->central nervous system/psychotropic medication;2-->depression;1-->male;3-->polypharmacy -FG	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -SH	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -CR
Fall Risk Score	9 -JB		9 -FG	9 -SH	9 -CR
Danger to Self					
Danger to Self (WDL)	-- -JB	WDL -MB	WDL -FG	WDL -SH	WDL -CR
Danger to Self	-- -JB	no suicidal ideation or behavior indicators observed or expressed Pt asleep -MB			
Danger to Others					
Danger to Others (WDL)	-- -JB	WDL Pt asleep -MB	WDL -FG	WDL -SH	WDL -CR

BH Initial Eval

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Initial Eval (continued)

	08/17/16 1900	08/17/16 1540	08/17/16 0822	08/17/16 0638	08/17/16 0100
Legal Status					
Legal status	voluntary -EM		voluntary -RE		voluntary -FSA
Evidence of Mood Disorders					
Manic Symptoms (WDL)	WDL -EM		WDL -RE		
Evidence of Anxiety Disorders					
Anxiety Symptoms (WDL)	WDL except -EM		WDL -RE		-- Asleep -FSA
Anxiety Symptoms	generalized -EM		generalized -RE		
Height and Weight					
Weight			59.24 kg (130 lb 9.6 oz) -FS		
Danger to Self					
Danger to Self (WDL)	WDL -EM		WDL -RE		-- Asleep -FSA
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -EM		no suicidal ideation or behavior indicators observed or expressed -RE		
Keeps Self Safe	yes (describe) -EM		yes (describe) -RE		
Description of Suicide Plan	Denied -EM				
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -EM		no self-injurious ideation or behavior indicators observed or expressed -RE		
Self-injury Description	Denied -EM				
Agreement not to Harm Self	yes (describe) -EM		yes (describe) -RE		
Description of Agreement	verbal -EM				
Assessment Type					
Assessment timing	Shift -EM		Shift -RE		
Assessment of contributing factors					
Assessment of Risk Factors	Prior suicide attempts;Deficits in social, decision, and coping skills;History of childhood physicial/sexual abuse -EM		Current drug or alcohol abuse -RE		

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Initial Eval (continued)

	08/17/16 1900	08/17/16 1540	08/17/16 0822	08/17/16 0638	08/17/16 0100
Assessment of Protective Factors	Good access to health care/therapy -EM		Good access to health care/therapy -RE		
Suicide Risk Assessment- Mood					
Agitation			Low -RE		
Anxiety or Fearfulness			None -RE		
Depression or Sadness			None -RE		
Danger to Others					
Danger to Others (WDL)	WDL -EM		WDL -RE		-- Asleep -FSA
Mental Status					
Level Of Consciousness	alert -EM		alert -RE		
Orientation	oriented x 4 -EM		oriented x 4 -RE		
General Appearance WDL	WDL except -EM		WDL except -RE		
General Appearance	unkempt -EM		unkempt -RE		
Mood/Behavior/ Affect WDL	WDL except;all;affect;mood/behavior -EM		WDL except -RE		
Affect	blunted -EM		flat -RE		
Mood/Behavior	anxious;cooperative -EM		anxious -RE		
Speech	WDL -EM		WDL -RE		
Speech			clear -RE		
Judgment and Insight	judgment appropriate to situation -EM		judgment appropriate to situation -RE		
Insight	fair -EM		fair -RE		
Concentration	fair -EM		fair -RE		
Memory Deficit	intact -EM		intact -RE		
Thought Process	circumstantial thought -EM		circumstantial thought -RE		
Behavior (WDL)	WDL except -EM		WDL except -RE		
Sleep/Rest/Relaxation					
Sleep/Rest/Relaxation	sleep interrupted -EM			no problem identified -FSA	
Daily Hours of Sleep				7.5 -EA	
Vital Signs					
Temp		98 °F (36.7 °C) -AS	98.1 °F (36.7 °C) -FS		
Pulse		72 -AS	80 -FS		
BP		128/74 mmHg -AS	111/88 mmHg -FS		
Patient Position		Sitting -AS	Sitting -FS		

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Initial Eval (continued)

	08/17/16 1900	08/17/16 1540	08/17/16 0822	08/17/16 0638	08/17/16 0100
Resp		16 -AS	16 -FS		
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -EM				FACES (Wong-Baker FACES Pain Rating Scale) -FSA
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -EM		0 -FS		
Pain Rating (0-10): Activity	0 -EM				
Comfort/Acceptable Pain Level	3 -EM				
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest					0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA
FACES Pain Rating: Activity					0-->no hurt -FSA
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -EM		3-->polypharmacy -RE		3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -FSA
Fall Risk Score	9 -EM		3 -RE		9 -FSA
	08/16/16 1609	08/16/16 1100	08/16/16 1008	08/16/16 0905	08/16/16 0800
Legal Status					
Legal status	voluntary -EM		voluntary -JB		
Evidence of Mood Disorders					
Manic Symptoms (WDL)	WDL -EM	WDL -JB	-- -JB		
Manic Symptoms			-- -JB		
Evidence of Anxiety Disorders					
Anxiety Symptoms (WDL)	WDL except -EM	WDL except -JB	-- -JB		
Anxiety Symptoms	generalized -EM	generalized restless -JB			
Danger to Self					
Danger to Self	WDL -EM	WDL -JB	-- -JB		

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Initial Eval (continued)

	08/16/16 1609	08/16/16 1100	08/16/16 1008	08/16/16 0905	08/16/16 0800
(WDL)					
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -EM	no suicidal ideation or behavior indicators observed or expressed -JB	-- -JB		
Keeps Self Safe	yes (describe) -EM	yes (describe) -JB			
Description of Suicide Plan	Denied -EM				
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -EM	no self-injurious ideation or behavior indicators observed or expressed -JB			
Self-injury Description	Denied -EM				
Agreement not to Harm Self	yes (describe) -EM	yes (describe) -JB			
Description of Agreement	verbal -EM	verbal -JB			
Assessment Type					
Assessment timing	Shift -EM				
Assessment of contributing factors					
Assessment of Risk Factors	Prior suicide attempts;Deficits in social, decision, and coping skills;History of childhood physicial/sexual abuse -EM				
Assessment of Protective Factors	Good access to health care/therapy -EM				
Danger to Others					
Danger to Others (WDL)	WDL -EM	WDL -JB	-- -JB		
Mental Status					
Level Of Consciousness	alert -EM	alert -JB	-- -JB		
Orientation	oriented x 4 -EM	oriented x 4 -JB			
General Appearance WDL	WDL except -EM	WDL except;appearance -JB			
General Appearance	unkempt -EM	unkempt -JB			
Mood/Behavior/ Affect WDL	WDL except;all;affect;m	WDL except;all;affect;m			

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Initial Eval (continued)

	08/16/16 1609	08/16/16 1100	08/16/16 1008	08/16/16 0905	08/16/16 0800
	ood/behavior -EM	ood/behavior -JB			
Affect	blunted -EM	flat -JB			
Mood/Behavior	anxious;cooperative -EM	anxious;cooperative;restless -JB			
Speech	WDL except -EM	WDL -JB			
Speech	hyperverbal -EM	clear -JB			
Judgment and Insight	judgment appropriate to situation -EM				
Insight	fair -EM	fair -JB			
Concentration	fair -EM	fair -JB			
Memory Deficit	intact -EM	intact -JB			
Thought Process	circumstantial thought -EM	organized anxious but appears organized -JB			
Behavior (WDL)	WDL except -EM	WDL except -JB	-- -JB		
Sleep/Rest/Relaxation					
Sleep/Rest/Relaxation	sleep interrupted -EM		-- -JB		
Vital Signs					
Temp	98.5 °F (36.9 °C) -JT				98.4 °F (36.9 °C) -AP
Pulse	94 -JT				84 -AP
BP	120/74 mmHg -JT				134/72 mmHg -AP
Patient Position	Sitting -JT				
Resp	16 -JT				18 -AP
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -EM				
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -EM		0 -JB	3 -JB	0 -JB
Pain Rating (0-10): Activity	0 -EM		0 -JB	3 -JB	0 -JB
Comfort/Acceptable Pain Level	3 -EM				
Pain Body Location - Side			Bilateral -JB	Bilateral -JB	
Pain Body Location - Orientation			-- pelvic pain -JB	other (see comments) pelvic -JB	
Pain Body Location			-- pelvic pain -JB	other (see comments) "pelvic pain" -JB	
Pain Quality				aching -JB	
Pain Management				single medication modality -JB	

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Initial Eval (continued)

	08/16/16 1609	08/16/16 1100	08/16/16 1008	08/16/16 0905	08/16/16 0800
Interventions					
Fall Risk Assessment					
Fall Risk Indicators	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -EM		3-->central nervous system/psychotropic medication;2-->depression;1-->male;3-->polypharmacy -JB		
Fall Risk Score	9 -EM		9 -JB		
	08/16/16 0700	**08/16/16 0200**	**08/15/16 2200**	**08/15/16 2044**	**08/15/16 1630**
Legal Status					
Legal status		voluntary -MB			voluntary -FG
Evidence of Mood Disorders					
Manic Symptoms (WDL)		WDL -MB			WDL -FG
Manic Symptoms		no problems reported or observed. -MB			
Evidence of Anxiety Disorders					
Anxiety Symptoms (WDL)		WDL -MB			WDL except -FG
Anxiety Symptoms					generalized -FG
Danger to Self					
Danger to Self (WDL)		WDL -MB			WDL -FG
Danger to Self		no suicidal ideation or behavior indicators observed or expressed Pt asleep -MB			
Danger to Others					
Danger to Others (WDL)		WDL Pt asleep -MB			WDL -FG
Mental Status					
Level Of Consciousness		asleep -MB			alert -FG
Orientation					oriented x 4 -FG
General Appearance WDL					WDL except;appearance -FG
General Appearance					unkempt;unclean -FG
Mood/Behavior/ Affect WDL					WDL -FG

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Initial Eval (continued)

	08/16/16 0700	08/16/16 0200	08/15/16 2200	08/15/16 2044	08/15/16 1630
Affect					congruent -FG
Mood/Behavior					cooperative;hyperactive -FG
Speech					WDL -FG
Speech					clear -FG
Judgment and Insight					judgment appropriate to situation -FG
Insight					fair -FG
Concentration					fair -FG
Behavior (WDL)		WDL Pt asleep -MB			WDL except -FG
Sleep/Rest/Relaxation					
Sleep/Rest/Relaxation		no problem identified;appears asleep;limb movements periodically during sleep -MB			
Daily Hours of Sleep	8 -MB				
Pain/Comfort					
Preferred Pain Scale			number (Numeric Rating Pain Scale) -FG		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest			0 -FG	0 -FG	
Pain Rating (0-10): Activity			0 -FG	0 -FG	
Comfort/Acceptable Pain Level			0 -FG		
Fall Risk Assessment					
Fall Risk Indicators					3-->central nervous system/psychotropic medication;2-->depression;1-->male;3-->polypharmacy -FG
Fall Risk Score					9 -FG
	08/15/16 1544	08/15/16 1000	08/15/16 0851	08/15/16 0659	08/15/16 0100
Legal Status					
Legal status		voluntary -SH			voluntary -CR
Evidence of Mood Disorders					
Manic Symptoms (WDL)		WDL -SH			

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Initial Eval (continued)

	08/15/16 1544	08/15/16 1000	08/15/16 0851	08/15/16 0659	08/15/16 0100
Evidence of Anxiety Disorders					
Anxiety Symptoms (WDL)		WDL except -SH			
Anxiety Symptoms		generalized -SH			
Danger to Self					
Danger to Self (WDL)		WDL -SH			WDL -CR
Danger to Others					
Danger to Others (WDL)		WDL -SH			WDL -CR
Mental Status					
Level Of Consciousness		alert -SH			asleep -CR
Orientation		oriented x 4 -SH			
General Appearance WDL		WDL except;appearance Does look dischelved -SH			
General Appearance		body odor -SH			
Mood/Behavior/ Affect WDL		WDL except;all -SH			
Affect		guarded;restricted -SH			
Mood/Behavior		isolative -SH			
Speech		WDL -SH			
Speech		clear -SH			
Judgment and Insight		judgment not appropriate to situation;insight not appropriate to situation -SH			
Insight		fair -SH			
Concentration		fair -SH			
Memory Deficit		intact -SH			
Behavior (WDL)		WDL except -SH			
Sleep/Rest/Relaxation					
Daily Hours of Sleep				7.25 hrs. -KS	
Vital Signs					
Temp	98.5 °F (36.9 °C) -AS		97.5 °F (36.4 °C) -FS		
Pulse	98 -AS		114 -FS		
BP	133/85 mmHg -AS		117/70 mmHg -FS		
Patient Position	Sitting -AS		Sitting -FS		
Resp	16 -AS		16 -FS		

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH Initial Eval (continued)

	08/15/16 1544	08/15/16 1000	08/15/16 0851	08/15/16 0659	08/15/16 0100
Pain/Comfort					
Preferred Pain Scale					number (Numeric Rating Pain Scale) -CR
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -SH	0 -FS		0 -CR
Pain Rating (0-10): Activity		0 -SH			
Comfort/Acceptable Pain Level		0 -SH			
Fall Risk Assessment					
Fall Risk Indicators		3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -SH			3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -CR
Fall Risk Score		9 -SH			9 -CR

BH OT Observations NAV IP

	08/17/16 1900	08/17/16 0822	08/16/16 1609	08/16/16 1100	08/15/16 1630
General Observations					
Mood/Behavior/Affect WDL	WDL except;all;affect;mood/behavior -EM	WDL except -RE	WDL except;all;affect;mood/behavior -EM	WDL except;all;affect;mood/behavior -JB	WDL -FG
Affect	blunted -EM	flat -RE	blunted -EM	flat -JB	congruent -FG
Mood	anxious;depressed -EM	anxious -RE	anxious;depressed -EM	anxious;depressed -JB	depressed -FG
Orientation	oriented x 4 -EM	oriented x 4 -RE	oriented x 4 -EM	oriented x 4 -JB	oriented x 4 -FG
Thought Process	circumstantial thought -EM	circumstantial thought -RE	circumstantial thought -EM	organized anxious but appears organized -JB	
Speech		clear -RE	hyperverbal -EM	clear -JB	clear -FG
General Appearance WDL	WDL except -EM	WDL except -RE	WDL except -EM	WDL except;appearance -JB	WDL except;appearance -FG
General Appearance	unkempt -EM	unkempt -RE	unkempt -EM	unkempt -JB	unkempt;unclean -FG

	08/15/16 1000
General Observations	
Mood/Behavior/Affect WDL	WDL except;all -SH
Affect	guarded;restricted -SH
Mood	anxious;depressed;withdrawn -SH

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

BH OT Observations NAV IP (continued)

	08/15/16 1000
Orientation	oriented x 4 -SH
Speech	clear -SH
General Appearance WDL	WDL except;appearance Does look dischelved -SH
General Appearance	body odor -SH

Adult Nutrition Assessment

	08/17/16 0822
Height and Weight	
Weight	59.24 kg (130 lb 9.6 oz) -FS

Adult Care Sum F14

	08/17/16 2328	08/17/16 1900	08/17/16 1131	08/17/16 0822	08/17/16 0638
Plan of Care Review					
Plan Of Care Reviewed With	patient -EM	patient -EM	patient -RE	patient -RE	
Pain/Comfort/Sleep					
Preferred Pain Scale		number (Numeric Rating Pain Scale) -EM			
Sleep/Rest/Relaxation		sleep interrupted -EM			no problem identified -FSA
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -EM		0 -FS	
Pain Rating (0-10): Activity		0 -EM			
Comfort/Acceptable Pain Level		3 -EM			
Sleep/Rest/Relaxation					
Daily Hours of Sleep					7.5 -EA
Pain/Comfort/Sleep Interventions					
Sleep/Rest Enhancement		awakenings minimized;regular sleep/rest pattern promoted -EM			
Coping/Psychosocial					
Observed Emotional State		accepting;anxious;cooperative;restless -EM		accepting -RE	
Verbalized Emotional State		anxiety;depression;acceptance -EM		anxiety -RE	
Coping Strategies					
Supportive		active listening		active listening	

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/17/16 2328	08/17/16 1900	08/17/16 1131	08/17/16 0822	08/17/16 0638
Measures		utilized;verbalization of feelings encouraged -EM		utilized;counseling provided -RE	
Coping/Psychosocial Interventions					
Behavior Management		behavioral plan reviewed -EM			
HEENT					
HEENT WDL		WDL -EM		WDL -RE	
Cognitive					
Memory Deficit		intact -EM		intact -RE	
Neuro					
Level Of Consciousness		alert -EM		alert -RE	
Orientation		oriented x 4 -EM		oriented x 4 -RE	
General Appearance					
General Appearance WDL		WDL except -EM		WDL except -RE	
General Appearance		unkempt -EM		unkempt -RE	
Mood/Behavior/Affect					
Mood/Behavior/ Affect WDL		WDL except;all;affect;mood/behavior -EM		WDL except -RE	
Affect		blunted -EM		flat -RE	
Mood/Behavior		anxious;cooperative -EM		anxious -RE	
Speech					
Speech		WDL -EM		WDL -RE	
Speech				clear -RE	
Thought Process					
Judgment and Insight		judgment appropriate to situation -EM		judgment appropriate to situation -RE	
Thought Process		circumstantial thought -EM		circumstantial thought -RE	
Oxygen Therapy					
SpO2				96 % -FS	
O2 Device				room air -FS	
Skin					
Skin WDL		WDL except;all;color -EM		WDL except -RE	
Skin Integrity		other (see comments) psoriasis -EM			
Safety Interventions					
Precautions (displays in banner)		None -EM		None -RE	

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/17/16 2328	08/17/16 1900	08/17/16 1131	08/17/16 0822	08/17/16 0638
Fall Risk Indicators		3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -EM		3-->polypharmacy -RE	
Fall Risk Score		9 -EM		3 -RE	
	08/17/16 0100	08/16/16 2233	08/16/16 2200	08/16/16 1609	08/16/16 1347
Plan of Care Review					
Plan Of Care Reviewed With		patient -EM		patient -EM	patient -JT (r) JB (t)
Significant Event					
Significant Event Comments			30 -HS		
Pain/Comfort/Sleep					
Preferred Pain Scale	FACES (Wong-Baker FACES Pain Rating Scale) -FSA			number (Numeric Rating Pain Scale) -EM	
Sleep/Rest/Relaxation				sleep interrupted -EM	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest				0 -EM	
Pain Rating (0-10): Activity				0 -EM	
Comfort/Acceptable Pain Level				3 -EM	
Pain Assessment: FACES Scale					
FACES Pain Rating: Rest	0-->no hurt Appears asleep with no signs/sx of pain/discomfort observed -FSA				
FACES Pain Rating: Activity	0-->no hurt -FSA				
Pain/Comfort/Sleep Interventions					
Sleep/Rest Enhancement				awakenings minimized;regular sleep/rest pattern promoted -EM	
Coping/Psychosocial					
Observed Emotional State				accepting;anxious;cooperative;restless -EM	
Verbalized Emotional State				anxiety;depression;acceptance -EM	
Coping Strategies					

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/17/16 0100	08/16/16 2233	08/16/16 2200	08/16/16 1609	08/16/16 1347
Supportive Measures				active listening utilized;verbalization of feelings encouraged -EM	
Coping/Psychosocial Interventions					
Behavior Management				behavioral plan reviewed -EM	
HEENT					
HEENT WDL				WDL -EM	
Cognitive					
Memory Deficit				intact -EM	
Neuro					
Level Of Consciousness				alert -EM	
Orientation				oriented x 4 -EM	
General Appearance					
General Appearance WDL				WDL except -EM	
General Appearance				unkempt -EM	
Mood/Behavior/Affect					
Mood/Behavior/ Affect WDL				WDL except;all;affect;mood/behavior -EM	
Affect				blunted -EM	
Mood/Behavior				anxious;cooperative -EM	
Speech					
Speech				WDL except -EM	
Speech				hyperverbal -EM	
Thought Process					
Judgment and Insight				judgment appropriate to situation -EM	
Thought Process				circumstantial thought -EM	
Oxygen Therapy					
SpO2				95 % -JT	
O2 Device				room air -JT	
Skin					
Skin WDL	WDL except;all;color -FSA			WDL except;all;color -EM	
Skin Integrity				other (see comments) psoriasis -EM	
Safety Interventions					
Precautions	None -FSA			None -EM	

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/17/16 0100	08/16/16 2233	08/16/16 2200	08/16/16 1609	08/16/16 1347
(displays in banner)					
Fall Risk Indicators	3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -FSA			3-->polypharmacy;2-->depression;1-->male;3-->central nervous system/psychotropic medication -EM	
Fall Risk Score	9 -FSA			9 -EM	
	08/16/16 1100	08/16/16 1008	08/16/16 0905	08/16/16 0800	08/16/16 0700
Plan of Care Review					
Plan Of Care Reviewed With	patient -JB				
Pain/Comfort/Sleep					
Sleep/Rest/Relaxation		-- -JB			
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -JB	3 -JB	0 -JB	
Pain Rating (0-10): Activity		0 -JB	3 -JB	0 -JB	
Pain Body Location - Side		Bilateral -JB	Bilateral -JB		
Pain Body Location - Orientation		-- pelvic pain -JB	other (see comments) pelvic -JB		
Pain Body Location		-- pelvic pain -JB	other (see comments) "pelvic pain" -JB		
Pain Quality			aching -JB		
Pain Management Interventions			single medication modality -JB		
Sleep/Rest/Relaxation					
Daily Hours of Sleep					8 -MB
Coping/Psychosocial					
Observed Emotional State	withdrawn;quiet -JB				
Verbalized Emotional State	anxiety;depression -JB				
Cognitive					
Memory Deficit	intact -JB				
Neuro					
Level Of Consciousness	alert -JB	-- -JB			
Orientation	oriented x 4 -JB				
General Appearance					

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/16/16 1100	08/16/16 1008	08/16/16 0905	08/16/16 0800	08/16/16 0700
General Appearance WDL	WDL except;appearance -JB				
General Appearance	unkempt -JB				
Mood/Behavior/Affect					
Mood/Behavior/ Affect WDL	WDL except;all;affect;mood/behavior -JB				
Affect	flat -JB				
Mood/Behavior	anxious;cooperative;restless -JB				
Speech					
Speech	WDL -JB				
Speech	clear -JB				
Thought Process					
Thought Process	organized anxious but appears organized -JB				
Oxygen Therapy					
SpO2				99 % -AP	
Skin					
Skin WDL		WDL except;all;color -JB			
Skin Integrity		other (see comments) psoriasis -JB			
Additional Documentation		-- hx psoriasis -JB			
Safety Interventions					
Precautions (displays in banner)		None -JB			
Fall Risk Indicators		3-->central nervous system/psychotropic medication;2-->depression;1-->male;3-->polypharmacy -JB			
Fall Risk Score		9 -JB			
	08/16/16 0200	08/15/16 2200	08/15/16 2044	08/15/16 1932	08/15/16 1630
Plan of Care Review					
Plan Of Care Reviewed With				patient -FG	patient -FG
Pain/Comfort/Sleep					
Preferred Pain Scale		number (Numeric Rating Pain Scale) -FG			
Sleep/Rest/Rela	no problem				

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/16/16 0200	08/15/16 2200	08/15/16 2044	08/15/16 1932	08/15/16 1630
xation	identified;appears asleep;limb movements periodically during sleep -MB				
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -FG	0 -FG		
Pain Rating (0-10): Activity		0 -FG	0 -FG		
Comfort/Acceptable Pain Level		0 -FG			
Coping/Psychosocial					
Observed Emotional State					withdrawn;quiet -FG
Verbalized Emotional State					depression;frustration -FG
Coping Strategies					
Supportive Measures					active listening utilized -FG
Family/Support System Care					self-care encouraged -FG
HEENT					
HEENT WDL					WDL -FG
Neuro					
Level Of Consciousness	asleep -MB				alert -FG
Orientation					oriented x 4 -FG
General Appearance					
General Appearance WDL					WDL except;appearance -FG
General Appearance					unkempt;unclean -FG
Mood/Behavior/Affect					
Mood/Behavior/Affect WDL					WDL -FG
Affect					congruent -FG
Mood/Behavior					cooperative;hyperactive -FG
Speech					
Speech					WDL -FG
Speech					clear -FG
Thought Process					
Judgment and Insight					judgment appropriate to situation -FG
Skin					

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/16/16 0200	08/15/16 2200	08/15/16 2044	08/15/16 1932	08/15/16 1630
Skin WDL					WDL -FG
Safety Interventions					
Precautions (displays in banner)	None -MB				None -FG
Fall Risk Indicators					3-->central nervous system/psychotropic medication;2-->depression;1-->male;3-->polypharmacy -FG
Fall Risk Score					9 -FG
	08/15/16 1434	08/15/16 1000	08/15/16 0851	08/15/16 0659	08/15/16 0100
Plan of Care Review					
Plan Of Care Reviewed With	patient -SH	patient -SH			
Significant Event					
Significant Event Comments	15 -SH				
Pain/Comfort/Sleep					
Preferred Pain Scale					number (Numeric Rating Pain Scale) -CR
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -SH	0 -FS		0 -CR
Pain Rating (0-10): Activity		0 -SH			
Comfort/Acceptable Pain Level		0 -SH			
Sleep/Rest/Relaxation					
Daily Hours of Sleep				7.25 hrs. -KS	
Coping/Psychosocial					
Observed Emotional State		anxious;withdrawn;withholds information;quiet -SH			
Verbalized Emotional State		anxiety;depression -SH			
Coping Strategies					
Supportive Measures		active listening utilized -SH			
Cognitive					
Memory Deficit		intact -SH			

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/15/16 1434	08/15/16 1000	08/15/16 0851	08/15/16 0659	08/15/16 0100
Neuro					
Level Of Consciousness		alert -SH			asleep -CR
Orientation		oriented x 4 -SH			
General Appearance					
General Appearance WDL		WDL except;appearance Does look dischelved -SH			
General Appearance		body odor -SH			
Mood/Behavior/Affect					
Mood/Behavior/ Affect WDL		WDL except;all -SH			
Affect		guarded;restricted -SH			
Mood/Behavior		isolative -SH			
Speech					
Speech		WDL -SH			
Speech		clear -SH			
Thought Process					
Judgment and Insight		judgment not appropriate to situation;insight not appropriate to situation -SH			
Oxygen Therapy					
SpO2			97 % -FS		
O2 Device			room air -FS		
Skin					
Skin WDL		WDL -SH			
Safety Interventions					
Precautions (displays in banner)		None -SH			None -CR
Fall Risk Indicators		3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -SH			3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -CR
Fall Risk Score		9 -SH			9 -CR

Social Work Assessment

	08/17/16 1900	08/17/16 0822	08/16/16 1609	08/16/16 1100	
Suicide Risk					

All Flowsheet Data (08/15/16 0000--08/17/16 2359) (continued)

Social Work Assessment (continued)

	08/17/16 1900	08/17/16 0822	08/16/16 1609	08/16/16 1100
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -EM	no self-injurious ideation or behavior indicators observed or expressed -RE	no self-injurious ideation or behavior indicators observed or expressed -EM	no self-injurious ideation or behavior indicators observed or expressed -JB
Self-injury Description	Denied -EM		Denied -EM	

(r) = User Recd, (t) = User Taken, (c) = User Cosigned

User Key

Initials	Name	Effective Dates
JB	Britt, Julia Anna, RN	03/12/15 -
MB	Borja, Maryann L, RN	03/12/15 -
FG	Ghebreselassie, Freweini, RN	03/12/15 -
LM	Marin, Lisa Nicole, RN	05/20/15 -
EM	McCullough, Elizabeth Ann, RN	04/15/15 -
EA	Angeles Pagtakhan, Edna R, RN	02/05/15 -
RE	Ellison, Ricky, RN	02/05/15 -
PK	Kader, Paz T, RN	02/02/15 -
AP	Parrish, Alan	03/31/16 -
CR	Richardson, Cleo, RN	02/05/15 -
FSA	Scurry-Scott, Frazier M, RN	02/05/15 -
FS	Sepulveda, Francis R	04/06/16 -
AS	Smith, Arthur L, CNA	07/02/15 -
HS	Smith, Hilda, RN	02/05/15 -
KS	Smith, Karl J, RN	02/05/15 -
JT	Tamo, Josefina E, LVN	02/05/15 -
SH	Harris, Stephanie, RN	07/02/15 -

All Flowsheet Data (08/12/16 0000--08/14/16 2359)

MAR MINI-FLOWSHEET DATA

	08/14/16 1700	08/14/16 1115	08/14/16 1100	08/14/16 0130	08/13/16 1800
Pain					
Pain Rating (0-10): Rest	0 -HS	0 -GW	0 -RM	0 sleeping soundly, no c/o pain or discomfort -HS	5 -HS
Pain Rating (0-10): Activity	0 -HS	0 -GW	0 -RM		5 -HS
	08/13/16 1100	08/13/16 1001	08/12/16 1900	08/12/16 1205	08/12/16 1152
Pain					
Pain Rating (0-10): Rest	5 -GW	8 -GW	4 -MA	3 -GW	0 -GW
Pain Rating (0-10): Activity	5 -GW	8 -GW	4 -MA	3 -GW	0 -GW
	08/12/16 0758				
Pain					
Pain Rating (0-10): Rest	0 -FS				

CARE PLAN MINI-FLOWSHEET DATA

	08/14/16 1700	08/14/16 1250	08/14/16 1115	08/13/16 1800	08/13/16 1133
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -HS	patient -GW	patient -GW	patient -HS	patient -GW
	08/13/16 1055	08/12/16 1928	08/12/16 1900	08/12/16 1310	08/12/16 1152
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -GW	patient -MA	patient -MA	patient -GW	patient -GW
Plan of Care Review					
Progress		progress toward functional goals is gradual -MA			

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	08/14/16 1700	08/14/16 1552	08/14/16 1115	08/14/16 1100	08/14/16 0130
Vital Signs					
Temp		98.2 °F (36.8 °C) -AS		98.6 °F (37 °C) -RM	
Temp src				Oral -RM	
Cardiac Monitor				no -RM	
Pulse		90 -AS		100 -RM	
BP		132/72 mmHg -AS		111/80 mmHg -RM	
Patient Position		Sitting -AS		Sitting -RM	
BP Location		Right arm -AS		Left arm -RM	
BP Method				Automatic -RM	
Resp		16 -AS		16 -RM	
Pain/Comfort, Non Labor					
Pain Rating (0-10): Rest	0 -HS		0 -GW	0 -RM	0 sleeping soundly, no c/o pain or

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/14/16 1700	08/14/16 1552	08/14/16 1115	08/14/16 1100	08/14/16 0130
					discomfort -HS
Pain Rating (0-10): Activity	0 -HS		0 -GW	0 -RM	
Comfort/Acceptable Pain Level	0 -HS			0 -RM	
Post Anesthesia					
Orientation	oriented x 4 -HS		oriented x 4 -GW		
Oxygen Therapy during Labor					
SpO2				100 % -RM	
O2 Device				room air -RM	
Patient Observation					
Observations	Q 30 mins -HS		Q 30 mins -GW		Q 30 mins -HS
Cognitive					
Memory Deficit	intact -HS		intact -GW		
Fall Risk Assessment					
Fall Risk Indicators	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -HS		3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -GW		3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -HS
Fall Risk Score	9 -HS		9 -GW		9 -HS
Danger to Self					
Danger to Self (WDL)	WDL -HS		WDL -GW		WDL -HS
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -HS				no suicidal ideation or behavior indicators observed or expressed -HS
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -HS				no self-injurious ideation or behavior indicators observed or expressed -HS
Danger to Others					
Danger to Others (WDL)	WDL -HS		WDL -GW		WDL -HS
Precautions/Isolation					
Precautions (displays in banner)	None -HS		None -GW		None -HS
	08/13/16 1800	08/13/16 1548	08/13/16 1400	08/13/16 1133	08/13/16 1100
Vital Signs					

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/13/16 1800	08/13/16 1548	08/13/16 1400	08/13/16 1133	08/13/16 1100
Temp		98.7 °F (37.1 °C) -AS			
Pulse		115 -AS			
BP		145/79 mmHg -AS			
Patient Position		Sitting -AS			
BP Location		Right arm -AS			
Resp		17 -AS			
Skin					
Skin WDL	WDL except;color -HS		WDL except;color -GW		
Skin Color/Characteristics	bruised (ecchymotic) areas of discoloration -HS		bruised (ecchymotic) legs, thighs -GW		
Pain/Comfort, Non Labor					
Pain Rating (0-10): Rest	5 -HS				5 -GW
Pain Rating (0-10): Activity	5 -HS				5 -GW
Comfort/Acceptable Pain Level	5 -HS				
Postpartum Interventions					
Bathing/Skin Care	shaved face;shampoo;shower -HS			patient refused -GW	
Post Anesthesia					
Orientation	oriented x 4 -HS			oriented x 4 -GW	
Patient Observation					
Observations	Q 30 mins -HS				
Cognitive					
Memory Deficit	intact -HS			intact -GW	
Fall Risk Assessment					
Fall Risk Indicators	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -HS			3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -GW	
Fall Risk Score	9 -HS			9 -GW	
Danger to Self					
Danger to Self (WDL)	WDL -HS			WDL -GW	
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -HS				
Self-Injurious	no self-injurious				

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/13/16 1800	08/13/16 1548	08/13/16 1400	08/13/16 1133	08/13/16 1100
Behavior	ideation or behavior indicators observed or expressed -HS				
Danger to Others					
Danger to Others (WDL)	WDL -HS			WDL -GW	
Precautions/Isolation					
Precautions (displays in banner)	None -HS			None -GW	
	08/13/16 1001	08/13/16 0939	08/13/16 0200	08/12/16 1900	08/12/16 1550
Vital Signs					
Temp	98.1 °F (36.7 °C) -GW	98.2 °F (36.8 °C) -LL			97.9 °F (36.6 °C) -JT
Temp src	Oral -GW	Oral -LL			Oral -JT
Pulse	87 -GW	77 -LL			79 -JT
BP	120/71 mmHg -GW	109/68 mmHg -LL			130/83 mmHg -JT
Patient Position	Lying right side fetal position -GW	Sitting -LL			Sitting -JT
BP Location	Right arm -GW	Left arm -LL			Left arm -JT
BP Method	Automatic -GW	Automatic -LL			Automatic -JT
Resp	20 -GW	18 -LL			18 -JT
Skin					
Skin WDL				WDL -MA	
Pain/Comfort, Non Labor					
Pain Rating (0-10): Rest	8 -GW			4 -MA	
Pain Rating (0-10): Activity	8 -GW			4 -MA	
Post Anesthesia					
Orientation				oriented x 4 -MA	
Pain Assessment					
Pain Management Interventions	no interventions per patient request -GW				
Oxygen Therapy during Labor					
SpO2	100 % -GW	100 % -LL			100 % -JT
O2 Device		room air -LL			room air -JT
Patient Observation					
Observations			Q30 -MB	q30 -MA	
Cognitive					
Memory Deficit				intact -MA	
Fall Risk Assessment					
Fall Risk Indicators				3-->central nervous system/psychotropic medication;3--	

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/13/16 1001	08/13/16 0939	08/13/16 0200	08/12/16 1900	08/12/16 1550
				>polypharmacy;2-->depression;1-->male -MA	
Fall Risk Score				9 -MA	
Danger to Self					
Danger to Self (WDL)			WDL -MB	WDL -MA	
Danger to Self			no suicidal ideation or behavior indicators observed or expressed Pt sleeping -MB	no suicidal ideation or behavior indicators observed or expressed -MA	
Keeps Self Safe				yes (describe) -MA	
Agreement not to Harm Self				yes (describe) -MA	
Danger to Others					
Danger to Others (WDL)			WDL Pt sleeping -MB	WDL -MA	
Precautions/Isolation					
Precautions (displays in banner)			None -MB	None -MA	
	08/12/16 1205	08/12/16 1152	08/12/16 0758	08/12/16 0148	
Vital Signs					
Temp			98.2 °F (36.8 °C) -FS		
Temp src			Oral -FS		
Pulse			78 -FS		
BP			136/88 mmHg -FS		
Patient Position			Sitting -FS		
BP Location			Left arm -FS		
BP Method			Automatic -FS		
Resp			16 -FS		
Pain/Comfort, Non Labor					
Pain Rating (0-10): Rest	3 -GW	0 -GW	0 -FS		
Pain Rating (0-10): Activity	3 -GW	0 -GW			
Post Anesthesia					
Orientation		oriented x 4 -GW			
Oxygen Therapy during Labor					
SpO2			96 % -FS		
O2 Device			room air -FS		
Patient Observation					
Observations		q30 -GW		Q15 -MB	
Fall Risk Assessment					
Fall Risk Indicators		3-->central nervous			

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/12/16 1205	08/12/16 1152	08/12/16 0758	08/12/16 0148
		system/psychotropic medication;1-->male -GW		
Fall Risk Score		4 -GW		
Danger to Self				
Danger to Self (WDL)	WDL -GW			WDL Pt asleep not displaying any discomfort/distress @ this time -MB
Danger to Self				no suicidal ideation or behavior indicators observed or expressed Pt asleep not displaying any discomfort/distress @ this time -MB
Danger to Others				
Danger to Others (WDL)	WDL -GW			WDL Pt asleep not displaying any discomfort/distress @ this time -MB
Precautions/Isolation				
Precautions (displays in banner)		None -GW		None -MB

BH PS Main

	08/14/16 1700	08/14/16 1115	08/14/16 0130	08/13/16 1800	08/13/16 1133
Legal Status					
Legal status	voluntary -HS	voluntary -GW	voluntary -HS	voluntary -HS	voluntary -GW
Risk Assessment					
Danger to Self (WDL)	WDL -HS	WDL -GW	WDL -HS	WDL -HS	WDL -GW
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -HS		no suicidal ideation or behavior indicators observed or expressed -HS	no suicidal ideation or behavior indicators observed or expressed -HS	
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -HS		no self-injurious ideation or behavior indicators observed or expressed -HS	no self-injurious ideation or behavior indicators observed or expressed -HS	
Danger to Others (WDL)	WDL -HS	WDL -GW	WDL -HS	WDL -HS	WDL -GW

	08/13/16 0200	08/12/16 1900	08/12/16 1205	08/12/16 1152	08/12/16 0148
Legal Status					
Legal status	voluntary -MB	voluntary -MA		voluntary -GW	voluntary -MB

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH PS Main (continued)

	08/13/16 0200	08/12/16 1900	08/12/16 1205	08/12/16 1152	08/12/16 0148
Risk Assessment					
Danger to Self (WDL)	WDL -MB	WDL -MA	WDL -GW		WDL Pt asleep not displaying any discomfort/distress @ this time -MB
Danger to Self	no suicidal ideation or behavior indicators observed or expressed Pt sleeping -MB	no suicidal ideation or behavior indicators observed or expressed -MA			no suicidal ideation or behavior indicators observed or expressed Pt asleep not displaying any discomfort/distress @ this time -MB
Keeps Self Safe		yes (describe) -MA			
Agreement not to Harm Self		yes (describe) -MA			
Assessment timing		Shift -MA			
Assessment of Risk Factors		History of childhood physicial/sexual abuse;Prior suicide attempts -MA			
Assessment of Protective Factors		Good access to health care/therapy -MA			
Danger to Others (WDL)	WDL Pt sleeping -MB	WDL -MA	WDL -GW		WDL Pt asleep not displaying any discomfort/distress @ this time -MB

BH Tx Plan MH IP

	08/12/16 1014
Patient Assets/Stressors	
Patient Assets	general fund of knowledge;average or above intelligence;motivation for treatment/growth;capable of independent living;supportive family/friends;work skills;physical health;ability for insight;communication skills -JH

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Tx Plan MH IP (continued)

	08/12/16 1014
Patient Stressors	medication change or non-compliance -JH
Discharge Planning	
Discharge Criteria	improved stabilization in mood, thinking and/or behavior;verbal commitment to aftercare and medication compliance -JH
Recommended Discharge Plan	return to previous living environment;medication management with psychiatrist or other physician -JH
Pt's Acceptance of Discharge Plan	yes -JH
Why Continues to Need Hospitalization	severe impairment of level of functioning;danger to self or others;medication stabilization -JH
Estimated Length of Stay	3-5 days -JH
Provisional DSM 5 Diagnoses	
Problem Being Addressed	refer to problem list -JH
Goal: Will work with social worker/treatment coordinator to develop safe discharge plan	
Goal Status	goal initiated -JH
Goal: Will attend Occupational Therapy groups up to seven days weekly as tolerated	
Objectives	increase coping skills -JH
Goal Status	progress made toward outcome -JH
Treatment Plan Reviewed by	
Psychiatric Social Worker	Himot -JH
Registered Nurse	Seeley, Kader -JH
Nurse Manager	Han -JH
Other	Leveton -JH

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

VS Simple

	08/14/16 1700	08/14/16 1552	08/14/16 1115	08/14/16 1100	08/14/16 0130
Vital Signs					
Temp		98.2 °F (36.8 °C) -AS		98.6 °F (37 °C) -RM	
Temp src				Oral -RM	
Cardiac Monitor				no -RM	
Pulse		90 -AS		100 -RM	
Pulse Source				Brachial -RM	
BP		132/72 mmHg -AS		111/80 mmHg -RM	
Patient Position		Sitting -AS		Sitting -RM	
BP Location		Right arm -AS		Left arm -RM	
BP Method				Automatic -RM	
Resp		16 -AS		16 -RM	
Orthostatic BP Ordered?				No -RM	
Oxygen Therapy					
SpO2				100 % -RM	
O2 Device				room air -RM	
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -HS			number (Numeric Rating Pain Scale) -RM	number (Numeric Rating Pain Scale) -HS
Sleep/Rest/Relaxation					no problem identified;appears asleep -HS
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -HS		0 -GW	0 -RM	0 sleeping soundly, no c/o pain or discomfort -HS
Pain Rating (0-10): Activity	0 -HS		0 -GW	0 -RM	
Comfort/Acceptable Pain Level	0 -HS			0 -RM	
Patient Observation					
Observations	Q 30 mins -HS		Q 30 mins -GW		Q 30 mins -HS
	08/13/16 1800	08/13/16 1548	08/13/16 1133	08/13/16 1100	08/13/16 1001
Vital Signs					
Temp		98.7 °F (37.1 °C) -AS			98.1 °F (36.7 °C) -GW
Temp src					Oral -GW
Pulse		115 -AS			87 -GW
BP		145/79 mmHg -AS			120/71 mmHg -GW
Patient Position		Sitting -AS			Lying right side fetal position -GW
BP Location		Right arm -AS			Right arm -GW
BP Method					Automatic -GW
Resp		17 -AS			20 -GW
Oxygen Therapy					

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

VS Simple (continued)

	08/13/16 1800	08/13/16 1548	08/13/16 1133	08/13/16 1100	08/13/16 1001
SpO2					100 % -GW
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -HS				
Sleep/Rest/Relaxation			feeling unrested -GW		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	5 -HS			5 -GW	8 -GW
Pain Rating (0-10): Activity	5 -HS			5 -GW	8 -GW
Comfort/Acceptable Pain Level	5 -HS				
Pain Management Interventions					no interventions per patient request -GW
Patient Observation					
Observations	Q 30 mins -HS				

	08/13/16 0939	08/13/16 0200	08/12/16 1900	08/12/16 1550	08/12/16 1205
Vital Signs					
Temp	98.2 °F (36.8 °C) -LL			97.9 °F (36.6 °C) -JT	
Temp src	Oral -LL			Oral -JT	
Pulse	77 -LL			79 -JT	
Pulse Source	Brachial -LL			Brachial -JT	
BP	109/68 mmHg -LL			130/83 mmHg -JT	
Patient Position	Sitting -LL			Sitting -JT	
BP Location	Left arm -LL			Left arm -JT	
BP Method	Automatic -LL			Automatic -JT	
Resp	18 -LL			18 -JT	
Oxygen Therapy					
SpO2	100 % -LL			100 % -JT	
O2 Device	room air -LL			room air -JT	
Pain/Comfort/Sleep					
Preferred Pain Scale		number (Numeric Rating Pain Scale) Pt sleeping -MB	number (Numeric Rating Pain Scale) -MA		
Sleep/Rest/Relaxation		no problem identified;appears asleep -MB	no problem identified;appears asleep;limb movements periodically during sleep -MA		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest			4 -MA		3 -GW
Pain Rating (0-10): Activity			4 -MA		3 -GW

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

VS Simple (continued)

	08/13/16 0939	08/13/16 0200	08/12/16 1900	08/12/16 1550	08/12/16 1205
Patient Observation					
Observations		Q30 -MB	q30 -MA		
	08/12/16 1152	08/12/16 0758	08/12/16 0148		
Vital Signs					
Temp		98.2 °F (36.8 °C) -FS			
Temp src		Oral -FS			
Pulse		78 -FS			
BP		136/88 mmHg -FS			
Patient Position		Sitting -FS			
BP Location		Left arm -FS			
BP Method		Automatic -FS			
Resp		16 -FS			
Oxygen Therapy					
SpO2		96 % -FS			
O2 Device		room air -FS			
Pain/Comfort/Sleep					
Preferred Pain Scale			number (Numeric Rating Pain Scale) Pt asleep not displaying any discomfort/distress @ this time -MB		
Sleep/Rest/Relaxation			no problem identified;appears asleep;limb movements periodically during sleep -MB		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -GW	0 -FS			
Pain Rating (0-10): Activity	0 -GW				
Patient Observation					
Observations	q30 -GW		Q15 -MB		

VS Simple

	08/14/16 1700	08/14/16 1552	08/14/16 1115	08/14/16 1100	08/14/16 0130
Vital Signs					
Temp		98.2 °F (36.8 °C) -AS		98.6 °F (37 °C) -RM	
Temp src				Oral -RM	
Cardiac Monitor				no -RM	
Pulse		90 -AS		100 -RM	
Pulse Source				Brachial -RM	
BP		132/72 mmHg -AS		111/80 mmHg -RM	
Patient Position		Sitting -AS		Sitting -RM	
BP Location		Right arm -AS		Left arm -RM	

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

VS Simple (continued)

	08/14/16 1700	08/14/16 1552	08/14/16 1115	08/14/16 1100	08/14/16 0130
BP Method				Automatic -RM	
Resp		16 -AS		16 -RM	
Orthostatic BP Ordered?				No -RM	
Oxygen Therapy					
SpO2				100 % -RM	
O2 Device				room air -RM	
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -HS			number (Numeric Rating Pain Scale) -RM	number (Numeric Rating Pain Scale) -HS
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -HS		0 -GW	0 -RM	0 sleeping soundly, no c/o pain or discomfort -HS
Pain Rating (0-10): Activity	0 -HS		0 -GW	0 -RM	
Comfort/Acceptable Pain Level	0 -HS			0 -RM	
Patient Observation					
Observations	Q 30 mins -HS		Q 30 mins -GW		Q 30 mins -HS
	08/13/16 1800	08/13/16 1548	08/13/16 1100	08/13/16 1001	08/13/16 0939
Vital Signs					
Temp		98.7 °F (37.1 °C) -AS		98.1 °F (36.7 °C) -GW	98.2 °F (36.8 °C) -LL
Temp src				Oral -GW	Oral -LL
Pulse		115 -AS		87 -GW	77 -LL
Pulse Source					Brachial -LL
BP		145/79 mmHg -AS		120/71 mmHg -GW	109/68 mmHg -LL
Patient Position		Sitting -AS		Lying right side fetal position -GW	Sitting -LL
BP Location		Right arm -AS		Right arm -GW	Left arm -LL
BP Method				Automatic -GW	Automatic -LL
Resp		17 -AS		20 -GW	18 -LL
Oxygen Therapy					
SpO2				100 % -GW	100 % -LL
O2 Device					room air -LL
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -HS				
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	5 -HS		5 -GW	8 -GW	
Pain Rating (0-10): Activity	5 -HS		5 -GW	8 -GW	
Comfort/Accept	5 -HS				

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

VS Simple (continued)

	08/13/16 1800	08/13/16 1548	08/13/16 1100	08/13/16 1001	08/13/16 0939
able Pain Level					
Pain Management Interventions				no interventions per patient request -GW	
Patient Observation					
Observations	Q 30 mins -HS				
	08/13/16 0200	08/12/16 1900	08/12/16 1550	08/12/16 1205	08/12/16 1152
Vital Signs					
Temp			97.9 °F (36.6 °C) -JT		
Temp src			Oral -JT		
Pulse			79 -JT		
Pulse Source			Brachial -JT		
BP			130/83 mmHg -JT		
Patient Position			Sitting -JT		
BP Location			Left arm -JT		
BP Method			Automatic -JT		
Resp			18 -JT		
Oxygen Therapy					
SpO2			100 % -JT		
O2 Device			room air -JT		
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) Pt sleeping -MB	number (Numeric Rating Pain Scale) -MA			
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		4 -MA		3 -GW	0 -GW
Pain Rating (0-10): Activity		4 -MA		3 -GW	0 -GW
Patient Observation					
Observations	Q30 -MB	q30 -MA			q30 -GW
	08/12/16 0758	08/12/16 0148			
Vital Signs					
Temp	98.2 °F (36.8 °C) -FS				
Temp src	Oral -FS				
Pulse	78 -FS				
BP	136/88 mmHg -FS				
Patient Position	Sitting -FS				
BP Location	Left arm -FS				
BP Method	Automatic -FS				
Resp	16 -FS				
Oxygen Therapy					
SpO2	96 % -FS				
O2 Device	room air -FS				
Pain/Comfort					
Preferred Pain		number (Numeric			

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

VS Simple (continued)

	08/12/16 0758	08/12/16 0148
Scale		Rating Pain Scale) Pt asleep not displaying any discomfort/distress @ this time -MB
Pain Assessment: Number Scale (0-10)		
Pain Rating (0-10): Rest	0 -FS	
Patient Observation		
Observations		Q15 -MB

Pain Scales

	08/14/16 1700	08/14/16 1115	08/14/16 1100	08/14/16 0130	08/13/16 1800
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -HS		number (Numeric Rating Pain Scale) -RM	number (Numeric Rating Pain Scale) -HS	number (Numeric Rating Pain Scale) -HS
Sleep/Rest/Relaxation				no problem identified;appears asleep -HS	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -HS	0 -GW	0 -RM	0 sleeping soundly, no c/o pain or discomfort -HS	5 -HS
Pain Rating (0-10): Activity	0 -HS	0 -GW	0 -RM		5 -HS
Comfort/Acceptable Pain Level	0 -HS		0 -RM		5 -HS

	08/13/16 1133	08/13/16 1100	08/13/16 1001	08/13/16 0200	08/12/16 1900
Pain/Comfort/Sleep					
Preferred Pain Scale				number (Numeric Rating Pain Scale) Pt sleeping -MB	number (Numeric Rating Pain Scale) -MA
Sleep/Rest/Relaxation	feeling unrested -GW			no problem identified;appears asleep -MB	no problem identified;appears asleep;limb movements periodically during sleep -MA
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		5 -GW	8 -GW		4 -MA
Pain Rating (0-10): Activity		5 -GW	8 -GW		4 -MA
Pain Management Interventions			no interventions per patient request -GW		

	08/12/16 1205	08/12/16 1152	08/12/16 0758	08/12/16 0148
Pain/Comfort/Sleep				
Preferred Pain				number (Numeric

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

Pain Scales (continued)

	08/12/16 1205	08/12/16 1152	08/12/16 0758	08/12/16 0148	
Scale				Rating Pain Scale) Pt asleep not displaying any discomfort/distress @ this time -MB	
Sleep/Rest/Relaxation				no problem identified;appears asleep;limb movements periodically during sleep -MB	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	3 -GW	0 -GW	0 -FS		
Pain Rating (0-10): Activity	3 -GW	0 -GW			

Pain Reassessment

	08/14/16 1700	08/14/16 1115	08/14/16 1100	08/14/16 0130	08/13/16 1800
Pain/Comfort/Sleep					
Sleep/Rest/Relaxation				no problem identified;appears asleep -HS	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -HS	0 -GW	0 -RM	0 sleeping soundly, no c/o pain or discomfort -HS	5 -HS
Pain Rating (0-10): Activity	0 -HS	0 -GW	0 -RM		5 -HS
Comfort/Acceptable Pain Level	0 -HS		0 -RM		5 -HS
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -HS		number (Numeric Rating Pain Scale) -RM	number (Numeric Rating Pain Scale) -HS	number (Numeric Rating Pain Scale) -HS

	08/13/16 1133	08/13/16 1100	08/13/16 1001	08/13/16 0200	08/12/16 1900
Pain/Comfort/Sleep					
Sleep/Rest/Relaxation	feeling unrested -GW			no problem identified;appears asleep -MB	no problem identified;appears asleep;limb movements periodically during sleep -MA
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		5 -GW	8 -GW		4 -MA
Pain Rating (0-10): Activity		5 -GW	8 -GW		4 -MA
Pain Management			no interventions per patient request		

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

Pain Reassessment (continued)

	08/13/16 1133	08/13/16 1100	08/13/16 1001	08/13/16 0200	08/12/16 1900
Interventions			-GW		
Pain/Comfort					
Preferred Pain Scale				number (Numeric Rating Pain Scale) Pt sleeping -MB	number (Numeric Rating Pain Scale) -MA
	08/12/16 1205	08/12/16 1152	08/12/16 0758	08/12/16 0148	
Pain/Comfort/Sleep					
Sleep/Rest/Relaxation				no problem identified;appears asleep;limb movements periodically during sleep -MB	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	3 -GW	0 -GW	0 -FS		
Pain Rating (0-10): Activity	3 -GW	0 -GW			
Pain/Comfort					
Preferred Pain Scale				number (Numeric Rating Pain Scale) Pt asleep not displaying any discomfort/distress @ this time -MB	

BH Daily Assess

	08/14/16 1700	08/14/16 1552	08/14/16 1250	08/14/16 1200	08/14/16 1115
Legal Status					
Legal status	voluntary -HS				voluntary -GW
Vital Signs					
Temp		98.2 °F (36.8 °C) -AS			
Pulse		90 -AS			
BP		132/72 mmHg -AS			
Patient Position		Sitting -AS			
BP Location		Right arm -AS			
Resp		16 -AS			
Patient Observation					
Observations	Q 30 mins -HS				Q 30 mins -GW
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -HS				
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -HS				0 -GW
Pain Rating (0-10): Activity	0 -HS				0 -GW
Comfort/Accept	0 -HS				

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Daily Assess (continued)

	08/14/16 1700	08/14/16 1552	08/14/16 1250	08/14/16 1200	08/14/16 1115
able Pain Level					
HEENT					
HEENT WDL	WDL -HS				
Fall Risk Assessment					
Fall Risk Indicators	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -HS				3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -GW
Fall Risk Score	9 -HS				9 -GW
Patient Rights Denials					
Rights Denied or Restrictions Imposed	no -HS				no -GW
Precautions/Isolation					
Precautions (displays in banner)	None -HS				None -GW
Precautions Interventions					
Interventions Performed	yes -HS				
Level of Observation	every 30 minutes -HS				
Activities of Daily Living					
ADL's (WDL)	WDL He did shower and shaved last night -HS				WDL Except -GW
Daily Sleep					
Daily Sleep (WDL)	WDL -HS				
Nutritional Intake					
Lunch (%)				0 % -GW	
Daily Nutrition					
Daily Nutrition (WDL)	WDL except -HS				WDL except -GW
Appetite Change	decreased -HS				decreased -GW
Barriers to Nutrition	constipation -HS				constipation -GW
Level of Assistance	needs encouragement -HS				needs encouragement -GW
Mental Status					
Orientation	oriented x 4 -HS				oriented x 4 -GW
Level Of	alert -HS				alert -GW

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Daily Assess (continued)

	08/14/16 1700	08/14/16 1552	08/14/16 1250	08/14/16 1200	08/14/16 1115
Consciousness					
General Appearance WDL	WDL except;appearance Does look dischelved -HS				WDL except;appearance -GW
General Appearance	body odor -HS				body odor;unshaven;unkempt -GW
Mood	anxious;depressed;withdrawn -HS				anxious;depressed;withdrawn -GW
Mood/Behavior/ Affect WDL	WDL except;all -HS				WDL except;all -GW
Affect	guarded;restricted -HS				guarded;restricted -GW
Behavior (WDL)	WDL except -HS				WDL except -GW
Mood/Behavior	isolative -HS				isolative -GW
Speech	WDL -HS				WDL -GW
Speech	clear -HS				
Judgment and Insight	judgment not appropriate to situation;insight not appropriate to situation -HS				judgment not appropriate to situation;insight not appropriate to situation -GW
Insight	fair -HS				
Concentration	fair -HS				
Memory Deficit	intact -HS				intact -GW
Thought (WDL)	WDL -HS				WDL -GW
Coping/Psychosocial Response					
Observed Emotional State	anxious;withdrawn;withholds information;quiet -HS				anxious;withdrawn;withholds information;quiet -GW
Verbalized Emotional State	anxiety;depression -HS				anxiety;depression -GW
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -HS		patient -GW		patient -GW
Supportive Measures	active listening utilized;journaling promoted -HS				
Psychiatric Symptoms					
Anxiety Symptoms (WDL)	WDL except -HS				WDL except -GW
Anxiety Symptoms	generalized -HS				generalized -GW
Manic	WDL -HS				WDL -GW

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Daily Assess (continued)

	08/14/16 1700	08/14/16 1552	08/14/16 1250	08/14/16 1200	08/14/16 1115
Symptoms (WDL)					
Manic Symptoms	no problems reported or observed. -HS				
Psychotic symptoms (WDL)	WDL except -HS				WDL except -GW
Danger to Self					
Danger to Self (WDL)	WDL -HS				WDL -GW
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -HS				
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -HS				
Danger to Others					
Danger to Others (WDL)	WDL -HS				WDL -GW
	08/14/16 1100	08/14/16 0800	08/14/16 0719	08/14/16 0130	08/13/16 1800
Legal Status					
Legal status				voluntary -HS	voluntary -HS
Vital Signs					
Temp	98.6 °F (37 °C) -RM				
Temp src	Oral -RM				
Cardiac Monitor	no -RM				
Pulse	100 -RM				
Pulse Source	Brachial -RM				
BP	111/80 mmHg -RM				
Patient Position	Sitting -RM				
BP Location	Left arm -RM				
BP Method	Automatic -RM				
Resp	16 -RM				
Orthostatic BP Ordered?	No -RM				
Patient Observation					
Observations				Q 30 mins -HS	Q 30 mins -HS
Oxygen Therapy					
SpO2	100 % -RM				
O2 Device	room air -RM				
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale)			number (Numeric Rating Pain Scale)	number (Numeric Rating

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Daily Assess (continued)

	08/14/16 1100	08/14/16 0800	08/14/16 0719	08/14/16 0130	08/13/16 1800
	-RM			-HS	Pain Scale) -HS
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -RM			0 sleeping soundly, no c/o pain or discomfort -HS	5 -HS
Pain Rating (0-10): Activity	0 -RM				5 -HS
Comfort/Acceptable Pain Level	0 -RM				5 -HS
Skin WDL					
Skin WDL					WDL except;color -HS
Skin Color/Characteristics					bruised (ecchymotic) areas of discoloration -HS
HEENT					
HEENT WDL				WDL -HS	WDL -HS
Fall Risk Assessment					
Fall Risk Indicators				3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -HS	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -HS
Fall Risk Score				9 -HS	9 -HS
Patient Rights Denials					
Rights Denied or Restrictions Imposed				no -HS	no -HS
Precautions/Isolation					
Precautions (displays in banner)				None -HS	None -HS
Activities of Daily Living					
ADL's (WDL)				WDL -HS	WDL -HS
Bathing/Skin Care					shaved face;shampoo;shower -HS
Daily Sleep					
Daily Sleep (WDL)				WDL -HS	WDL -HS
Sleep/Rest/Relaxation				no problem identified;appears asleep -HS	
Daily Hours of			7 -EA		

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Daily Assess (continued)

	08/14/16 1100	08/14/16 0800	08/14/16 0719	08/14/16 0130	08/13/16 1800
Sleep					
Nutritional Intake					
Breakfast (%)		-- 2 sausage links -GW			
Daily Nutrition					
Daily Nutrition (WDL)					WDL except Feeling full with nausea, not eating well -HS
Appetite Change					decreased -HS
Barriers to Nutrition					constipation -HS
Level of Assistance					needs encouragement -HS
Mental Status					
Orientation					oriented x 4 -HS
Level Of Consciousness				asleep -HS	alert -HS
General Appearance WDL					WDL -HS
General Appearance					dress appropriate for weather/appropriate for setting -HS
Mood					anxious;depressed;withdrawn -HS
Mood/Behavior/ Affect WDL					WDL -HS
Affect					affect consistent with mood -HS
Behavior (WDL)					WDL except -HS
Mood/Behavior					isolative -HS
Somatic Symptoms					nausea -HS
Speech					WDL -HS
Speech					clear -HS
Judgment and Insight					insight not appropriate to situation;judgment not appropriate to situation -HS
Insight					fair -HS
Concentration					fair -HS
Memory Deficit					intact -HS

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Daily Assess (continued)

	08/14/16 1100	08/14/16 0800	08/14/16 0719	08/14/16 0130	08/13/16 1800
Coping/Psychosocial Response					
Observed Emotional State					anxious -HS
Verbalized Emotional State					fear;sadness Concerned does not know what is going on with his body -HS
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With					patient -HS
Supportive Measures					active listening utilized;journaling promoted -HS
Psychiatric Symptoms					
Anxiety Symptoms (WDL)				WDL Sleeping -HS	WDL except -HS
Anxiety Symptoms					difficulty controlling anxiety or worry;excessive anxiety or worry -HS
Manic Symptoms (WDL)				WDL -HS	WDL -HS
Psychotic symptoms (WDL)				WDL -HS	WDL -HS
Danger to Self					
Danger to Self (WDL)				WDL -HS	WDL -HS
Danger to Self				no suicidal ideation or behavior indicators observed or expressed -HS	no suicidal ideation or behavior indicators observed or expressed -HS
Self-Injurious Behavior				no self-injurious ideation or behavior indicators observed or expressed -HS	no self-injurious ideation or behavior indicators observed or expressed -HS
Danger to Others					
Danger to Others (WDL)				WDL -HS	WDL -HS
	08/13/16 1548	08/13/16 1400	08/13/16 1133	08/13/16 1100	08/13/16 1055
Legal Status					

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Daily Assess (continued)

	08/13/16 1548	08/13/16 1400	08/13/16 1133	08/13/16 1100	08/13/16 1055
Legal status			voluntary -GW		
Vital Signs					
Temp	98.7 °F (37.1 °C) -AS				
Pulse	115 -AS				
BP	145/79 mmHg -AS				
Patient Position	Sitting -AS				
BP Location	Right arm -AS				
Resp	17 -AS				
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest				5 -GW	
Pain Rating (0-10): Activity				5 -GW	
Skin WDL					
Skin WDL		WDL except;color -GW			
Skin Color/Characteristics		bruised (ecchymotic) legs, thighs -GW			
Fall Risk Assessment					
Fall Risk Indicators			3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -GW		
Fall Risk Score			9 -GW		
Patient Rights Denials					
Rights Denied or Restrictions Imposed			no -GW		
Precautions/Isolation					
Precautions (displays in banner)			None -GW		
Activities of Daily Living					
ADL's (WDL)			WDL Except -GW		
Bathing/Skin Care			patient refused -GW		
Daily Sleep					
Daily Sleep (WDL)			WDL Except -GW		
Sleep/Rest/Relaxation			feeling unrested -GW		
Daily Nutrition					
Daily Nutrition (WDL)			WDL -GW		

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Daily Assess (continued)

	08/13/16 1548	08/13/16 1400	08/13/16 1133	08/13/16 1100	08/13/16 1055
Mental Status					
Orientation			oriented x 4 -GW		
Level Of Consciousness			alert -GW		
General Appearance WDL			WDL except;appearance -GW		
General Appearance			body odor;unkempt;unshaven;unclean -GW		
Mood			anxious;depressed;withdrawn -GW		
Mood/Behavior/ Affect WDL			WDL except;all -GW		
Affect			blunted -GW		
Behavior (WDL)			WDL except -GW		
Mood/Behavior			isolative -GW		
Speech			WDL -GW		
Memory Deficit			intact -GW		
Thought (WDL)			WDL Except -GW		
Thought Process			-- uable to accurately assess at this time -GW		
Coping/Psychosocial Response					
Observed Emotional State			anxious -GW		
Verbalized Emotional State			other (see comments) worried of having food poisoning -GW		
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With			patient -GW		patient -GW
Supportive Measures			active listening utilized;verbalization of feelings encouraged -GW		
Psychiatric Symptoms					
Anxiety Symptoms (WDL)			WDL except -GW		
Anxiety Symptoms			difficulty controlling anxiety or worry;excessive anxiety or worry -GW		
Manic Symptoms			WDL -GW		

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Daily Assess (continued)

	08/13/16 1548	08/13/16 1400	08/13/16 1133	08/13/16 1100	08/13/16 1055
(WDL)					
Psychotic symptoms (WDL)			WDL except -GW		
Danger to Self					
Danger to Self (WDL)			WDL -GW		
Danger to Others					
Danger to Others (WDL)			WDL -GW		
	08/13/16 1001	08/13/16 0939	08/13/16 0600	08/13/16 0200	08/12/16 1928
Legal Status					
Legal status				voluntary -MB	
Vital Signs					
Temp	98.1 °F (36.7 °C) -GW	98.2 °F (36.8 °C) -LL			
Temp src	Oral -GW	Oral -LL			
Pulse	87 -GW	77 -LL			
Pulse Source		Brachial -LL			
BP	120/71 mmHg -GW	109/68 mmHg -LL			
Patient Position	Lying right side fetal position -GW	Sitting -LL			
BP Location	Right arm -GW	Left arm -LL			
BP Method	Automatic -GW	Automatic -LL			
Resp	20 -GW	18 -LL			
Patient Observation					
Observations				Q30 -MB	
Oxygen Therapy					
SpO2	100 % -GW	100 % -LL			
O2 Device		room air -LL			
Pain/Comfort					
Preferred Pain Scale				number (Numeric Rating Pain Scale) Pt sleeping -MB	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	8 -GW				
Pain Rating (0-10): Activity	8 -GW				
Pain Management Interventions	no interventions per patient request -GW				
Precautions/Isolation					
Precautions (displays in banner)				None -MB	
Daily Sleep					
Daily Sleep (WDL)				WDL -MB	

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Daily Assess (continued)

	08/13/16 1001	08/13/16 0939	08/13/16 0600	08/13/16 0200	08/12/16 1928
Sleep/Rest/Relaxation				no problem identified;appears asleep -MB	
Daily Hours of Sleep			5 -MB		
Mental Status					
Level Of Consciousness				asleep -MB	
Behavior (WDL)				WDL Pt sleeping -MB	
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With					patient -MA
Psychiatric Symptoms					
Anxiety Symptoms (WDL)				WDL Pt sleeping -MB	
Manic Symptoms (WDL)				WDL -MB	
Manic Symptoms				no problems reported or observed. Pt sleeping -MB	
Psychotic symptoms (WDL)				WDL Pt sleeping -MB	
Danger to Self					
Danger to Self (WDL)				WDL -MB	
Danger to Self				no suicidal ideation or behavior indicators observed or expressed Pt sleeping -MB	
Danger to Others					
Danger to Others (WDL)				WDL Pt sleeping -MB	

	08/12/16 1900	08/12/16 1550	08/12/16 1310	08/12/16 1205	08/12/16 1152
Legal Status					
Legal status	voluntary -MA				voluntary -GW
Vital Signs					
Temp		97.9 °F (36.6 °C) -JT			
Temp src		Oral -JT			
Pulse		79 -JT			
Pulse Source		Brachial -JT			
BP		130/83 mmHg -JT			
Patient Position		Sitting -JT			

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Daily Assess (continued)

	08/12/16 1900	08/12/16 1550	08/12/16 1310	08/12/16 1205	08/12/16 1152
BP Location		Left arm -JT			
BP Method		Automatic -JT			
Resp		18 -JT			
Patient Observation					
Observations	q30 -MA				q30 -GW
Oxygen Therapy					
SpO2		100 % -JT			
O2 Device		room air -JT			
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -MA				
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	4 -MA			3 -GW	0 -GW
Pain Rating (0-10): Activity	4 -MA			3 -GW	0 -GW
Skin WDL					
Skin WDL	WDL -MA				
HEENT					
HEENT WDL	WDL -MA				
Fall Risk Assessment					
Fall Risk Indicators	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -MA				3-->central nervous system/psychotropic medication;1-->male -GW
Fall Risk Score	9 -MA				4 -GW
Patient Rights Denials					
Rights Denied or Restrictions Imposed	no -MA				no -GW
Precautions/Isolation					
Precautions (displays in banner)	None -MA				None -GW
Precautions Interventions					
Interventions Performed	yes -MA				
Activities of Daily Living					
ADL's (WDL)	WDL -MA				WDL -GW
Daily Sleep					
Daily Sleep (WDL)	WDL -MA				
Sleep/Rest/Relaxation	no problem identified;appears asleep;limb				

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Daily Assess (continued)

	08/12/16 1900	08/12/16 1550	08/12/16 1310	08/12/16 1205	08/12/16 1152
	movements periodically during sleep -MA				
Daily Nutrition					
Daily Nutrition (WDL)	WDL -MA				WDL -GW
Mental Status					
Orientation	oriented x 4 -MA				oriented x 4 -GW
Level Of Consciousness	alert -MA				alert -GW
General Appearance WDL	WDL except -MA				WDL except;appearance -GW
General Appearance	unkempt;unshaven;body odor -MA				unkempt;unshaven;body odor -GW
Mood	depressed -MA				euthymic -GW
Mood/Behavior/ Affect WDL	WDL -MA				WDL except;all -GW
Affect	blunted -MA				guarded;restricted -GW
Behavior (WDL)	WDL -MA				WDL -GW
Mood/Behavior	anxious -MA				cooperative;positive goal-directed -GW
Speech	WDL -MA				WDL -GW
Judgment and Insight	insight not appropriate to situation;judgment not appropriate to situation -MA				insight not appropriate to situation;judgment not appropriate to situation -GW
Insight	fair -MA				
Concentration	fair -MA				
Memory Deficit	intact -MA				
Thought (WDL)	WDL -MA				WDL -GW
Thought Process	disorganized -MA				
Coping/Psychosocial Response					
Observed Emotional State	calm;cooperative -MA				calm;cooperative -GW
Verbalized Emotional State	hopefulness -MA				hopefulness -GW
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -MA		patient -GW		patient -GW
Psychiatric Symptoms					
Anxiety Symptoms	WDL except -MA			WDL except -GW	

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Daily Assess (continued)

	08/12/16 1900	08/12/16 1550	08/12/16 1310	08/12/16 1205	08/12/16 1152
(WDL)					
Anxiety Symptoms	generalized -MA			generalized -GW	
Manic Symptoms (WDL)	WDL -MA			WDL -GW	
Psychotic symptoms (WDL)	WDL -MA			WDL -GW	
Danger to Self					
Danger to Self (WDL)	WDL -MA			WDL -GW	
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -MA				
Keeps Self Safe	yes (describe) -MA				
Agreement not to Harm Self	yes (describe) -MA				
Assessment Type					
Assessment timing	Shift -MA				
Assessment of contributing factors					
Assessment of Risk Factors	History of childhood physicial/sexual abuse;Prior suicide attempts -MA				
Assessment of Protective Factors	Good access to health care/therapy -MA				
Danger to Others					
Danger to Others (WDL)	WDL -MA			WDL -GW	

	08/12/16 0758	08/12/16 0700	08/12/16 0148
Legal Status			
Legal status			voluntary -MB
Vital Signs			
Temp	98.2 °F (36.8 °C) -FS		
Temp src	Oral -FS		
Pulse	78 -FS		
BP	136/88 mmHg -FS		
Patient Position	Sitting -FS		
BP Location	Left arm -FS		
BP Method	Automatic -FS		
Resp	16 -FS		

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Daily Assess (continued)

	08/12/16 0758	08/12/16 0700	08/12/16 0148
Patient Observation			
Observations			Q15 -MB
Oxygen Therapy			
SpO2	96 % -FS		
O2 Device	room air -FS		
Pain/Comfort			
Preferred Pain Scale			number (Numeric Rating Pain Scale) Pt asleep not displaying any discomfort/distress @ this time -MB
Pain Assessment: Number Scale (0-10)			
Pain Rating (0-10): Rest	0 -FS		
Precautions/Isolation			
Precautions (displays in banner)			None -MB
Daily Sleep			
Daily Sleep (WDL)			WDL -MB
Sleep/Rest/Relaxation			no problem identified;appears asleep;limb movements periodically during sleep -MB
Daily Hours of Sleep		7.5 -CR	
Mental Status			
Level Of Consciousness			asleep -MB
Behavior (WDL)			WDL Pt asleep not displaying any discomfort/distress @ this time -MB
Psychiatric Symptoms			
Anxiety Symptoms (WDL)			WDL Pt asleep not displaying any discomfort/distress @ this time -MB
Manic Symptoms (WDL)			WDL Pt asleep not displaying any discomfort/distress @ this time -MB
Psychotic symptoms (WDL)			WDL -MB

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Daily Assess (continued)

	08/12/16 0758	08/12/16 0700	08/12/16 0148
Danger to Self			
Danger to Self (WDL)			WDL Pt asleep not displaying any discomfort/distress @ this time -MB
Danger to Self			no suicidal ideation or behavior indicators observed or expressed Pt asleep not displaying any discomfort/distress @ this time -MB
Danger to Others			
Danger to Others (WDL)			WDL Pt asleep not displaying any discomfort/distress @ this time -MB

Risk Screening

	08/14/16 1700	08/14/16 1115	08/14/16 0130	08/13/16 1800	08/13/16 1133
Fall Risk Assessment					
Fall Risk Indicators	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -HS	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -GW	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -HS	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -HS	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -GW
Fall Risk Score	9 -HS	9 -GW	9 -HS	9 -HS	9 -GW
Danger to Self					
Danger to Self (WDL)	WDL -HS	WDL -GW	WDL -HS	WDL -HS	WDL -GW
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -HS		no suicidal ideation or behavior indicators observed or expressed -HS	no suicidal ideation or behavior indicators observed or expressed -HS	
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -HS		no self-injurious ideation or behavior indicators observed or expressed -HS	no self-injurious ideation or behavior indicators observed or expressed -HS	
Danger to Others					
Danger to Others (WDL)	WDL -HS	WDL -GW	WDL -HS	WDL -HS	WDL -GW

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

Risk Screening (continued)

	08/13/16 0200	08/12/16 1900	08/12/16 1300	08/12/16 1205	08/12/16 1152
Nutrition/Metabolic					
Patient Reported Diet / Restrictions / Preferences			-- Extra soup serving w/ L&D -SI		
Fall Risk Assessment					
Fall Risk Indicators		3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -MA			3-->central nervous system/psychotropic medication;1-->male -GW
Fall Risk Score		9 -MA			4 -GW
Danger to Self					
Danger to Self (WDL)	WDL -MB	WDL -MA		WDL -GW	
Danger to Self	no suicidal ideation or behavior indicators observed or expressed Pt sleeping -MB	no suicidal ideation or behavior indicators observed or expressed -MA			
Keeps Self Safe		yes (describe) -MA			
Agreement not to Harm Self		yes (describe) -MA			
Danger to Others					
Danger to Others (WDL)	WDL Pt sleeping -MB	WDL -MA		WDL -GW	

	08/12/16 0148
Danger to Self	
Danger to Self (WDL)	WDL Pt asleep not displaying any discomfort/distress @ this time -MB
Danger to Self	no suicidal ideation or behavior indicators observed or expressed Pt asleep not displaying any discomfort/distress @ this time -MB
Danger to Others	
Danger to Others (WDL)	WDL Pt asleep not displaying any discomfort/distress @ this time -MB

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Initial Eval

	08/14/16 1700	08/14/16 1552	08/14/16 1115	08/14/16 1100	08/14/16 0719
Legal Status					
Legal status	voluntary -HS		voluntary -GW		
Evidence of Mood Disorders					
Manic Symptoms (WDL)	WDL -HS		WDL -GW		
Manic Symptoms	no problems reported or observed. -HS				
Evidence of Anxiety Disorders					
Anxiety Symptoms (WDL)	WDL except -HS		WDL except -GW		
Anxiety Symptoms	generalized -HS		generalized -GW		
Danger to Self					
Danger to Self (WDL)	WDL -HS		WDL -GW		
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -HS				
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -HS				
Danger to Others					
Danger to Others (WDL)	WDL -HS		WDL -GW		
Mental Status					
Level Of Consciousness	alert -HS		alert -GW		
Orientation	oriented x 4 -HS		oriented x 4 -GW		
General Appearance WDL	WDL except;appearance Does look dischelved -HS		WDL except;appearance -GW		
General Appearance	body odor -HS		body odor;unshaven;unkempt -GW		
Mood/Behavior/ Affect WDL	WDL except;all -HS		WDL except;all -GW		
Affect	guarded;restricted -HS		guarded;restricted -GW		
Mood/Behavior	isolative -HS		isolative -GW		
Speech	WDL -HS		WDL -GW		
Speech	clear -HS				

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Initial Eval (continued)

	08/14/16 1700	08/14/16 1552	08/14/16 1115	08/14/16 1100	08/14/16 0719
Judgment and Insight	judgment not appropriate to situation;insight not appropriate to situation -HS		judgment not appropriate to situation;insight not appropriate to situation -GW		
Insight	fair -HS				
Concentration	fair -HS				
Memory Deficit	intact -HS		intact -GW		
Behavior (WDL)	WDL except -HS		WDL except -GW		
Sleep/Rest/Relaxation					
Daily Hours of Sleep					7 -EA
Vital Signs					
Temp		98.2 °F (36.8 °C) -AS		98.6 °F (37 °C) -RM	
Pulse		90 -AS		100 -RM	
BP		132/72 mmHg -AS		111/80 mmHg -RM	
Patient Position		Sitting -AS		Sitting -RM	
Resp		16 -AS		16 -RM	
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -HS			number (Numeric Rating Pain Scale) -RM	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -HS		0 -GW	0 -RM	
Pain Rating (0-10): Activity	0 -HS		0 -GW	0 -RM	
Comfort/Acceptable Pain Level	0 -HS			0 -RM	
Fall Risk Assessment					
Fall Risk Indicators	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -HS		3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -GW		
Fall Risk Score	9 -HS		9 -GW		
	08/14/16 0130	08/13/16 1800	08/13/16 1548	08/13/16 1133	08/13/16 1100
Legal Status					
Legal status	voluntary -HS	voluntary -HS		voluntary -GW	
Evidence of Mood Disorders					
Manic Symptoms (WDL)	WDL -HS	WDL -HS		WDL -GW	
Evidence of Anxiety Disorders					
Anxiety Symptoms	WDL Sleeping -HS	WDL except -HS		WDL except -GW	

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Initial Eval (continued)

	08/14/16 0130	08/13/16 1800	08/13/16 1548	08/13/16 1133	08/13/16 1100
(WDL)					
Anxiety Symptoms		difficulty controlling anxiety or worry;excessive anxiety or worry -HS		difficulty controlling anxiety or worry;excessive anxiety or worry -GW	
Danger to Self					
Danger to Self (WDL)	WDL -HS	WDL -HS		WDL -GW	
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -HS	no suicidal ideation or behavior indicators observed or expressed -HS			
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -HS	no self-injurious ideation or behavior indicators observed or expressed -HS			
Danger to Others					
Danger to Others (WDL)	WDL -HS	WDL -HS		WDL -GW	
Mental Status					
Level Of Consciousness	asleep -HS	alert -HS		alert -GW	
Orientation		oriented x 4 -HS		oriented x 4 -GW	
General Appearance WDL		WDL -HS		WDL except;appearance -GW	
General Appearance		dress appropriate for weather/appropriate for setting -HS		body odor;unkempt;unshaven;unclean -GW	
Mood/Behavior/ Affect WDL		WDL -HS		WDL except;all -GW	
Affect		affect consistent with mood -HS		blunted -GW	
Mood/Behavior		isolative -HS		isolative -GW	
Speech		WDL -HS		WDL -GW	
Speech		clear -HS			
Judgment and Insight		insight not appropriate to situation;judgment not appropriate to situation -HS			
Insight		fair -HS			
Concentration		fair -HS			
Memory Deficit		intact -HS		intact -GW	
Thought				-- uable to accurately	

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Initial Eval (continued)

	08/14/16 0130	08/13/16 1800	08/13/16 1548	08/13/16 1133	08/13/16 1100
Process				assess at this time -GW	
Behavior (WDL)		WDL except -HS		WDL except -GW	
Sleep/Rest/Relaxation					
Sleep/Rest/Relaxation	no problem identified;appears asleep -HS			feeling unrested -GW	
Vital Signs					
Temp			98.7 °F (37.1 °C) -AS		
Pulse			115 -AS		
BP			145/79 mmHg -AS		
Patient Position			Sitting -AS		
Resp			17 -AS		
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -HS	number (Numeric Rating Pain Scale) -HS			
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 sleeping soundly, no c/o pain or discomfort -HS	5 -HS			5 -GW
Pain Rating (0-10): Activity		5 -HS			5 -GW
Comfort/Acceptable Pain Level		5 -HS			
Fall Risk Assessment					
Fall Risk Indicators	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -HS	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -HS		3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -GW	
Fall Risk Score	9 -HS	9 -HS		9 -GW	

	08/13/16 1001	08/13/16 0939	08/13/16 0600	08/13/16 0200	08/12/16 1900
Legal Status					
Legal status				voluntary -MB	voluntary -MA
Evidence of Mood Disorders					
Manic Symptoms (WDL)				WDL -MB	WDL -MA
Manic Symptoms				no problems reported or observed. Pt sleeping -MB	
Evidence of Anxiety Disorders					
Anxiety Symptoms				WDL Pt sleeping -MB	WDL except -MA

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Initial Eval (continued)

	08/13/16 1001	08/13/16 0939	08/13/16 0600	08/13/16 0200	08/12/16 1900
(WDL)					
Anxiety Symptoms					generalized -MA
Danger to Self					
Danger to Self (WDL)				WDL -MB	WDL -MA
Danger to Self				no suicidal ideation or behavior indicators observed or expressed Pt sleeping -MB	no suicidal ideation or behavior indicators observed or expressed -MA
Keeps Self Safe					yes (describe) -MA
Agreement not to Harm Self					yes (describe) -MA
Assessment Type					
Assessment timing					Shift -MA
Assessment of contributing factors					
Assessment of Risk Factors					History of childhood physicial/sexual abuse;Prior suicide attempts -MA
Assessment of Protective Factors					Good access to health care/therapy -MA
Danger to Others					
Danger to Others (WDL)				WDL Pt sleeping -MB	WDL -MA
Mental Status					
Level Of Consciousness				asleep -MB	alert -MA
Orientation					oriented x 4 -MA
General Appearance WDL					WDL except -MA
General Appearance					unkempt;unshaven;body odor -MA
Mood/Behavior/ Affect WDL					WDL -MA
Affect					blunted -MA
Mood/Behavior					anxious -MA
Speech					WDL -MA
Judgment and Insight					insight not appropriate to situation;judgme

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Initial Eval (continued)

	08/13/16 1001	08/13/16 0939	08/13/16 0600	08/13/16 0200	08/12/16 1900
					nt not appropriate to situation -MA
Insight					fair -MA
Concentration					fair -MA
Memory Deficit					intact -MA
Thought Process					disorganized -MA
Behavior (WDL)				WDL Pt sleeping -MB	WDL -MA
Sleep/Rest/Relaxation					
Sleep/Rest/Relaxation				no problem identified;appears asleep -MB	no problem identified;appears asleep;limb movements periodically during sleep -MA
Daily Hours of Sleep			5 -MB		
Vital Signs					
Temp	98.1 °F (36.7 °C) -GW	98.2 °F (36.8 °C) -LL			
Pulse	87 -GW	77 -LL			
BP	120/71 mmHg -GW	109/68 mmHg -LL			
Patient Position	Lying right side fetal position -GW	Sitting -LL			
Resp	20 -GW	18 -LL			
Pain/Comfort					
Preferred Pain Scale				number (Numeric Rating Pain Scale) Pt sleeping -MB	number (Numeric Rating Pain Scale) -MA
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	8 -GW				4 -MA
Pain Rating (0-10): Activity	8 -GW				4 -MA
Pain Management Interventions	no interventions per patient request -GW				
Fall Risk Assessment					
Fall Risk Indicators					3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -MA
Fall Risk Score					9 -MA

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Initial Eval (continued)

	08/12/16 1550	08/12/16 1300	08/12/16 1205	08/12/16 1152	08/12/16 0758
Legal Status					
Legal status				voluntary -GW	
Evidence of Mood Disorders					
Manic Symptoms (WDL)			WDL -GW		
Evidence of Anxiety Disorders					
Anxiety Symptoms (WDL)			WDL except -GW		
Anxiety Symptoms			generalized -GW		
Nutrition/Metabolic					
Patient Reported Diet / Restrictions / Preferences		-- Extra soup serving w/ L&D -SI			
Danger to Self					
Danger to Self (WDL)			WDL -GW		
Danger to Others					
Danger to Others (WDL)			WDL -GW		
Mental Status					
Level Of Consciousness				alert -GW	
Orientation				oriented x 4 -GW	
General Appearance WDL				WDL except;appearance -GW	
General Appearance				unkempt;unshaven;body odor -GW	
Mood/Behavior/ Affect WDL				WDL except;all -GW	
Affect				guarded;restricted -GW	
Mood/Behavior				cooperative;positive goal-directed -GW	
Speech				WDL -GW	
Judgment and Insight				insight not appropriate to situation;judgment not appropriate to situation -GW	
Behavior (WDL)				WDL -GW	
Vital Signs					
Temp	97.9 °F (36.6 °C) -JT				98.2 °F (36.8 °C) -FS

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Initial Eval (continued)

	08/12/16 1550	08/12/16 1300	08/12/16 1205	08/12/16 1152	08/12/16 0758
Pulse	79 -JT				78 -FS
BP	130/83 mmHg -JT				136/88 mmHg -FS
Patient Position	Sitting -JT				Sitting -FS
Resp	18 -JT				16 -FS
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest			3 -GW	0 -GW	0 -FS
Pain Rating (0-10): Activity			3 -GW	0 -GW	
Fall Risk Assessment					
Fall Risk Indicators				3-->central nervous system/psychotropic medication;1-->male -GW	
Fall Risk Score				4 -GW	

	08/12/16 0700	08/12/16 0148
Legal Status		
Legal status		voluntary -MB
Evidence of Mood Disorders		
Manic Symptoms (WDL)		WDL Pt asleep not displaying any discomfort/distress @ this time -MB
Evidence of Anxiety Disorders		
Anxiety Symptoms (WDL)		WDL Pt asleep not displaying any discomfort/distress @ this time -MB
Danger to Self		
Danger to Self (WDL)		WDL Pt asleep not displaying any discomfort/distress @ this time -MB
Danger to Self		no suicidal ideation or behavior indicators observed or expressed Pt asleep not displaying any discomfort/distress @ this time -MB
Danger to Others		
Danger to Others (WDL)		WDL Pt asleep not displaying any discomfort/distress @ this time -MB

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH Initial Eval (continued)

	08/12/16 0700	08/12/16 0148
Mental Status		
Level Of Consciousness		asleep -MB
Behavior (WDL)		WDL Pt asleep not displaying any discomfort/distress @ this time -MB
Sleep/Rest/Relaxation		
Sleep/Rest/Relaxation		no problem identified;appears asleep;limb movements periodically during sleep -MB
Daily Hours of Sleep	7.5 -CR	
Pain/Comfort		
Preferred Pain Scale		number (Numeric Rating Pain Scale) Pt asleep not displaying any discomfort/distress @ this time -MB

BH OT Observations NAV IP

	08/14/16 1700	08/14/16 1115	08/13/16 1800	08/13/16 1133	08/12/16 1900
General Observations					
Mood/Behavior/Affect WDL	WDL except;all -HS	WDL except;all -GW	WDL -HS	WDL except;all -GW	WDL -MA
Affect	guarded;restricted -HS	guarded;restricted -GW	affect consistent with mood -HS	blunted -GW	blunted -MA
Mood	anxious;depressed;withdrawn -HS	anxious;depressed;withdrawn -GW	anxious;depressed;withdrawn -HS	anxious;depressed;withdrawn -GW	depressed -MA
Orientation	oriented x 4 -HS	oriented x 4 -GW	oriented x 4 -HS	oriented x 4 -GW	oriented x 4 -MA
Thought Process				-- uable to accurately assess at this time -GW	disorganized -MA
Speech	clear -HS		clear -HS		
General Appearance WDL	WDL except;appearance Does look dischelved -HS	WDL except;appearance -GW	WDL -HS	WDL except;appearance -GW	WDL except -MA
General Appearance	body odor -HS	body odor;unshaven;unkempt -GW	dress appropriate for weather/appropriate for setting -HS	body odor;unkempt;unshaven;unclean -GW	unkempt;unshaven;body odor -MA

	08/12/16 1152
General Observations	
Mood/Behavior/	WDL except;all -

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

BH OT Observations NAV IP (continued)

	08/12/16 1152
Affect WDL	GW
Affect	guarded;restricted -GW
Mood	euthymic -GW
Orientation	oriented x 4 -GW
General Appearance WDL	WDL except;appearance -GW
General Appearance	unkempt;unshaven;body odor -GW

Adult Nutrition Assessment

	08/12/16 1300
Nutrition/Diet History	
Patient Reported Diet / Restrictions / Preferences	-- Extra soup serving w/ L&D -SI
Nutrition Risk	
Level Of Risk - Acuity	moderate -SI
Follow Up Date	08/18/16 f/u -SI

Adult Care Sum F14

	08/14/16 1700	08/14/16 1250	08/14/16 1115	08/14/16 1100	08/14/16 0719
Plan of Care Review					
Plan Of Care Reviewed With	patient -HS	patient -GW	patient -GW		
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -HS			number (Numeric Rating Pain Scale) -RM	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -HS		0 -GW	0 -RM	
Pain Rating (0-10): Activity	0 -HS		0 -GW	0 -RM	
Comfort/Acceptable Pain Level	0 -HS			0 -RM	
Sleep/Rest/Relaxation					
Daily Hours of Sleep					7 -EA
Coping/Psychosocial					
Observed Emotional State	anxious;withdrawn;withholds information;quiet -HS		anxious;withdrawn;withholds information;quiet -GW		
Verbalized Emotional State	anxiety;depression -HS		anxiety;depression -GW		

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/14/16 1700	08/14/16 1250	08/14/16 1115	08/14/16 1100	08/14/16 0719
Coping Strategies					
Supportive Measures	active listening utilized;journaling promoted -HS				
HEENT					
HEENT WDL	WDL -HS				
Cognitive					
Memory Deficit	intact -HS		intact -GW		
Neuro					
Level Of Consciousness	alert -HS		alert -GW		
Orientation	oriented x 4 -HS		oriented x 4 -GW		
General Appearance					
General Appearance WDL	WDL except;appearance Does look dischelved -HS		WDL except;appearance -GW		
General Appearance	body odor -HS		body odor;unshaven;unkempt -GW		
Mood/Behavior/Affect					
Mood/Behavior/ Affect WDL	WDL except;all -HS		WDL except;all -GW		
Affect	guarded;restricted -HS		guarded;restricted -GW		
Mood/Behavior	isolative -HS		isolative -GW		
Speech					
Speech	WDL -HS		WDL -GW		
Speech	clear -HS				
Thought Process					
Judgment and Insight	judgment not appropriate to situation;insight not appropriate to situation -HS		judgment not appropriate to situation;insight not appropriate to situation -GW		
Oxygen Therapy					
SpO2				100 % -RM	
O2 Device				room air -RM	
Safety Interventions					
Precautions (displays in banner)	None -HS		None -GW		
Fall Risk Indicators	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1--		3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1--		

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/14/16 1700	08/14/16 1250	08/14/16 1115	08/14/16 1100	08/14/16 0719
	>male -HS		>male -GW		
Fall Risk Score	9 -HS		9 -GW		
	08/14/16 0130	08/13/16 1800	08/13/16 1400	08/13/16 1133	08/13/16 1100
Plan of Care Review					
Plan Of Care Reviewed With		patient -HS		patient -GW	
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -HS	number (Numeric Rating Pain Scale) -HS			
Sleep/Rest/Relaxation	no problem identified;appears asleep -HS			feeling unrested -GW	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 sleeping soundly, no c/o pain or discomfort -HS	5 -HS			5 -GW
Pain Rating (0-10): Activity		5 -HS			5 -GW
Comfort/Acceptable Pain Level		5 -HS			
Coping/Psychosocial					
Observed Emotional State		anxious -HS		anxious -GW	
Verbalized Emotional State		fear;sadness Concerned does not know what is going on with his body -HS		other (see comments) worried of having food poisoning -GW	
Coping Strategies					
Supportive Measures		active listening utilized;journaling promoted -HS		active listening utilized;verbalization of feelings encouraged -GW	
HEENT					
HEENT WDL	WDL -HS	WDL -HS			
Cognitive					
Memory Deficit		intact -HS		intact -GW	
Neuro					
Level Of Consciousness	asleep -HS	alert -HS		alert -GW	
Orientation		oriented x 4 -HS		oriented x 4 -GW	
General Appearance					
General Appearance WDL		WDL -HS		WDL except;appearance -GW	
General Appearance		dress appropriate for weather/appropriate for setting -HS		body odor;unkempt;unshaven;unclean -GW	

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/14/16 0130	08/13/16 1800	08/13/16 1400	08/13/16 1133	08/13/16 1100
Mood/Behavior/Affect					
Mood/Behavior/ Affect WDL		WDL -HS		WDL except;all -GW	
Affect		affect consistent with mood -HS		blunted -GW	
Mood/Behavior		isolative -HS		isolative -GW	
Speech					
Speech		WDL -HS		WDL -GW	
Speech		clear -HS			
Thought Process					
Judgment and Insight		insight not appropriate to situation;judgment not appropriate to situation -HS			
Thought Process				-- uable to accurately assess at this time -GW	
Skin					
Skin WDL		WDL except;color -HS	WDL except;color -GW		
Skin Color/Characteristics		bruised (ecchymotic) areas of discoloration -HS	bruised (ecchymotic) legs, thighs -GW		
Safety Interventions					
Precautions (displays in banner)	None -HS	None -HS		None -GW	
Fall Risk Indicators	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -HS	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -HS		3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -GW	
Fall Risk Score	9 -HS	9 -HS		9 -GW	
	08/13/16 1055	08/13/16 1001	08/13/16 0939	08/13/16 0600	08/13/16 0200
Plan of Care Review					
Plan Of Care Reviewed With	patient -GW				
Pain/Comfort/Sleep					
Preferred Pain Scale					number (Numeric Rating Pain Scale) Pt sleeping -MB
Sleep/Rest/Relaxation					no problem identified;appears asleep -MB

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/13/16 1055	08/13/16 1001	08/13/16 0939	08/13/16 0600	08/13/16 0200
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		8 -GW			
Pain Rating (0-10): Activity		8 -GW			
Pain Management Interventions		no interventions per patient request -GW			
Sleep/Rest/Relaxation					
Daily Hours of Sleep				5 -MB	
Neuro					
Level Of Consciousness					asleep -MB
Oxygen Therapy					
SpO2		100 % -GW	100 % -LL		
O2 Device			room air -LL		
Safety Interventions					
Precautions (displays in banner)					None -MB

	08/12/16 1928	08/12/16 1900	08/12/16 1550	08/12/16 1310	08/12/16 1205
Plan of Care Review					
Plan Of Care Reviewed With	patient -MA	patient -MA		patient -GW	
Pain/Comfort/Sleep					
Preferred Pain Scale		number (Numeric Rating Pain Scale) -MA			
Sleep/Rest/Relaxation		no problem identified;appears asleep;limb movements periodically during sleep -MA			
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		4 -MA			3 -GW
Pain Rating (0-10): Activity		4 -MA			3 -GW
Coping/Psychosocial					
Observed Emotional State		calm;cooperative -MA			
Verbalized Emotional State		hopefulness -MA			
HEENT					
HEENT WDL		WDL -MA			
Cognitive					
Memory Deficit		intact -MA			

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/12/16 1928	08/12/16 1900	08/12/16 1550	08/12/16 1310	08/12/16 1205
Neuro					
Level Of Consciousness		alert -MA			
Orientation		oriented x 4 -MA			
General Appearance					
General Appearance WDL		WDL except -MA			
General Appearance		unkempt;unshaven;body odor -MA			
Mood/Behavior/Affect					
Mood/Behavior/ Affect WDL		WDL -MA			
Affect		blunted -MA			
Mood/Behavior		anxious -MA			
Speech					
Speech		WDL -MA			
Thought Process					
Judgment and Insight		insight not appropriate to situation;judgment not appropriate to situation -MA			
Thought Process		disorganized -MA			
Oxygen Therapy					
SpO2			100 % -JT		
O2 Device			room air -JT		
Skin					
Skin WDL		WDL -MA			
Safety Interventions					
Precautions (displays in banner)		None -MA			
Fall Risk Indicators		3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male -MA			
Fall Risk Score		9 -MA			

	08/12/16 1152	08/12/16 0758	08/12/16 0700	08/12/16 0148
Plan of Care Review				
Plan Of Care Reviewed With	patient -GW			
Pain/Comfort/Sleep				
Preferred Pain Scale				number (Numeric Rating Pain Scale)

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/12/16 1152	08/12/16 0758	08/12/16 0700	08/12/16 0148
				Pt asleep not displaying any discomfort/distress @ this time -MB
Sleep/Rest/Relaxation				no problem identified;appears asleep;limb movements periodically during sleep -MB
Pain Assessment: Number Scale (0-10)				
Pain Rating (0-10): Rest	0 -GW	0 -FS		
Pain Rating (0-10): Activity	0 -GW			
Sleep/Rest/Relaxation				
Daily Hours of Sleep			7.5 -CR	
Coping/Psychosocial				
Observed Emotional State	calm;cooperative -GW			
Verbalized Emotional State	hopefulness -GW			
Neuro				
Level Of Consciousness	alert -GW			asleep -MB
Orientation	oriented x 4 -GW			
General Appearance				
General Appearance WDL	WDL except;appearance -GW			
General Appearance	unkempt;unshaven;body odor -GW			
Mood/Behavior/Affect				
Mood/Behavior/Affect WDL	WDL except;all -GW			
Affect	guarded;restricted -GW			
Mood/Behavior	cooperative;positive goal-directed -GW			
Speech				
Speech	WDL -GW			
Thought Process				
Judgment and Insight	insight not appropriate to situation;judgment not appropriate to situation -GW			
Oxygen Therapy				

All Flowsheet Data (08/12/16 0000--08/14/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/12/16 1152	08/12/16 0758	08/12/16 0700	08/12/16 0148
SpO2		96 % -FS		
O2 Device		room air -FS		
Safety Interventions				
Precautions (displays in banner)	None -GW			None -MB
Fall Risk Indicators	3-->central nervous system/psychotropic medication;1-->male -GW			
Fall Risk Score	4 -GW			

Social Work Assessment

	08/14/16 1700	08/14/16 0130	08/13/16 1800
Suicide Risk			
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -HS	no self-injurious ideation or behavior indicators observed or expressed -HS	no self-injurious ideation or behavior indicators observed or expressed -HS

(r) = User Recd, (t) = User Taken, (c) = User Cosigned

User Key

Initials	Name	Effective Dates
MB	Borja, Maryann L, RN	03/12/15 -
GW	Webb, Gina Marie, RN	07/02/15 -
MA	Abend, Marquel Marie, RN	11/10/15 -
EA	Angeles Pagtakhan, Edna R, RN	02/05/15 -
JH	Han, Janet Z, RN	02/05/15 -
LL	Lewis, Linda A, CNA	07/02/15 -
RM	MacLean, Robert A	03/31/16 -
CR	Richardson, Cleo, RN	02/05/15 -
FS	Sepulveda, Francis R	04/06/16 -
AS	Smith, Arthur L, CNA	07/02/15 -
HS	Smith, Hilda, RN	02/05/15 -
JT	Tamo, Josefina E, LVN	02/05/15 -
SI	Iwamura, Scott, RD	03/12/15 -

All Flowsheet Data (08/09/16 0000--08/11/16 2359)

MAR MINI-FLOWSHEET DATA

	08/11/16 1947	08/11/16 0800	08/10/16 1600	08/10/16 0730	08/10/16 0000
Pain					
Pain Rating (0-10): Rest	0 -FG	0 -RE	0 -AR	0 -JM	0 wearing pain patch to rt chest -JB
Pain Rating (0-10): Activity	0 -FG	0 -RE			0 -JB
	08/09/16 2216	08/09/16 2130			
Pain					
Pain Rating (0-10): Rest	0 -AS	0 -LD			
Pain Rating (0-10): Activity	0 -AS	0 -LD			

CARE PLAN MINI-FLOWSHEET DATA

	08/11/16 1947	08/11/16 1417	08/11/16 0800	08/10/16 1805	08/10/16 1221
Depression (Adult,Obstetrics,Pediatric)					
Establish/Maintain Self-Care Routine					making progress toward outcome -MM
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -FG	patient -RE	patient -RE	patient -AR	patient -MM
Plan of Care Review					
Progress	progress towards functional goals is fair -FG				progress toward functional goals is gradual -MM
	08/10/16 1220	08/10/16 1109	08/10/16 0256	08/09/16 2208	
Suicide Risk					
Suicide Risk: Related Risk Factors				mental health diagnosis;previous suicide attempt -AS	
Signs and Symptoms (Suicide Risk)				overwhelming hopelessness/helplessness;suicidal ideation/intent/plan -AS	
Depression					
Related Risk Factors (Depression)				abuse history;history of depression;prior suicide attempt -AS	
Signs and Symptoms (Depression)				appetite changes;negative outlook;overwhelmed;suicidal/homicidal behaviors/thoughts;weight gain or loss, excessive -AS	

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

CARE PLAN MINI-FLOWSHEET DATA (continued)

	08/10/16 1220	08/10/16 1109	08/10/16 0256	08/09/16 2208
Suicide Risk (Adult,Obstetrics,Pediatric)				
Strength-Based Wellness/Recovery	making progress toward outcome -MM			
Physical Safety	making progress toward outcome -MM		making progress toward outcome -JB	
Depression (Adult,Obstetrics,Pediatric)				
Improved/Stable Mood	making progress toward outcome -MM		making progress toward outcome -JB	
Coping/Psychosocial Response Interventions				
Plan Of Care Reviewed With		patient -MM	patient -JB	

Custom Formula Data

	08/09/16 2220	08/09/16 2130
Nutritional Screening Tool (modified PG-SGA) If Total: Calculated Risk Score for Cancer is 4 or greater, intervention by dietitian, in conjunction with nurse or physician, is strongly indicated.		
Percent weight Change		0 % -LD
Score For Calculated % weight Change Value		0 -LD
Anthropometrics		
IBW		67.13 -LD
Weight Information		
IBW (Calculated - kg)		67.1 kg -LD
EBW (Calculated - kg)		-8.6 kg -LD
Vital Signs		
Predicted Body Weight (kg)		66.1 kg -LD
Healthy Eating		
Weight change (+/-)		0 -LD
Ideal Body Weight (IBW)		
Ideal Body Weight (IBW), (kg)		68.1 -LD
% Ideal Body Weight		85.93 -LD
OTHER		
BMI (Calculated)		20.2 -LD
Pneumonia	Yes -AS	

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

Custom Formula Data (continued)

	08/09/16 2220	08/09/16 2130
Vaccine Refused		
Length and Weight		
Weight change (gms)		0 -LD

DO NOT DELETE - Nav Reporting Template

	08/11/16 1947	08/11/16 1645	08/11/16 1600	08/11/16 0800	08/11/16 0400
Vital Signs					
Temp			98.2 °F (36.8 °C) -ASA	97.8 °F (36.6 °C) -AP	
Pulse			83 -ASA	101 -AP	
BP			128/74 mmHg -ASA	**(!)** 154/92 mmHg -AP	
Patient Position			Sitting -ASA		
BP Location			Right arm -ASA		
Resp			16 -ASA	16 -AP	
Skin					
Skin WDL	WDL -FG				
Pain/Comfort, Non Labor					
Pain Rating (0-10): Rest	0 -FG			0 -RE	
Pain Rating (0-10): Activity	0 -FG			0 -RE	
Post Anesthesia					
Orientation	oriented x 4 -FG	oriented x 4 -HE		oriented x 4 -RE	
Oxygen Therapy during Labor					
SpO2				99 % -AP	
O2 Device	room air -FG				
Patient Observation					
Observations	Q15 -FG				Q15 -MB
Cognitive					
Memory Deficit	intact -FG			intact -RE	
Fall Risk Assessment					
Fall Risk Indicators	3-->central nervous system/psychotropic medication;1-->male -FG			0-->no indicators present -RE	
Fall Risk Score	4 -FG			0 -RE	
Danger to Self					
Danger to Self (WDL)	WDL -FG			WDL -RE	WDL -MB
Danger to Self				no suicidal ideation or behavior indicators observed or expressed -RE	no suicidal ideation or behavior indicators observed or expressed

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/11/16 1947	08/11/16 1645	08/11/16 1600	08/11/16 0800	08/11/16 0400
					Pt sleeping -MB
Self-Injurious Behavior				no self-injurious ideation or behavior indicators observed or expressed -RE	
Danger to Others					
Danger to Others (WDL)	WDL -FG			WDL -RE	WDL Pt sleeping -MB
Precautions/Isolation					
Precautions (displays in banner)	None -FG			None -RE	None -MB
	08/10/16 1600	08/10/16 1109	08/10/16 1000	08/10/16 0730	08/10/16 0000
Vital Signs					
Temp	98.1 °F (36.7 °C) -SD				
Pulse	77 -SD			95 -JM	
BP	117/70 mmHg -SD			113/77 mmHg -JM	
Patient Position	Sitting -SD			Sitting -JM	
BP Location	Left arm -SD			Left arm -JM	
BP Method	Automatic -SD			Automatic -JM	
Resp	16 -SD			14 -JM	
Skin					
Skin WDL	WDL except psoriasis -AR	WDL except -MM			WDL except -JB
Pain/Comfort, Non Labor					
Pain Rating (0-10): Rest	0 -AR			0 -JM	0 wearing pain patch to rt chest -JB
Pain Rating (0-10): Activity					0 -JB
General Information					
Arrived From			emergency department -CH		
Post Anesthesia					
Orientation	oriented x 4 -AR	oriented x 4 -MM			oriented x 4 -JB
Activity/Exercise/Self-Care					
Equipment Currently Used at Home			none -CH		
Oxygen Therapy during Labor					
SpO2	98 % -SD			98 % -JM	
O2 Device	room air -SD	room air -MM		room air -JM	
Patient Observation					
Observations					Q 15 -JB
Cognitive					
Memory Deficit	intact -AR	intact -MM			intact -JB
Fall Risk Assessment					

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/10/16 1600	08/10/16 1109	08/10/16 1000	08/10/16 0730	08/10/16 0000
Fall Risk Indicators	2-->depression;1-->male -AR	2-->depression;1-->male -MM			2-->depression;1-->male -JB
Fall Risk Score	3 -AR	3 -MM			3 -JB
Current Health and Illness					
Anticipated Changes Related to Illness			none -CH		
Danger to Self					
Danger to Self (WDL)	WDL -AR	WDL -MM			WDL -JB
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -AR	no suicidal ideation or behavior indicators observed or expressed -MM			no suicidal ideation or behavior indicators observed or expressed -JB
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -AR	no self-injurious ideation or behavior indicators observed or expressed -MM	no self-injurious ideation or behavior indicators observed or expressed -CH		no self-injurious ideation or behavior indicators observed or expressed -JB
Pain/Comfort/Sleep Interventions					
Sleep/Rest Enhancement					awakenings minimized;noise level reduced;regular sleep/rest pattern promoted -JB
Discharge Needs Assessment					
Concerns To Be Addressed			care coordination/care conferences;coping/stress concerns;mental health concerns;suicidal concerns -CH		
Concerns Comments			This is pt's first suicide attempt/gesture. He lives alone. He denies any family hx of suicide attempts or gestures. Will contact his case		

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/10/16 1600	08/10/16 1109	08/10/16 1000	08/10/16 0730	08/10/16 0000
			manager for collateral information and request his current medication list. Consider referral to PHP program. -CH		
Readmission Within The Last 30 Days			no previous admission in last 30 days -CH		
Community Agency Name(S)			Oakland Community Support Services. -CH		
Equipment Needed After Discharge			none -CH		
Discharge Facility/Level Of Care Needs			other (see comments) Home, referral to PHP -CH		
Transportation Available			public transportation -CH		
Current Discharge Risk			lives alone;psychiatric illness -CH		
Discharge Disposition			still a patient -CH		
Discharge Planning Comments			See SW Plan -CH		
Danger to Others					
Danger to Others (WDL)	WDL -AR	WDL -MM			WDL -JB
Precautions/Isolation					
Precautions (displays in banner)	Suicide -AR	Suicide -MM			Suicide -JB
	08/09/16 2248	08/09/16 2226	08/09/16 2224	08/09/16 2220	08/09/16 2217
General Information					
How to be Addressed					Vincent -AS
Preferred Language					English -AS
Interpreter Needed					no -AS
Communication					0-->understands/communicates

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/09/16 2248	08/09/16 2226	08/09/16 2224	08/09/16 2220	08/09/16 2217
					without difficulty -AS
Is patient able to participate in admission?					Yes -AS
Arrived From					emergency department -AS
Is there someone we should notify about your admission?					no -AS
Health and Illness History					
Previous General Health		good -AS			
Post Anesthesia					
Orientation	oriented x 4 -AS				
Skin Review of Systems					
Skin Conditions			psoriasis all over chest and legs -AS		
Activity/Exercise/Self-Care					
Is the person deaf or does he/she have serious difficulty hearing?			No -AS		
Is this person blind or does he/she have serious difficulty seeing even when wearing glasses?			No -AS		
Does this person have serious difficulty walking or climbing stairs?			No -AS		
Does this person have difficulty with toileting, bathing, dressing or eating?			No -AS		
Because of a physical, mental, or emotional			Yes -AS		

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/09/16 2248	08/09/16 2226	08/09/16 2224	08/09/16 2220	08/09/16 2217
condition, does this person have difficulty doing errands alone such as visiting a doctor's office or shopping?					
Because of a physical, mental, or emotional condition, does this person have serious difficulty concentrating, remembering, or making decisions?			Yes -AS		
Braden Risk Assessment					
Sensory Perception				4-->no impairment -AS	
Moisture				4-->rarely moist -AS	
Activity				3-->walks occasionally -AS	
Mobility				4-->no limitation -AS	
Nutrition				2-->probably inadequate -AS	
Friction and Shear				3-->no apparent problem -AS	
Braden Score				20 -AS	
Functional/Cognitive Screening					
Change in Functional Status Since Onset of Current Illness/Injury			no -AS		
Immunizations					
If no contraindications, would patient like to receive the pneumococcal vaccination?				no -AS	
Has the patient				Will assess later	

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/09/16 2248	08/09/16 2226	08/09/16 2224	08/09/16 2220	08/09/16 2217
received the Influenza vaccine this season				during this hospital stay -AS	
Communicable Diseases					
MRSA Screening for Nasal Swab Culture				no - does not meet criteria for nasal swab culture -AS	
Recent Exposure to Communicable Disease				none -AS	
Communicable Disease History				none -AS	
Recent Travel				no -AS	
Exposure to Resistant Organisms				none -AS	
Nutrition/Metabolic					
Current Appetite				poor -AS	
Nutrition Comment				past 2 weeks pt has lost "a lot" of weight -AS	
Advance Directive (Medical Healthcare)					
Advance Directive (Medical Healthcare)					no -AS
Chronic Pain					
Chronic Pain			yes chronic pelvic pain syndrome and fibromyalgia -AS		
Pain Rating at Rest			0 -AS		
Pain Rating with Activity			0 -AS		
Chronic Pain Comment			pt has a Butran 10mcg/h patch on at time of admission -AS		
TB Risk					
TB Screen				No -AS	
Cognitive					
Memory Deficit	intact -AS				
Abuse					
Are You or Have You Been Threatened or				yes hx of childhood sexual abuse from ages 4-9 -	

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/09/16 2248	08/09/16 2226	08/09/16 2224	08/09/16 2220	08/09/16 2217
Abused Physically, Emotionally, or Sexually By A Partner/Spouse/ Family Member?				AS	
Do You Feel Unsafe Going Back to the Place Where You Are Living?				no -AS	
Fall Risk Assessment					
Fall Risk Indicators				1-->male;2-->depression -AS	
Fall Risk Score				3 -AS	
Current Health and Illness					
Reason for Admission as Stated by Patient					"I have severe Paxil withdraw, panic attacks and SI" -AS
Referrals					
Referrals		dietitian/nutrition services -AS			
Danger to Self					
Danger to Self (WDL)	WDL -AS			WDL -AS	
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -AS			no suicidal ideation or behavior indicators observed or expressed -AS	
Keeps Self Safe	yes (describe) -AS				
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -AS				
Agreement not to Harm Self	yes (describe) -AS				
Description of Agreement	verbal contract -AS				
Discharge Needs Assessment					
Concerns To Be Addressed					coping/stress concerns;discharge planning concerns;suicidal concerns -AS
Readmission					no previous

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/09/16 2248	08/09/16 2226	08/09/16 2224	08/09/16 2220	08/09/16 2217
Within The Last 30 Days					admission in last 30 days -AS
Danger to Others					
Danger to Others (WDL)	WDL -AS			WDL -AS	
Precautions/Isolation					
Precautions (displays in banner)	Suicide -AS				Suicide -AS

	08/09/16 2216	08/09/16 2208	08/09/16 2130
Vital Signs			
Temp			99.5 °F (37.5 °C) -LD
Temp src			Oral -LD
Pulse			75 -LD
BP			126/88 mmHg -LD
Patient Position			Sitting -LD
BP Location			Left arm -LD
BP Method			Automatic -LD
Resp			18 -LD
Pain/Comfort, Non Labor			
Pain Rating (0-10): Rest	0 -AS		0 -LD
Pain Rating (0-10): Activity	0 -AS		0 -LD
Comfort/Acceptable Pain Level			0 -LD
Oxygen Therapy during Labor			
SpO2			100 % -LD
O2 Device			room air -LD
Suicide Risk			
Suicide Risk: Related Risk Factors		mental health diagnosis;previous suicide attempt -AS	
Signs and Symptoms (Suicide Risk)		overwhelming hopelessness/helplessness;suicidal ideation/intent/plan -AS	
Height and Weight			
Height			1.702 m (5' 7") -LD
Weight			58.514 kg (129 lb) -LD
Weight Source			Standing -LD
BSA (Calculated - sq m)			1.66 sq meters -LD
BMI (kg/m2)			20.25 -LD
BMI (Calculated)			20.2 -LD

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

DO NOT DELETE - Nav Reporting Template (continued)

	08/09/16 2216	08/09/16 2208	08/09/16 2130
Length and Weight			
Weight change (gms)			0 -LD

BH PS Main

	08/11/16 1947	08/11/16 0800	08/11/16 0400	08/10/16 1600	08/10/16 1109
Legal Status					
Legal status	voluntary -FG	voluntary -RE	voluntary -MB	voluntary -AR	5150 - involuntary -MM
Legal Status - 5150					
Start Date 5150		-- -PR			08/09/16 -MM
Start Time 5150		-- -PR			0925 -MM
End Date 5150		-- -PR			08/12/16 -MM
End Time 5150		-- -PR			0925 -MM
Risk Assessment					
Danger to Self (WDL)	WDL -FG	WDL -RE	WDL -MB	WDL -AR	WDL -MM
Danger to Self		no suicidal ideation or behavior indicators observed or expressed -RE	no suicidal ideation or behavior indicators observed or expressed Pt sleeping -MB	no suicidal ideation or behavior indicators observed or expressed -AR	no suicidal ideation or behavior indicators observed or expressed -MM
Self-Injurious Behavior		no self-injurious ideation or behavior indicators observed or expressed -RE		no self-injurious ideation or behavior indicators observed or expressed -AR	no self-injurious ideation or behavior indicators observed or expressed -MM
Assessment timing		Shift -RE		Shift -AR	Shift -MM
Assessment of Risk Factors				History of childhood physicial/sexual abuse;Prior suicide attempts -AR	History of childhood physicial/sexual abuse;Prior suicide attempts -MM
Assessment of Protective Factors				Good access to health care/therapy -AR	Good access to health care/therapy -MM
Agitation		Low -RE		None -AR	None -MM
Anxiety or Fearfulness				Moderate -AR	Moderate -MM
Loss of Pleasure or Interest				Moderate -AR	Moderate -MM
Depression or Sadness				Moderate -AR	Moderate -MM
Suicide Plan for				None -AR	None -MM

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH PS Main (continued)

	08/11/16 1947	08/11/16 0800	08/11/16 0400	08/10/16 1600	08/10/16 1109
Today					
Hopeless or Overwhelmed				High -AR	High -MM
Sleep Disturbances		None -RE		Moderate -AR	Moderate -MM
Cognition Problems				None -AR	None -MM
Psychotic Symptoms				None -AR	None -MM
Withholding Information		None -RE		None -AR	None -MM
Resistance to Treatment				None -AR	None -MM
Impulsivity				None -AR	None -MM
Aggressive towards self/others				None -AR	None -MM
Pain, real or perceived		Low -RE		Low -AR	None -MM
Perceived Loss of Health				Moderate -AR	Moderate -MM
Suicide Plan outside of Hospital		Low -RE		None -AR	None -MM
Lack of Support if Discharged				Low -AR	Low -MM
Pessimism if Discharged				Low -AR	Low -MM
Suicide Ideation for Today		Low -RE		None -AR	None -MM
Suicide Ideation Comments				-- "was on the wrong medication" -AR	
Behavior congruent with Verbal and Non-Verbal				Yes -AR	Yes -MM
Assessment of Current Suicide Risk				low while in the hospital -AR	low while in the hospital -MM
Danger to Others (WDL)	WDL -FG	WDL -RE	WDL Pt sleeping -MB	WDL -AR	WDL -MM
	08/10/16 1000	08/10/16 0000	08/09/16 2248	08/09/16 2226	08/09/16 2220
Legal Status					
Legal status		5150 - involuntary -JB	5150 - involuntary -AS		
Legal Status - 5150					
Start Date 5150		08/09/16 -JB	08/09/16 -AS		
Start Time 5150		0925 -JB	0925 -AS		

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH PS Main (continued)

	08/10/16 1000	08/10/16 0000	08/09/16 2248	08/09/16 2226	08/09/16 2220
End Date 5150		08/12/16 -JB	08/12/16 -AS		
End Time 5150		0925 -JB	0925 -AS		
Current Situation					
Lives With	alone -CH				
Living Arrangements	apartment -CH				
Risk Assessment					
Danger to Self (WDL)		WDL -JB	WDL -AS		WDL -AS
Danger to Self		no suicidal ideation or behavior indicators observed or expressed -JB	no suicidal ideation or behavior indicators observed or expressed -AS		no suicidal ideation or behavior indicators observed or expressed -AS
Keeps Self Safe			yes (describe) -AS		
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -CH	no self-injurious ideation or behavior indicators observed or expressed -JB	no self-injurious ideation or behavior indicators observed or expressed -AS		
Agreement not to Harm Self			yes (describe) -AS		
Description of Agreement			verbal contract -AS		
Assessment timing		Shift -JB	Admission -AS		
Assessment of Risk Factors		History of childhood physicial/sexual abuse;Prior suicide attempts -JB	Prior suicide attempts;Sense of powerlessness/hopelessness -AS		
Assessment of Protective Factors		Good access to health care/therapy -JB	Good access to health care/therapy -AS		
Agitation		None -JB	None -AS		
Anxiety or Fearfulness		Moderate -JB	Moderate -AS		
Loss of Pleasure or Interest		Moderate -JB	Moderate -AS		
Depression or Sadness		Moderate -JB	Moderate -AS		
Suicide Plan for Today		None -JB	None -AS		
Hopeless or Overwhelmed		High -JB	High -AS		
Sleep		Moderate -JB	Low -AS		

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH PS Main (continued)

	08/10/16 1000	08/10/16 0000	08/09/16 2248	08/09/16 2226	08/09/16 2220
Disturbances					
Cognition Problems		None -JB	None -AS		
Psychotic Symptoms		None -JB	None -AS		
Withholding Information		None -JB	None -AS		
Resistance to Treatment		None -JB	None -AS		
Impulsivity		None -JB	None -AS		
Aggressive towards self/others		None -JB	None -AS		
Pain, real or perceived		None -JB	None -AS		
Perceived Loss of Health		Moderate -JB	Moderate -AS		
Suicide Plan outside of Hospital		None -JB			
Lack of Support if Discharged		Low -JB			
Pessimism if Discharged		Low -JB			
Suicide Ideation for Today		None -JB	None -AS		
Behavior congruent with Verbal and Non-Verbal		Yes -JB	Yes -AS		
Assessment of Current Suicide Risk		low while in the hospital -JB	low in hospital, higher if discharged -AS		
Danger to Others (WDL)		WDL -JB	WDL -AS		WDL -AS
Abuse					
Are You or Have You Been Threatened or Abused Physically, Emotionally, or Sexually By A Partner/Spouse/ Family Member?					yes hx of childhood sexual abuse from ages 4-9 -AS
Do You Feel Unsafe Going Back to the					no -AS

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH PS Main (continued)

	08/10/16 1000	08/10/16 0000	08/09/16 2248	08/09/16 2226	08/09/16 2220
Place Where You Are Living?					
Major Change/Loss/Stressor					
Major Change/Loss/Stressor	other (see comments) recent tapering of his psych medications -CH			none -AS	

	08/09/16 2219	08/09/16 2217
Current Situation		
How to be Addressed		Vincent -AS
Lives With	alone -AS	
Living Arrangements	apartment -AS	

BH Tx Plan MH IP

	08/10/16 1210
Patient Assets/Stressors	
Patient Assets	general fund of knowledge;average or above intelligence;motivation for treatment/growth;capable of independent living;supportive family/friends;work skills;physical health;ability for insight;communication skills -WR
Patient Stressors	medication change or non-compliance -WR
Discharge Planning	
Discharge Criteria	improved stabilization in mood, thinking and/or behavior;verbal commitment to aftercare and medication compliance -WR
Recommended Discharge Plan	return to previous living environment;medication management with psychiatrist or

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Tx Plan MH IP (continued)

	08/10/16 1210
	other physician -WR
Pt's Acceptance of Discharge Plan	yes -WR
Why Continues to Need Hospitalization	severe impairment of level of functioning;danger to self or others;medication stabilization -WR
Estimated Length of Stay	3-5 days -WR
Provisional DSM 5 Diagnoses	
Problem Being Addressed	refer to problem list -WR
Goal: Will work with social worker/treatment coordinator to develop safe discharge plan	
Goal Status	goal initiated -WR
Goal: Will attend Occupational Therapy groups up to seven days weekly as tolerated	
Objectives	increase coping skills -WR
Goal Status	progress made toward outcome -WR
Treatment Plan Reviewed by	
Physician	Fitzpatrick -WR
Psychiatric Social Worker	Himot -WR
Registered Nurse	Robertson -WR

VS Simple

	08/11/16 1947	08/11/16 1600	08/11/16 0800	08/11/16 0400	08/10/16 1600
Vital Signs					
Temp		98.2 °F (36.8 °C) -ASA	97.8 °F (36.6 °C) -AP		98.1 °F (36.7 °C) -SD
Pulse		83 -ASA	101 -AP		77 -SD
Pulse Source					Oximetry -SD
BP		128/74 mmHg -ASA	**(!)** 154/92 mmHg -AP		117/70 mmHg -SD
Patient Position		Sitting -ASA			Sitting -SD
BP Location		Right arm -ASA			Left arm -SD
BP Method					Automatic -SD
Resp		16 -ASA	16 -AP		16 -SD
Oxygen Therapy					
SpO2			99 % -AP		98 % -SD
O2 Device	room air -FG				room air -SD
Pain/Comfort/Sleep					
Preferred Pain	number (Numeric			number (Numeric	

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

VS Simple (continued)

	08/11/16 1947	08/11/16 1600	08/11/16 0800	08/11/16 0400	08/10/16 1600
Scale	Rating Pain Scale) -FG			Rating Pain Scale) Pt sleeping -MB	
Sleep/Rest/Relaxation			no problem identified -RE	no problem identified;appears asleep;limb movements periodically during sleep -MB	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -FG		0 -RE		0 -AR
Pain Rating (0-10): Activity	0 -FG		0 -RE		
Patient Observation					
Observations	Q15 -FG			Q15 -MB	

	08/10/16 1109	08/10/16 0730	08/10/16 0630	08/10/16 0000	08/09/16 2216
Vital Signs					
Pulse		95 -JM			
Pulse Source		Oximetry -JM			
BP		113/77 mmHg -JM			
Patient Position		Sitting -JM			
BP Location		Left arm -JM			
BP Method		Automatic -JM			
Resp		14 -JM			
Oxygen Therapy					
SpO2		98 % -JM			
O2 Device	room air -MM	room air -JM			
Pain/Comfort/Sleep					
Preferred Pain Scale				number (Numeric Rating Pain Scale) -JB	number (Numeric Rating Pain Scale) -AS
Sleep/Rest/Relaxation			no problem identified -JB	awake;difficulty falling asleep pt stated his rouine is to fall asleep by midnight -JB	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -JM		0 wearing pain patch to rt chest -JB	0 -AS
Pain Rating (0-10): Activity				0 -JB	0 -AS
Patient Observation					
Observations				Q 15 -JB	

	08/09/16 2130
Vital Signs	
Temp	99.5 °F (37.5 °C) -LD
Temp src	Oral -LD
Pulse	75 -LD

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

VS Simple (continued)

	08/09/16 2130
Pulse Source	Oximetry -LD
BP	126/88 mmHg -LD
Patient Position	Sitting -LD
BP Location	Left arm -LD
BP Method	Automatic -LD
Resp	18 -LD
Oxygen Therapy	
SpO2	100 % -LD
O2 Device	room air -LD
Pain/Comfort/Sleep	
Preferred Pain Scale	number (Numeric Rating Pain Scale) -LD
Pain Assessment: Number Scale (0-10)	
Pain Rating (0-10): Rest	0 -LD
Pain Rating (0-10): Activity	0 -LD
Comfort/Acceptable Pain Level	0 -LD
Height and Weight	
Height	1.702 m (5' 7") -LD
Weight	58.514 kg (129 lb) -LD
Weight Source	Standing -LD
BSA (Calculated - sq m)	1.66 sq meters -LD
BMI (kg/m2)	20.25 -LD
BMI (Calculated)	20.2 -LD

VS Simple

	08/11/16 1947	08/11/16 1600	08/11/16 0800	08/11/16 0400	08/10/16 1600
Vital Signs					
Temp		98.2 °F (36.8 °C) -ASA	97.8 °F (36.6 °C) -AP		98.1 °F (36.7 °C) -SD
Pulse		83 -ASA	101 -AP		77 -SD
Pulse Source					Oximetry -SD
BP		128/74 mmHg -ASA	**(!)** 154/92 mmHg -AP		117/70 mmHg -SD
Patient Position		Sitting -ASA			Sitting -SD
BP Location		Right arm -ASA			Left arm -SD
BP Method					Automatic -SD
Resp		16 -ASA	16 -AP		16 -SD
Oxygen Therapy					
SpO2			99 % -AP		98 % -SD
O2 Device	room air -FG				room air -SD
Pain/Comfort					
Preferred Pain	number (Numeric			number (Numeric	

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

VS Simple (continued)

	08/11/16 1947	08/11/16 1600	08/11/16 0800	08/11/16 0400	08/10/16 1600
Scale	Rating Pain Scale) -FG			Rating Pain Scale) Pt sleeping -MB	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -FG		0 -RE		0 -AR
Pain Rating (0-10): Activity	0 -FG		0 -RE		
Patient Observation					
Observations	Q15 -FG			Q15 -MB	

	08/10/16 1109	08/10/16 0730	08/10/16 0000	08/09/16 2216	08/09/16 2130
Height and Weight					
Height					1.702 m (5' 7") -LD
Weight					58.514 kg (129 lb) -LD
Weight Source					Standing -LD
BSA (Calculated - sq m)					1.66 sq meters -LD
BMI (kg/m2)					20.25 -LD
BMI (Calculated)					20.2 -LD
Vital Signs					
Temp					99.5 °F (37.5 °C) -LD
Temp src					Oral -LD
Pulse		95 -JM			75 -LD
Pulse Source		Oximetry -JM			Oximetry -LD
BP		113/77 mmHg -JM			126/88 mmHg -LD
Patient Position		Sitting -JM			Sitting -LD
BP Location		Left arm -JM			Left arm -LD
BP Method		Automatic -JM			Automatic -LD
Resp		14 -JM			18 -LD
Oxygen Therapy					
SpO2		98 % -JM			100 % -LD
O2 Device	room air -MM	room air -JM			room air -LD
Pain/Comfort					
Preferred Pain Scale			number (Numeric Rating Pain Scale) -JB	number (Numeric Rating Pain Scale) -AS	number (Numeric Rating Pain Scale) -LD
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -JM	0 wearing pain patch to rt chest -JB	0 -AS	0 -LD
Pain Rating (0-10): Activity			0 -JB	0 -AS	0 -LD
Comfort/Acceptable Pain Level					0 -LD
Patient Observation					

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

VS Simple (continued)

	08/10/16 1109	08/10/16 0730	08/10/16 0000	08/09/16 2216	08/09/16 2130
Observations			Q 15 -JB		

Pain Scales

	08/11/16 1947	08/11/16 0800	08/11/16 0400	08/10/16 1600	08/10/16 0730
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -FG		number (Numeric Rating Pain Scale) Pt sleeping -MB		
Sleep/Rest/Relaxation		no problem identified -RE	no problem identified;appears asleep;limb movements periodically during sleep -MB		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -FG	0 -RE		0 -AR	0 -JM
Pain Rating (0-10): Activity	0 -FG	0 -RE			

	08/10/16 0630	08/10/16 0000	08/09/16 2216	08/09/16 2130
Pain/Comfort/Sleep				
Preferred Pain Scale		number (Numeric Rating Pain Scale) -JB	number (Numeric Rating Pain Scale) -AS	number (Numeric Rating Pain Scale) -LD
Sleep/Rest/Relaxation	no problem identified -JB	awake;difficulty falling asleep pt stated his rouine is to fall asleep by midnight -JB		
Pain Assessment: Number Scale (0-10)				
Pain Rating (0-10): Rest		0 wearing pain patch to rt chest -JB	0 -AS	0 -LD
Pain Rating (0-10): Activity		0 -JB	0 -AS	0 -LD
Comfort/Acceptable Pain Level				0 -LD

Pain Reassessment

	08/11/16 1947	08/11/16 0800	08/11/16 0400	08/10/16 1600	08/10/16 0730
Pain/Comfort/Sleep					
Sleep/Rest/Relaxation		no problem identified -RE	no problem identified;appears asleep;limb movements periodically during sleep -MB		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -FG	0 -RE		0 -AR	0 -JM
Pain Rating (0-	0 -FG	0 -RE			

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

Pain Reassessment (continued)

	08/11/16 1947	08/11/16 0800	08/11/16 0400	08/10/16 1600	08/10/16 0730
10): Activity					
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -FG		number (Numeric Rating Pain Scale) Pt sleeping -MB		
	08/10/16 0630	08/10/16 0000	08/09/16 2216	08/09/16 2130	
Pain/Comfort/Sleep					
Sleep/Rest/Relaxation	no problem identified -JB	awake;difficulty falling asleep pt stated his rouine is to fall asleep by midnight -JB			
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 wearing pain patch to rt chest -JB	0 -AS	0 -LD	
Pain Rating (0-10): Activity		0 -JB	0 -AS	0 -LD	
Comfort/Acceptable Pain Level				0 -LD	
Pain/Comfort					
Preferred Pain Scale		number (Numeric Rating Pain Scale) -JB	number (Numeric Rating Pain Scale) -AS	number (Numeric Rating Pain Scale) -LD	

Social Factors

	08/10/16 1000	08/09/16 2219
Roles/Relationships		
Significant Relationships		friend -AS
Provides Primary Care For	no one -CH	no one -AS
Living Environment		
Lives With	alone -CH	alone -AS
Living Arrangements	apartment -CH	apartment -AS
Transportation Available	public transportation -CH	

Personal/Mutuality

	08/10/16 1000	08/09/16 2226
Health and Illness History		
Previous General Health		good -AS
Self-Perception/Self-Concept		
Words to Describe Yourself		"I am traumatized" -AS
Do You Like Yourself		other (see comments)

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

Personal/Mutuality (continued)

	08/10/16 1000	08/09/16 2226
		"no idea right now" -AS
Patient Personal Strengths	able to adapt;expressive of emotions;expressive of needs;flexibility;future/goal oriented;positive attitude;resourceful;successful coping history -CH	other (see comments) dicipline -AS
Coping/Stress Tolerance		
Major Change/Loss/Stressor	other (see comments) recent tapering of his psych medications -CH	none -AS
Values/Beliefs/Spiritual Care		
(F) Faith and Belief: Do you consider yourself spiritual or religious?		yes -AS
(F) Faith and Belief: Do you have spiritual beliefs that help you cope with stress?		yes -AS
(F) Faith and Belief: What gives your life meaning?		"no idea right now" -AS
(I) Importance: What importance does your faith or belief have in your life?		"no idea right now" -AS
(I) Importance: Have your beliefs influenced how you take care of yourself in this illness?		no -AS
(F) Faith: Importance of Culture, Spirituality, Religion in Life	Christian. Not currently active or involved in the chruch. -CH	

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

Personal/Mutuality (continued)

	08/10/16 1000	08/09/16 2226
Mutuality/Individual Preferences		
Patient Specific Goals		to get help in the hospital -AS
Patient Specific Interventions		pain mangagment -AS
Referrals		
Referrals		dietitian/nutrition services -AS

BH Daily Assess

	08/11/16 1947	08/11/16 1645	08/11/16 1600	08/11/16 1417	08/11/16 0800
Legal Status					
Legal status	voluntary -FG				voluntary -RE
Legal Status - 5150					
Start Date 5150					-- -PR
Start Time 5150					-- -PR
End Date 5150					-- -PR
End Time 5150					-- -PR
Vital Signs					
Temp			98.2 °F (36.8 °C) -ASA		97.8 °F (36.6 °C) -AP
Pulse			83 -ASA		101 -AP
BP			128/74 mmHg -ASA		**(!)** 154/92 mmHg -AP
Patient Position			Sitting -ASA		
BP Location			Right arm -ASA		
Resp			16 -ASA		16 -AP
Patient Observation					
Observations	Q15 -FG				
Oxygen Therapy					
SpO2					99 % -AP
O2 Device	room air -FG				
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -FG				
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -FG				0 -RE
Pain Rating (0-10): Activity	0 -FG				0 -RE
Skin WDL					
Skin WDL	WDL -FG				
HEENT					
HEENT WDL	WDL -FG				
Fall Risk Assessment					
Fall Risk Indicators	3-->central nervous				0-->no indicators

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Daily Assess (continued)

	08/11/16 1947	08/11/16 1645	08/11/16 1600	08/11/16 1417	08/11/16 0800
	system/psychotropic medication;1-->male -FG				present -RE
Fall Risk Score	4 -FG				0 -RE
Patient Rights Denials					
Rights Denied or Restrictions Imposed	no -FG				no -RE
Precautions/Isolation					
Precautions (displays in banner)	None -FG				None -RE
Precautions Interventions					
Interventions Performed	yes -FG				yes -RE
Level of Observation	every 30 minutes -FG				every 15 minutes -RE
Activities of Daily Living					
ADL's (WDL)	WDL showered -FG				
Daily Sleep					
Daily Sleep (WDL)					WDL -RE
Sleep/Rest/Relaxation					no problem identified -RE
Mental Status					
Orientation	oriented x 4 -FG	oriented x 4 -HE			oriented x 4 -RE
Level Of Consciousness	alert -FG				alert -RE
General Appearance WDL	WDL -FG				WDL except -RE
General Appearance	-- showered, clean gowns -FG	unkempt -HE			unkempt -RE
Mood	calm;hopeful -FG	anxious;depressed -HE			anxious;depressed -RE
Mood/Behavior/Affect WDL					WDL except -RE
Behavior (WDL)	WDL -FG				WDL -RE
Mood/Behavior	cooperative;positive goal-directed -FG				anxious -RE
Speech	WDL -FG				WDL except -RE
Speech	clear -FG	clear;hyperverbal -HE			clear;hyperverbal -RE
Judgment and Insight	judgment appropriate to situation -FG				insight appropriate to situation;judgment appropriate to

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Daily Assess (continued)

	08/11/16 1947	08/11/16 1645	08/11/16 1600	08/11/16 1417	08/11/16 0800
					situation -RE
Insight	fair -FG				fair -RE
Concentration	fair -FG				fair -RE
Memory Deficit	intact -FG				intact -RE
Thought (WDL)	WDL -FG				WDL -RE
Thought Process		disorganized perseverated -HE			
Coping/Psychosocial Response					
Observed Emotional State	calm;cooperative -FG				anxious -RE
Verbalized Emotional State	hopefulness -FG				
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -FG			patient -RE	patient -RE
Psychiatric Symptoms					
Anxiety Symptoms (WDL)	WDL -FG				WDL -RE
Anxiety Symptoms					generalized -RE
Manic Symptoms (WDL)	WDL -FG				WDL -RE
Manic Symptoms					no problems reported or observed. -RE
Psychotic symptoms (WDL)	WDL -FG				WDL -RE
Danger to Self					
Danger to Self (WDL)	WDL -FG				WDL -RE
Danger to Self					no suicidal ideation or behavior indicators observed or expressed -RE
Self-Injurious Behavior					no self-injurious ideation or behavior indicators observed or expressed -RE
Assessment Type					
Assessment timing					Shift -RE
Suicide Risk Assessment- Mood					

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Daily Assess (continued)

	08/11/16 1947	08/11/16 1645	08/11/16 1600	08/11/16 1417	08/11/16 0800
Agitation					Low -RE
Suicide Risk Assessment - Thinking					
Sleep Disturbances					None -RE
Suicide Risk Assessment- Behavior					
Withholding Information					None -RE
Suicide Risk Assessment- Health					
Pain, real or perceived					Low -RE
Suicide Risk Assessment- Discharge (for hospitalized patients only)					
Suicide Plan outside of Hospital					Low -RE
Suicidal Inquiry					
Suicide Ideation for Today					Low -RE
Danger to Others					
Danger to Others (WDL)	WDL -FG				WDL -RE

	08/11/16 0600	08/11/16 0400	08/10/16 1805	08/10/16 1600	08/10/16 1221
Legal Status					
Legal status		voluntary -MB		voluntary -AR	
Vital Signs					
Temp				98.1 °F (36.7 °C) -SD	
Pulse				77 -SD	
Pulse Source				Oximetry -SD	
BP				117/70 mmHg -SD	
Patient Position				Sitting -SD	
BP Location				Left arm -SD	
BP Method				Automatic -SD	
Resp				16 -SD	
Patient Observation					
Observations		Q15 -MB			
Oxygen Therapy					
SpO2				98 % -SD	
O2 Device				room air -SD	
Pain/Comfort					
Preferred Pain Scale		number (Numeric Rating Pain Scale) Pt sleeping -MB			
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest				0 -AR	
Skin WDL					
Skin WDL				WDL except psoriasis -AR	

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Daily Assess (continued)

	08/11/16 0600	08/11/16 0400	08/10/16 1805	08/10/16 1600	08/10/16 1221
Fall Risk Assessment					
Fall Risk Indicators				2-->depression;1-->male -AR	
Fall Risk Score				3 -AR	
Patient Rights Denials					
Rights Denied or Restrictions Imposed				no -AR	
Precautions/Isolation					
Precautions (displays in banner)		None -MB		Suicide -AR	
Precautions Interventions					
Level of Observation				every 15 minutes -AR	
Suicide Precautions				potential cords (belt, shoe laces, scarves, ties, etc.) removed from patient's possession -AR	
Self Harm Precautions				every 15 minute checks -AR	
Daily Sleep					
Daily Sleep (WDL)		WDL -MB			
Sleep/Rest/Relaxation		no problem identified;appears asleep;limb movements periodically during sleep -MB			
Daily Hours of Sleep	7.5 -CR				
Nutritional Intake					
Dinner (%)				100 % -AR	
Mental Status					
Orientation				oriented x 4 -AR	
Level Of Consciousness		asleep -MB		alert -AR	
General Appearance				unkempt -AR	
Mood				calm -AR	
Mood/Behavior/Affect WDL				WDL except;mood/behavior -AR	
Behavior (WDL)		WDL Pt sleeping -MB			
Mood/Behavior				cooperative -AR	

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Daily Assess (continued)

	08/11/16 0600	08/11/16 0400	08/10/16 1805	08/10/16 1600	08/10/16 1221
Speech				clear;hyperverbal -AR	
Judgment and Insight				insight appropriate to situation -AR	
Insight				fair -AR	
Concentration				fair -AR	
Memory Deficit				intact -AR	
Thought (WDL)				WDL -AR	
Coping/Psychosocial Response					
Observed Emotional State				anxious;calm -AR	
Verbalized Emotional State				acceptance -AR	
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With			patient -AR		patient -MM
Psychiatric Symptoms					
Anxiety Symptoms (WDL)		WDL Pt sleeping -MB			
Anxiety Symptoms				generalized -AR	
Manic Symptoms (WDL)		WDL -MB			
Manic Symptoms		no problems reported or observed. Pt sleeping -MB		pressured speech hyperverbal -AR	
Psychotic symptoms (WDL)		WDL Pt sleeping -MB		WDL -AR	
Danger to Self					
Danger to Self (WDL)		WDL -MB		WDL -AR	
Danger to Self		no suicidal ideation or behavior indicators observed or expressed Pt sleeping -MB		no suicidal ideation or behavior indicators observed or expressed -AR	
Self-Injurious Behavior				no self-injurious ideation or behavior indicators observed or expressed -AR	
Assessment Type					
Assessment timing				Shift -AR	
Assessment of contributing factors					

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Daily Assess (continued)

	08/11/16 0600	08/11/16 0400	08/10/16 1805	08/10/16 1600	08/10/16 1221
Assessment of Risk Factors				History of childhood physicial/sexual abuse;Prior suicide attempts -AR	
Assessment of Protective Factors				Good access to health care/therapy -AR	
Suicide Risk Assessment- Mood					
Agitation				None -AR	
Anxiety or Fearfulness				Moderate -AR	
Loss of Pleasure or Interest				Moderate -AR	
Depression or Sadness				Moderate -AR	
Suicide Plan for Today				None -AR	
Hopeless or Overwhelmed				High -AR	
Suicide Risk Assessment - Thinking					
Sleep Disturbances				Moderate -AR	
Cognition Problems				None -AR	
Psychotic Symptoms				None -AR	
Suicide Risk Assessment- Behavior					
Withholding Information				None -AR	
Resistance to Treatment				None -AR	
Impulsivity				None -AR	
Aggressive towards self/others				None -AR	
Suicide Risk Assessment- Health					
Pain, real or perceived				Low -AR	
Perceived Loss of Health				Moderate -AR	
Suicide Risk Assessment- Discharge (for hospitalized patients only)					
Suicide Plan outside of Hospital				None -AR	
Lack of Support if Discharged				Low -AR	

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Daily Assess (continued)

	08/11/16 0600	08/11/16 0400	08/10/16 1805	08/10/16 1600	08/10/16 1221
Pessimism if Discharged				Low -AR	
Suicidal Inquiry					
Suicide Ideation for Today				None -AR	
Suicide Ideation Comments				-- "was on the wrong medication" -AR	
Behavior congruent with Verbal and Non-Verbal				Yes -AR	
Assessment of Current Suicide Risk					
Assessment of Current Suicide Risk				low while in the hospital -AR	
Danger to Others					
Danger to Others (WDL)		WDL Pt sleeping -MB		WDL -AR	

	08/10/16 1109	08/10/16 1000	08/10/16 0730	08/10/16 0630	08/10/16 0256
Legal Status					
Legal status	5150 - involuntary -MM				
Legal Status - 5150					
Start Date 5150	08/09/16 -MM				
Start Time 5150	0925 -MM				
End Date 5150	08/12/16 -MM				
End Time 5150	0925 -MM				
Vital Signs					
Pulse			95 -JM		
Pulse Source			Oximetry -JM		
BP			113/77 mmHg -JM		
Patient Position			Sitting -JM		
BP Location			Left arm -JM		
BP Method			Automatic -JM		
Resp			14 -JM		
Oxygen Therapy					
SpO2			98 % -JM		
O2 Device	room air -MM		room air -JM		
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest			0 -JM		
Skin WDL					
Skin WDL	WDL except -MM				
Fall Risk Assessment					
Fall Risk Indicators	2-->depression;1-->male -MM				
Fall Risk Score	3 -MM				
Patient Rights Denials					

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Daily Assess (continued)

	08/10/16 1109	08/10/16 1000	08/10/16 0730	08/10/16 0630	08/10/16 0256
Rights Denied or Restrictions Imposed	no -MM				
Precautions/Isolation					
Precautions (displays in banner)	Suicide -MM				
Precautions Interventions					
Interventions Performed	yes -MM				
Level of Observation	every 15 minutes -MM				
Suicide Precautions	potential cords (belt, shoe laces, scarves, ties, etc.) removed from patient's possession -MM				
Daily Sleep					
Sleep/Rest/Relaxation				no problem identified -JB	
Daily Hours of Sleep				6.5 -JB	
Mental Status					
Orientation	oriented x 4 -MM				
Level Of Consciousness	alert -MM				
General Appearance WDL	WDL except -MM				
General Appearance	unkempt -MM				
Mood	anxious;depressed;sad -MM				
Mood/Behavior/Affect WDL	WDL except;mood/behavior -MM				
Behavior (WDL)	WDL except -MM				
Mood/Behavior	anxious;alert;cooperative;flat affect -MM				
Speech	WDL except -MM				
Speech	clear;hyperverbal -MM				
Judgment and Insight	insight appropriate to situation -MM				
Insight	fair -MM				
Concentration	fair -MM				
Memory Deficit	intact -MM				

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Daily Assess (continued)

	08/10/16 1109	08/10/16 1000	08/10/16 0730	08/10/16 0630	08/10/16 0256
Thought (WDL)	WDL -MM				
Coping/Psychosocial Response					
Observed Emotional State	anxious;cooperative;flat;withdrawn -MM				
Verbalized Emotional State	frustration -MM				
Coping/Psychosocial Response Interventions					
Plan Of Care Reviewed With	patient -MM				patient -JB
Psychiatric Symptoms					
Anxiety Symptoms (WDL)	WDL except -MM				
Anxiety Symptoms	excessive anxiety or worry -MM				
Manic Symptoms (WDL)	WDL Except -MM				
Manic Symptoms	pressured speech hyperverbal -MM				
Psychotic symptoms (WDL)	WDL -MM				
Danger to Self					
Danger to Self (WDL)	WDL -MM				
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -MM				
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -MM	no self-injurious ideation or behavior indicators observed or expressed -CH			
Assessment Type					
Assessment timing	Shift -MM				
Assessment of contributing factors					
Assessment of Risk Factors	History of childhood physicial/sexual abuse;Prior suicide attempts -MM				
Assessment of Protective Factors	Good access to health care/therapy -MM				

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Daily Assess (continued)

	08/10/16 1109	08/10/16 1000	08/10/16 0730	08/10/16 0630	08/10/16 0256
Suicide Risk Assessment- Mood					
Agitation	None -MM				
Anxiety or Fearfulness	Moderate -MM				
Loss of Pleasure or Interest	Moderate -MM				
Depression or Sadness	Moderate -MM				
Suicide Plan for Today	None -MM				
Hopeless or Overwhelmed	High -MM				
Suicide Risk Assessment - Thinking					
Sleep Disturbances	Moderate -MM				
Cognition Problems	None -MM				
Psychotic Symptoms	None -MM				
Suicide Risk Assessment- Behavior					
Withholding Information	None -MM				
Resistance to Treatment	None -MM				
Impulsivity	None -MM				
Aggressive towards self/others	None -MM				
Suicide Risk Assessment- Health					
Pain, real or perceived	None -MM				
Perceived Loss of Health	Moderate -MM				
Suicide Risk Assessment- Discharge (for hospitalized patients only)					
Suicide Plan outside of Hospital	None -MM				
Lack of Support if Discharged	Low -MM				
Pessimism if Discharged	Low -MM				
Suicidal Inquiry					
Suicide Ideation for Today	None -MM				
Behavior congruent with Verbal and Non-Verbal	Yes -MM				

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Daily Assess (continued)

	08/10/16 1109	08/10/16 1000	08/10/16 0730	08/10/16 0630	08/10/16 0256
Assessment of Current Suicide Risk					
Assessment of Current Suicide Risk	low while in the hospital -MM				
Danger to Others					
Danger to Others (WDL)	WDL -MM				
Clinician Communication					
Care Provider Communication	shift report -MM				
Notification Method	exchange -MM				
Notification Reason	condition update -MM				

	08/10/16 0000	08/09/16 2248	08/09/16 2220	08/09/16 2217	08/09/16 2216
Legal Status					
Legal status	5150 - involuntary -JB	5150 - involuntary -AS			
Legal Status - 5150					
Start Date 5150	08/09/16 -JB	08/09/16 -AS			
Start Time 5150	0925 -JB	0925 -AS			
End Date 5150	08/12/16 -JB	08/12/16 -AS			
End Time 5150	0925 -JB	0925 -AS			
Patient Observation					
Observations	Q 15 -JB				
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -JB				number (Numeric Rating Pain Scale) -AS
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 wearing pain patch to rt chest -JB				0 -AS
Pain Rating (0-10): Activity	0 -JB				0 -AS
Skin WDL					
Skin WDL	WDL except -JB				
Fall Risk Assessment					
Fall Risk Indicators	2-->depression;1-->male -JB		1-->male;2-->depression -AS		
Fall Risk Score	3 -JB		3 -AS		
Patient Rights Denials					
Rights Denied or Restrictions Imposed	no -JB				
Precautions/Isolation					
Precautions (displays in banner)	Suicide -JB	Suicide -AS		Suicide -AS	

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Daily Assess (continued)

	08/10/16 0000	08/09/16 2248	08/09/16 2220	08/09/16 2217	08/09/16 2216
Precautions Interventions					
Interventions Performed	yes -JB	yes -AS			
Level of Observation	every 15 minutes -JB	every 15 minutes -AS			
Suicide Precautions	potential cords (belt, shoe laces, scarves, ties, etc.) removed from patient's possession -JB	potential cords (belt, shoe laces, scarves, ties, etc.) removed from patient's possession;patient checked for contraband -AS			
Daily Sleep					
Daily Sleep (WDL)	WDL Except -JB				
Sleep/Rest/Relaxation	awake;difficulty falling asleep pt stated his rouine is to fall asleep by midnight -JB				
Sleep/Rest Enhancement	awakenings minimized;noise level reduced;regular sleep/rest pattern promoted -JB				
Mental Status					
Orientation	oriented x 4 -JB	oriented x 4 -AS			
Level Of Consciousness	alert -JB	alert -AS			
General Appearance WDL	WDL except -JB	WDL except -AS			
General Appearance	unkempt -JB	unkempt;unshaven;bizarre appearance -AS			
Mood	anxious;depressed;sad -JB	anxious;depressed;feelings of doom;mood shifts -AS			
Mood/Behavior/Affect WDL	WDL except;mood/behavior -JB	WDL except -AS			
Behavior (WDL)	WDL except -JB	WDL except -AS			
Mood/Behavior	anxious;alert;cooperative;flat affect -JB	anxious;cooperative;hyperactive;increased energy -AS			
Speech		WDL except -AS			
Speech	clear;hyperverbal -	rapid;pressured;hy			

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Daily Assess (continued)

	08/10/16 0000	08/09/16 2248	08/09/16 2220	08/09/16 2217	08/09/16 2216
	JB	perverbal -AS			
Judgment and Insight	insight appropriate to situation -JB	insight appropriate to situation;judgment appropriate to situation -AS			
Insight	fair -JB	fair -AS			
Concentration	fair -JB	fair -AS			
Memory Deficit	intact -JB	intact -AS			
Thought (WDL)	WDL -JB	WDL -AS			
Coping/Psychosocial Response					
Observed Emotional State	anxious;cooperative;flat;withdrawn -JB				
Verbalized Emotional State	frustration voiced therapist had taken him off paxil 3 months ago -JB				
Psychiatric Symptoms					
Anxiety Symptoms (WDL)	WDL except -JB	WDL except -AS			
Anxiety Symptoms	excessive anxiety or worry -JB	excessive anxiety or worry -AS			
Manic Symptoms (WDL)	WDL Except -JB	WDL Except -AS			
Manic Symptoms	pressured speech hyperverbal -JB	flight of ideas;increased energy;pressured speech hyperverbal -AS			
Psychotic symptoms (WDL)	WDL -JB	WDL -AS			
Danger to Self					
Danger to Self (WDL)	WDL -JB	WDL -AS	WDL -AS		
Danger to Self	no suicidal ideation or behavior indicators observed or expressed -JB	no suicidal ideation or behavior indicators observed or expressed -AS	no suicidal ideation or behavior indicators observed or expressed -AS		
Keeps Self Safe		yes (describe) -AS			
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -JB	no self-injurious ideation or behavior indicators observed or expressed -AS			
Agreement not		yes (describe) -AS			

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Daily Assess (continued)

	08/10/16 0000	08/09/16 2248	08/09/16 2220	08/09/16 2217	08/09/16 2216
to Harm Self					
Description of Agreement		verbal contract -AS			
Assessment Type					
Assessment timing	Shift -JB	Admission -AS			
Assessment of contributing factors					
Assessment of Risk Factors	History of childhood physicial/sexual abuse;Prior suicide attempts -JB	Prior suicide attempts;Sense of powerlessness/hopelessness -AS			
Assessment of Protective Factors	Good access to health care/therapy -JB	Good access to health care/therapy -AS			
Suicide Risk Assessment- Mood					
Agitation	None -JB	None -AS			
Anxiety or Fearfulness	Moderate -JB	Moderate -AS			
Loss of Pleasure or Interest	Moderate -JB	Moderate -AS			
Depression or Sadness	Moderate -JB	Moderate -AS			
Suicide Plan for Today	None -JB	None -AS			
Hopeless or Overwhelmed	High -JB	High -AS			
Suicide Risk Assessment - Thinking					
Sleep Disturbances	Moderate -JB	Low -AS			
Cognition Problems	None -JB	None -AS			
Psychotic Symptoms	None -JB	None -AS			
Suicide Risk Assessment- Behavior					
Withholding Information	None -JB	None -AS			
Resistance to Treatment	None -JB	None -AS			
Impulsivity	None -JB	None -AS			
Aggressive towards self/others	None -JB	None -AS			
Suicide Risk Assessment- Health					
Pain, real or perceived	None -JB	None -AS			
Perceived Loss	Moderate -JB	Moderate -AS			

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Daily Assess (continued)

	08/10/16 0000	08/09/16 2248	08/09/16 2220	08/09/16 2217	08/09/16 2216
of Health					
Suicide Risk Assessment- Discharge (for hospitalized patients only)					
Suicide Plan outside of Hospital	None -JB				
Lack of Support if Discharged	Low -JB				
Pessimism if Discharged	Low -JB				
Suicidal Inquiry					
Suicide Ideation for Today	None -JB	None -AS			
Behavior congruent with Verbal and Non-Verbal	Yes -JB	Yes -AS			
Assessment of Current Suicide Risk					
Assessment of Current Suicide Risk	low while in the hospital -JB	low in hospital, higher if discharged -AS			
Danger to Others					
Danger to Others (WDL)	WDL -JB	WDL -AS	WDL -AS		
	08/09/16 2130				
Vital Signs					
Temp	99.5 °F (37.5 °C) -LD				
Temp src	Oral -LD				
Pulse	75 -LD				
Pulse Source	Oximetry -LD				
BP	126/88 mmHg -LD				
Patient Position	Sitting -LD				
BP Location	Left arm -LD				
BP Method	Automatic -LD				
Resp	18 -LD				
Oxygen Therapy					
SpO2	100 % -LD				
O2 Device	room air -LD				
Height and Weight					
Height	1.702 m (5' 7") -LD				
Weight	58.514 kg (129 lb) -LD				
Weight Source	Standing -LD				
BSA (Calculated - sq m)	1.66 sq meters -LD				
BMI (kg/m2)	20.25 -LD				
BMI (Calculated)	20.2 -LD				
Pain/Comfort					

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Daily Assess (continued)

	08/09/16 2130
Preferred Pain Scale	number (Numeric Rating Pain Scale) -LD
Pain Assessment: Number Scale (0-10)	
Pain Rating (0-10): Rest	0 -LD
Pain Rating (0-10): Activity	0 -LD
Comfort/Acceptable Pain Level	0 -LD

Risk Screening

	08/11/16 1947	08/11/16 0800	08/11/16 0400	08/10/16 1600	08/10/16 1109
Fall Risk Assessment					
Fall Risk Indicators	3-->central nervous system/psychotropic medication;1-->male -FG	0-->no indicators present -RE		2-->depression;1-->male -AR	2-->depression;1-->male -MM
Fall Risk Score	4 -FG	0 -RE		3 -AR	3 -MM
Danger to Self					
Danger to Self (WDL)	WDL -FG	WDL -RE	WDL -MB	WDL -AR	WDL -MM
Danger to Self		no suicidal ideation or behavior indicators observed or expressed -RE	no suicidal ideation or behavior indicators observed or expressed Pt sleeping -MB	no suicidal ideation or behavior indicators observed or expressed -AR	no suicidal ideation or behavior indicators observed or expressed -MM
Self-Injurious Behavior		no self-injurious ideation or behavior indicators observed or expressed -RE		no self-injurious ideation or behavior indicators observed or expressed -AR	no self-injurious ideation or behavior indicators observed or expressed -MM
Danger to Others					
Danger to Others (WDL)	WDL -FG	WDL -RE	WDL Pt sleeping -MB	WDL -AR	WDL -MM

	08/10/16 1000	08/10/16 0000	08/09/16 2248	08/09/16 2220
Immunizations				
If no contraindications, would patient like to receive the pneumococcal vaccination?				no -AS
Has the patient received the Influenza				Will assess later during this hospital stay -AS

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

Risk Screening (continued)

	08/10/16 1000	08/10/16 0000	08/09/16 2248	08/09/16 2220
vaccine this season				
Abuse				
Are You or Have You Been Threatened or Abused Physically, Emotionally, or Sexually By A Partner/Spouse/ Family Member?				yes hx of childhood sexual abuse from ages 4-9 - AS
Do You Feel Unsafe Going Back to the Place Where You Are Living?				no -AS
Nutrition/Metabolic				
Nutrition Risk Screen				recent unintentional weight loss -AS
Current Appetite				poor -AS
Access to Food				yes -AS
Who Prepares Meals				self -AS
Nutrition Comment				past 2 weeks pt has lost "a lot" of weight -AS
Communicable Diseases				
MRSA Screening for Nasal Swab Culture				no - does not meet criteria for nasal swab culture -AS
Recent Exposure to Communicable Disease				none -AS
Communicable Disease History				none -AS
Recent Travel				no -AS
Exposure to Resistant Organisms				none -AS
TB Risk				
TB Screen				No -AS
Fall Risk Assessment				
Fall Risk Indicators		2-->depression;1-->male -JB		1-->male;2-->depression -AS

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

Risk Screening (continued)

	08/10/16 1000	08/10/16 0000	08/09/16 2248	08/09/16 2220
Fall Risk Score		3 -JB		3 -AS
Braden Risk Assessment				
Sensory Perception				4-->no impairment -AS
Moisture				4-->rarely moist -AS
Activity				3-->walks occasionally -AS
Mobility				4-->no limitation -AS
Nutrition				2-->probably inadequate -AS
Friction and Shear				3-->no apparent problem -AS
Braden Score				20 -AS
Danger to Self				
Danger to Self (WDL)		WDL -JB	WDL -AS	WDL -AS
Danger to Self		no suicidal ideation or behavior indicators observed or expressed -JB	no suicidal ideation or behavior indicators observed or expressed -AS	no suicidal ideation or behavior indicators observed or expressed -AS
Keeps Self Safe			yes (describe) -AS	
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -CH	no self-injurious ideation or behavior indicators observed or expressed -JB	no self-injurious ideation or behavior indicators observed or expressed -AS	
Agreement not to Harm Self			yes (describe) -AS	
Description of Agreement			verbal contract -AS	
Danger to Others				
Danger to Others (WDL)		WDL -JB	WDL -AS	WDL -AS

BH Initial Eval

	08/11/16 1947	08/11/16 1645	08/11/16 1600	08/11/16 0800	08/11/16 0600
Legal Status					
Legal status	voluntary -FG			voluntary -RE	
Legal Status - 5150					
Start Date 5150				-- -PR	
Start Time 5150				-- -PR	
End Date 5150				-- -PR	
End Time 5150				-- -PR	
Evidence of Mood Disorders					
Manic Symptoms	WDL -FG			WDL -RE	

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Initial Eval (continued)

	08/11/16 1947	08/11/16 1645	08/11/16 1600	08/11/16 0800	08/11/16 0600
(WDL)					
Manic Symptoms				no problems reported or observed. -RE	
Evidence of Anxiety Disorders					
Anxiety Symptoms (WDL)	WDL -FG			WDL -RE	
Anxiety Symptoms				generalized -RE	
Danger to Self					
Danger to Self (WDL)	WDL -FG			WDL -RE	
Danger to Self				no suicidal ideation or behavior indicators observed or expressed -RE	
Self-Injurious Behavior				no self-injurious ideation or behavior indicators observed or expressed -RE	
Assessment Type					
Assessment timing				Shift -RE	
Suicide Risk Assessment- Mood					
Agitation				Low -RE	
Suicide Risk Assessment - Thinking					
Sleep Disturbances				None -RE	
Suicide Risk Assessment- Behavior					
Withholding Information				None -RE	
Suicide Risk Assessment- Health					
Pain, real or perceived				Low -RE	
Suicide Risk Assessment- Discharge (for hospitalized patients only)					
Suicide Plan outside of Hospital				Low -RE	
Suicidal Inquiry					
Suicide Ideation for Today				Low -RE	
Danger to Others					
Danger to Others (WDL)	WDL -FG			WDL -RE	
Mental Status					
Level Of	alert -FG			alert -RE	

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Initial Eval (continued)

	08/11/16 1947	08/11/16 1645	08/11/16 1600	08/11/16 0800	08/11/16 0600
Consciousness					
Orientation	oriented x 4 -FG	oriented x 4 -HE		oriented x 4 -RE	
General Appearance WDL	WDL -FG			WDL except -RE	
General Appearance	-- showered, clean gowns -FG	unkempt -HE		unkempt -RE	
Mood/Behavior/ Affect WDL				WDL except -RE	
Mood/Behavior	cooperative;positive goal-directed -FG			anxious -RE	
Speech	WDL -FG			WDL except -RE	
Speech	clear -FG	clear;hyperverbal -HE		clear;hyperverbal -RE	
Judgment and Insight	judgment appropriate to situation -FG			insight appropriate to situation;judgment appropriate to situation -RE	
Insight	fair -FG			fair -RE	
Concentration	fair -FG			fair -RE	
Memory Deficit	intact -FG			intact -RE	
Thought (WDL)		WDL except -HE			
Thought Process		disorganized perseverated -HE			
Behavior (WDL)	WDL -FG			WDL -RE	
Sleep/Rest/Relaxation					
Sleep/Rest/Relaxation				no problem identified -RE	
Daily Hours of Sleep					7.5 -CR
Vital Signs					
Temp			98.2 °F (36.8 °C) -ASA	97.8 °F (36.6 °C) -AP	
Pulse			83 -ASA	101 -AP	
BP			128/74 mmHg -ASA	**(!)** 154/92 mmHg -AP	
Patient Position			Sitting -ASA		
Resp			16 -ASA	16 -AP	
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -FG				
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -FG			0 -RE	
Pain Rating (0-10): Activity	0 -FG			0 -RE	
Fall Risk Assessment					

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Initial Eval (continued)

	08/11/16 1947	08/11/16 1645	08/11/16 1600	08/11/16 0800	08/11/16 0600
Fall Risk Indicators	3-->central nervous system/psychotropic medication;1-->male -FG			0-->no indicators present -RE	
Fall Risk Score	4 -FG			0 -RE	
	08/11/16 0400	08/10/16 1600	08/10/16 1109	08/10/16 1000	08/10/16 0730
General Information					
Arrived From				emergency department -CH	
Legal Status					
Legal status	voluntary -MB	voluntary -AR	5150 - involuntary -MM		
Legal Status - 5150					
Start Date 5150			08/09/16 -MM		
Start Time 5150			0925 -MM		
End Date 5150			08/12/16 -MM		
End Time 5150			0925 -MM		
Roles/Relationships					
Provides Primary Care For				no one -CH	
Living Environment					
Lives With				alone -CH	
Living Arrangements				apartment -CH	
Evidence of Mood Disorders					
Manic Symptoms (WDL)	WDL -MB		WDL Except -MM		
Manic Symptoms	no problems reported or observed. Pt sleeping -MB	pressured speech hyperverbal -AR	pressured speech hyperverbal -MM		
Evidence of Anxiety Disorders					
Anxiety Symptoms (WDL)	WDL Pt sleeping -MB		WDL except -MM		
Anxiety Symptoms		generalized -AR	excessive anxiety or worry -MM		
Major Change/Loss/Stressor					
Major Change/Loss/Stressor				other (see comments) recent tapering of his psych medications -CH	
Danger to Self					
Danger to Self (WDL)	WDL -MB	WDL -AR	WDL -MM		
Danger to Self	no suicidal	no suicidal	no suicidal		

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Initial Eval (continued)

	08/11/16 0400	08/10/16 1600	08/10/16 1109	08/10/16 1000	08/10/16 0730
	ideation or behavior indicators observed or expressed Pt sleeping -MB	ideation or behavior indicators observed or expressed -AR	ideation or behavior indicators observed or expressed -MM		
Self-Injurious Behavior		no self-injurious ideation or behavior indicators observed or expressed -AR	no self-injurious ideation or behavior indicators observed or expressed -MM	no self-injurious ideation or behavior indicators observed or expressed -CH	
Assessment Type					
Assessment timing		Shift -AR	Shift -MM		
Assessment of contributing factors					
Assessment of Risk Factors		History of childhood physicial/sexual abuse;Prior suicide attempts -AR	History of childhood physicial/sexual abuse;Prior suicide attempts -MM		
Assessment of Protective Factors		Good access to health care/therapy -AR	Good access to health care/therapy -MM		
Suicide Risk Assessment- Mood					
Agitation		None -AR	None -MM		
Anxiety or Fearfulness		Moderate -AR	Moderate -MM		
Loss of Pleasure or Interest		Moderate -AR	Moderate -MM		
Depression or Sadness		Moderate -AR	Moderate -MM		
Suicide Plan for Today		None -AR	None -MM		
Hopeless or Overwhelmed		High -AR	High -MM		
Suicide Risk Assessment - Thinking					
Sleep Disturbances		Moderate -AR	Moderate -MM		
Cognition Problems		None -AR	None -MM		
Psychotic Symptoms		None -AR	None -MM		
Suicide Risk Assessment- Behavior					
Withholding Information		None -AR	None -MM		
Resistance to Treatment		None -AR	None -MM		
Impulsivity		None -AR	None -MM		
Aggressive		None -AR	None -MM		

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Initial Eval (continued)

	08/11/16 0400	08/10/16 1600	08/10/16 1109	08/10/16 1000	08/10/16 0730
towards self/others					
Suicide Risk Assessment- Health					
Pain, real or perceived		Low -AR	None -MM		
Perceived Loss of Health		Moderate -AR	Moderate -MM		
Suicide Risk Assessment- Discharge (for hospitalized patients only)					
Suicide Plan outside of Hospital		None -AR	None -MM		
Lack of Support if Discharged		Low -AR	Low -MM		
Pessimism if Discharged		Low -AR	Low -MM		
Suicidal Inquiry					
Suicide Ideation for Today		None -AR	None -MM		
Suicide Ideation Comments		-- "was on the wrong medication" -AR			
Behavior congruent with Verbal and Non-Verbal		Yes -AR	Yes -MM		
Assessment of Current Suicide Risk					
Assessment of Current Suicide Risk		low while in the hospital -AR	low while in the hospital -MM		
Danger to Others					
Danger to Others (WDL)	WDL Pt sleeping -MB	WDL -AR	WDL -MM		
Mental Status					
Level Of Consciousness	asleep -MB	alert -AR	alert -MM		
Orientation		oriented x 4 -AR	oriented x 4 -MM		
General Appearance WDL			WDL except -MM		
General Appearance		unkempt -AR	unkempt -MM		
Mood/Behavior/ Affect WDL		WDL except;mood/behavior -AR	WDL except;mood/behavior -MM		
Mood/Behavior		cooperative -AR	anxious;alert;cooperative;flat affect -MM		
Speech			WDL except -MM		
Speech		clear;hyperverbal -AR	clear;hyperverbal -MM		

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Initial Eval (continued)

	08/11/16 0400	08/10/16 1600	08/10/16 1109	08/10/16 1000	08/10/16 0730
Judgment and Insight		insight appropriate to situation -AR	insight appropriate to situation -MM		
Insight		fair -AR	fair -MM		
Concentration		fair -AR	fair -MM		
Memory Deficit		intact -AR	intact -MM		
Behavior (WDL)	WDL Pt sleeping -MB		WDL except -MM		
Sleep/Rest/Relaxation					
Sleep/Rest/Relaxation	no problem identified;appears asleep;limb movements periodically during sleep -MB				
Vital Signs					
Temp		98.1 °F (36.7 °C) -SD			
Pulse		77 -SD			95 -JM
BP		117/70 mmHg -SD			113/77 mmHg -JM
Patient Position		Sitting -SD			Sitting -JM
Resp		16 -SD			14 -JM
Pain/Comfort					
Preferred Pain Scale	number (Numeric Rating Pain Scale) Pt sleeping -MB				
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 -AR			0 -JM
Fall Risk Assessment					
Fall Risk Indicators		2-->depression;1-->male -AR	2-->depression;1-->male -MM		
Fall Risk Score		3 -AR	3 -MM		
	08/10/16 0630	08/10/16 0000	08/09/16 2248	08/09/16 2226	08/09/16 2224
Legal Status					
Legal status		5150 - involuntary -JB	5150 - involuntary -AS		
Legal Status - 5150					
Start Date 5150		08/09/16 -JB	08/09/16 -AS		
Start Time 5150		0925 -JB	0925 -AS		
End Date 5150		08/12/16 -JB	08/12/16 -AS		
End Time 5150		0925 -JB	0925 -AS		
Evidence of Mood Disorders					
Manic Symptoms (WDL)		WDL Except -JB	WDL Except -AS		
Manic Symptoms		pressured speech hyperverbal -JB	flight of ideas;increased energy;pressured		

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Initial Eval (continued)

	08/10/16 0630	08/10/16 0000	08/09/16 2248	08/09/16 2226	08/09/16 2224
			speech hyperverbal -AS		
Evidence of Anxiety Disorders					
Anxiety Symptoms (WDL)		WDL except -JB	WDL except -AS		
Anxiety Symptoms		excessive anxiety or worry -JB	excessive anxiety or worry -AS		
Self Perception/Self-Concept					
Do You Like Yourself				other (see comments) "no idea right now" -AS	
Major Change/Loss/Stressor					
Major Change/Loss/Stressor				none -AS	
Danger to Self					
Danger to Self (WDL)		WDL -JB	WDL -AS		
Danger to Self		no suicidal ideation or behavior indicators observed or expressed -JB	no suicidal ideation or behavior indicators observed or expressed -AS		
Keeps Self Safe			yes (describe) -AS		
Self-Injurious Behavior		no self-injurious ideation or behavior indicators observed or expressed -JB	no self-injurious ideation or behavior indicators observed or expressed -AS		
Agreement not to Harm Self			yes (describe) -AS		
Description of Agreement			verbal contract -AS		
Assessment Type					
Assessment timing		Shift -JB	Admission -AS		
Assessment of contributing factors					
Assessment of Risk Factors		History of childhood physicial/sexual abuse;Prior suicide attempts -JB	Prior suicide attempts;Sense of powerlessness/hopelessness -AS		
Assessment of Protective Factors		Good access to health care/therapy -JB	Good access to health care/therapy -AS		
Suicide Risk Assessment- Mood					
Agitation		None -JB	None -AS		
Anxiety or		Moderate -JB	Moderate -AS		

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Initial Eval (continued)

	08/10/16 0630	08/10/16 0000	08/09/16 2248	08/09/16 2226	08/09/16 2224
Fearfulness					
Loss of Pleasure or Interest		Moderate -JB	Moderate -AS		
Depression or Sadness		Moderate -JB	Moderate -AS		
Suicide Plan for Today		None -JB	None -AS		
Hopeless or Overwhelmed		High -JB	High -AS		
Suicide Risk Assessment - Thinking					
Sleep Disturbances		Moderate -JB	Low -AS		
Cognition Problems		None -JB	None -AS		
Psychotic Symptoms		None -JB	None -AS		
Suicide Risk Assessment- Behavior					
Withholding Information		None -JB	None -AS		
Resistance to Treatment		None -JB	None -AS		
Impulsivity		None -JB	None -AS		
Aggressive towards self/others		None -JB	None -AS		
Suicide Risk Assessment- Health					
Pain, real or perceived		None -JB	None -AS		
Perceived Loss of Health		Moderate -JB	Moderate -AS		
Suicide Risk Assessment- Discharge (for hospitalized patients only)					
Suicide Plan outside of Hospital		None -JB			
Lack of Support if Discharged		Low -JB			
Pessimism if Discharged		Low -JB			
Suicidal Inquiry					
Suicide Ideation for Today		None -JB	None -AS		
Behavior congruent with Verbal and Non-Verbal		Yes -JB	Yes -AS		
Assessment of Current Suicide Risk					
Assessment of Current Suicide		low while in the hospital -JB	low in hospital, higher if		

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Initial Eval (continued)

	08/10/16 0630	08/10/16 0000	08/09/16 2248	08/09/16 2226	08/09/16 2224
Risk			discharged -AS		
Danger to Others					
Danger to Others (WDL)		WDL -JB	WDL -AS		
Mental Status					
Level Of Consciousness		alert -JB	alert -AS		
Orientation		oriented x 4 -JB	oriented x 4 -AS		
General Appearance WDL		WDL except -JB	WDL except -AS		
General Appearance		unkempt -JB	unkempt;unshaven;bizarre appearance -AS		
Mood/Behavior/ Affect WDL		WDL except;mood/behavior -JB	WDL except -AS		
Mood/Behavior		anxious;alert;cooperative;flat affect -JB	anxious;cooperative;hyperactive;increased energy -AS		
Speech			WDL except -AS		
Speech		clear;hyperverbal -JB	rapid;pressured;hyperverbal -AS		
Judgment and Insight		insight appropriate to situation -JB	insight appropriate to situation;judgment appropriate to situation -AS		
Insight		fair -JB	fair -AS		
Concentration		fair -JB	fair -AS		
Memory Deficit		intact -JB	intact -AS		
Behavior (WDL)		WDL except -JB	WDL except -AS		
Sleep/Rest/Relaxation					
Sleep/Rest/Relaxation	no problem identified -JB	awake;difficulty falling asleep pt stated his rouine is to fall asleep by midnight -JB			
Daily Hours of Sleep	6.5 -JB				
Pain/Comfort					
Preferred Pain Scale		number (Numeric Rating Pain Scale) -JB			
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest		0 wearing pain patch to rt chest -JB			
Pain Rating (0-10): Activity		0 -JB			

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Initial Eval (continued)

	08/10/16 0630	08/10/16 0000	08/09/16 2248	08/09/16 2226	08/09/16 2224
Prescription Misuse					
Chronic Pain					yes chronic pelvic pain syndrome and fibromyalgia -AS
Chronic Pain Comment					pt has a Butran 10mcg/h patch on at time of admission -AS
Fall Risk Assessment					
Fall Risk Indicators		2-->depression;1-->male -JB			
Fall Risk Score		3 -JB			

	08/09/16 2220	08/09/16 2219	08/09/16 2217	08/09/16 2216	08/09/16 2207
General Information					
How to be Addressed			Vincent -AS		
Arrived From			emergency department -AS		
Roles/Relationships					
Significant Relationships		friend -AS			
Provides Primary Care For		no one -AS			
Living Environment					
Lives With		alone -AS			
Living Arrangements		apartment -AS			
Alcohol AUDIT					
1. How often did you have a drink containing alcohol in the past year?					Never -AS
3. How often did you have six or more drinks on one occasion in the past year?					Never -AS
Gender-weighting row					Male -AS
Nutrition/Metabolic					
Current Appetite	poor -AS				
Danger to Self					
Danger to Self (WDL)	WDL -AS				
Danger to Self	no suicidal ideation or behavior indicators				

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Initial Eval (continued)

	08/09/16 2220	08/09/16 2219	08/09/16 2217	08/09/16 2216	08/09/16 2207
	observed or expressed -AS				
Danger to Others					
Danger to Others (WDL)	WDL -AS				
Abuse					
Are You or Have You Been Threatened or Abused Physically, Emotionally, or Sexually By A Partner/Spouse/ Family Member?	yes hx of childhood sexual abuse from ages 4-9 -AS				
Do You Feel Unsafe Going Back to the Place Where You Are Living?	no -AS				
Pain/Comfort					
Preferred Pain Scale				number (Numeric Rating Pain Scale) -AS	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest				0 -AS	
Pain Rating (0-10): Activity				0 -AS	
Fall Risk Assessment					
Fall Risk Indicators	1-->male;2-->depression -AS				
Fall Risk Score	3 -AS				

	08/09/16 2130
Height and Weight	
Height	1.702 m (5' 7") -LD
Weight	58.514 kg (129 lb) -LD
Weight Source	Standing -LD
BMI (kg/m2)	20.25 -LD
Vital Signs	
Temp	99.5 °F (37.5 °C) -LD
Pulse	75 -LD
BP	126/88 mmHg -LD
Patient Position	Sitting -LD
Resp	18 -LD
Pain/Comfort	

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH Initial Eval (continued)

	08/09/16 2130
Preferred Pain Scale	number (Numeric Rating Pain Scale) -LD
Pain Assessment: Number Scale (0-10)	
Pain Rating (0-10): Rest	0 -LD
Pain Rating (0-10): Activity	0 -LD
Comfort/Acceptable Pain Level	0 -LD

BH OT History NAV IP

	08/11/16 1642
History	
Reason for admit	Presents to ABER on the advice of his outpatient psychiatrist secondary to acute SI (w/ active plan of jumping out of a window); UDS positive for benzos (denies any substance abuse issues) -HE
Prior Psych/CD HX	BPD; spontaneous anxiety, dyspnea, dizziness, heart palpitations, faintness, nausea, fear of dying; sexual abuse which he most recently recalled in July 2016 -HE
Prior level of function (Living/work history)	47 yo male, lives by himself in the city of Oakland, CA -HE

BH OT Observations NAV IP

	08/11/16 1947	08/11/16 1645	08/11/16 0800	08/10/16 1600	08/10/16 1109
General Observations					
Mood/Behavior/Affect WDL			WDL except -RE	WDL except;mood/behavior -AR	WDL except;mood/behavior -MM
Mood	calm;hopeful -FG	anxious;depressed -HE	anxious;depressed -RE	calm -AR	anxious;depressed;sad -MM
Orientation	oriented x 4 -FG	oriented x 4 -HE	oriented x 4 -RE	oriented x 4 -AR	oriented x 4 -MM

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH OT Observations NAV IP (continued)

	08/11/16 1947	08/11/16 1645	08/11/16 0800	08/10/16 1600	08/10/16 1109
Thought (WDL)		WDL except -HE			
Thought Process		disorganized perseverated -HE			
Speech	clear -FG	clear;hyperverbal -HE	clear;hyperverbal -RE	clear;hyperverbal -AR	clear;hyperverbal -MM
General Appearance WDL	WDL -FG		WDL except -RE		WDL except -MM
General Appearance	-- showered, clean gowns -FG	unkempt -HE	unkempt -RE	unkempt -AR	unkempt -MM

	08/10/16 0000	08/09/16 2248
General Observations		
Mood/Behavior/ Affect WDL	WDL except;mood/behavior -JB	WDL except -AS
Mood	anxious;depressed;sad -JB	anxious;depressed;feelings of doom;mood shifts -AS
Orientation	oriented x 4 -JB	oriented x 4 -AS
Speech	clear;hyperverbal -JB	rapid;pressured;hyperverbal -AS
General Appearance WDL	WDL except -JB	WDL except -AS
General Appearance	unkempt -JB	unkempt;unshaven;bizarre appearance -AS

BH OT Assessment Adult NAV IP

	08/11/16 1645
Is Patient Adult?	
Is this an Adult patient?	Yes -HE
Functional Status - Basic Skills	
Grooming/hygiene	1 Dysfunctional -HE
Functional Status - General Behavior	
Attends group	1 Dysfunctional -HE
Stays through group	1 Dysfunctional -HE
Initiates activity/motivation	1 Dysfunctional -HE
Functional Status - Task Behavior	
Alert/attentive	2 Inconsistently functional -HE
Retains/recalls	2 Inconsistently

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH OT Assessment Adult NAV IP (continued)

	08/11/16 1645
directions	functional -HE
Follows directions	2 Inconsistently functional -HE
Judgment/problem solving	1 Dysfunctional -HE
Functional Status - Interpersonal Behavior	
Socially visible/engageable	1 Dysfunctional -HE
Interaction with peers	1 Dysfunctional -HE
Use of staff	1 Dysfunctional -HE
Affect/mood congruent	2 Inconsistently functional -HE
Self Esteem	1 Dysfunctional -HE
Recreation/Leisure	
Deficit in fitness routine	yes -HE
Deficit engaging in leisure interest/hobbies	yes -HE
Life Skills	
Deficit in stress management	yes -HE
Deficit in ability to express emotions	yes -HE
Summary Comments	
Evaluation Time	60 -HE
Summary comments	4 units @ 15 minutes each. -HE

BH OT Goals NAV IP

	08/11/16 1646
Goals Established	
Goals established?	yes -HE
Increase Self-esteem	
As demonstrated by patient's ability to state	two positive qualities about self -HE
Increase Socialization	
As demonstrated by patient's ability to initiate	two interactions with a peer per group -HE

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH OT Goals NAV IP (continued)

	08/11/16 1646
As demonstrated by patient's ability to state at least	one way to positively interact with others outside of the hospital -HE
Increase Attendance in OT Groups	
As demonstrated by patient's attending at least	two OT groups per day -HE
Increase Coping Skills	
As demonstrated by patient identifying at least	one positive coping technique -HE
As demonstrated by patient's ability to learn and practice	one new DBT skill to enable patient to self regulate emotions -HE
As demonstrated by patient's ability to state at least	one way to deal with;stress -HE

BH OT Treatment Plan NAV IP

	08/11/16 1646
Treatment Plan	
Therapeutic Activity/Educational Modalities	Communication Skills;Coping Skills;Cognitive Behavioral Therapy;Expressive Therapy Groups;Discharge Planning;Dialectical Behavioral Therapy;Fitness/Movement Groups;Goals Group;Leisure Skills;Socialization;Self-Esteem;Psych Education;Stress Management Skills;Task Groups

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

BH OT Treatment Plan NAV IP (continued)

	08/11/16 1646
	(crafts, cooking);1:1 Treatment for (specify): -HE
Discharge Recommendation:	Continued outpatient therapy as appropriate. -HE

BH OT Source of Data

	08/11/16 1642
Source of Data	
Source of Data	chart audit;task observation;patient interview -HE
Diagnosis	Bipolar disorder without psychotic features -HE
Precautions	SI -HE

Adult Nutrition Assessment

	08/10/16 0800	08/09/16 2220	08/09/16 2130
Reason for Assessment			
Reason For Assessment	nurse/nurse practitioner consult -SI		
Nutrition Risk			
Nutrition Risk Screen		recent unintentional weight loss -AS	
Level Of Risk - Acuity	high -SI		
Follow Up Date	08/13/16 f/u -SI		
Height and Weight			
Height			1.702 m (5' 7") -LD
Weight			58.514 kg (129 lb) -LD
Weight Source			Standing -LD
BSA (Calculated - sq m)			1.66 sq meters -LD
BMI (kg/m2)			20.25 -LD
BMI (Calculated)			20.2 -LD
Ideal Body Weight (IBW)			
Ideal Body Weight (IBW), (kg)			68.1 -LD
% Ideal Body Weight			85.93 -LD
Nutrition/Metabolic			

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

Adult Nutrition Assessment (continued)

	08/10/16 0800	08/09/16 2220	08/09/16 2130
Current Appetite		poor -AS	
Access to Food		yes -AS	
Who Prepares Meals		self -AS	
Nutrition Comment		past 2 weeks pt has lost "a lot" of weight -AS	

Adult Care Sum F14

	08/11/16 1947	08/11/16 1645	08/11/16 1417	08/11/16 0800	08/11/16 0600
Plan of Care Review					
Plan Of Care Reviewed With	patient -FG		patient -RE	patient -RE	
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) -FG				
Sleep/Rest/Relaxation				no problem identified -RE	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -FG			0 -RE	
Pain Rating (0-10): Activity	0 -FG			0 -RE	
Sleep/Rest/Relaxation					
Daily Hours of Sleep					7.5 -CR
Coping/Psychosocial					
Observed Emotional State	calm;cooperative -FG			anxious -RE	
Verbalized Emotional State	hopefulness -FG				
HEENT					
HEENT WDL	WDL -FG				
Cognitive					
Memory Deficit	intact -FG			intact -RE	
Neuro					
Level Of Consciousness	alert -FG			alert -RE	
Orientation	oriented x 4 -FG	oriented x 4 -HE		oriented x 4 -RE	
General Appearance					
General Appearance WDL	WDL -FG			WDL except -RE	
General Appearance	-- showered, clean gowns -FG	unkempt -HE		unkempt -RE	
Mood/Behavior/Affect					
Mood/Behavior/				WDL except -RE	

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/11/16 1947	08/11/16 1645	08/11/16 1417	08/11/16 0800	08/11/16 0600
Affect WDL					
Mood/Behavior	cooperative;positive goal-directed -FG			anxious -RE	
Speech					
Speech	WDL -FG			WDL except -RE	
Speech	clear -FG	clear;hyperverbal -HE		clear;hyperverbal -RE	
Thought Process					
Judgment and Insight	judgment appropriate to situation -FG			insight appropriate to situation;judgment appropriate to situation -RE	
Thought Process		disorganized perseverated -HE			
Oxygen Therapy					
SpO2				99 % -AP	
O2 Device	room air -FG				
Skin					
Skin WDL	WDL -FG				
Safety Interventions					
Precautions (displays in banner)	None -FG			None -RE	
Fall Risk Indicators	3-->central nervous system/psychotropic medication;1-->male -FG			0-->no indicators present -RE	
Fall Risk Score	4 -FG			0 -RE	
	08/11/16 0400	08/10/16 1805	08/10/16 1600	08/10/16 1221	08/10/16 1109
Plan of Care Review					
Plan Of Care Reviewed With		patient -AR		patient -MM	patient -MM
Pain/Comfort/Sleep					
Preferred Pain Scale	number (Numeric Rating Pain Scale) Pt sleeping -MB				
Sleep/Rest/Relaxation	no problem identified;appears asleep;limb movements periodically during sleep -MB				
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest			0 -AR		
Coping/Psychosocial					
Observed			anxious;calm -AR		anxious;coopera

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/11/16 0400	08/10/16 1805	08/10/16 1600	08/10/16 1221	08/10/16 1109
Emotional State					tive;flat;withdrawn -MM
Verbalized Emotional State			acceptance -AR		frustration -MM
Cognitive					
Memory Deficit			intact -AR		intact -MM
Neuro					
Level Of Consciousness	asleep -MB		alert -AR		alert -MM
Orientation			oriented x 4 -AR		oriented x 4 -MM
General Appearance					
General Appearance WDL					WDL except -MM
General Appearance			unkempt -AR		unkempt -MM
Mood/Behavior/Affect					
Mood/Behavior/ Affect WDL			WDL except;mood/behavior -AR		WDL except;mood/behavior -MM
Mood/Behavior			cooperative -AR		anxious;alert;cooperative;flat affect -MM
Speech					
Speech					WDL except -MM
Speech			clear;hyperverbal -AR		clear;hyperverbal -MM
Thought Process					
Judgment and Insight			insight appropriate to situation -AR		insight appropriate to situation -MM
Oxygen Therapy					
SpO2			98 % -SD		
O2 Device			room air -SD		room air -MM
Skin					
Skin WDL			WDL except psoriasis -AR		WDL except -MM
Safety Interventions					
Precautions (displays in banner)	None -MB		Suicide -AR		Suicide -MM
Fall Risk Indicators			2-->depression;1-->male -AR		2-->depression;1-->male -MM
Fall Risk Score			3 -AR		3 -MM
	08/10/16 0730	08/10/16 0630	08/10/16 0256	08/10/16 0000	08/09/16 2248
Plan of Care Review					
Plan Of Care			patient -JB		

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/10/16 0730	08/10/16 0630	08/10/16 0256	08/10/16 0000	08/09/16 2248
Reviewed With					
Pain/Comfort/Sleep					
Preferred Pain Scale				number (Numeric Rating Pain Scale) -JB	
Sleep/Rest/Relaxation		no problem identified -JB		awake;difficulty falling asleep pt stated his rouine is to fall asleep by midnight -JB	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest	0 -JM			0 wearing pain patch to rt chest -JB	
Pain Rating (0-10): Activity				0 -JB	
Sleep/Rest/Relaxation					
Daily Hours of Sleep		6.5 -JB			
Pain/Comfort/Sleep Interventions					
Sleep/Rest Enhancement				awakenings minimized;noise level reduced;regular sleep/rest pattern promoted -JB	
Coping/Psychosocial					
Observed Emotional State				anxious;cooperative;flat;withdrawn -JB	
Verbalized Emotional State				frustration voiced therapist had taken him off paxil 3 months ago -JB	
Cognitive					
Memory Deficit				intact -JB	intact -AS
Neuro					
Level Of Consciousness				alert -JB	alert -AS
Orientation				oriented x 4 -JB	oriented x 4 -AS
General Appearance					
General Appearance WDL				WDL except -JB	WDL except -AS
General Appearance				unkempt -JB	unkempt;unshaven;bizarre appearance -AS
Mood/Behavior/Affect					
Mood/Behavior/Affect WDL				WDL except;mood/behavior -JB	WDL except -AS

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/10/16 0730	08/10/16 0630	08/10/16 0256	08/10/16 0000	08/09/16 2248
Mood/Behavior				anxious;alert;cooperative;flat affect -JB	anxious;cooperative;hyperactive;increased energy -AS
Speech					
Speech					WDL except -AS
Speech				clear;hyperverbal -JB	rapid;pressured;hyperverbal -AS
Thought Process					
Judgment and Insight				insight appropriate to situation -JB	insight appropriate to situation;judgment appropriate to situation -AS
Oxygen Therapy					
SpO2	98 % -JM				
O2 Device	room air -JM				
Skin					
Skin WDL				WDL except -JB	
Safety Interventions					
Precautions (displays in banner)				Suicide -JB	Suicide -AS
Fall Risk Indicators				2-->depression;1-->male -JB	
Fall Risk Score				3 -JB	
	08/09/16 2226	08/09/16 2220	08/09/16 2217	08/09/16 2216	08/09/16 2207
Individualization					
Patient Specific Goals	to get help in the hospital -AS				
Patient Specific Interventions	pain mangagment -AS				
Significant Event					
Significant Event Comments					S -AS
Pain/Comfort/Sleep					
Preferred Pain Scale				number (Numeric Rating Pain Scale) -AS	
Pain Assessment: Number Scale (0-10)					
Pain Rating (0-10): Rest				0 -AS	
Pain Rating (0-10): Activity				0 -AS	
Nutrition					
Nutrition Risk Screen		recent unintentional			

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

Adult Care Sum F14 (continued)

	08/09/16 2226	08/09/16 2220	08/09/16 2217	08/09/16 2216	08/09/16 2207
		weight loss -AS			
Safety Interventions					
Precautions (displays in banner)			Suicide -AS		
Fall Risk Indicators		1-->male;2-->depression -AS			
Fall Risk Score		3 -AS			

	08/09/16 2130
Pain/Comfort/Sleep	
Preferred Pain Scale	number (Numeric Rating Pain Scale) -LD
Pain Assessment: Number Scale (0-10)	
Pain Rating (0-10): Rest	0 -LD
Pain Rating (0-10): Activity	0 -LD
Comfort/Acceptable Pain Level	0 -LD
Oxygen Therapy	
SpO2	100 % -LD
O2 Device	room air -LD

Social Work Assessment

	08/11/16 0800	08/10/16 1600	08/10/16 1109	08/10/16 1000	08/10/16 0000
Referral Information					
Arrived From				emergency department -CH	
Referral Source				community -CH	
Reason For Consult				care coordination/care conference;discharge planning;mental health concerns -CH	
Record Reviewed				medical record -CH	
Social Worker Assigned to Case				Himot -CH	
Contact Information					
Comments				Pt gives verbal permission to talk with his case manager, psychiatrist, friend Katy Kaminski) -CH	

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

Social Work Assessment (continued)

	08/11/16 0800	08/10/16 1600	08/10/16 1109	08/10/16 1000	08/10/16 0000
Community Case Manager Information					
Name				Al Boozer and Maureen Costello at Oakland Community Support Services -CH	
Phone				510-777-3820 and 510- 777-3850 -CH	
Fax				510-777-3806 -CH	
Psychiatrist Information					
Name				Dr. James Hinson at Oakland Community Support Services -CH	
Phone				510-777-3847 -CH	
Primary Care Physician Information					
Name				Dr. Mark Robinson G.P. at Lifelong Medical Care -CH	
Phone				510-430-8740 -CH	
Living Environment					
Lives With				alone -CH	
Living Arrangements				apartment -CH	
Provides Primary Care For				no one -CH	
Able to Return to Prior Living Arrangements				yes -CH	
Living Arrangement Comments				Pt has lived at this residence in Oakland for the past 8 years and plans to return there upon discharge. -CH	
Values/Beliefs					
(F) Faith: Importance of Culture, Spirituality, Religion in Life				Christian. Not currently active or involved in the chruch. -CH	
Substance Use, Patient					
Substance Use Comment				Pt denies current or past illicit drug or alcohol use. -CH	
Substance Use, Family					

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

Social Work Assessment (continued)

	08/11/16 0800	08/10/16 1600	08/10/16 1109	08/10/16 1000	08/10/16 0000
Substance Use Comments				Did not ask. -CH	
Cognitive/Perceptual/Developmental					
Recent Changes in Mental Status/Cognitive Functioning				mood -CH	
Developmental Stage (Eriksson's Stages of Development)				Stage 7 (35-65 years/Middle Adulthood) Generativity vs. Stagnation -CH	
Employment/Financial					
Source Of Income				disability -CH	
Emotional/Psychological					
Affect				other (see comments) hypomanic -CH	
Mood				elevated -CH	
Verbal Skills				no deficits noted -CH	
Current Interpersonal Conduct/Behavior				appropriate to situation -CH	
Mental Health Conditions/Symptoms				bipolar affective disorder;labile mood;suicide attempt -CH	
Previous Mental Health Treatment				case management;inpatient treatment;medication;outpatient treatment;psychiatrist -CH	
Previous Mental Health Treatment Date				Several prior hospitalizations in 2006 and 2007 in New Mexico. -CH	
Mental Health Treatment				case management;inpatient treatment;medication;outpatient treatment;psychiatrist -CH	
Suicide Risk					

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

Social Work Assessment (continued)

	08/11/16 0800	08/10/16 1600	08/10/16 1109	08/10/16 1000	08/10/16 0000
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -RE	no self-injurious ideation or behavior indicators observed or expressed -AR	no self-injurious ideation or behavior indicators observed or expressed -MM	no self-injurious ideation or behavior indicators observed or expressed -CH	no self-injurious ideation or behavior indicators observed or expressed -JB
Coping/Stress					
Major Change/Loss/Stressor				other (see comments) recent tapering of his psych medications -CH	
Patient Personal Strengths				able to adapt;expressive of emotions;expressive of needs;flexibility;future/goal oriented;positive attitude;resourceful;successful coping history -CH	
Sources Of Support				friend(s);mental health providers -CH	
Reaction To Health Status				accepting -CH	
Understanding Of Condition And Treatment				partial understanding of medical condition;partial understanding of treatment -CH	
Coping/Stress Comments				Thought about jumping out of the window on Saturday. Pt reports that his doctor at Oakland community Support (intern, now no longer works there) tapered his psych medications over the past several months. Pt believes he is going through "Paxil withdrawal". He has been	

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

Social Work Assessment (continued)

	08/11/16 0800	08/10/16 1600	08/10/16 1109	08/10/16 1000	08/10/16 0000
				having "panic attacks," epression. Recent wt loss. Feels "overwhelmed and traumatized" by his "Paxil withdrawl." -CH	
Legal					
Criminal Activity/Legal Involvement Pertinent to Current Situation/Hospitalization				Denies current or past legal involvement. -CH	
Discharge Needs Assessment					
Concerns To Be Addressed				care coordination/care conferences;coping/stress concerns;mental health concerns;suicidal concerns -CH	
Concerns Comments				This is pt's first suicide attempt/gesture. He lives alone. He denies any family hx of suicide attempts or gestures. Will contact his case manager for collateral information and request his current medication list. Consider referral to PHP program. -CH	
Readmission Within The Last 30 Days				no previous admission in last 30 days -CH	
Community Agency Name(S)				Oakland Community Support Services. -CH	
Anticipated Changes				none -CH	

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

Social Work Assessment (continued)

	08/11/16 0800	08/10/16 1600	08/10/16 1109	08/10/16 1000	08/10/16 0000
Related to Illness					
Equipment Currently Used at Home				none -CH	
Equipment Needed After Discharge				none -CH	
Discharge Facility/Level Of Care Needs				other (see comments) Home, referral to PHP -CH	
Transportation Available				public transportation -CH	
Current Discharge Risk				lives alone;psychiatric illness -CH	
Discharge Disposition				still a patient -CH	
Discharge Planning Comments				See SW Plan -CH	
Social Work Plan					
Plan				Contact pt's case manager for collateral information, discharge planning recommendations and outpatient treatment follow-up appointments. -CH	

	08/09/16 2248	08/09/16 2226	08/09/16 2224	08/09/16 2219	08/09/16 2217
Referral Information					
Arrived From					emergency department -AS
Living Environment					
Lives With				alone -AS	
Living Arrangements				apartment -AS	
Provides Primary Care For				no one -AS	
Functional Status Current					
Change in Functional Status Since Onset of Current			no -AS		

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

Social Work Assessment (continued)

	08/09/16 2248	08/09/16 2226	08/09/16 2224	08/09/16 2219	08/09/16 2217
Illness/Injury					
Functional Status Prior					
Communication					0-->understands/communicates without difficulty -AS
Suicide Risk					
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed -AS				
Coping/Stress					
Major Change/Loss/Stressor		none -AS			
Patient Personal Strengths		other (see comments) dicipline -AS			
Advance Directive					
Advance Directive (Medical Healthcare)					no -AS
Discharge Needs Assessment					
Concerns To Be Addressed					coping/stress concerns;discharge planning concerns;suicidal concerns -AS
Readmission Within The Last 30 Days					no previous admission in last 30 days -AS

(r) = User Recd, (t) = User Taken, (c) = User Cosigned

User Key

Initials	Name	Effective Dates
HE	Elliott, Harold Edward, OT	03/13/15 -
MB	Borja, Maryann L, RN	03/12/15 -
FG	Ghebreselassie, Freweini, RN	03/12/15 -
RE	Ellison, Ricky, RN	02/05/15 -
CH	Himot, Craig	01/04/16 -
MM	Mack, Marcus Darryl, RN	02/05/15 -
JM	Makonnen, Joseph	03/31/16 -
AP	Parrish, Alan	03/31/16 -
CR	Richardson, Cleo, RN	02/05/15 -
PR	Roberts, Pamela L	-
WR	Robertson, William B, RN	02/05/15 -

All Flowsheet Data (08/09/16 0000--08/11/16 2359) (continued)

(r) = User Recd, (t) = User Taken, (c) = User Cosigned

User Key (continued)

Initials	Name	Effective Dates
AR	Rossman, Ayla L, RN	04/11/16 -
AS	Silver, Amy E, RN	02/05/15 -
ASA	Smith, Arthur L, CNA	07/02/15 -
LD	Durden, Latonja, RN	07/02/15 -
SD	Dalrymple, Scott Charles, RN	03/12/15 -
JB	Blackwood, Joan Caroline, RN	07/14/15 -
SI	Iwamura, Scott, RD	03/12/15 -

All Meds and Administrations

All Meds and Administrations (continued)

aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL [657580099] — Status: Discontinued (Past End Date/Time)

Ordering Provider: Michel, Christopher S, MD
Ordered On: 08/10/16 0019
Dose (Remaining/Total): 30 mL (-/-)
Route: Oral
Admin Instructions: Maximum 120mL in 24 hours. Shake well before using.
Starts/Ends: 08/09/16 2353 - 08/26/16 1953
Frequency: Q4H PRN
Rate/Duration: - / -
Comments:

(No admins scheduled or recorded for this medication)

magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL [657580100] — Status: Discontinued (Past End Date/Time)

Ordering Provider: Michel, Christopher S, MD
Ordered On: 08/10/16 0019
Dose (Remaining/Total): 30 mL (-/-)
Route: Oral
Admin Instructions: Shake well before using --- Follow dose with a full glass of water
Starts/Ends: 08/09/16 2353 - 08/26/16 1953
Frequency: BEDTIME PRN
Rate/Duration: - / -
Comments:

(No admins scheduled or recorded for this medication)

clonAZEPAM (klonoPIN) Tab 1 mg [657580109] — Status: Discontinued (Past End Date/Time), Reason: Inactivated medication

Ordering Provider: Michel, Christopher S, MD
Ordered On: 08/10/16 0019
Dose (Remaining/Total): 1 mg (-/-)
Route: Oral
Admin Instructions: Not to exceed 4mg
Starts/Ends: 08/10/16 0015 - 08/10/16 0902
Frequency: Q4H PRN
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/10/16 0645	Given	1 mg	Oral		Blackwood, Joan Caroline, RN

ibuprofen (MOTRIN) Tab 400 mg [657580110] — Status: Discontinued (Past End Date/Time), Reason: Inactivated medication

Ordering Provider: Michel, Christopher S, MD
Ordered On: 08/10/16 0019
Dose (Remaining/Total): 400 mg (-/-)
Route: Oral
Admin Instructions: May be taken with food. **BLACK BOX WARNING**
Starts/Ends: 08/10/16 0016 - 08/10/16 1629
Frequency: Q6H PRN
Rate/Duration: - / -
Comments:

(No admins scheduled or recorded for this medication)

ibuprofen (MOTRIN) Tab 200 mg [657580111] — Status: Discontinued (Past End Date/Time), Reason: Inactivated medication

Ordering Provider: Michel, Christopher S, MD
Ordered On: 08/10/16 0019
Dose (Remaining/Total): 200 mg (-/-)
Route: Oral
Admin Instructions: May be taken with food. **BLACK BOX WARNING**
Starts/Ends: 08/10/16 0016 - 08/10/16 1629
Frequency: Q6H PRN
Rate/Duration: - / -
Comments:

(No admins scheduled or recorded for this medication)

All Meds and Administrations (continued)

HYDROcodone/acetaminophen (NORCO 5) 5mg/325mg 1 Tab [657580112]

Status: Discontinued (Past End Date/Time), Reason: Inactivated medication

Ordering Provider: Michel, Christopher S, MD
Ordered On: 08/10/16 0019
Dose (Remaining/Total): 1 Tab (-/-)
Route: Oral
Admin Instructions: Acetaminophen limits: Pts younger than 12: max 75mg/kg/day, not to exceed 650mg/dose; do not exceed 5 doses in 24 hours. Pts 12 and older: max 4g/day.

Starts/Ends: 08/10/16 0016 - 08/10/16 1629
Frequency: Q6H PRN
Rate/Duration: - / -
Comments:

(No admins scheduled or recorded for this medication)

methotrexate Tab 7.5 mg [657580113]

Status: Discontinued (Past End Date/Time), Reason: Duplicate Entry

Ordering Provider: Michel, Christopher S, MD
Ordered On: 08/10/16 0019
Dose (Remaining/Total): 7.5 mg (-/-)
Route: Oral
Admin Instructions: CHEMOTHERAPY - DISPOSE OF PROPERLY --- Do NOT handle or break tablets **BLACK BOX WARNING**

Starts/Ends: 08/10/16 0900 - 08/10/16 0901
Frequency: EVERY 7 DAYS
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/10/16 0900	Not Given Reason: Med Not Available	7.5 mg	Oral		Mack, Marcus Darryl, RN

buprenorphine (BUTRANS) 5mcg/hr 2 Patch [657580128]

Status: Discontinued (Past End Date/Time)

Ordering Provider: Michel, Christopher S, MD
Ordered On: 08/10/16 0023
Dose (Remaining/Total): 2 Patch (-/-)
Route: Transdermal
Admin Instructions: Remove old patch. **BLACK BOX WARNING**

Starts/Ends: 08/15/16 0900 - 08/10/16 1918
Frequency: EVERY 7 DAYS
Rate/Duration: - / -
Comments:

(No admins scheduled or recorded for this medication)

ibuprofen (MOTRIN) Tab 600 mg [657989936]

Status: Discontinued (Past End Date/Time), Reason: Inactivated medication

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/10/16 0859
Dose (Remaining/Total): 600 mg (-/-)
Route: Oral
Admin Instructions: May be taken with food. **BLACK BOX WARNING**

Starts/Ends: 08/10/16 0859 - 08/10/16 1629
Frequency: Q6H PRN
Rate/Duration: - / -
Comments:

(No admins scheduled or recorded for this medication)

methotrexate Tab 7.5 mg [657989937]

Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/10/16 0900
Dose (Remaining/Total): 7.5 mg (-/-)
Route: Oral
Admin Instructions: CHEMOTHERAPY - DISPOSE OF PROPERLY --- Do NOT handle or break tablets **BLACK BOX WARNING**

Starts/Ends: 08/10/16 0915 - 08/10/16 1644
Frequency: EVERY 7 DAYS
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/10/16 0915	Dose Held Reason: See Comments	0 mg	Oral	Comments: Pt says that he took his last does on 8/09/16, before he left for the hospital	Mack, Marcus Darryl, RN

All Meds and Administrations (continued)

gabapentin (NEURONTIN) Cap 300 mg [657989944] — Status: Discontinued (Past End Date/Time), Reason: Inactivated medication

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/10/16 0902
Dose (Remaining/Total): 300 mg (-/-)
Route: Oral
Admin Instructions: Give at least 2 hours before or 2 hours after antacids containing aluminum or magnesium
Starts/Ends: 08/10/16 0902 - 08/10/16 1626
Frequency: Q4H PRN
Rate/Duration: - / -
Comments:

(No admins scheduled or recorded for this medication)

lactulose (ENULOSE) Oral Soln 30 mL [657989946] — Status: Discontinued (Past End Date/Time)

Ordering Provider: Sharma, Kanika, MD
Ordered On: 08/10/16 1211
Dose (Remaining/Total): 30 mL (-/-)
Route: Oral
Admin Instructions:
Starts/Ends: 08/10/16 2100 - 08/13/16 1656
Frequency: EVERY BEDTIME
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/12/16 2106	Given	30 mL	Oral		Abend, Marquel Marie, RN
08/11/16 2100	Given	30 mL	Oral		Ghebreselassie, Freweini, RN
08/10/16 2110	Given	30 mL	Oral		Hudson II, William Howard, RN

divalproex 24Hr-ER (DEPAKOTE ER) Tab 1,500 mg [657989947] — Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/10/16 1626
Dose (Remaining/Total): 1,500 mg (-/-)
Route: Oral
Admin Instructions: Do NOT chew, crush or break. **BLACK BOX WARNING**
Starts/Ends: 08/10/16 2100 - 08/15/16 1129
Frequency: EVERY BEDTIME
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/14/16 2123	Given	1,500 mg	Oral		Smith, Hilda, RN
08/13/16 2048	Given	1,500 mg	Oral		Smith, Hilda, RN
08/12/16 2106	Given	1,500 mg	Oral		Abend, Marquel Marie, RN
08/11/16 2059	Given	1,500 mg	Oral		Ghebreselassie, Freweini, RN
08/10/16 2108	Given	1,500 mg	Oral		Hudson II, William Howard, RN

OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg [657989948] — Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/10/16 1626
Dose (Remaining/Total): 2.5 mg (-/-)
Route: Oral
Admin Instructions: Dissolve on tongue; do NOT chew or swallow whole. **BLACK BOX WARNING**
Starts/Ends: 08/10/16 1625 - 08/26/16 1953
Frequency: BEDTIME PRN MAY REPEAT X 1
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/25/16 2249	Given	2.5 mg	Oral		McCullough, Elizabeth Ann, RN
08/25/16 0205	Given	2.5 mg	Oral		Richardson, Cleo, RN
08/23/16 2240	Given	2.5 mg	Oral		Senior, Adolfo A, RN
08/21/16 2314	Given	2.5 mg	Oral		McCullough, Elizabeth Ann, RN
08/21/16 2120	Given	2.5 mg	Oral		Rowny, Katharine Lynne, RN
08/20/16 2134	Given	2.5 mg	Oral		Abend, Marquel Marie, RN
08/20/16 2102	Given	2.5 mg	Oral		Abend, Marquel Marie, RN
08/19/16 2146	Given	2.5 mg	Oral		McCullough, Elizabeth Ann, RN
08/19/16 2056	Given	2.5 mg	Oral		McCullough, Elizabeth Ann, RN
08/17/16 2256	Given	2.5 mg	Oral		McCullough, Elizabeth Ann, RN
08/16/16 2017	Given	2.5 mg	Oral		McCullough, Elizabeth Ann, RN
08/14/16 2124	Given	2.5 mg	Oral		Smith, Hilda, RN
08/13/16 0258	Given	2.5 mg	Oral		Borja, Maryann L, RN

All Meds and Administrations (continued)

gabapentin (NEURONTIN) Cap 300 mg [657989949] — Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/10/16 1626
Dose (Remaining/Total): 300 mg (-/-)
Route: Oral
Admin Instructions: Give at least 2 hours before or 2 hours after antacids containing aluminum or magnesium
Starts/Ends: 08/10/16 1626 - 08/14/16 1549
Frequency: Q4H PRN
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/14/16 1432	Given	300 mg	Oral		Webb, Gina Marie, RN
08/12/16 1205	Given	300 mg	Oral		Webb, Gina Marie, RN
08/11/16 0950	Given	300 mg	Oral		Ellison, Ricky, RN

buprenorphine/naloxone SL (SUBOXONE) 2mg/0.5mg 1 Film [657989950] — Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/10/16 1629
Dose (Remaining/Total): 1 Film (-/-)
Route: Sublingual
Admin Instructions: Do not swallow or chew film. Films need to completely dissolve under the tongue.
Starts/Ends: 08/10/16 1628 - 08/10/16 1635
Frequency: Q12H PRN
Rate/Duration: - / -
Comments:

(No admins scheduled or recorded for this medication)

buprenorphine/naloxone SL (SUBOXONE) 2mg/0.5mg 1 Film [657989954] — Status: Discontinued (Past End Date/Time), Reason: Inactivated medication

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/10/16 1635
Dose (Remaining/Total): 1 Film (-/-)
Route: Sublingual
Admin Instructions: Not to exceed two dosages / 24 hour period.
Do not swallow or chew film. Films need to completely dissolve under the tongue.
Starts/Ends: 08/10/16 1635 - 08/10/16 1907
Frequency: Q6H PRN
Rate/Duration: - / -
Comments:

(No admins scheduled or recorded for this medication)

methotrexate Tab 7.5 mg [657989962] — Status: Discontinued (Past End Date/Time), Reason: Duplicate Entry

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/10/16 1644
Dose (Remaining/Total): 7.5 mg (-/-)
Route: Oral
Admin Instructions: CHEMOTHERAPY - DISPOSE OF PROPERLY --- Do NOT handle or break tablets **BLACK BOX WARNING**
Starts/Ends: 08/15/16 2100 - 08/15/16 1519
Frequency: EVERY 7 DAYS
Rate/Duration: - / -
Comments:

(No admins scheduled or recorded for this medication)

methotrexate Tab 5 mg [657989963] — Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/10/16 1644
Dose (Remaining/Total): 5 mg (-/-)
Route: Oral
Admin Instructions: CHEMOTHERAPY - DISPOSE OF PROPERLY --- Do NOT handle or break tablets **BLACK BOX WARNING**
Starts/Ends: 08/16/16 0900 - 08/26/16 1953
Frequency: EVERY 7 DAYS
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/23/16 0913	Given	5 mg	Oral		Marin, Lisa Nicole, RN
08/16/16 0853	Given	5 mg	Oral		Britt, Julia Anna, RN

All Meds and Administrations (continued)

foLIC acid Tab 1 mg [657989964] Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/10/16 1645
Dose (Remaining/Total): 1 mg (-/-)
Route: Oral
Admin Instructions:
Starts/Ends: 08/10/16 1700 - 08/26/16 1953
Frequency: DAILY
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/26/16 0828	Given	1 mg	Oral		Harris, Stephanie, RN
08/25/16 0937	Given	1 mg	Oral		Edwards, Sarah C, RN
08/24/16 0836	Given	1 mg	Oral		Edwards, Sarah C, RN
08/23/16 0829	Given	1 mg	Oral		Marin, Lisa Nicole, RN
08/22/16 0836	Given	1 mg	Oral		Edwards, Sarah C, RN
08/21/16 0830	Given	1 mg	Oral		Britt, Julia Anna, RN
08/20/16 0947	Given	1 mg	Oral		Yerby, Derrick J, RN
08/19/16 0909	Given	1 mg	Oral		Marin, Lisa Nicole, RN
08/18/16 0927	Given	1 mg	Oral		Marin, Lisa Nicole, RN
08/17/16 0832	Given	1 mg	Oral		Ellison, Ricky, RN
08/16/16 0852	Given	1 mg	Oral		Britt, Julia Anna, RN
08/15/16 0842	Given	1 mg	Oral		Harris, Stephanie, RN
08/14/16 0857	Given	1 mg	Oral		Webb, Gina Marie, RN
08/13/16 0900	Refused	1 mg	Oral		Webb, Gina Marie, RN
08/12/16 0826	Given	1 mg	Oral		Webb, Gina Marie, RN
08/11/16 0828	Given	1 mg	Oral		Ellison, Ricky, RN
08/10/16 1700	Refused	1 mg	Oral		Hudson II, William Howard, RN

buprenorphine SL (SUBUTEX) Tab 2 mg [657989965] Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/10/16 1907
Dose (Remaining/Total): 2 mg (-/-)
Route: Sublingual
Admin Instructions: Not to exceed two dosages/ 24 hour period
Do not swallow or chew the tablets. The tablets need to completely dissolve under the tongue.
BLACK BOX WARNING
Starts/Ends: 08/10/16 1906 - 08/26/16 1953
Frequency: Q6H PRN
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/26/16 1028	Given	2 mg	Sublingual		Harris, Stephanie, RN
08/16/16 0905	Given	2 mg	Sublingual		Britt, Julia Anna, RN
	Comments: 3/10 pelvic pain, pt requesting				
08/12/16 1844	Given	2 mg	Sublingual		Abend, Marquel Marie, RN
08/12/16 1205	Given	2 mg	Sublingual		Webb, Gina Marie, RN

phenazopyridine (PYRIDIUM) Tab 200 mg [657989966] Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/10/16 1918
Dose (Remaining/Total): 200 mg (-/-)
Route: Oral
Admin Instructions: Take after meals.
Starts/Ends: 08/10/16 1910 - 08/26/16 1953
Frequency: Q8H PRN
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/13/16 1008	Given	200 mg	Oral		Webb, Gina Marie, RN

All Meds and Administrations (continued)

buprenorphine (BUTRANS) 5mcg/hr 2 Patch [657989967] Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/10/16 1918
Dose (Remaining/Total): 2 Patch (-/-)
Route: Transdermal
Admin Instructions: Remove old patch.
BLACK BOX WARNING
Starts/Ends: 08/15/16 2100 - 08/22/16 1110
Frequency: EVERY 7 DAYS
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/15/16 2100	Given	2 Patch	Transdermal		Ghebreselassie, Freweini, RN

ondansetron (ZOFRAN) ODT Solutab 4 mg [658693008] Status: Completed (Past End Date/Time)

Ordering Provider: Schumm, Derek Daniel, MD
Ordered On: 08/13/16 0944
Dose (Remaining/Total): 4 mg (0/1)
Route: Oral
Admin Instructions: Dissolve on tongue; do NOT chew or swallow whole ---
Starts/Ends: 08/13/16 0945 - 08/13/16 0948
Frequency: NOW
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/13/16 0948	Given	4 mg	Oral		Webb, Gina Marie, RN

bisacodyl (DULCOLAX) Supp 10 mg [658693015] Status: Discontinued (Past End Date/Time)

Ordering Provider: Sharma, Kanika, MD
Ordered On: 08/13/16 1656
Dose (Remaining/Total): 10 mg (-/-)
Route: Rectal
Admin Instructions:
Starts/Ends: 08/13/16 1700 - 08/26/16 1953
Frequency: DAILY
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/26/16 0900	Refused	10 mg	Rectal		Harris, Stephanie, RN
08/25/16 0936	Given	10 mg	Rectal		Edwards, Sarah C, RN
08/24/16 0900	Refused	10 mg	Rectal		Edwards, Sarah C, RN
08/23/16 0829	Refused	10 mg	Rectal		Marin, Lisa Nicole, RN
08/22/16 0900	Refused	10 mg	Rectal		Edwards, Sarah C, RN
08/21/16 0900	Given	10 mg	Rectal		Britt, Julia Anna, RN
08/20/16 0947	Given	10 mg	Rectal		Yerby, Derrick J, RN
08/19/16 0909	Given	10 mg	Rectal		Marin, Lisa Nicole, RN
08/18/16 0927	Given	10 mg	Rectal		Marin, Lisa Nicole, RN
08/17/16 0832	Given	10 mg	Rectal		Ellison, Ricky, RN
08/16/16 0852	Given	10 mg	Rectal		Britt, Julia Anna, RN
08/15/16 0900	Given	10 mg	Rectal		Harris, Stephanie, RN
08/14/16 0857	Given	10 mg	Rectal		Webb, Gina Marie, RN
08/13/16 1817	Given	10 mg	Rectal		Smith, Hilda, RN

All Meds and Administrations (continued)

sennosides (SENOKOT) Tab 17.2 mg [658693016] Status: Discontinued (Past End Date/Time)

Ordering Provider: Sharma, Kanika, MD
Ordered On: 08/13/16 1656
Dose (Remaining/Total): 17.2 mg (-/-)
Route: Oral
Admin Instructions:
Starts/Ends: 08/13/16 2100 - 08/26/16 1953
Frequency: EVERY BEDTIME
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/25/16 2100	Given	17.2 mg	Oral		McCullough, Elizabeth Ann, RN
08/24/16 2112	Given	17.2 mg	Oral		Scurry-Scott, Frazier M, RN
08/23/16 2107	Given	17.2 mg	Oral		Senior, Adolfo A, RN
08/22/16 2005	Given	17.2 mg	Oral		Abend, Marquel Marie, RN
08/21/16 2056	Given	17.2 mg	Oral		Rowny, Katharine Lynne, RN
08/20/16 2009	Given	17.2 mg	Oral		Abend, Marquel Marie, RN
08/19/16 2056	Given	17.2 mg	Oral		McCullough, Elizabeth Ann, RN
08/18/16 2120	Given	17.2 mg	Oral		Abend, Marquel Marie, RN
08/17/16 2209	Given	17.2 mg	Oral		McCullough, Elizabeth Ann, RN
08/16/16 2017	Given	17.2 mg	Oral		McCullough, Elizabeth Ann, RN
08/15/16 2100	Not Given	17.2 mg	Oral		Ghebreselassie, Freweini, RN
	Reason: See Comments			Comments: patient wanted to skip this dose tonight.	
08/14/16 2124	Given	17.2 mg	Oral		Smith, Hilda, RN
08/13/16 2047	Given	17.2 mg	Oral		Smith, Hilda, RN

lactulose (ENULOSE) Oral Soln 30 mL [658693017] Status: Discontinued (Past End Date/Time)

Ordering Provider: Sharma, Kanika, MD
Ordered On: 08/13/16 1656
Dose (Remaining/Total): 30 mL (-/-)
Route: Oral
Admin Instructions:
Starts/Ends: 08/13/16 2100 - 08/26/16 1953
Frequency: BID
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/26/16 0834	Given	30 mL	Oral		Harris, Stephanie, RN
08/25/16 2100	Given	30 mL	Oral		McCullough, Elizabeth Ann, RN
08/25/16 0938	Given	30 mL	Oral		Edwards, Sarah C, RN
08/24/16 2100	Not Given	30 mL	Oral		Harris, Stephanie, RN
	Reason: See Comments			Comments: unknown if given. Resolving overdue status for current shift, 8/26/16, 7a.	
08/24/16 0836	Given	30 mL	Oral		Edwards, Sarah C, RN
08/23/16 2105	Given	30 mL	Oral		Senior, Adolfo A, RN
08/23/16 0913	Given	30 mL	Oral		Marin, Lisa Nicole, RN
08/22/16 2100	Given	30 mL	Oral		Abend, Marquel Marie, RN
08/22/16 0900	Given	30 mL	Oral		Edwards, Sarah C, RN
08/21/16 2111	Given	30 mL	Oral		Rowny, Katharine Lynne, RN
08/21/16 0830	Given	30 mL	Oral		Britt, Julia Anna, RN
08/20/16 2014	Given	30 mL	Oral		Abend, Marquel Marie, RN
08/20/16 0900	Given	30 mL	Oral		Yerby, Derrick J, RN
08/19/16 2056	Given	30 mL	Oral		McCullough, Elizabeth Ann, RN
08/19/16 0908	Given	30 mL	Oral		Marin, Lisa Nicole, RN
08/18/16 2120	Given	30 mL	Oral		Abend, Marquel Marie, RN
08/18/16 1007	Given	30 mL	Oral		Marin, Lisa Nicole, RN
08/17/16 2209	Given	30 mL	Oral		McCullough, Elizabeth Ann, RN
08/17/16 0839	Given	30 mL	Oral		Ellison, Ricky, RN
08/16/16 2018	Given	30 mL	Oral		McCullough, Elizabeth Ann, RN
08/16/16 0929	Given	30 mL	Oral		Britt, Julia Anna, RN
08/15/16 2043	Given	30 mL	Oral		Ghebreselassie, Freweini, RN
08/15/16 0900	Refused	30 mL	Oral		Harris, Stephanie, RN
	Comments: takes at night only				
08/14/16 2123	Given	30 mL	Oral		Smith, Hilda, RN
08/14/16 0857	Given	30 mL	Oral		Webb, Gina Marie, RN
08/13/16 2047	Given	30 mL	Oral		Smith, Hilda, RN

All Meds and Administrations (continued)

clonAZEPAM (klonoPIN) Tab 0.5 mg [658693025]
Status: Discontinued (Past End Date/Time), Reason: Inactivated medication

Ordering Provider: Schumm, Derek Daniel, MD
Ordered On: 08/14/16 1549
Dose (Remaining/Total): 0.5 mg (-/-)
Route: Oral
Admin Instructions:
Starts/Ends: 08/14/16 1549 - 08/15/16 1135
Frequency: BID PRN
Rate/Duration: - / -
Comments:

(No admins scheduled or recorded for this medication)

divalproex 24Hr-ER (DEPAKOTE ER) Tab 2,000 mg [658693037]
Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/15/16 1129
Dose (Remaining/Total): 2,000 mg (-/-)
Route: Oral
Admin Instructions: Do NOT chew, crush or break. **BLACK BOX WARNING**
Starts/Ends: 08/15/16 2100 - 08/20/16 1417
Frequency: EVERY BEDTIME
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/19/16 2056	Given	2,000 mg	Oral		McCullough, Elizabeth Ann, RN
08/18/16 2205	Given	2,000 mg	Oral		Abend, Marquel Marie, RN
08/17/16 2209	Given	2,000 mg	Oral		McCullough, Elizabeth Ann, RN
08/16/16 2018	Given	2,000 mg	Oral		McCullough, Elizabeth Ann, RN
08/15/16 2039	Given	2,000 mg	Oral		Ghebreselassie, Freweini, RN

gabapentin (NEURONTIN) Cap 300 mg [658693043]
Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/15/16 1135
Dose (Remaining/Total): 300 mg (-/-)
Route: Oral
Admin Instructions: Give at least 2 hours before or 2 hours after antacids containing aluminum or magnesium
Starts/Ends: 08/15/16 1135 - 08/16/16 1401
Frequency: Q4H PRN
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/16/16 0901	Given	300 mg	Oral		Britt, Julia Anna, RN
08/15/16 1419	Given	300 mg	Oral		Harris, Stephanie, RN

methotrexate Tab 7.5 mg [658693044]
Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/15/16 1516
Dose (Remaining/Total): 7.5 mg (-/-)
Route: Oral
Admin Instructions: CHEMOTHERAPY - DISPOSE OF PROPERLY --- Do NOT handle or break tablets **BLACK BOX WARNING**
Starts/Ends: 08/15/16 2100 - 08/26/16 1953
Frequency: EVERY 7 DAYS
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/22/16 2114	Given	7.5 mg	Oral		Abend, Marquel Marie, RN
08/15/16 2100	Given	7.5 mg	Oral		Ghebreselassie, Freweini, RN

gabapentin (NEURONTIN) Cap 300 mg [659990800]
Status: Completed (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/16/16 0934
Dose (Remaining/Total): 300 mg (0/1)
Route: Oral
Admin Instructions: Give at least 2 hours before or 2 hours after antacids containing aluminum or magnesium
Starts/Ends: 08/16/16 0945 - 08/16/16 0937
Frequency: STAT
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/16/16 0937	Given	300 mg	Oral		Britt, Julia Anna, RN

All Meds and Administrations (continued)

gabapentin (NEURONTIN) Cap 600 mg [659990801] — Status: Discontinued (Past End Date/Time), Reason: Inactivated medication

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/16/16 1401
Dose (Remaining/Total): 600 mg (-/-)
Route: Oral
Admin Instructions: Give at least 2 hours before or 2 hours after antacids containing aluminum or magnesium
Starts/Ends: 08/16/16 1401 - 08/22/16 1642
Frequency: Q4H PRN
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/22/16 1546	Given	600 mg	Oral		Abend, Marquel Marie, RN
08/19/16 2121	Given	600 mg	Oral		McCullough, Elizabeth Ann, RN
08/19/16 1342	Given	600 mg	Oral		Marin, Lisa Nicole, RN
08/18/16 1500	Given	600 mg	Oral		Grotle, Denise Terri, RN
08/17/16 1254	Given	600 mg	Oral		Ellison, Ricky, RN

lurasidone (LATUDA) Tab 20 mg [659990803] — Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/18/16 1457
Dose (Remaining/Total): 20 mg (-/-)
Route: Oral
Admin Instructions: Administer with food (Greater than or equal to 350 calories) **BLACK BOX WARNING**
Starts/Ends: 08/18/16 1700 - 08/19/16 1340
Frequency: DAILY WITH DINNER
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/18/16 1804	Given	20 mg	Oral		Abend, Marquel Marie, RN

lurasidone (LATUDA) Tab 40 mg [659990828] — Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/19/16 1340
Dose (Remaining/Total): 40 mg (-/-)
Route: Oral
Admin Instructions: Administer with food (Greater than or equal to 350 calories) **BLACK BOX WARNING**
Starts/Ends: 08/19/16 1700 - 08/21/16 1219
Frequency: DAILY WITH DINNER
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/20/16 1840	Given	40 mg	Oral		Abend, Marquel Marie, RN
08/19/16 1802	Given	40 mg	Oral		McCullough, Elizabeth Ann, RN

divalproex 24Hr-ER (DEPAKOTE ER) Tab 2,250 mg [659990835] — Status: Completed (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/20/16 1417
Dose (Remaining/Total): 2,250 mg (0/4)
Route: Oral
Admin Instructions: Do NOT chew, crush or break. **BLACK BOX WARNING**
Starts/Ends: 08/20/16 2100 - 08/23/16 2105
Frequency: EVERY BEDTIME
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/23/16 2105	Given	2,250 mg	Oral		Senior, Adolfo A, RN
08/22/16 2006	Given	2,250 mg	Oral		Abend, Marquel Marie, RN
08/21/16 2055	Given	2,250 mg	Oral		Rowny, Katharine Lynne, RN
08/20/16 2009	Given	2,250 mg	Oral		Abend, Marquel Marie, RN

All Meds and Administrations (continued)

benztropine (COGENTIN) Tab 1 mg [659990837] — Status: Completed (Past End Date/Time)

Ordering Provider: Trautner, Rick Jeffrey, MD
Ordered On: 08/20/16 2235
Dose (Remaining/Total): 1 mg (0/1)
Route: Oral
Admin Instructions: For EPS may repeat in 1 hour if ineffective
Starts/Ends: 08/20/16 2245 - 08/20/16 2240
Frequency: NOW
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/20/16 2240	Given	1 mg	Oral		Abend, Marquel Marie, RN

benztropine (COGENTIN) Tab 1 mg [659990838] — Status: Discontinued (Past End Date/Time), Reason: Inactivated medication

Ordering Provider: Trautner, Rick Jeffrey, MD
Ordered On: 08/20/16 2235
Dose (Remaining/Total): 1 mg (1/1)
Route: Oral
Admin Instructions: If first dose of cogentin 1mg is ineffective.
Starts/Ends: 08/20/16 2245 - 08/22/16 1642
Frequency: ONCE
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/20/16 2245	Not Given Reason: Patient sleeping	1 mg	Oral		Abend, Marquel Marie, RN

benztropine (COGENTIN) Tab 1 mg [659990839] — Status: Discontinued (Past End Date/Time)

Ordering Provider: Trautner, Rick Jeffrey, MD
Ordered On: 08/20/16 2235
Dose (Remaining/Total): 1 mg (-/-)
Route: Oral
Admin Instructions:
Starts/Ends: 08/20/16 2234 - 08/26/16 1953
Frequency: Q4H PRN
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/21/16 2109	Given	1 mg	Oral		Rowny, Katharine Lynne, RN
08/21/16 0859	Given	1 mg	Oral		Britt, Julia Anna, RN

lurasidone (LATUDA) Tab 20 mg [659990843] — Status: Discontinued (Past End Date/Time), Reason: Inactivated medication

Ordering Provider: Hirschtritt, Matthew E, MD
Ordered On: 08/21/16 1219
Dose (Remaining/Total): 20 mg (-/-)
Route: Oral
Admin Instructions: Administer with food (Greater than or equal to 350 calories) **BLACK BOX WARNING**
Starts/Ends: 08/21/16 1700 - 08/22/16 1642
Frequency: DAILY WITH DINNER
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/21/16 2056	Given	20 mg	Oral		Rowny, Katharine Lynne, RN

buprenorphine (BUTRANS) 5mcg/hr 2 Patch [659990844] — Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/22/16 1110
Dose (Remaining/Total): 2 Patch (-/-)
Route: Transdermal
Admin Instructions: Remove old patch.
BLACK BOX WARNING
Starts/Ends: 08/22/16 1115 - 08/26/16 1953
Frequency: EVERY MONDAY
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/22/16 1202	Given	2 Patch	Transdermal		Edwards, Sarah C, RN

All Meds and Administrations (continued)

OLANZapine ODT (zyPREXA ZYDIS) Solutab 5 mg [662630357] — Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/22/16 1642
Dose (Remaining/Total): 5 mg (-/-)
Route: Oral
Admin Instructions: Dissolve on tongue; do NOT chew or swallow whole. **BLACK BOX WARNING**
Starts/Ends: 08/22/16 2100 - 08/24/16 1845
Frequency: EVERY BEDTIME
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/23/16 2108	Given	5 mg	Oral		Senior, Adolfo A, RN
08/22/16 2006	Given	5 mg	Oral		Abend, Marquel Marie, RN

OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg [662630358] — Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/22/16 1642
Dose (Remaining/Total): 2.5 mg (-/-)
Route: Oral
Admin Instructions: Dissolve on tongue; do NOT chew or swallow whole. **BLACK BOX WARNING**
Starts/Ends: 08/22/16 1642 - 08/26/16 1953
Frequency: Q4H PRN
Rate/Duration: - / -
Comments:

(No admins scheduled or recorded for this medication)

pantoprazole (PROTONIX) Tab 40 mg [662630362] — Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/22/16 1644
Dose (Remaining/Total): 40 mg (-/-)
Route: Oral
Admin Instructions: Take 30 minute before a meal --- Do NOT crush, chew, or break.
Starts/Ends: 08/22/16 1645 - 08/26/16 1953
Frequency: DAILY 30 MIN BEFORE BKFST
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/26/16 0808	Given	40 mg	Oral		Harris, Stephanie, RN
08/25/16 0745	Given	40 mg	Oral		Edwards, Sarah C, RN
08/24/16 0755	Given	40 mg	Oral		Edwards, Sarah C, RN
08/23/16 0829	Given	40 mg	Oral		Marin, Lisa Nicole, RN
08/22/16 1756	Given	40 mg	Oral		Abend, Marquel Marie, RN

divalproex 12Hr-DR (DEPAKOTE) Tab 1,000 mg [662630366] — Status: Discontinued (Past End Date/Time), Reason: Inactivated medication

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/23/16 1541
Dose (Remaining/Total): 1,000 mg (-/-)
Route: Oral
Admin Instructions: Do NOT chew, crush or break. **BLACK BOX WARNING**
Starts/Ends: 08/24/16 0900 - 08/24/16 1845
Frequency: DAILY
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/24/16 0836	Given	1,000 mg	Oral		Edwards, Sarah C, RN

divalproex 12Hr-DR (DEPAKOTE) Tab 1,000 mg [662630367] — Status: Discontinued (Past End Date/Time), Reason: Inactivated medication

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/23/16 1541
Dose (Remaining/Total): 1,000 mg (-/-)
Route: Oral
Admin Instructions: Do NOT chew, crush or break. **BLACK BOX WARNING**
Starts/Ends: 08/24/16 2100 - 08/24/16 1845
Frequency: EVERY BEDTIME
Rate/Duration: - / -
Comments:

(No admins scheduled or recorded for this medication)

All Meds and Administrations (continued)

divalproex DR (DEPAKOTE SPRINKLE) Cap 1,000 mg [662630375] Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/24/16 1843
Dose (Remaining/Total): 1,000 mg (-/-)
Route: Oral
Admin Instructions: Capsules may be swallowed whole or opened and sprinkled on a small amount (1 teaspoonful) of soft food (e.g., pudding, applesauce) to be used immediately (do not store or chew)
BLACK BOX WARNING
Starts/Ends: 08/24/16 2100 - 08/26/16 1953
Frequency: EVERY BEDTIME
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/25/16 2100	Given	1,000 mg	Oral		McCullough, Elizabeth Ann, RN
08/24/16 2109	Given	1,000 mg	Oral		Scurry-Scott, Frazier M, RN

divalproex DR (DEPAKOTE SPRINKLE) Cap 1,000 mg [662630376] Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/24/16 1843
Dose (Remaining/Total): 1,000 mg (-/-)
Route: Oral
Admin Instructions: Capsules may be swallowed whole or opened and sprinkled on a small amount (1 teaspoonful) of soft food (e.g., pudding, applesauce) to be used immediately (do not store or chew)
BLACK BOX WARNING
Starts/Ends: 08/25/16 0900 - 08/26/16 1953
Frequency: DAILY
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/26/16 0827	Given	1,000 mg	Oral		Harris, Stephanie, RN
08/25/16 0937	Given	1,000 mg	Oral		Edwards, Sarah C, RN

OLANZapine ODT (zyPREXA ZYDIS) Solutab 7.5 mg [662630377] Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/24/16 1845
Dose (Remaining/Total): 7.5 mg (-/-)
Route: Oral
Admin Instructions: Dissolve on tongue; do NOT chew or swallow whole.
BLACK BOX WARNING
Starts/Ends: 08/24/16 2100 - 08/26/16 1953
Frequency: EVERY BEDTIME
Rate/Duration: - / -
Comments:

Administration	Status	Dose	Route	Site	Given by
08/25/16 2100	Given	7.5 mg	Oral		McCullough, Elizabeth Ann, RN
08/24/16 2116	Given	7.5 mg	Oral		Scurry-Scott, Frazier M, RN

***Rx Communication - Pharmacist drug regimen review [662630391]** Status: Discontinued (Past End Date/Time)

Ordering Provider: Cruz, John Michael de Vera, MD
Ordered On: 08/26/16 1452
Dose (Remaining/Total): 1 Each (1/1)
Route: Communication
Admin Instructions: Please release patient's medications that are being held in pharmacy. He will discharge today.
Starts/Ends: 08/26/16 1452 - 08/26/16 1953
Frequency: ONCE (UNSCHEDULED)
Rate/Duration: - / -
Comments:

(No admins scheduled or recorded for this medication)

Progress Notes

Behavioral Health Note by Tangorra, Joseph Peter, PHD at 08/09/16 1350

Author: Tangorra, Joseph Peter, PHD
Filed: 08/09/16 1355
Editor: Tangorra, Joseph Peter, PHD (Psychologist)
Service: Adult Mental Health
Note Time: 08/09/16 1350
Author Type: Psychologist
Status: Signed

Psychiatric Intake Note

Progress Notes (continued)

Behavioral Health Note by Tangorra, Joseph Peter, PHD at 08/09/16 1350 (continued)

Presenting Clinical:
The patient is a 47 yo male with an hx of mood disorder who presents to ABER on the advice of his outpatient psychiatrist secondary to acute SI. The patient's friend had to stop him from jumping out of a window. The patient has been increasingly depressed after stopping his Paxil rx two months ago. The patient was placed on a 5150 in the ED. No medical issues reported, labs and vital signs WNL per Dr. Brown. No violence toward others reported. No substance abuse reported, UDS positive for benzos in the ED.

Prior Psychiatric Treatment:
Hospitalizations: Unknown
Outpatient Therapist:
Outpatient Psychiatrist**:**

Drug and Alcohol History: No substance abuse reported, UDS positive for benzos in the ED.

Medical Problems: No medical issues reported, labs and vital signs WNL per Dr. Brown.

Admit Unit: 4EB

Admitting Doctor : 8AM-12PM
12PM-6PM STANGER
6PM-8AM MICHEL

Admitting Diagnosis: Mood dx NOS.

Signed by Tangorra, Joseph Peter, PHD at 08/09/16 1355

Behavioral Health Note by Tangorra, Joseph Peter, PHD at 08/09/16 1356

Author: Tangorra, Joseph Peter, PHD | Service: Adult Mental Health | Author Type: Psychologist
Filed: 08/09/16 1357 | Note Time: 08/09/16 1356 | Status: Signed
Editor: Tangorra, Joseph Peter, PHD (Psychologist)

The patient has been cleared for a bed at Herrick after 7:30pm, unit 4EB. Please phone report to x4452.

Signed by Tangorra, Joseph Peter, PHD at 08/09/16 1357

Behavioral Health Note by Silver, Amy E, RN at 08/09/16 1848

Author: Silver, Amy E, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/09/16 1851 | Note Time: 08/09/16 1848 | Status: Signed
Editor: Silver, Amy E, RN (Registered Nurse)

BEHAVIORAL HEALTH HAND OFF COMMUNICATION TOOL

☒ **ADMISSION** ☐ **PHP / OP** ☐ **ECT**

S = SITUATION

Progress Notes (continued)

Behavioral Health Note by Silver, Amy E, RN at 08/09/16 1848 (continued)

The patient is a 47 yo male with an hx of mood disorder who presents to ABER on the advice of his outpatient psychiatrist secondary to acute SI. The patient's friend had to stop him from jumping out of a window. The patient has been increasingly depressed after stopping his Paxil rx two months ago. The patient was placed on a 5150 in the ED. No medical issues reported, labs and vital signs WNL per Dr. Brown. No violence toward others reported. No substance abuse reported, UDS positive for benzos in the ED.

B = BACKGROUND

Special Needs: ☐ Vision ☐ Hearing ☐ Language(specify):

Mobility: ☐ With Assistance ☒ Without Assistance ☐ Total Assistance Needed
Type of assistive device used:

Abnormal / significant lab or test results: UDS positive for benzos
Abnormal / significant vital signs:

Infection control: ☐ Contact ☐ Airborne ☐ Droplet ☐ Other(Specify):

A = ASSESSMENT: *Assessment about the patient situation.*

Current mental status:
Anxious but calm and cooperative

Current Behavior: pleasant and calm

Active Medical Problems: hx of appendectomy and in 2004 had TURP

Skin: intact

Restraints:no

Has the client been searched? ☐ Yes ☒ No

Medication received: none

Pain status / intensity (1 – 10):
Location:
Last pain med given at:
Name of med:

Progress Notes (continued)

Behavioral Health Note by Silver, Amy E, RN at 08/09/16 1848 (continued)

R = RECOMMENDATION

Comments:

Information received from:Jocelle,RN
Phone number / extension:x2500

Signed by Silver, Amy E, RN at 08/09/16 1851

Behavioral Health Note by Silver, Amy E, RN at 08/09/16 2255

Author: Silver, Amy E, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/09/16 2255 | Note Time: 08/09/16 2255 | Status: Signed
Editor: Silver, Amy E, RN (Registered Nurse)

	08/09/16 2248
Legal Status	
Legal status	2 - 5150 - involuntary
Legal Status - 5150	
Start Date 5150	08/09/16
Start Time 5150	0925
End Date 5150	08/12/16
End Time 5150	0925
Precautions/Isolation	
Precautions (displays in banner)	13
Precautions Interventions	
Interventions Performed	yes
Level of Observation	every 15 minutes
Suicide Precautions	potential cords (belt, shoe laces, scarves, ties, etc.) removed from patient's possession;patient checked for contraband
Mental Status	
Orientation	oriented x 4
Level Of Consciousness	alert
General Appearance WDL	ex
General	unkempt;unshaven;bizarre appearance

Progress Notes (continued)

Behavioral Health Note by Silver, Amy E, RN at 08/09/16 2255 (continued)

Appearance	
Mood	anxious;depressed;feelings of doom;mood shifts
Mood/Behavior/ Affect WDL	ex
Behavior (WDL)	Ex
Mood/Behavior	anxious;cooperative;hyperactive;increased energy
Speech	ex
Speech	rapid;pressured;hyperverbal
Judgment and Insight	insight appropriate to situation;judgment appropriate to situation
Insight	fair
Concentration	fair
Memory Deficit	intact
Thought (WDL)	WDL
Psychiatric Symptoms	
Anxiety Symptoms (WDL)	Ex
Anxiety Symptoms	excessive anxiety or worry
Manic Symptoms (WDL)	Ex
Manic Symptoms	flight of ideas;increased energy;pressured speech hyperverbal
Psychotic symptoms (WDL)	WDL
Danger to Self	
Danger to Self (WDL)	WDL
Danger to Self	no suicidal ideation or behavior indicators observed or expressed
Keeps Self Safe	yes (describe)
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed
Agreement not to Harm Self	yes (describe)
Description of Agreement	verbal contract
Assessment Type	
Assessment timing	Admission

Progress Notes (continued)

Behavioral Health Note by Silver, Amy E, RN at 08/09/16 2255 (continued)

Assessment of contributing factors	
Assessment of Risk Factors	Prior suicide attempts;Sense of powerlessness/hopelessness
Assessment of Protective Factors	Good access to health care/therapy
Suicide Risk Assessment- Mood	
Agitation	None
Anxiety or Fearfulness	Moderate
Loss of Pleasure or Interest	Moderate
Depression or Sadness	Moderate
Suicide Plan for Today	None
Hopeless or Overwhelmed	High
Suicide Risk Assessment - Thinking	
Sleep Disturbances	Low
Cognition Problems	None
Psychotic Symptoms	None
Suicide Risk Assessment- Behavior	
Withholding Information	None
Resistance to Treatment	None
Impulsivity	None
Aggressive towards self/others	None
Suicide Risk Assessment- Health	
Pain, real or perceived	None
Perceived Loss of Health	Moderate
Suicidal Inquiry	
Suicide Ideation for Today	None
Behavior congruent with	Yes

Progress Notes (continued)

Behavioral Health Note by Silver, Amy E, RN at 08/09/16 2255 (continued)

Verbal and Non-Verbal	
Assessment of Current Suicide Risk	
Assessment of Current Suicide Risk	low in hospital, higher if discharged
Danger to Others	
Danger to Others (WDL)	WDL

Signed by Silver, Amy E, RN at 08/09/16 2255

Behavioral Health Note by Silver, Amy E, RN at 08/09/16 2100

Author: Silver, Amy E, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/09/16 2316 | Note Time: 08/09/16 2100 | Status: Signed
Editor: Silver, Amy E, RN (Registered Nurse)

☐Day Shift ☒PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	2	3.5	2

Signed by Silver, Amy E, RN at 08/09/16 2316

Behavioral Health Note by Silver, Amy E, RN at 08/09/16 2319

Author: Silver, Amy E, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/09/16 2321 | Note Time: 08/09/16 2319 | Status: Addendum
Editor: Silver, Amy E, RN (Registered Nurse)
Related Notes: Original Note by Silver, Amy E, RN (Registered Nurse) filed at 08/09/16 2247

Pt arrived on unit via AMR. Pt appears disheveled and unkempt. Pt was hyperverbal with pressured speech, but stated that he has hx of depression and bipolar but "I haven't been manic for a long time." Pt does appear to have flight of ideas. Pt denies A/V hallucinations and SI/HI. States that now that he is here in the hospital he

Progress Notes (continued)

Behavioral Health Note by Silver, Amy E, RN at 08/09/16 2319 (continued)

is not feeling suicidal. Pt has on at this time a Butran patch 10mcg/h which is a q week patch. Pt stated that he has Chronic Pelvic Pain Syndrome since 2003 and Fibromyalgia since 2009. Pt is treated at the Highland Pain Clinic, Amy Smith at 510 437-8377 is his contact person. Pt is on the Butran patch, Butran 2 mg prn and Norco 10/325 mg prn. Pt has Psoriasis all over his chest and legs, with no open wounds but is quite red with rashes. Pt states that he is going through "Paxil withdrawal." Pt is "overwhelmed and traumatized" by his "Paxil withdrawal" which started in May and ended up with him trying to jump out a window on Saturday. He has been having "panic attacks, " severe depression, and a suicide attempt that was stopped by a friend. Pt wants help and is contractible for safety in the hospital. Pt denies allergies or any other medical problems. Pt described sexual abuse that was between 4-9 years of age. Pt never smoked and denies using any ETOH or recreational drugs. This recent suicide attempt was the first time he has ever had an attempt. Pt has lost "a huge amount of weight" in the past few weeks and has a very poor appetite, a nutritional consult was ordered for this pt. Pt is stable for admit.

Signed by Silver, Amy E, RN at 08/09/16 2247
Signed by Silver, Amy E, RN at 08/09/16 2321

CarePlan Notes by Blackwood, Joan Caroline, RN at 08/10/16 0618

Author: Blackwood, Joan Caroline, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/10/16 0619 | Note Time: 08/10/16 0618 | Status: In Progress
Editor: Blackwood, Joan Caroline, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Pt resting in bed with eyes closed during Safety rounds. Pt was awake at start of shift, anxious, ambulating in the hall, stated he did not need med for sleep or anxiety.Pt stated being awake until 0000 was his usual sleep pattern. Pt did fall asleep soon after going to bed. No signs of distress. No complaints or signs of discomfort. Continue to monitor and assist as needed.

EVALYSIS

[ ]Day Shift [ ]PM Shift [X]Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS ACUITY	[ ]1	[ ]2	[X]3	[ ]4
ADL: Independent	[X]			
ADL: Partial assist / supervise		[ ]	[ ]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[ ]	[ ]	[ ]

Progress Notes (continued)

CarePlan Notes by Blackwood, Joan Caroline, RN at 08/10/16 0618 (continued)

Assess / Intervene: Above average			[X]	[X]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[X]	[X]
Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	2	1	2.5	2

Signed by Blackwood, Joan Caroline, RN at 08/10/16 0619

Progress Notes by Cruz, John Michael de Vera, MD at 08/10/16 0831

Author: Cruz, John Michael de Vera, MD | Service: Psychiatry | Author Type: Physician
Filed: 08/10/16 0832 | Note Time: 08/10/16 0831 | Status: Signed
Editor: Cruz, John Michael de Vera, MD (Physician)

INITIAL CERTIFICATION FOR MEDICARE

Due date: 8/9/2016

I certify that the inpatient psychiatric hospital admission was medically necessary for psychiatric treatment which would necessarily be expected to improve the patient's condition.

I estimate 7 days of hospitalization is necessary for proper treatment of the patient. My plans for post-hospital care for this patient are coordinating with outpatient provider.

Signed by Cruz, John Michael de Vera, MD at 08/10/16 0832

Care Team Note by Iwamura, Scott, RD at 08/10/16 0848

Author: Iwamura, Scott, RD | Service: Nutrition | Author Type: Dietitian/Nutritionist
Filed: 08/10/16 0859 | Note Time: 08/10/16 0848 | Status: Signed
Editor: Iwamura, Scott, RD (Dietitian/Nutritionist)

Nutrition Assessment

Consult received from nursing for recent unintentional weight loss. Patient confirms severe weight decrease over the past 2-3 weeks, roughly 15 lbs, during which time he has completely lost his appetite in setting of medication changes. Normally is 144 lbs, now down to 129 lbs on standing scale. He states he has only eaten 4 meals total over the past week. He has mostly been subsisting on Gatorade at home, usually not eating solid food. He reports a strange aversion to some solid foods such as sandwiches and is not clear as to why this is the case. He did eat well at breakfast this morning however. Sounds to do well with liquid/non-solid items.

Progress Notes (continued)

Care Team Note by Iwamura, Scott, RD at 08/10/16 0848 (continued)

Date of Admission: 8/9/2016
Admission Dx: Mood disorder (HCC) [F39]

Height: 5' 7" 8/9/16

Ideal Body Weight: 148 lbs. (± 10% to account for small to large framed individuals)./% Ideal Body Weight: 87.2%
Body Mass Index is 20.20 kg/m2. (Normal weight, BMI 19-25)
Wt Readings from Last 5 Encounters:
08/09/16 : 58.514 kg (129 lb)
Usual weight: 144 lbs

No intake or output data in the 24 hours ending 08/10/16 0700
Food allergies/intolerances: None
Religious/cultural/ethnic food preferences: None

Energy needs per Mifflin St. Jeor Equation: ~1980 kcal/day (1.4 activity factor)
Protein: 59-70 g/day (1-1.2 g/kg)
Fluid: 1 mL/kcal or per MD
Needs based on: Admit weight: 58.5 kg

Nutrition Rx: Regular diet (generic menu provides ~2150 kcal, 118g protein per day)

PO Intake: Ate all of breakfast this AM per patient, but poor intake 2-3 weeks PTA

Nutrition Dx: Inadequate oral intake related to poor appetite as evidenced by 15 lb decrease x 2-3 weeks

Interventions
- Regular diet
- Add Ensure Plus TID - currently doing well with liquids
- Extra items with trays - yogurt
- Honor food preferences

Monitor/Evaluate/Goals
- Weight: no further weight loss during admission
- PO adequacy: intake > 75% of meals and snacks daily
- Nutrition discharge plan: Too soon to determine discharge needs

Scott Iwamura, RD 8/10/2016 8:48 AM

Signed by Iwamura, Scott, RD at 08/10/16 0859

Behavioral Health Note by Himot, Craig at 08/10/16 1122

Author: Himot, Craig | Service: Social Services | Author Type: Others
Filed: 08/10/16 1140 | Note Time: 08/10/16 1122 | Status: Signed
Editor: Himot, Craig (Others)

Received chart for review and discussed case with inpatient care team. Met with patient to introduce self and explain role as Treatment Coordinator. Oriented patient to inpatient setting, provided emotional support and psycho education, and explored treatment and discharge planning goals. Patient identified to get my

Progress Notes (continued)

Behavioral Health Note by Himot, Craig at 08/10/16 1122 (continued)

medications right as treatment goal/s and return to his current residence as discharge planning goal/s. Patient participated in and is in agreement with plan of care.

Plan to continue to work with patient and care team to develop appropriate treatment and discharge planning goals. Will work to secure consent to contact patient's outpatient care team to coordinate care and ensure follow up care and support upon discharge.

This is a 47 y/o single, disabled, male who was admitted on a 5150 as DTS because of worsening depressed mood. On 8/6/16 he called his friend and told her he took medications and was having thoughts/urges to jump out of the window. He reports that he quit Paxil cold turkey approximately two months ago. He finally went to Sausal Creek last week and began to take 5 mg of Paxil per day. His psychiatrist increased it to 10 mg due to the severity of his depression. Pt denies current or past illicit drug or alcohol use. His current UDS was positive for benzo's. Pt reports having several prior psych hospitalizations in New Mexico, in 2006 and 2007. He was eventually diagnosed with Bipolar Disorder. He lives alone in an Oakland apartment, for the past 8 years and plans/wants to return there post discharge. He receives outpatient mental health services at Oakland Community Support Services. He also has a PCP as well as receiving services at the Highland Pain Clinic, for Fibromyalgia and Pelvic Pain Syndrome. He reports being estranged from his 2 sisters. He identifies Katy Kaminsky as a supportive friend and his case manager as part of his support system. Pt states that he graduated from William and Mary's and then received 2 graduate degrees at San Francisco State in music and business admin. Pt is cooperative with interview. He hypomanic, pressured, mood somewhat elevated. He denies prior suicide attempts. He denies any family history of suicide attempts. **Plan: Called pt's case manager for collateral information. Awaiting call back. Consider PHP referral.**

	08/10/16 1000
Referral Information	
Arrived From	emergency department
Referral Source	community
Reason For Consult	care coordination/care conference;discharge planning;mental health concerns
Record Reviewed	medical record
Social Worker Assigned to Case	Himot
Contact Information	
Comments	Pt gives verbal permission to talk with his case manager, psychiatrist, friend Katy Kaminski)
Community Case Manager Information	
Name	Al Boozer and Maureen Costello at Oakland Community Support Services
Phone	510-777-3820 and 510- 777-3850
Fax	510-777-3806
Psychiatrist Information	
Name	Dr. James Hinson at Oakland Community Support Services
Phone	510-777-3847
Primary Care Physician Information	
Name	Dr. Mark Robinson G.P. at Lifelong Medical Care
Phone	510-430-8740

Progress Notes (continued)

Behavioral Health Note by Himot, Craig at 08/10/16 1122 (continued)

Living Environment	
Lives With	alone
Living Arrangements	apartment
Provides Primary Care For	no one
Able to Return to Prior Living Arrangements	yes
Living Arrangement Comments	Pt has lived at this residence in Oakland for the past 8 years and plans to return there upon discharge.
Values/Beliefs	
(F) Faith: Importance of Culture, Spirituality, Religion in Life	Christian. Not currently active or involved in the chruch.
Substance Use, Patient	
Substance Use Comment	Pt denies current or past illicit drug or alcohol use.
Substance Use, Family	
Substance Use Comments	Did not ask.
Cognitive/Perceptual/Developmental	
Recent Changes in Mental Status/Cognitive Functioning	mood
Developmental Stage (Eriksson's Stages of Development)	Stage 7 (35-65 years/Middle Adulthood) Generativity vs. Stagnation
Employment/Financial	
Source Of Income	disability
Emotional/Psychological	
Affect	other (see comments) *(hypomanic)*
Mood	elevated
Verbal Skills	no deficits noted
Current	appropriate to situation

Progress Notes (continued)

Behavioral Health Note by Himot, Craig at 08/10/16 1122 (continued)

Interpersonal Conduct/Behavior	
Mental Health Conditions/Symptoms	bipolar affective disorder;labile mood;suicide attempt
Previous Mental Health Treatment	case management;inpatient treatment;medication;outpatient treatment;psychiatrist
Previous Mental Health Treatment Date	Several prior hospitalizations in 2006 and 2007 in New Mexico.
Mental Health Treatment	case management;inpatient treatment;medication;outpatient treatment;psychiatrist
Suicide Risk	
Self-Injurious Behavior	no self-injurious ideation or behavior indicators observed or expressed
Coping/Stress	
Major Change/Loss/Stressor	other (see comments) *(recent tapering of his psych medications)*
Patient Personal Strengths	able to adapt;expressive of emotions;expressive of needs;flexibility;future/goal oriented;positive attitude;resourceful;successful coping history
Sources Of Support	friend(s);mental health providers
Reaction To Health Status	accepting
Understanding Of Condition And Treatment	partial understanding of medical condition;partial understanding of treatment
Coping/Stress Comments	Thought about jumping out of the window on Saturday. Pt reports that his doctor at Oakland community Support (intern, now no longer works there) tapered his psych medications over the past several months. Pt believes he is going through "Paxil withdrawal". He has been having "panic attacks," epression. Recent wt loss. Feels "overwhelmed and traumatized" by his "Paxil withdrawl."
Legal	
Criminal Activity/Legal Involvement Pertinent to Current Situation/Hospitalization	Denies current or past legal involvement.
Discharge Needs Assessment	
Concerns To Be	care coordination/care conferences;coping/stress concerns;mental health concerns;suicidal

Progress Notes (continued)

Behavioral Health Note by Himot, Craig at 08/10/16 1122 (continued)

Addressed	concerns
Concerns Comments	This is pt's first suicide attempt/gesture. He lives alone. He denies any family hx of suicide attempts or gestures. Will contact his case manager for collateral information and request his current medication list. Consider referral to PHP program.
Readmission Within The Last 30 Days	no previous admission in last 30 days
Community Agency Name(S)	Oakland Community Support Services.
Anticipated Changes Related to Illness	none
Equipment Currently Used at Home	none
Equipment Needed After Discharge	none
Discharge Facility/Level Of Care Needs	other (see comments) *(Home, referral to PHP)*
Transportation Available	public transportation
Current Discharge Risk	lives alone;psychiatric illness
Discharge Disposition	still a patient
Discharge Planning Comments	See SW Plan
Social Work Plan	
Plan	Contact pt's case manager for collateral information, discharge planning recommendations and outpatient treatment follow-up appointments.

Signed by Himot, Craig at 08/10/16 1140

Interdisciplinary Rounding Note by Robertson, William B, RN at 08/10/16 1216

Author: Robertson, William B, RN
Filed: 08/10/16 1218
Editor: Robertson, William B, RN (Registered Nurse)
Service: Adult Mental Health
Note Time: 08/10/16 1216
Author Type: Registered Nurse
Status: Signed
Cosigner: Cruz, John Michael de Vera, MD at 08/10/16 1314

Pt has of bipolar. He is currently depressed with SI. Pt has a place to live and has a CM at Oakland Community Support. SW to follow up.

Progress Notes (continued)

Interdisciplinary Rounding Note by Robertson, William B, RN at 08/10/16 1216 (continued)

	08/10/16 1210
Patient Assets/Stressors	
Patient Assets	general fund of knowledge;average or above intelligence;motivation for treatment/growth;capable of independent living;supportive family/friends;work skills;physical health;ability for insight;communication skills
Patient Stressors	medication change or non-compliance
Discharge Planning	
Discharge Criteria	improved stabilization in mood, thinking and/or behavior;verbal commitment to aftercare and medication compliance
Recommended Discharge Plan	return to previous living environment;medication management with psychiatrist or other physician
Pt's Acceptance of Discharge Plan	yes
Why Continues to Need Hospitalization	severe impairment of level of functioning;danger to self or others;medication stabilization
Estimated Length of Stay	3-5 days
Provisional DSM 5 Diagnoses	
Problem Being Addressed	refer to problem list
Goal: Will work with social worker/treatment coordinator to develop safe discharge plan	

Progress Notes (continued)

Interdisciplinary Rounding Note by Robertson, William B, RN at 08/10/16 1216 (continued)

Goal Status	goal initiated
Goal: Will attend Occupational Therapy groups up to seven days weekly as tolerated	
Objectives	increase coping skills
Goal Status	progress made toward outcome
Treatment Plan Reviewed by	
Physician	Fitzpatrick
Psychiatric Social Worker	Himot
Registered Nurse	Robertson

Signed by Robertson, William B, RN at 08/10/16 1218
Signed by Cruz, John Michael de Vera, MD at 08/10/16 1314

CarePlan Notes by Mack, Marcus Darryl, RN at 08/10/16 1222

Author: Mack, Marcus Darryl, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/10/16 1508 | Note Time: 08/10/16 1222 | Status: Addendum
Editor: Mack, Marcus Darryl, RN (Registered Nurse)
Related Notes: Original Note by Mack, Marcus Darryl, RN (Registered Nurse) filed at 08/10/16 1254

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Pt was visible on the unit minimal interaction with staff or peers. Pt denies A/V hallucinations or SI this shift. Pt blames current hospitilization on "Paxil withdrawal".

EVALYSIS

[X]Day Shift [ ]PM Shift [ ]Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS ACUITY	[ ]1	[X]2	[ ]3	[ ]4
ADL: Independent	[X]			
ADL: Partial assist / supervise		[ ]	[ ]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			

Progress Notes (continued)

CarePlan Notes by Mack, Marcus Darryl, RN at 08/10/16 1222 (continued)

Assess / Intervene: Average		[X]	[X]	[X]
Assess / Intervene: Above average			[ ]	[ ]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[ ]	[ ]
Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	2	2	1.5	1

Signed by Mack, Marcus Darryl, RN at 08/10/16 1223
Signed by Mack, Marcus Darryl, RN at 08/10/16 1254
Signed by Mack, Marcus Darryl, RN at 08/10/16 1508

CarePlan Notes by Rossman, Ayla L, RN at 08/10/16 1812

Author: Rossman, Ayla L, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/10/16 1812 | Note Time: 08/10/16 1812 | Status: Signed
Editor: Rossman, Ayla L, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Denies suicidal ideation, stated he was on the wrong medication yet some medications have the side effect of feeling suicidal. He stated he would talk with his lawyer
Concerned about losing his job He helps children to prepare for the Olympics.
He presents with certain amount of anxiety.. He is willing to work on his issues and will be transferred to 4EA
Will give report to Bill RN prior to transfer. Ate 100% at dinner, signed in voluntarily .

Signed by Rossman, Ayla L, RN at 08/10/16 1812

Care Team Note by Rossman, Ayla L, RN at 08/10/16 1813

Author: Rossman, Ayla L, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/10/16 1813 | Note Time: 08/10/16 1813 | Status: Signed
Editor: Rossman, Ayla L, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☒PM Shift ☐Noc Shift

PATIENT CARE INDICATORS

Progress Notes (continued)

Care Team Note by Rossman, Ayla L, RN at 08/10/16 1813 (continued)

CARE INDICATORS → ACUITY ↓	☐1	☐2	☒3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	2	3.5	2

Signed by Rossman, Ayla L, RN at 08/10/16 1813

CarePlan Notes by Hudson II, William Howard, RN at 08/10/16 2230

Author: Hudson II, William Howard, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/10/16 2231 | Note Time: 08/10/16 2230 | Status: Addendum
Editor: Hudson II, William Howard, RN (Registered Nurse)
Related Notes: Original Note by Hudson II, William Howard, RN (Registered Nurse) filed at 08/10/16 2230

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Patient transferred from 4EB. He is disheveled and somewhat bizarre. He is focused on the scores of the "shooting team from the Olympics." He claims he is a coach or somehow involved with the team. He is dressed in pants with a Hospital gown tucked into them with it partially open in the back. He has shirts available. Patient denied any SI HI AH VH, contracted for safety on the unit. q15 minute checks, suicide precautions will continue to monitor.

EVALYSIS

☐Day Shift ☒PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☒2	☐3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐

Progress Notes (continued)

CarePlan Notes by Hudson II, William Howard, RN at 08/10/16 2230 (continued)

Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	3	2.5	1

Signed by Hudson II, William Howard, RN at 08/10/16 2230
Signed by Hudson II, William Howard, RN at 08/10/16 2231

CarePlan Notes by Borja, Maryann L, RN at 08/10/16 2356

Author: Borja, Maryann L, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/11/16 0730 | Note Time: 08/10/16 2356 | Status: Addendum
Editor: Borja, Maryann L, RN (Registered Nurse)
Related Notes: Original Note by Borja, Maryann L, RN (Registered Nurse) filed at 08/10/16 2356

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
PM shift reports pt to have transferred from 4EB, is bizarre, disheveled, focused on the Olympics and claims to be a coach, dressed strangely, denied any SI/HI and A/V hallucinations.

During the night shift, Pt in bed asleep @ change of shift w/no respiratory distress/discomfort noted. Will continue to monitor for changes.

Failed attempt to draw pt's blood on left anticubital and left had, pt drank water to hydrate and was cooperative and wanted this writer to try a 3rd time, advised pt to continue drinking water and that we would try tomorrow morning.

EVALYSIS

[ ]Day Shift [ ]PM Shift **[X]Noc Shift**

PATIENT CARE INDICATORS				
CARE INDICATORS ACUITY				
	[ ]1	[X]2	[ ]3	[ ]4
ADL: Independent	[ ]			
ADL: Partial assist / supervise		[X]	[X]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[X]	[X]	[X]

Progress Notes (continued)

CarePlan Notes by Borja, Maryann L, RN at 08/10/16 2356 (continued)

Assess / Intervene: Above average			[ ]	[ ]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[ ]	[ ]
Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	1	3	2.5	1

Signed by Borja, Maryann L, RN at 08/10/16 2356
Signed by Borja, Maryann L, RN at 08/11/16 0730

CarePlan Notes by Gurian, Nancy M, LCSW at 08/11/16 1252

Author: Gurian, Nancy M, LCSW | Service: Social Services | Author Type: Licensed Clinical Social Worker
Filed: 08/11/16 1252 | Note Time: 08/11/16 1252 | Status: Signed
Editor: Gurian, Nancy M, LCSW (Licensed Clinical Social Worker)

Problem: Patient Care Overview
Goal: Discharge Needs Assessment
Outcome: Ongoing (interventions implemented as appropriate)
Received a call from Pt's IHHS worker, William, who informed this writer that he is taking care of Pt's mail and Pt's cat. William also reported that a month or so before admission Pt. was dealing with lots of stress related to trying to evict a roommate who trashed his apartment. The process took four court appearances to ask the roommate to vacate the apartment. Pt. has to purchased all new things resulting in financial debt. Pt. had to call father in China for financial help, causing him more distress. According to William, Pt. had firearms that he then removed from his home and locked up to sell. He has one firearm left and is in the process of selling it. SW staff will review this with Pt. and with CM, Al Boozer. This writer left a message with CM, Al Boozer. Waiting for a return call.

Signed by Gurian, Nancy M, LCSW at 08/11/16 1252

CarePlan Notes by Ellison, Ricky, RN at 08/11/16 1420

Author: Ellison, Ricky, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/11/16 1420 | Note Time: 08/11/16 1420 | Status: Signed
Editor: Ellison, Ricky, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Pts affect flat moods depressed and anxious at times,pt verbalizes feeling slightly more relaxed today but says

CarePlan Notes by Ellison, Ricky, RN at 08/11/16 1420 (continued)

that he still wouldn't be safe at home without structure and since his moods are still unstable.

Signed by Ellison, Ricky, RN at 08/11/16 1420

Progress Notes by Cruz, John Michael de Vera, MD at 08/11/16 0823

Author: Cruz, John Michael de Vera, MD | Service: Psychiatry | Author Type: Physician
Filed: 08/11/16 1706 | Note Time: 08/11/16 0823 | Status: Signed
Editor: Cruz, John Michael de Vera, MD (Physician)

PSYCHIATRY PROGRESS NOTE

Thursday, August 11, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- Slept - 5 hours
- Failed blood draw

In speaking to the psychiatrist, the patient states
- mood: "little depressed" - slightly better than yesterday though
- appetite: "good" and eating solid foods now - better than yesterday
- anxiety: Had a panic attack in the middle of group today and the panic attack decreased and stopped after taking the PRN Gabapentin 300 mg
- psychomotor agitation: denies
- sleep: "good" and had no difficulties falling asleep or staying asleep and slept until 7:00am this morning and woke up feeling rested - better than yesterday
- energy: "good" and rates it 40/100 (0 - poor, 100 - too elevated) - better than yesterday
- pain: denies
- passive death wish: denies
- suicidal ideation: denies
- racing thoughts: denies
- psychomotor agitation: denies
- homicidal ideation: denies

- overall: His depressive states are not as intense as they used to be.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 117/70 | Pulse 77 | Temp (Src) 98.1 °F (36.7 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 98%
Wt Readings from Last 3 Encounters:
08/09/16 : 58.514 kg (129 lb)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: Not applicable
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: euthymic
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Good

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for:, anxiety and panic attacks

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:

Recent Labs

Lab	08/09/16 1025

WBC	2.2 L
HGB	13.3 L
HCT	40.2
PLT	233

Recent Labs

Lab	08/09/16 1025
NA	144
K	4.0
CL	106
CO2	32
BUN	18
CREATININE	0.93
GLU	100 H
CA	9.1

Recent Labs

Lab	08/09/16 1025
TBILI	0.8
AST	39 H
ALT	61 H
ALP	103
ALB	4.0

No results for input(s): GLUCAP in the last 72 hours.

Recent Labs

Lab	08/09/16 1025
TSH	0.67

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• aluminum/magnesium hydroxide/simethicon	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD		

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/11/16 0823 (continued)

e (MYLANTA) Oral Susp 30 mL					
• [START ON 8/15/2016] buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD	
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD	
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 1,500 mg	1,500 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD	1,500 mg at 08/10/16 2108
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/10/16 1700
• gabapentin (NEURONTIN) Cap 300 mg	300 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD	
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	Q BEDTIME	Sharma, Kanika, MD	30 mL at 08/10/16 2110
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• [START ON 8/16/2016] methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	
• [START ON 8/15/2016] methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:

- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations
- monitor for toxicity of Divalproex ER which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia

PLAN:

 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 1500 mg PO at bedtime
- f/ Valproic Acid trough level on Saturday night, adjusting level to reach goal between 50 - 125
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime, may repeat x 1

 # Post Traumatic Stress Disorder
- continue PRN Gabapentin 300 mg PO q4h for anxiety
- f/u with outpatient therapy

 # Panic Attacks:
- continue PRN Gabapentin 300 mg PO q4h for anxiety

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP

 # Estimated Length of Stay
- ~ 5 - 8 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Thursday, August 11, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
mood instability

Intervention:
Increase awareness of emotional states/reality testing
Demonstrate interventions in thought-emotion-behavior triad
Motivational interviewing to assess/assist readiness to change
Increase insight into illness and treatment plan
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided positive reinforcement for being honestly reporting his mental state. Provided psychoeducation about the projected course of treatment of bipolar disorder which is that a person's moods will swing between being extremely elevated to being extremely depressed, but once treatment is initiated, the range between

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/11/16 0823 (continued)

these two poles will be much less. He understood. In addition, I also explained that the panic attack that he felt this morning was most likely a component of a depressive episode that he is currently experiencing. He voiced understanding.

ATTENDING PHYSICIAN:
John M Cruz, MD

Signed by Cruz, John Michael de Vera, MD at 08/11/16 1706

CarePlan Notes by Elliott, Harold Edward, OT at 08/11/16 1706

Author: Elliott, Harold Edward, OT | Service: Occupational Therapy | Author Type: Occupational Therapist
Filed: 08/11/16 1707 | Note Time: 08/11/16 1706 | Status: Signed
Editor: Elliott, Harold Edward, OT (Occupational Therapist)

Occupational Therapy Assessment Note
Adult Inpatient Behavioral Health

Assessment Completed on: 8/11/16

Source of Data

Source of Data
Source of Data: chart audit, task observation, patient interview
Diagnosis: Bipolar disorder without psychotic features
Precautions: SI

History

History
Reason for admit: Presents to ABER on the advice of his outpatient psychiatrist secondary to acute SI (w/ active plan of jumping out of a window); UDS positive for benzos (denies any substance abuse issues)
Prior Psych/CD HX: BPD; spontaneous anxiety, dyspnea, dizziness, heart palpitations, faintness, nausea, fear of dying; sexual abuse which he most recently recalled in July 2016
Prior level of function (Living/work history): 47 yo male, lives by himself in the city of Oakland, CA

Observations

General Observations
Mood/Behavior/Affect WDL: WDL except
Mood: anxious, depressed
Orientation: oriented x 4
Thought (WDL): WDL except
Thought Process: disorganized (perseverated)
Speech: clear, hyperverbal
General Appearance WDL: WDL except
General Appearance: unkempt

Assessment

Functional Status - Basic Skills
Grooming/hygiene: 1 Dysfunctional
Functional Status - General Behavior
Attends group: 1 Dysfunctional

Stays through group: 1 Dysfunctional
Initiates activity/motivation: 1 Dysfunctional
Functional Status - Task Behavior
Alert/attentive: 2 Inconsistently functional
Retains/recalls directions: 2 Inconsistently functional
Follows directions: 2 Inconsistently functional
Judgment/problem solving: 1 Dysfunctional
Functional Status - Interpersonal Behavior
Socially visible/engageable: 1 Dysfunctional
Interaction with peers: 1 Dysfunctional
Use of staff: 1 Dysfunctional
Affect/mood congruent: 2 Inconsistently functional
Self Esteem: 1 Dysfunctional
Recreation/Leisure
Deficit in fitness routine: yes
Deficit engaging in leisure interest/hobbies: yes
Life Skills
Deficit in stress management: yes
Deficit in ability to express emotions: yes

Summary Comments
Evaluation Time: 60
Summary comments: 4 units @ 15 minuten
s each.

Occupational Therapy Treatment Plan

Goals Group;Leisure Skills;Coping Skills;Cognitive Behavioral Therapy;Self-Esteem;Dialectical Behavioral Therapy;Socialization;Stress Management Skills;Expressive Therapy Groups;Fitness/Movement Groups;1:1 Treatment as needed;Task Groups (crafts, cooking);Communication Skills;Discharge Planning;Psych Education

Discharge Plan: Continued outpatient therapy as appropriate.

OT Goals:

1. Increase Engagement in OT Groups as demonstrated by patient's attending and participating in at least two OT groups per day.

2. Increase Coping Skills as demonstrated by patient's ability to learn and practice one new DBT skill to enable patient to self regulate emotions including depression and by patient's ability to state at least 2 ways to deal with stress.

3. Increase Self-esteem as demonstrated by patient's ability to state two positive qualities about self.

4. Increase Socialization as demonstrated by patient's ability to initiate one interaction with a peer per group and by patient's ability to state at least one way to positively interact with others outside of the hospital.

Progress Notes (continued)

CarePlan Notes by Elliott, Harold Edward, OT at 08/11/16 1706 (continued)

Edward Elliott, OTR/L

Signed by Elliott, Harold Edward, OT at 08/11/16 1707

CarePlan Notes by Elliott, Harold Edward, OT at 08/11/16 1739

Author: Elliott, Harold Edward, OT | Service: Occupational Therapy | Author Type: Occupational Therapist
Filed: 08/11/16 1739 | Note Time: 08/11/16 1739 | Status: Signed
Editor: Elliott, Harold Edward, OT (Occupational Therapist)

Problem: Depression (Adult,Obstetrics,Pediatric)
Goal: Improved/Stable Mood
Outcome: Ongoing (interventions implemented as appropriate)

Check-in (Community) Meeting
Group Start Time: 9:30

Group focused on review of program schedule and guidelines, identification of treatment issues, mood rating and identification and formulation of daily therapeutic goal(s).

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

AFFECT: Restricted, Guarded

APPEARANCE/BEHAVIOR: withdrawn:

COGNITION: disorganized and perseverated

INTERVENTION/EDUCATION: Unit orientation, Individual patient check-in, mood identification, goal setting. Prompted patient to participate, Provided support, Redirected patient and Encouraged interaction with peers

PATIENT RESPONSE: Attentive/Engaged, Stated feeling "depression/ scared/ panic" and shared that he just realized a sexual abuse trauma from the past.

GOAL SET: set treatment goal for day, to "talk to other".

3 of 3 units @ 15 min.

Expressive Modalities / Improvisation
Group Start Time: 14

Modalities include paper and pencil, ink, crayon, paint, or theatrical improvisation to encourage individual and group expression of feelings; use of creative imagination and the exercise of established skills to increase self-worth and encourage insight.

Patient did not attend this group.

0 of 4 units @ 15 min.

Progress Notes (continued)

CarePlan Notes by Elliott, Harold Edward, OT at 08/11/16 1739 (continued)

Signed by Elliott, Harold Edward, OT at 08/11/16 1739

CarePlan Notes by Ghebreselassie, Freweini, RN at 08/11/16 1952

Author: Ghebreselassie, Freweini, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/11/16 1952 | Note Time: 08/11/16 1952 | Status: Signed
Editor: Ghebreselassie, Freweini, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)

Described mood "stable" in relation to the normally stable feelings he experienced around 1700 every day. Expressed sadness after receiving a phone call on the sudden death of a close and supportive roommate. Patient denied any SI. Slept well last night "after so long" credited it to medication adjustment. Hopeful on continued medication adjustment before his discharge. No psychosis noted.
Calm and cooperative; visible in the unit . Went out on a walk. Instructed to shower, and did not resist.

Will continue to monitor in the unit. Often interactive with other peers.

EVALYSIS

[ ]Day Shift [X]PM Shift [ ]Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS ACUITY	[ ]1	[X]2	[ ]3	[ ]4
ADL: Independent	[X]			
ADL: Partial assist / supervise		[ ]	[ ]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[X]	[X]	[X]
Assess / Intervene: Above average			[ ]	[ ]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[ ]	[ ]

Progress Notes (continued)

CarePlan Notes by Ghebreselassie, Freweini, RN at 08/11/16 1952 (continued)

Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	2	2	1.5	1

Signed by Ghebreselassie, Freweini, RN at 08/11/16 1952

CarePlan Notes by Borja, Maryann L, RN at 08/12/16 0054

Author: Borja, Maryann L, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/12/16 0634 | Note Time: 08/12/16 0054 | Status: Addendum
Editor: Borja, Maryann L, RN (Registered Nurse)
Related Notes: Original Note by Borja, Maryann L, RN (Registered Nurse) filed at 08/12/16 0054

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
PM shift reports feeling stable, expressed feeling sad after a phone call he received, was calm, went out on a walk and expressed that the medication has helped him sleep.

During the night shift, Received pt asleep in bed w/eyes closed, unlabored respirations and did not wake up once during the night. Will continue to monitor for any changes.

EVALYSIS

[ ]Day Shift [ ]PM Shift **[X]Noc Shift**

PATIENT CARE INDICATORS				
CARE INDICATORS ACUITY				
	[ ]1	[X]2	[ ]3	[ ]4
ADL: Independent	[ ]			
ADL: Partial assist / supervise		[X]	[X]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[X]	[X]	[X]
Assess / Intervene: Above average			[ ]	[ ]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[ ]	[ ]

Progress Notes (continued)

CarePlan Notes by Borja, Maryann L, RN at 08/12/16 0054 (continued)

Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	1	3	2.5	1

Signed by Borja, Maryann L, RN at 08/12/16 0054
Signed by Borja, Maryann L, RN at 08/12/16 0634

Interdisciplinary Rounding Note by Han, Janet Z, RN at 08/12/16 1014

Author: Han, Janet Z, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/12/16 1017 | Note Time: 08/12/16 1014 | Status: Signed
Editor: Han, Janet Z, RN (Registered Nurse)

Transferred from 4EB, able to tolerate program well, seems preoccupied., MD continues medication adjustment. Provide support and monitor safety.

	08/12/16 1014
Patient Assets/Stressors	
Patient Assets	general fund of knowledge;average or above intelligence;motivation for treatment/growth;capable of independent living;supportive family/friends;work skills;physical health;ability for insight;communication skills
Patient Stressors	medication change or non-compliance
Discharge Planning	
Discharge Criteria	improved stabilization in mood, thinking and/or behavior;verbal commitment to aftercare and medication compliance
Recommended Discharge Plan	return to previous living environment;medication management with

Progress Notes (continued)

Interdisciplinary Rounding Note by Han, Janet Z, RN at 08/12/16 1014 (continued)

	psychiatrist or other physician
Pt's Acceptance of Discharge Plan	yes
Why Continues to Need Hospitalization	severe impairment of level of functioning;danger to self or others;medication stabilization
Estimated Length of Stay	3-5 days
Provisional DSM 5 Diagnoses	
Problem Being Addressed	refer to problem list
Goal: Will work with social worker/treatment coordinator to develop safe discharge plan	
Goal Status	goal initiated
Goal: Will attend Occupational Therapy groups up to seven days weekly as tolerated	
Objectives	increase coping skills
Goal Status	progress made toward outcome
Treatment Plan Reviewed by	
Psychiatric Social Worker	Himot
Registered Nurse	Seeley, Kader
Nurse Manager	Han
Other	Leveton

Signed by Han, Janet Z, RN at 08/12/16 1017

CarePlan Notes by Webb, Gina Marie, RN at 08/12/16 1312

Author: Webb, Gina Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/12/16 1312 | Note Time: 08/12/16 1312 | Status: Signed
Editor: Webb, Gina Marie, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Visible in milieu. Pleasant upon approach, social with peers. Disheveled and malodorous. Encouraged attention to ADL's. Attended groups. Reported last night he had "the best sleep" that he has had since April. Requested and received gabapentin for anxiety around 1200. Stated anxiety wasn't "as bad as it has been." Denied SI. Compliant with blood draw.

Progress Notes (continued)

CarePlan Notes by Webb, Gina Marie, RN at 08/12/16 1312 (continued)

EVALYSIS

[ ]Day Shift [X]PM Shift [ ]Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS ACUITY	[ ]1	[ ]2	[X]3	[ ]4
ADL: Independent	[ ]			
ADL: Partial assist / supervise		[X]	[X]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[ ]	[ ]	[ ]
Assess / Intervene: Above average			[X]	[X]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[ ]	[ ]
Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	1	2	2.5	1

Signed by Webb, Gina Marie, RN at 08/12/16 1312

Care Team Note by Iwamura, Scott, RD at 08/12/16 1335

Author: Iwamura, Scott, RD | Service: Nutrition | Author Type: Dietitian/Nutritionist
Filed: 08/12/16 1339 | Note Time: 08/12/16 1335 | Status: Signed
Editor: Iwamura, Scott, RD (Dietitian/Nutritionist)

Nutrition Follow Up

Progress Notes (continued)

Care Team Note by Iwamura, Scott, RD at 08/12/16 1335 (continued)

Appetite improving, still having aversions to certain foods but overall doing well with most meal items. Drinking supplements TID. Food preferences updated.

Interventions
- Regular diet, Ensure Plus TID
- Honor food preferences - extra soup, yogurt TID

Date of Admission: 8/9/2016
Admission Dx: Mood disorder (HCC) [F39]

Height: 5' 7" 8/9/16

Ideal Body Weight: 148 lbs. (± 10% to account for small to large framed individuals)./% Ideal Body Weight: 87.2%
Body Mass Index is 20.20 kg/m2. (Normal weight, BMI 19-25)
Wt Readings from Last 5 Encounters:
08/09/16 : 58.514 kg (129 lb)

No intake or output data in the 24 hours ending 08/12/16 0700
Energy needs per Mifflin St. Jeor Equation: ~1980 kcal/day (1.4 activity factor)
Protein: 59-70 g/day (1-1.2 g/kg)
Fluid: 1 mL/kcal or per MD
Needs based on: Admit weight: 58.5 kg

Nutrition Rx: Regular diet (generic menu provides ~2150 kcal, 118g protein per day)

PO Intake: Inadequate oral intake related to poor appetite as evidenced by 15 lb decrease x 2-3 weeks - improved/resolving

Nutrition Dx: Only 1 meal recorded 100%; reports eating well > 75% meals, drinking Ensure Plus TID

Interventions
- Regular diet, Ensure Plus TID
- Honor food preferences - extra soup, yogurt TID

Monitor/Evaluate/Goals
- Weight: Maintain weight within +/- 5% during admission
- PO adequacy: intake > 75% of meals and snacks daily
- Nutrition discharge plan: Continue supplements following discharge

Scott Iwamura, RD 8/12/2016 1:35 PM

Signed by Iwamura, Scott, RD at 08/12/16 1339

Behavioral Health Note by Leveton, Julian at 08/12/16 0930

Author: Leveton, Julian | Service: (none) | Author Type: Others
Filed: 08/12/16 1729 | Note Time: 08/12/16 0930 | Status: Signed
Editor: Leveton, Julian (Others)

Check-in (Community) Meeting

Behavioral Health Note by Leveton, Julian at 08/12/16 0930 (continued)

Group focused on review of program schedule and guidelines, identification of treatment issues, mood rating and identification and formulation of daily therapeutic goal(s).

AFFECT: Appropriate

APPEARANCE/BEHAVIOR: appropriate:

COGNITION: coherent and goal directed

INTERVENTION: Unit orientation, Individual patient check-in, mood identification, goal setting. Provided support

PATIENT RESPONSE: Attentive/Engaged

GOAL SET: set treatment goal for day

COMMENTS: Discuss pass Trauma, and learn to let go of negative feelings brought on by past events

Signed by Leveton, Julian at 08/12/16 1729

Behavioral Health Note by Leveton, Julian at 08/12/16 1100

Author: Leveton, Julian | Service: (none) | Author Type: Others
Filed: 08/12/16 1738 | Note Time: 08/12/16 1100 | Status: Signed
Editor: Leveton, Julian (Others)

Process Group

Group focused on promotion of improved communication and positive, interpersonal experiences—generalizable to relationships outside of the program—to provide opportunity for verbal expression and processing.

AFFECT: Appropriate

APPEARANCE/BEHAVIOR: appropriate:

COGNITION: coherent and goal directed

INTERVENTION/EDUCATION: Provided support

PATIENT RESPONSE: Attentive/Engaged

Progress Notes (continued)

Behavioral Health Note by Leveton, Julian at 08/12/16 1100 (continued)

COMMENTS: This patient attended this group, and was able to join in on the group process. This patient discussed past traumatic events not in detail, but in the negative feelings brought on by them, and wanting and needing to find way's to let go, and feel calm. This patient and writer talked about discussing his feelings with his therapist, and or others, and letting people know when he feels triggered or angered by something, and then letting go of it. The patient is very interested in practicing this, while also practicing meditation, learning to do walking meditations, to try something different. This patient found a lot of support from his peers, as he was also supportive of them, as they shared as well.

Signed by Leveton, Julian at 08/12/16 1738

Behavioral Health Note by Leveton, Julian at 08/12/16 1400

Author: Leveton, Julian | Service: (none) | Author Type: Others
Filed: 08/12/16 1741 | Note Time: 08/12/16 1400 | Status: Signed
Editor: Leveton, Julian (Others)

Creative Writing Group

AFFECT: Appropriate

APPEARANCE/BEHAVIOR: appropriate:

COGNITION: coherent and goal directed

INTERVENTION/EDUCATION: Provided support

PATIENT RESPONSE: Attentive/Engaged

COMMENTS: This patient joined the group, and was able to complete the prompt given by this writer. In group patients were invited to either write, a guided imagery focussed meditation, or do free writing, and see what occur's. This patient explored a walking meditation process, and read his writing aloud to the group.

Signed by Leveton, Julian at 08/12/16 1741

Progress Notes by Cruz, John Michael de Vera, MD at 08/12/16 0830

Author: Cruz, John Michael de Vera, MD | Service: Psychiatry | Author Type: Physician
Filed: 08/12/16 1850 | Note Time: 08/12/16 0830 | Status: Signed
Editor: Cruz, John Michael de Vera, MD (Physician)

PSYCHIATRY PROGRESS NOTE

Friday, August 12, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- Learned of roommate's death
- Slept - 7.5 hours
- PRN Gabapentin 300 mg - 9:50

In speaking to the psychiatrist, the patient states
- mood: "sad and relief" - better than yesterday - because of learning of roommate's death. Roommate in the past trashed his apartment causing him to buy new furniture and asking his father for help.
- appetite: "good" - same as yesterday - eating solid foods and three meals a day with snacks
- anxiety: "yes" and had a panic attack earlier this morning, but the panic attack was much lower than yesterday - better than yesterday - because Gabapentin helps
- psychomotor agitation: denies
- sleep: "great" and slept 10 hours - better than the night before - because Divalproex is working
- energy: "very good" - better than yesterday - as a result of getting a good night's sleep.
- pain: "yes" and has a headache and rates it a 3/10 (0 - none, 10 - severe) - worse than yesterday
- passive death wish: denies
- suicidal ideation: denies

- energy: "good" - rates it 50/100 (0 - poor, 10 - too high) - same as yesterday
- homicidal ideation: denies

- overall: Feels calmer and recognizes that his thinking is slowing down and becoming more focused

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 136/88 | Pulse 78 | Temp (Src) 98.2 °F (36.8 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 96%
Wt Readings from Last 3 Encounters:
08/09/16 : 58.514 kg (129 lb)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: Not applicable
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL

- Affect:: Appropriate
- Mood: anxious and depressed
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Good

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for: and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:

Recent Labs

Lab	08/09/16 1025
WBC	2.2 L
HGB	13.3 L
HCT	40.2
PLT	233

Recent Labs

Lab	08/09/16 1025
NA	144
K	4.0
CL	106
CO2	32
BUN	18
CREATININE	0.93
GLU	100 H

CA	9.1

Recent Labs

Lab	08/09/16 1025
TBILI	0.8
AST	39 H
ALT	61 H
ALP	103
ALB	4.0

No results for input(s): GLUCAP in the last 72 hours.

Recent Labs

Lab	08/09/16 1025
TSH	0.67

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD		
• [START ON 8/15/2016] buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD		
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD		
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 1,500 mg	1,500 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		1,500 mg at 08/11/16 2059
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera,		1 mg at 08/12/16

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/12/16 0830 (continued)

				MD	0826
• gabapentin (NEURONTIN) Cap 300 mg	300 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD	300 mg at 08/11/16 0950
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	Q BEDTIME	Sharma, Kanika, MD	30 mL at 08/11/16 2100
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• [START ON 8/16/2016] methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	
• [START ON 8/15/2016] methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient

psychiatric hospitalizations

PLAN:
 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 1500 mg PO at bedtime
- f/ Valproic Acid trough level on Saturday night, goal between 50 - 125
- WEEKEND: Adjust Divalproex ER dosage based on trough level
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent initiation
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime, may repeat x 1

 # Post Traumatic Stress Disorder
- continue PRN Gabapentin 300 mg PO q4h for anxiety
- f/u with outpatient therapy

 # Panic Attacks:
- continue PRN Gabapentin 300 mg PO q4h for anxiety

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 4 - 7 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Friday, August 12, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
mania
social conflict/stressors

Intervention:
Increase awareness of emotional states/reality testing
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided positive reinforcement for being open with his feelings especially regarding his roommate's death.
- provided supportive psychotherapy and processed the following issues. He finds it strange that his roommate who harassed him so much is now dead. He feels sad for the ending of her life, but relief that she will no longer harass him and that his superintendent will be relieved as well. He said that he was experiencing a migraine with aura. He wonders whether this is due to the medication or a sign of Paroxetine withdrawal. He was told that it might not be due to anything, but a psychological relief from his roommate's death. It is unlikely to be Paroxetine withdrawal since the last time he took Paroxetine was on Monday. In addition, he was told that Divalproex does not necessarily cause migraines, and is in fact a medication that is often used as prophylactic for migraines. He was reminded that he will be getting his Divalproex level checked on Saturday and from there, medication changes, most likely an increase, will be done.

ATTENDING PHYSICIAN:
John M Cruz, MD

Signed by Cruz, John Michael de Vera, MD at 08/12/16 1850

CarePlan Notes by Abend, Marquel Marie, RN at 08/12/16 1933

Progress Notes (continued)

CarePlan Notes by Abend, Marquel Marie, RN at 08/12/16 1933 (continued)

Author: Abend, Marquel Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/12/16 1933 | Note Time: 08/12/16 1933 | Status: Signed
Editor: Abend, Marquel Marie, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Pt denies SI/HI/AH/VH. He appears internally preoccupied, paranoid with blunted guarded affect. He reports he slept well last night after finding out "someone whom was out to get him and kill him suddenly passed away" he states it was a female roommate who was going to shoot him. In nurse notes from last pm he stated he was very sad about a "close friend passing away". He reports having depression and a mild panic attack at 10 am. He reports attending groups, he isolates towards himself on the unit. Pt is medication compliant with no complaints of side effects. Will continue to monitor.

Signed by Abend, Marquel Marie, RN at 08/12/16 1933

Behavioral Health Note by Abend, Marquel Marie, RN at 08/12/16 2309

Author: Abend, Marquel Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/12/16 2311 | Note Time: 08/12/16 2309 | Status: Signed
Editor: Abend, Marquel Marie, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☒PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	2	2.5	2

Signed by Abend, Marquel Marie, RN at 08/12/16 2311

CarePlan Notes by Borja, Maryann L, RN at 08/13/16 0101

Progress Notes (continued)

CarePlan Notes by Borja, Maryann L, RN at 08/13/16 0101 (continued)

Author: Borja, Maryann L, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/13/16 0719 | Note Time: 08/13/16 0101 | Status: Addendum
Editor: Borja, Maryann L, RN (Registered Nurse)
Related Notes: Original Note by Borja, Maryann L, RN (Registered Nurse) filed at 08/13/16 0101

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
PM shift reports pt be internally preoccupied, paranoid, now states that the person who was shot from last night's report was a actually a female roommate who was going to shoot him, expressed having a mild panic attack, med complaint and kept to himself.

During the night shift, Pt in bed asleep @ change of shift w/no respiratory distress/discomfort noted, woke up @ 0030 pacing the unit, offered something to help him sleep, but refused wanting to pace for a bit to see if that would make him tired enough to go back to sleep, while pacing pt attempted to open the door to the computer room, redirected pt that it is closed and will open during the morning time, was able to lay back down to sleep, but woke up again and this time asked for something to help him sleep, medicated w/Zyprexa Zydis 2.5mg @ 0258. Will continue to monitor for changes.

EVALYSIS

[ ]Day Shift [ ]PM Shift **[X]Noc Shift**

PATIENT CARE INDICATORS				
CARE INDICATORS ACUITY				
	[ ]1	[X]2	[ ]3	[ ]4
ADL: Independent	[ ]			
ADL: Partial assist / supervise		[X]	[X]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[X]	[X]	[X]
Assess / Intervene: Above average			[ ]	[ ]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[ ]	[ ]
Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	1	3	2.5	1

Progress Notes (continued)

CarePlan Notes by Borja, Maryann L, RN at 08/13/16 0101 (continued)

Signed by Borja, Maryann L, RN at 08/13/16 0101
Signed by Borja, Maryann L, RN at 08/13/16 0719

Care Team Note by Tiller, Yvette L, RN at 08/13/16 1001

Author: Tiller, Yvette L, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/13/16 1012 | Note Time: 08/13/16 1001 | Status: Addendum
Editor: Tiller, Yvette L, RN (Registered Nurse)
Related Notes: Original Note by Tiller, Yvette L, RN (Registered Nurse) filed at 08/13/16 1003

Pt was found standing in the doorway of his room, doubled over in pain. "help...I think I have food poisoning" Pt states that 10 minutes after he ate breakfast he began to have abdominal cramps.

Signed by Tiller, Yvette L, RN at 08/13/16 1003
Signed by Tiller, Yvette L, RN at 08/13/16 1012

Care Team Note by SJAARDEMA-EVENHOUSE, GEORGIA at 08/13/16 0930

Author: SJAARDEMA-EVENHOUSE, GEORGIA | Service: Adult Mental Health | Author Type: Marriage,Family and Child Counselor
Filed: 08/13/16 1049 | Note Time: 08/13/16 0930 | Status: Signed
Editor: SJAARDEMA-EVENHOUSE, GEORGIA (Marriage,Family and Child Counselor)

Patient did not attend this group.

Signed by SJAARDEMA-EVENHOUSE, GEORGIA at 08/13/16 1049

Behavioral Health Note by Webb, Gina Marie, RN at 08/13/16 1055

Author: Webb, Gina Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/13/16 1055 | Note Time: 08/13/16 1055 | Status: Signed
Editor: Webb, Gina Marie, RN (Registered Nurse)

STAT labs drawn. Courier notified to p/u.

Signed by Webb, Gina Marie, RN at 08/13/16 1055

Behavioral Health Note by Webb, Gina Marie, RN at 08/13/16 1133

Author: Webb, Gina Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/13/16 1133 | Note Time: 08/13/16 1133 | Status: Signed
Editor: Webb, Gina Marie, RN (Registered Nurse)

1130: Specimens picked up by courier

Signed by Webb, Gina Marie, RN at 08/13/16 1133

Progress Notes by Schumm, Derek Daniel, MD at 08/13/16 1344

Author: Schumm, Derek Daniel, MD | Service: Adult Mental Health | Author Type: Physician
Filed: 08/13/16 1349 | Note Time: 08/13/16 1344 | Status: Signed
Editor: Schumm, Derek Daniel, MD (Physician)

PSYCHIATRY PROGRESS NOTE

8/13/16

Total Time Spent: 35 Minutes.

Hospital Care

CHIEF COMPLAINT:

47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY: Reports acute onset 9/10 R upper quadrant abdominal pain that started about 10 minutes after breakfast. In room using toilet and also "trying to vomit." Apparently dry heaved several times. Reported to nursing above and that I was worried about gall bladder dysfunctions. Vitals are normal. No other associated sx. Pt himself feels that he has food poisoning. Denies any current SI. Compliant w/ tx plan.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 120/71 | Pulse 87 | Temp (Src) 98.1 °F (36.7 °C) (Oral) | Resp 20 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 100%
Wt Readings from Last 3 Encounters:
08/09/16 : 58.514 kg (129 lb)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: Not applicable
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: anxious
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Good

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for: and difficulty coping

ADDITIONAL DATA REVIEWED:

Progress Notes (continued)

Progress Notes by Schumm, Derek Daniel, MD at 08/13/16 1344 (continued)

I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
WBC	3.8 L	3.3 L
HGB	14.6	13.8
HCT	43.7	41.1
PLT	229	224

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
NA	142	--
K	4.1	--
CL	102	--
CO2	34 H	--
BUN	16	--
CREATININE	0.98	--
GLU	107 H	--
CA	9.1	--
MG	--	2.5 H
PHOS	--	2.9

Recent Labs

Lab	08/13/16 1044
TBILI	0.3
AST	62 H
ALT	126 H
ALP	103
ALB	4.0

No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:

Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD		
• [START ON 8/15/2016] buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD		
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD		2 mg at 08/12/16 1844
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 1,500 mg	1,500 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		1,500 mg at 08/12/16 2106
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD		1 mg at 08/12/16 0826
• gabapentin (NEURONTIN) Cap 300 mg	300 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD		300 mg at 08/12/16 1205
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	Q BEDTIME	Sharma, Kanika, MD		30 mL at 08/12/16 2106
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD		
• [START ON 8/16/2016] methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD		
• [START ON 8/15/2016] methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD		
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD		2.5 mg at 08/13/16 0258
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD		200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:

None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:

- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:

 # Acute abdominal pain - screening labs ordered by IM. May need RUQ ultrasound - defer to IM. Vitals stable

 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 1500 mg PO at bedtime
- f/ Valproic Acid trough level on Saturday night, goal between 50 - 125
- WEEKEND: Adjust Divalproex ER dosage based on trough level
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent initiation
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime, may repeat x 1

 # Post Traumatic Stress Disorder
- continue PRN Gabapentin 300 mg PO q4h for anxiety
- f/u with outpatient therapy

 # Panic Attacks:
- continue PRN Gabapentin 300 mg PO q4h for anxiety

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

Progress Notes by Schumm, Derek Daniel, MD at 08/13/16 1344 (continued)

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 4 - 7 days

PROCEDURE CODES:
E/M 99233

ATTENDING PHYSICIAN:
Derek D Schumm

—

Signed by Schumm, Derek Daniel, MD at 08/13/16 1349

CarePlan Notes by Webb, Gina Marie, RN at 08/13/16 1102

Author: Webb, Gina Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/13/16 1406 | Note Time: 08/13/16 1102 | Status: Addendum
Editor: Webb, Gina Marie, RN (Registered Nurse)
Related Notes: Original Note by Webb, Gina Marie, RN (Registered Nurse) filed at 08/13/16 1225

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
1030: Patient continuing to endorse 8/10 sharp, "stabbing" abdominal pain. Stated sudden onset approx 10 minutes after breakfast. Insists that it is "food poisoning." Dry heaving noted- Zofran administered at 0948 with minimal effect. Pyridium administered at 1008 with no effect. No output noted (emesis or stool) although patient endorsed having urges. Patient endorsed to Dr. Schumm that pain is localized to right upper quadrant. Dr. Sharma notified and ordered STAT labs.
1100: Patient observed laying in fetal position on bed, endorsed pain down to 5/10. Will continue to monitor.
1215: Patient remains laying in bed. Stated feeling "better." Will wait to speak with Dr. Sharma before eating.
1400: Patient remains in bed. Stated feeling "better." Requesting to rest at this time.

EVALYSIS

[ ]Day Shift [X]PM Shift [ ]Noc Shift

PATIENT CARE INDICATORS	
CARE INDICATORS	

Progress Notes (continued)

CarePlan Notes by Webb, Gina Marie, RN at 08/13/16 1102 (continued)

ACUITY	[ ]1	[ ]2	[X]3	[ ]4
ADL: Independent	[ ]			
ADL: Partial assist / supervise		[X]	[X]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[ ]	[ ]	[ ]
Assess / Intervene: Above average			[X]	[X]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[ ]	[ ]
Behavior: Very unpredictable				[X]
Weighing factors	1	1	0.5	0
Total	1	2	2.5	2

Signed by Webb, Gina Marie, RN at 08/13/16 1102
Signed by Webb, Gina Marie, RN at 08/13/16 1225
Signed by Webb, Gina Marie, RN at 08/13/16 1406

Care Team Note by SJAARDEMA-EVENHOUSE, GEORGIA at 08/13/16 1100

Author: SJAARDEMA-EVENHOUSE, GEORGIA Service: Adult Mental Health Author Type: Marriage,Family and Child Counselor
Filed: 08/13/16 1723 Note Time: 08/13/16 1100 Status: Signed
Editor: SJAARDEMA-EVENHOUSE, GEORGIA (Marriage,Family and Child Counselor)

Patient did not attend this group.

Signed by SJAARDEMA-EVENHOUSE, GEORGIA at 08/13/16 1723

Care Team Note by SJAARDEMA-EVENHOUSE, GEORGIA at 08/13/16 1400

Author: SJAARDEMA-EVENHOUSE, GEORGIA Service: Adult Mental Health Author Type: Marriage,Family and Child Counselor
Filed: 08/13/16 1750 Note Time: 08/13/16 1400 Status: Signed
Editor: SJAARDEMA-EVENHOUSE, GEORGIA (Marriage,Family and Child Counselor)

Patient did not attend this group.

Signed by SJAARDEMA-EVENHOUSE, GEORGIA at 08/13/16 1750

CarePlan Notes by Smith, Hilda, RN at 08/13/16 2339

Progress Notes (continued)

CarePlan Notes by Smith, Hilda, RN at 08/13/16 2339 (continued)

Author: Smith, Hilda, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/13/16 2339 | Note Time: 08/13/16 2339 | Status: Signed
Editor: Smith, Hilda, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Isolates to his room, states he is not feeling well and refused dinner. When suggested that he try to eat, he became nauseated after eating little. Was given a suppository with fair results of hard round balls. Denies being suicidal and stated he was never suicidal. He got to a point that he knew that he need to do some intervention before something did happen. He showered, shaved and shampoo today. Stated that he did not want to look the way that he does, so he cleaned up.

EVALYSIS

[ ]Day Shift [X]PM Shift [ ]Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS ACUITY	[ ]1	[X]2	[ ]3	[ ]4
ADL: Independent	[ ]			
ADL: Partial assist / supervise		[X]	[X]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[X]	[X]	[X]
Assess / Intervene: Above average			[ ]	[ ]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[ ]	[ ]
Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	1	3	2.5	1

Progress Notes (continued)

CarePlan Notes by Smith, Hilda, RN at 08/13/16 2339 (continued)

Signed by Smith, Hilda, RN at 08/13/16 2339

CarePlan Notes by Smith, Hilda, RN at 08/14/16 0516

Author: Smith, Hilda, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/14/16 0516 | Note Time: 08/14/16 0516 | Status: Signed
Editor: Smith, Hilda, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Shift started with Vincent in bed and appears to be soundly sleeping. At 0345 up to the bathroom for what sounded and smelled like a very large bowel movement. Did not complain of any discomfort or pain at the time. He was back to bed and back to sleep. Continues to deny suicidal, stated that he was never suicidal. Will continue to monitor for safety and support. No falls or injuries this shift. Did not draw trough as ordered on evening shift will draw on Sunday evening. Depression/anxiety is a concern for what is going on with his body.

EVALYSIS

[ ]Day Shift [ ]PM Shift [X]Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS ACUITY	[ ]1	[X]2	[ ]3	[ ]4
ADL: Independent	[ ]			
ADL: Partial assist / supervise		[X]	[X]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[X]	[X]	[X]
Assess / Intervene: Above average			[ ]	[ ]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[ ]	[ ]
Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	1	3	2.5	1

CarePlan Notes by Smith, Hilda, RN at 08/14/16 0516 (continued)

Signed by Smith, Hilda, RN at 08/14/16 0516

Progress Notes by Sharma, Kanika, MD at 08/13/16 1944

Author: Sharma, Kanika, MD | Service: Hospitalist Medicine | Author Type: Physician
Filed: 08/14/16 0816 | Note Time: 08/13/16 1944 | Status: Signed
Editor: Sharma, Kanika, MD (Physician)

HOSPITALIST PROGRESS NOTE 8/13/2016

DOA: 8/9/2016

SUBJECTIVE:

RN asked me to eval patient for nausea and vomiting

Patient states that at 3AM last night, he took zyprexa for sleep. He ate breakfast this AM. 10 minutes after breakfast he had nausea and vomiting with a sharp stabbing pan in his stomach and intestines. The pain was so severe that he was down on the floor in a fetal position. He was given zofran and pyridium. He felt better and slept for most of the afternoon. He did not eat lunch. When I saw him he felt better with no abdominal pain. He is having trouble with severe constipation and thinks this may be contributing to his symptoms.

OBJECTIVE:

BP 145/79 | Pulse 115 | Temp (Src) 98.7 °F (37.1 °C) (Oral) | Resp 17 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 100%

Temp (36hrs), Avg:98.2 °F (36.8 °C), Min:97.9 °F (36.6 °C), Max:98.7 °F (37.1 °C)

Systolic (36hrs), Avg:128 mmHg, Min:109 mmHg, Max:145 mmHg
Diastolic (36hrs), Avg:78 mmHg, Min:68 mmHg, Max:88 mmHg

PE

General: No acute distress,
Neck: No JVD, No masses, Supple,
Respiratory: good inspiratory effort, No wheezes, No rales (crackles) and No rhonchi
Cardiovacular: Regular rhythm, Normal heart sounds, No murmur. No edema, peripheral pulses intact.
GI: Soft, Non-tender,Non-distended, Normal bowel sounds, no hepatosplenomegaly.
Musculoskeletal: muscle strength and tone normal, No muscle atrophy. Joint range of motion normal.
Neuro: Awake, Alert, Conversant, CN intact, Motor intact.
Skin: psoriatatic rash on abdomen and legs
Psych: Normal affect

Labs

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
WBC	3.8 L	3.3 L
HGB	14.6	13.8
HCT	43.7	41.1
PLT	229	224

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
NA	142	--
K	4.1	--
CL	102	--
CO2	34 H	--
BUN	16	--
CREATININE	0.98	--
GLU	107 H	--
CA	9.1	--
MG	--	2.5 H
PHOS	--	2.9

Recent Labs

Lab	08/13/16 1044
TBILI	0.3
AST	62 H
ALT	126 H
ALP	103
ALB	4.0

Medications

bisacodyl	10 mg	DAILY
lactulose	30 mL	BID
sennosides	17.2 mg	Q BEDTIME
[START ON 8/15/2016] buprenorphine	2 Patch	Q7 DAYS
divalproex 24Hr-ER	1,500 mg	Q BEDTIME
foLIC acid	1 mg	DAILY
[START ON 8/16/2016] methotrexate	5 mg	Q7 DAYS
[START ON 8/15/2016] methotrexate	7.5 mg	Q7 DAYS

Progress Notes by Sharma, Kanika, MD at 08/13/16 1944 (continued)

Review of patient's allergies indicates no known allergies.

ASSESSMENT and PLAN:

Nausea and vomiting
-probably secondary to obstipation
-increase bowel regimen

Transaminitis
-monitor
-check Hepatitis panel

Chronic pain syndrome with chronic pelvic pain and fibromyalgia.
-followed by the Highland General Hospital Pain Clinic
-Butrans patch
-Subutex
-Neurontin
-Pyridium.

Psoriasis.
-Methotrexate.

Bipolar affective disorder and posttraumatic stress disorder
-treatment as per psych

Kanika Sharma, MD
510-393-1453

Signed by Sharma, Kanika, MD at 08/14/16 0816

CarePlan Notes by Webb, Gina Marie, RN at 08/14/16 1255

Author: Webb, Gina Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/14/16 1435 | Note Time: 08/14/16 1255 | Status: Addendum
Editor: Webb, Gina Marie, RN (Registered Nurse)
Related Notes: Original Note by Webb, Gina Marie, RN (Registered Nurse) filed at 08/14/16 1427

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Mostly isolative to room. Attended 1100 group but left group early. Endorsed depressed and anxious mood. Guarded during interaction. Stated he would use "meditation" to help manage his anxiety. Disheveled, unkempt appearance. Refused shower this shift, stated he showered last night. Reported eating only 2 sausage links at breakfast and refused lunch.
1415: Continues to c/o high anxiety. Visited with friend this afternoon. Declined gabapentin when offered, stated doctor offered to order Klonopin. Stated he will wait for order to come through.

Progress Notes (continued)

CarePlan Notes by Webb, Gina Marie, RN at 08/14/16 1255 (continued)

1430: Patient re-approached RN and requested gabapentin PRN. Stated he would still like to take Klonopin when ordered.

EVALYSIS

[ ]Day Shift [X]PM Shift [ ]Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS ACUITY	[ ]1	[ ]2	[X]3	[ ]4
ADL: Independent	[ ]			
ADL: Partial assist / supervise		[X]	[X]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[ ]	[ ]	[ ]
Assess / Intervene: Above average			[X]	[X]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[X]	[X]
Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	1	2	3.5	2

Signed by Webb, Gina Marie, RN at 08/14/16 1255
Signed by Webb, Gina Marie, RN at 08/14/16 1427
Signed by Webb, Gina Marie, RN at 08/14/16 1435

Progress Notes by Schumm, Derek Daniel, MD at 08/14/16 1544

Author: Schumm, Derek Daniel, MD | Service: Adult Mental Health | Author Type: Physician
Filed: 08/14/16 1548 | Note Time: 08/14/16 1544 | Status: Signed
Editor: Schumm, Derek Daniel, MD (Physician)

PSYCHIATRY PROGRESS NOTE

8/13/16

Total Time Spent: 35 Minutes.

Hospital Care

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:

8/14: Reports having 2 panic attacks today. Unclear about precipitants. Did describe racing thoughts on Friday which "frightened," him. Most of Saturday was spent getting medically well. Depakote level not drawn last night. Notes moderate (6/10) degrees of depression. Requests prn clonazepam for panic. Does not feel that gabapentin has been useful. Remains disheveled and malodorous.

Per RN: Mostly isolative to room. Attended 1100 group but left group early. Endorsed depressed and anxious mood. Guarded during interaction. Stated he would use "meditation" to help manage his anxiety. Disheveled, unkempt appearance. Refused shower this shift, stated he showered last night. Reported eating only 2 sausage links at breakfast and refused lunch.
1415: Continues to c/o high anxiety. Visited with friend this afternoon. Declined gabapentin when offered, stated doctor offered to order Klonopin. Stated he will wait for order to come through.
1430: Patient re-approached RN and requested gabapentin PRN. Stated he would still like to take Klonopin when ordered.

8/13: Reports acute onset 9/10 R upper quadrant abdominal pain that started about 10 minutes after breakfast. In room using toilet and also "trying to vomit." Apparently dry heaved several times. Reported to nursing above and that I was worried about gall bladder dysfunctions. Vitals are normal. No other associated sx. Pt himself feels that he has food poisoning. Denies any current SI. Compliant w/ tx plan.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 111/80 | Pulse 100 | Temp (Src) 98.6 °F (37 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 100%
Wt Readings from Last 3 Encounters:
08/09/16 : 58.514 kg (129 lb)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt

- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: Not applicable
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: anxious
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Good

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for: and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
WBC	3.8 L	3.3 L
HGB	14.6	13.8
HCT	43.7	41.1
PLT	229	224

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
NA	142	--

K	4.1	--
CL	102	--
CO2	34 H	--
BUN	16	--
CREATININE	0.98	--
GLU	107 H	--
CA	9.1	--
MG	--	2.5 H
PHOS	--	2.9

Recent Labs

Lab	08/13/16 1044
TBILI	0.3
AST	62 H
ALT	126 H
ALP	103
ALB	4.0

No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD		10 mg at 08/14/16 0857
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD		30 mL at 08/14/16 0857
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD		17.2 mg at 08/13/16 2047
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD		
• [START ON 8/15/2016] buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD		
• buprenorphine SL	2 mg	Sublingual	Q6H PRN	Cruz, John Michael		2 mg at

Progress Notes (continued)

Progress Notes by Schumm, Derek Daniel, MD at 08/14/16 1544 (continued)

(SUBUTEX) Tab 2 mg				de Vera, MD	08/12/16 1844
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 1,500 mg	1,500 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD	1,500 mg at 08/13/16 2048
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/14/16 0857
• gabapentin (NEURONTIN) Cap 300 mg	300 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD	300 mg at 08/14/16 1432
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• [START ON 8/16/2016] methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	
• [START ON 8/15/2016] methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/13/16 0258
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:

None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:

- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:

 # Acute abdominal pain - screening labs ordered by IM. May need RUQ ultrasound - defer to IM. Vitals stable

 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 1500 mg PO at bedtime
- check Depakote level tonight
- WEEKEND: Adjust Divalproex ER dosage based on trough level
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent initiation
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime, may repeat x 1

 # Post Traumatic Stress Disorder
- continue PRN Gabapentin 300 mg PO q4h for anxiety
- f/u with outpatient therapy

 # Panic Attacks:
-stop gabapentin; start clonazepam 0.5mg po bid prn panic

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 4 - 7 days

PROCEDURE CODES:
E/M 99233

ATTENDING PHYSICIAN:

Progress Notes (continued)

Progress Notes by Schumm, Derek Daniel, MD at 08/14/16 1544 (continued)

Derek D Schumm

—

Signed by Schumm, Derek Daniel, MD at 08/14/16 1548

Progress Notes by Sharma, Kanika, MD at 08/14/16 2034

Author: Sharma, Kanika, MD | Service: Hospitalist Medicine | Author Type: Physician
Filed: 08/14/16 2037 | Note Time: 08/14/16 2034 | Status: Signed
Editor: Sharma, Kanika, MD (Physician)

HOSPITALIST PROGRESS NOTE 8/14/2016

DOA: 8/9/2016

SUBJECTIVE:
F/U abdominal pain.

Patient had a good BM early this AM.
He feels much better after that.
No nausea, no emesis. He was able to eat today.

OBJECTIVE:
BP 132/72 | Pulse 90 | Temp (Src) 98.2 °F (36.8 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 100%

Temp (36hrs), Avg:98.4 °F (36.9 °C), Min:98.1 °F (36.7 °C), Max:98.7 °F (37.1 °C)

Systolic (36hrs), Avg:123 mmHg, Min:109 mmHg, Max:145 mmHg
Diastolic (36hrs), Avg:74 mmHg, Min:68 mmHg, Max:80 mmHg

PE
General: No acute distress,
Neck: No JVD, No masses, Supple,
Respiratory: good inspiratory effort, No wheezes, No rales (crackles) and No rhonchi
Cardiovacular: Regular rhythm, Normal heart sounds, No murmur. No edema, peripheral pulses intact.
GI: Soft, Non-tender,Non-distended, Normal bowel sounds, no hepatosplenomegaly.
Musculoskeletal: muscle strength and tone normal, No muscle atrophy. Joint range of motion normal.
Neuro: Awake, Alert, Conversant, CN intact, Motor intact.
Skin: No Decubital ulcer, No rash.
Psych: Normal affect

Labs

Progress Notes (continued)

Progress Notes by Sharma, Kanika, MD at 08/14/16 2034 (continued)

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
WBC	3.8 L	3.3 L
HGB	14.6	13.8
HCT	43.7	41.1
PLT	229	224

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
NA	142	--
K	4.1	--
CL	102	--
CO2	34 H	--
BUN	16	--
CREATININE	0.98	--
GLU	107 H	--
CA	9.1	--
MG	--	2.5 H
PHOS	--	2.9

Recent Labs

Lab	08/13/16 1044
TBILI	0.3
AST	62 H
ALT	126 H
ALP	103
ALB	4.0

Medications

bisacodyl	10 mg	DAILY
lactulose	30 mL	BID
sennosides	17.2 mg	Q BEDTIME
[START ON 8/15/2016] buprenorphine	2 Patch	Q7 DAYS
divalproex 24Hr-ER	1,500 mg	Q BEDTIME
foLIC acid	1 mg	DAILY
[START ON 8/16/2016] methotrexate	5 mg	Q7 DAYS
[START ON 8/15/2016] methotrexate	7.5 mg	Q7 DAYS

Progress Notes by Sharma, Kanika, MD at 08/14/16 2034 (continued)

Review of patient's allergies indicates no known allergies.

ASSESSMENT and PLAN:

Nausea and vomiting
-improved with bowel regimen

Transaminitis
-monitor
-check Hepatitis panel

Chronic pain syndrome with chronic pelvic pain and fibromyalgia.
-followed by the Highland General Hospital Pain Clinic
-Butrans patch
-Subutex
-Neurontin
-Pyridium.

Psoriasis.
-Methotrexate.

Bipolar affective disorder and posttraumatic stress disorder
-treatment as per psych

Kanika Sharma, MD
510-393-1453

Signed by Sharma, Kanika, MD at 08/14/16 2037

CarePlan Notes by Smith, Hilda, RN at 08/14/16 2348

Author: Smith, Hilda, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/14/16 2348 | Note Time: 08/14/16 2348 | Status: Signed
Editor: Smith, Hilda, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Isolated in his room until late evening. Came out and was very social with peers and leading the conversations. States his most difficult time is during the early day. Could not explain why. Not eating much concerned about stomach and bowel movement. Had a bowel movement on the day shift after the suppository. He did shower and shave last evening but still have body odor. Stated that he would take a complete shower in the am and towels given. '
Venipuncture done per MD order, per aseptic technique, using 23,3/4 gage needle x 1 successfully to Left AC. Patient tolerated well, no excess bleeding or bruising. Hands washed before and after venipuncture. Blood specimen tube labeled/dated/timed and initials, prepared for processing. All sharps and soiled items disposed

Progress Notes (continued)

CarePlan Notes by Smith, Hilda, RN at 08/14/16 2348 (continued)

properly.

Still endorses being depressed to the point of not knowing what is going on. States is not suicidal and has not been so. No fall or injury this far this shift.

EVALYSIS

[ ]Day Shift [X]PM Shift [ ]Noc Shift

PATIENT CARE INDICATORS

CARE INDICATORS ACUITY	[ ]1	[X]2	[ ]3	[ ]4
ADL: Independent	[ ]			
ADL: Partial assist / supervise		[X]	[X]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[X]	[X]	[X]
Assess / Intervene: Above average			[ ]	[ ]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[ ]	[ ]
Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	1	3	2.5	1

Signed by Smith, Hilda, RN at 08/14/16 2348

Behavioral Health Note by Richardson, Cleo, RN at 08/15/16 0152

Author: Richardson, Cleo, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/15/16 0154 | Note Time: 08/15/16 0152 | Status: Signed
Editor: Richardson, Cleo, RN (Registered Nurse)

Progress Notes (continued)

Behavioral Health Note by Richardson, Cleo, RN at 08/15/16 0152 (continued)

EVALYSIS

☐Day Shift ☐PM Shift ☒Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☒2	☐3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	3	2.5	1

Signed by Richardson, Cleo, RN at 08/15/16 0154

Care Team Note by Richardson, Cleo, RN at 08/15/16 0726

Author: Richardson, Cleo, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/15/16 0728 | Note Time: 08/15/16 0726 | Status: Signed
Editor: Richardson, Cleo, RN (Registered Nurse)

Pt in bed eyes closed no apparent discomfort noted when observed on safety checks. Breathing even and unlabored, will continue to monitor pt for safety. 0630 Failed attempt at Blood Draw this a.m. Pt appears to be dehydrated
Encouraged to drink water.

Signed by Richardson, Cleo, RN at 08/15/16 0728

Progress Notes

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/15/16 0912

Author: Marin, Lisa Nicole, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/15/16 0913 | Note Time: 08/15/16 0912 | Status: Signed
Editor: Marin, Lisa Nicole, RN (Registered Nurse)

EVALYSIS

☒Day Shift ☐PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	1	2.5	2

Signed by Marin, Lisa Nicole, RN at 08/15/16 0913

Behavioral Health Note by Harris, Stephanie, RN at 08/15/16 1051

Author: Harris, Stephanie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/15/16 1051 | Note Time: 08/15/16 1051 | Status: Signed
Editor: Harris, Stephanie, RN (Registered Nurse)

	08/15/16 1000
Legal Status	
Legal status	1 - voluntary
Pain Assessment: Number Scale (0-10)	
Pain Rating (0-10): Rest	0
Pain Rating (0-10): Activity	0
Comfort/Acceptable Pain Level	0
Skin WDL	
Skin WDL	WDL
Fall Risk Assessment	

Progress Notes (continued)

Behavioral Health Note by Harris, Stephanie, RN at 08/15/16 1051 (continued)

Fall Risk Indicators	3-->central nervous system/psychotropic medication;3-->polypharmacy;2-->depression;1-->male
Fall Risk Score	9
Precautions/Isolation	
Precautions (displays in banner)	1
Precautions Interventions	
Interventions Performed	yes
Level of Observation	every 30 minutes
Activities of Daily Living	
ADL's (WDL)	WDL
Daily Sleep	
Daily Sleep (WDL)	WDL
Daily Nutrition	
Daily Nutrition (WDL)	Ex
Appetite Change	decreased
Barriers to Nutrition	constipation
Level of Assistance	needs encouragement
Mental Status	
Orientation	oriented x 4
Level Of Consciousness	alert
General Appearance WDL	ex;appearance *(Does look dischelved)*
General Appearance	body odor
Mood	anxious;depressed;withdrawn
Mood/Behavior/ Affect WDL	ex;all
Affect	guarded;restricted
Behavior (WDL)	Ex
Mood/Behavior	isolative
Speech	WDL

Progress Notes (continued)

Behavioral Health Note by Harris, Stephanie, RN at 08/15/16 1051 (continued)

Speech	clear
Judgment and Insight	judgment not appropriate to situation;insight not appropriate to situation
Insight	fair
Concentration	fair
Memory Deficit	intact
Thought (WDL)	WDL
Coping/Psychosocial Response	
Observed Emotional State	anxious;withdrawn;withholds information;quiet
Verbalized Emotional State	anxiety;depression
Coping/Psychosocial Response Interventions	
Plan Of Care Reviewed With	patient
Supportive Measures	active listening utilized
Psychiatric Symptoms	
Anxiety Symptoms (WDL)	Ex
Anxiety Symptoms	generalized
Manic Symptoms (WDL)	WDL
Psychotic symptoms (WDL)	WDL
Danger to Self	
Danger to Self (WDL)	WDL
Danger to Others	
Danger to Others (WDL)	WDL

Signed by Harris, Stephanie, RN at 08/15/16 1051

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/15/16 1055

Author: Marin, Lisa Nicole, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/15/16 1058 | Note Time: 08/15/16 1055 | Status: Cosign Needed
Editor: Marin, Lisa Nicole, RN (Registered Nurse) | Cosign Required: Yes

Continues with panic attacks, feelings of hopelessness; remains disheveled; revealed history of sexual abuse;

Progress Notes (continued)

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/15/16 1055 (continued)

has not been attending groups recently; Continue with medication stabilization; When stable may go home with in current in home support service, or attend PHP

	08/15/16 1054
Patient Assets/Stressors	
Patient Assets	general fund of knowledge;average or above intelligence;motivation for treatment/growth;capable of independent living;supportive family/friends;work skills;physical health;ability for insight;communication skills
Patient Stressors	medication change or non-compliance
Discharge Planning	
Discharge Criteria	improved stabilization in mood, thinking and/or behavior;verbal commitment to aftercare and medication compliance
Recommended Discharge Plan	return to previous living environment;medication management with psychiatrist or other physician
Pt's Acceptance of Discharge Plan	yes
Why Continues to Need Hospitalization	severe impairment of level of functioning;danger to self or others;medication stabilization
Estimated Length of Stay	3-5 days
Provisional DSM 5 Diagnoses	
Problem Being Addressed	refer to problem list
Goal: Will work with social	

Progress Notes (continued)

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/15/16 1055 (continued)

worker/treatment coordinator to develop safe discharge plan	
Goal Status	goal initiated
Goal: Will attend Occupational Therapy groups up to seven days weekly as tolerated	
Objectives	increase coping skills
Goal Status	progress made toward outcome
Treatment Plan Reviewed by	
Psychiatric Social Worker	Himot
Registered Nurse	Marin
Occupational Therapist	Bailey
Other	Byrne

Signed by Marin, Lisa Nicole, RN at 08/15/16 1058

CarePlan Notes by Harris, Stephanie, RN at 08/15/16 1434

Author: Harris, Stephanie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/15/16 1434 | Note Time: 08/15/16 1434 | Status: Signed
Editor: Harris, Stephanie, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Vincent has been moderately present in the milieu. Walks with a blanket around his shoulders. Is mildly anxious. Med-compliant; concerned that a blood draw has been attempted twice without success, and is ordered for this evening again. Approached this afternoon stating he was feeling panicky; "almost like when I was feeling suicidal." Could not identify why he was feeling panicky, but was noted to be sitting calmly with dog therapy dogs. Given Neurontin 300 mg prn dose; too early to assess result as of this note for shift change at 1500.

PLAN: **Draw VPA trough immediately before giving Monday's bed time dosage.**

Signed by Harris, Stephanie, RN at 08/15/16 1434

CarePlan Notes by Bailey, Peter Julian, OT at 08/15/16 1725

Author: Bailey, Peter Julian, OT | Service: Adult Mental Health | Author Type: Occupational Therapist
Filed: 08/15/16 1725 | Note Time: 08/15/16 1725 | Status: Signed
Editor: Bailey, Peter Julian, OT (Occupational Therapist)

Problem: Depression (Adult,Obstetrics,Pediatric)
Goal: Improved/Stable Mood
Outcome: Ongoing (interventions implemented as appropriate)

Progress Notes (continued)

CarePlan Notes by Bailey, Peter Julian, OT at 08/15/16 1725 (continued)

Check-in (Community) Meeting
Group Start Time: 930

Group focused on review of mental and functional status. Assess current status and symptoms and set therapeutic goals. Provide opportunity for verbal expression, incorporate morning breathing and stretching.

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4
Patent did not attend this group. Pt reported feeling too depressed to get out bed.
0 of 4 units @ 15 min.

Pet Therapy
Group Start Time: 1400

Provide creative opportunities for expression of feelings, distraction from negative or stressful thoughts, to decrease stress, isolation and increase socialization. Provide, opportunity to assess cognitive abilities.

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

AFFECT: blunted

APPEARANCE/BEHAVIOR: withdrawn and guarded; pt joined group but stayed on the periphery initially. When a chair became available a peer encouraged him to join the group. He accepted a dog to hold, but stared blankly forward and did not engage with the dog. Pt left group, reporting that he was feeling increased anxiety.
INTERVENTION/EDUCATION: Facilitated interaction with pets and peers. Prompted patient to participate, Provided support and Encouraged interaction with peers
2 of 2 units @ 15 min.

Signed by Bailey, Peter Julian, OT at 08/15/16 1725

CarePlan Notes by Ghebreselassie, Freweini, RN at 08/15/16 1943

Author: Ghebreselassie, Freweini, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/15/16 1943 | Note Time: 08/15/16 1943 | Status: Signed
Editor: Ghebreselassie, Freweini, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)

Verbalized mood "it was rough today" in relation to the change from depression to panic feelings in the morning. Patient related it to the continuous need of adjustment on his medications. Denied SI, AH. Mostly stayed in his room. Appeared to be withdrawn, and quiet, but would answer questions.
Will continue to monitor him in the unit.

EVALYSIS

Progress Notes (continued)

CarePlan Notes by Ghebreselassie, Freweini, RN at 08/15/16 1943 (continued)

[ ]Day Shift [X]PM Shift [ ]Noc Shift

PATIENT CARE INDICATORS

CARE INDICATORS ACUITY	[ ]1	[ ]2	[X]3	[ ]4
ADL: Independent	[X]			
ADL: Partial assist / supervise		[ ]	[ ]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[X]	[X]	[X]
Assess / Intervene: Above average			[ ]	[ ]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[X]	[X]	[X]
Behavior: Moderately unpredictable			[ ]	[ ]
Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	2	2	2.5	1

Signed by Ghebreselassie, Freweini, RN at 08/15/16 1943

Progress Notes by Cruz, John Michael de Vera, MD at 08/15/16 0828

Author: Cruz, John Michael de Vera, MD Service: Psychiatry Author Type: Physician
Filed: 08/15/16 2045 Note Time: 08/15/16 0828 Status: Signed
Editor: Cruz, John Michael de Vera, MD (Physician)

PSYCHIATRY PROGRESS NOTE

Monday, August 15, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:

47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- No over night events
- Sleep - 7.25 hours

In speaking to the psychiatrist, the patient states
- mood: Depressed in the morning, but improves gradually throughout the afternoon - worse than yesterday - because had panic attack in the afternoon
- appetite: good
- psychomotor retardation: "yes" - worse than yesterday - feels that the PRN Gabapentin slowed his mind down too much.
- anxiety: "yes" - worse than yesterday - had a panic attack in the afternoon where he was stomping on the ground and dissipated after he took PRN Gabapentin 300 mg PO x 1
- psychomotor agitation: "yes" - worse than yesterday - was stomping on the ground when he was feeling anxious
- sleep: "good" - same as yesterday - easily fell asleep, slept throughout the night and woke up feeling rested
- energy: "good" - same as yesterday - because got good sleep
- passive death wish: denies
- suicidal ideation: denies

- overall: Although his mood is better, his anxiety was worse today when he had a panic attack.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 132/72 | Pulse 90 | Temp (Src) 98.2 °F (36.8 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 100%
Wt Readings from Last 3 Encounters:
08/09/16 : 58.514 kg (129 lb)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: Not applicable
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Flat
- Mood: anxious and depressed

- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Fair

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for:, anxiety, panic attacks and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
WBC	3.8 L	3.3 L
HGB	14.6	13.8
HCT	43.7	41.1
PLT	229	224

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
NA	142	--
K	4.1	--
CL	102	--
CO2	34 H	--
BUN	16	--
CREATININE	0.98	--
GLU	107 H	--
CA	9.1	--

MG	--	2.5 H
PHOS	--	2.9

Recent Labs

Lab	08/13/16 1044
TBILI	0.3
AST	62 H
ALT	126 H
ALP	103
ALB	4.0

No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• clonAZEPAM (klonoPIN) Tab 0.5 mg	0.5 mg	Oral	BID PRN	Schumm, Derek Daniel, MD		
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD		10 mg at 08/14/16 0857
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD		30 mL at 08/14/16 2123
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD		17.2 mg at 08/14/16 2124
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD		
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD		
• buprenorphine SL (SUBUTEX) Tab 2	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera,		2 mg at 08/12/16

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/15/16 0828 (continued)

mg				MD	1844
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 1,500 mg	1,500 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD	1,500 mg at 08/14/16 2123
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/14/16 0857
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• [START ON 8/16/2016] methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/14/16 2124
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization

- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:
 # Bipolar Disorder Type I without Psychotic Features:
- increased Divalproex ER to 200 mg PO at bedtime
- f/ Valproic Acid trough level on Thursday night, goal between 50 - 125
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime, may repeat x 1

 # Post Traumatic Stress Disorder
- continue PRN Gabapentin 300 mg PO q4h for anxiety
- f/u with outpatient therapy

 # Panic Attacks:
- continue PRN Gabapentin 300 mg PO q4h for anxiety

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 4 - 7 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

Progress Notes by Cruz, John Michael de Vera, MD at 08/15/16 0828 (continued)

PSYCHOTHERAPY NOTE
Monday, August 15, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
extreme anxiety/panic

Intervention:
Increase awareness of emotional states/reality testing
Increase insight into illness and treatment plan
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided positive reinforcement for being open with his feelings of anxiety.
- provided supportive psychotherapy and processed the following issues. He said that his anxiety today was very high. He said that taking the Neurontin seemed to have slowed down his thoughts too much. He was told that with his anxiety being so high and his thoughts going so fast, that when his thoughts do slow down after taking the Neurontin, they may feel especially slow. In addition, I provided him psychoeducation about the treatment of bipolar disorder. Specifically, I told him that with Bipolar Disorder, a person's mood goes up and down, but that the goal of bipolar disorder is to get the range to be smaller and smaller until there is minimal range between his elevated moods and depressed moods.

ATTENDING PHYSICIAN:
John M Cruz, MD

Signed by Cruz, John Michael de Vera, MD at 08/15/16 2045

CarePlan Notes by Borja, Maryann L, RN at 08/16/16 0058

Progress Notes (continued)

CarePlan Notes by Borja, Maryann L, RN at 08/16/16 0058 (continued)

Author: Borja, Maryann L, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/16/16 0633 | Note Time: 08/16/16 0058 | Status: Addendum
Editor: Borja, Maryann L, RN (Registered Nurse)
Related Notes: Original Note by Borja, Maryann L, RN (Registered Nurse) filed at 08/16/16 0058

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
PM shift reports pt to have a rough day and relates it d/t med adjustment, isolative to his room and has been withdrawn.

During the night shift, Received pt asleep in bed w/eyes closed, unlabored respirations and did not wake up once during the night. Will continue to monitor for any changes.

EVALYSIS

[ ]Day Shift [ ]PM Shift **[X]Noc Shift**

PATIENT CARE INDICATORS				
CARE INDICATORS ACUITY				
	[ ]1	[X]2	[ ]3	[ ]4
ADL: Independent	[ ]			
ADL: Partial assist / supervise		[X]	[X]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[X]	[X]	[X]
Assess / Intervene: Above average			[ ]	[ ]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[ ]	[ ]
Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	1	3	2.5	1

Progress Notes (continued)

CarePlan Notes by Borja, Maryann L, RN at 08/16/16 0058 (continued)

EVALYSIS

[ ]Day Shift [ ]PM Shift **[X]Noc Shift**

PATIENT CARE INDICATORS				
CARE INDICATORS ACUITY				
	[ ]1	[X]2	[ ]3	[ ]4
ADL: Independent	[ ]			
ADL: Partial assist / supervise		[X]	[X]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[X]	[X]	[X]
Assess / Intervene: Above average			[ ]	[ ]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[ ]	[ ]
Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	1	3	2.5	1

Signed by Borja, Maryann L, RN at 08/16/16 0058
Signed by Borja, Maryann L, RN at 08/16/16 0633

CarePlan Notes by Britt, Julia Anna, RN at 08/16/16 1356

Author: Britt, Julia Anna, RN | Service: Adolescent Mental Health | Author Type: Registered Nurse
Filed: 08/16/16 1508 | Note Time: 08/16/16 1356 | Status: Addendum
Editor: Britt, Julia Anna, RN (Registered Nurse)
Related Notes: Original Note by Britt, Julia Anna, RN (Registered Nurse) filed at 08/16/16 1507

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
This morning on Vincent appeared organized and highly anxious. He stated he felt anxious and denied having racing thoughts. He appeared to be restless and tapping his legs and hands and was laying on his bed in a fetal position. He stated that this anxiety was beyond trying to deep breathe. He was given gabapentin at 0901 with poor effect and requested additional medication, order received from Dr. Cruz for an additional 300 mg of gabapentin and this was given. Pt appeared to calm down significantly after the second dose of gabapentin was given and stated to RN that he felt this extra dose was very helpful. He denies current suicidal thoughts but stated if his anxiety would have been left untreated this morning he fears he may have become suicidal. He contracts for safety on the unit. His behavior and speech has appeared organized. No unsafe behaviors

Progress Notes (continued)

CarePlan Notes by Britt, Julia Anna, RN at 08/16/16 1356 (continued)

observed. Appetite has been fair. Will continue to monitor and provide support as apprpriate. He denies auditory or visual hallucinations.

Vincent was asking about PHP program at Herrick today. He also stated he has some concerns about going back to his outpatient psychiatrist as he feels he was put on a medication regimen that made him feel worse and he saw an intern and "I barely even saw my psychiatrist". He was encouraged to talk to his social worker about this.

EVALYSIS

PATIENT CARE INDICATORS				
CARE INDICATORS → / ACUITY ↓	DAY			
	☐1	☐2	☒3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	2	3.5	2

Signed by Britt, Julia Anna, RN at 08/16/16 1429
Signed by Britt, Julia Anna, RN at 08/16/16 1429
Signed by Britt, Julia Anna, RN at 08/16/16 1507
Signed by Britt, Julia Anna, RN at 08/16/16 1508

CarePlan Notes by Himot, Craig at 08/16/16 1649

Author: Himot, Craig
Filed: 08/16/16 1649
Editor: Himot, Craig (Others)
Service: Social Services
Note Time: 08/16/16 1649
Author Type: Others
Status: Signed

Problem: Patient Care Overview
Goal: Discharge Needs Assessment
Outcome: Ongoing (interventions implemented as appropriate)
Returned call to pt's IHSS worker, Willie Franklin at 510-355-5016. He just wanted to make sure pt was getting good care. He continues to feed his cats, pick up his mail. His apartment is cleaned up. IHSS worker would like to be informed when pt is discharged. Willie will continue to visit pt.

Signed by Himot, Craig at 08/16/16 1649

Progress Notes (continued)

CarePlan Notes by Himot, Craig at 08/16/16 1649 (continued)

CarePlan Notes by Bailey, Peter Julian, OT at 08/16/16 1654

Author: Bailey, Peter Julian, OT | Service: Adult Mental Health | Author Type: Occupational Therapist
Filed: 08/16/16 1654 | Note Time: 08/16/16 1654 | Status: Signed
Editor: Bailey, Peter Julian, OT (Occupational Therapist)

Problem: Depression (Adult,Obstetrics,Pediatric)
Goal: Improved/Stable Mood
Outcome: Ongoing (interventions implemented as appropriate)

Check-in (Community) Meeting
Group Start Time: 930

Group focused on review of program schedule and guidelines, identification of treatment issues, mood rating and identification and formulation of daily therapeutic goal(s).

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

Patent did not attend this group.

0 of 3 units @ 15 min.

Focal Group
Group Start Time: 1100

Group focused on promotion of improved communication and positive, interpersonal experiences—generalizable to relationships outside of the program—to provide opportunity for verbal expression and processing.

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

Patent did not attend this group.

0 of 4 units @ 15 min.

Expressive Arts Therapy
Group Start Time: 1400

Provide creative opportunities for expression of feelings, distraction from negative or stressful thoughts, and opportunities to incorporate movement, drama, art and music into their lives.

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

Patent did not attend this group.

0 of 4 units @ 15 min.

CarePlan Notes by Bailey, Peter Julian, OT at 08/16/16 1654 (continued)

Signed by Bailey, Peter Julian, OT at 08/16/16 1654

Progress Notes by Cruz, John Michael de Vera, MD at 08/16/16 0908

Author: Cruz, John Michael de Vera, MD | Service: Psychiatry | Author Type: Physician
Filed: 08/16/16 1852 | Note Time: 08/16/16 0908 | Status: Signed
Editor: Cruz, John Michael de Vera, MD (Physician)

PSYCHIATRY PROGRESS NOTE

Tuesday, August 16, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- Had panic attack
- Felt hopeless
- Slept - 8 hours

In speaking to the psychiatrist, the patient states
- mood: "anxious and depressed" - worse than yesterday - woke up feeling this way
- anxiety: "extremely high" - worse than yesterday - woke up feeling extremely anxious, was curled up in fetal position on his bed and tapping his leg on his bad. His anxiety did not go away with PRN Gabapentin 300 mg. He required a second dosage of PRN Gabapentin 300 to help him feel better.
- sleep: "poor" - worse than yesterday - because he worried whether people were going to draw his blood tonight
- energy: "poor" - worse than yesterday - feels wiped out from the "panic attack"
- pain: denes
- passive death wish: denies
- suicidal ideation: If he experienced this level of panic outside of the hospital, he states that he definitely would have jumped out of the window of his apartment.
- racing thoughts: "yes" - same as yesterday - thoughts go through his mind so fast and makes him feel anxious
- psychomotor agitation: "yes" - worse than yesterday - was pacing up and down the hallway and jumping up and down in the day area during the panic attack
- homicidal ideation: denies

- overall: Patient continues to have break through panic attacks which worsens his depression and intensifies his anxiety

PAST FAMILY AND SOCIAL HISTORY:

- Unchanged

VITAL SIGNS:
BP 134/72 | Pulse 84 | Temp (Src) 98.4 °F (36.9 °C) (Oral) | Resp 18 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 99%
Wt Readings from Last 3 Encounters:
08/09/16 : 58.514 kg (129 lb)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: Not applicable
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: anxious and depressed
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Good

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for:, depression, anxiety, panic attacks and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:

Recent Labs

Lab	08/13/16 1044
WBC	3.8 L
HGB	14.6
HCT	43.7
PLT	229

Recent Labs

Lab	08/13/16 1044
NA	142
K	4.1
CL	102
CO2	34 H
BUN	16
CREATININE	0.98
GLU	107 H
CA	9.1

Recent Labs

Lab	08/13/16 1044
TBILI	0.3
AST	62 H
ALT	126 H
ALP	103
ALB	4.0

No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 2,000 mg	2,000 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		2,000 mg at 08/15/16 2039
• gabapentin (NEURONTIN) Cap	300 mg	Oral	Q4H PRN	Cruz, John Michael de Vera,		300 mg at

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/16/16 0908 (continued)

300 mg				MD	08/16/16 0901
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	7.5 mg at 08/15/16 2100
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD	10 mg at 08/16/16 0852
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD	30 mL at 08/15/16 2043
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD	17.2 mg at 08/14/16 2124
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD	
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD	2 Patch at 08/15/16 2100
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD	2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/16/16 0852
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/16/16 0853
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/14/16 2124
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:
 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER to 200 mg PO at bedtime
- f/ Valproic Acid trough level on Thursday night, goal between 50 - 125
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1

 # Post Traumatic Stress Disorder
- increased PRN Gabapentin to 600 mg PO q4h for anxiety
- monitor for ongoing toxicity of Gabapentin that includes but are not limited to dizziness, somnolence, ataxia, worsening depression, increased suicidality and erythema multiforme, especially given recent increase
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:
- Gabapentin as above
- Exposure Response Prevention Therapy as outpatient

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)

- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 3 - 5 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Tuesday, August 16, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
mood instability
extreme anxiety/panic

Intervention:
Increase awareness of emotional states/reality testing
Increase insight into illness and treatment plan
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/16/16 0908 (continued)

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided supportive psychotherapy and processed the following issues. I told him that I am glad that the Gabapentin is working for him and that we will increase his PRN dosages since 600 mg was effective at breaking his panic attack. In addition, I also told him that I do not like placing my patients on benzodiazepines as these medications can be extremely habit forming, often requiring higher and higher dosages for effectiveness. I also spoke to him about the course of treatment for bipolar disorder which is that with treatment, the range between his manic and depressive episodes will ideally decrease so the point where his mood is just even (not feeling manic nor depressed).

ATTENDING PHYSICIAN:
John M Cruz, MD

Signed by Cruz, John Michael de Vera, MD at 08/16/16 1852

Behavioral Health Note by McCullough, Elizabeth Ann, RN at 08/16/16 2232

Author: McCullough, Elizabeth Ann, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/16/16 2233 | Note Time: 08/16/16 2232 | Status: Signed
Editor: McCullough, Elizabeth Ann, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☒PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	2	3.5	2

Signed by McCullough, Elizabeth Ann, RN at 08/16/16 2233

Progress Notes (continued)

CarePlan Notes by McCullough, Elizabeth Ann, RN at 08/16/16 2236

Author: McCullough, Elizabeth Ann, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/16/16 2249 | Note Time: 08/16/16 2236 | Status: Addendum
Editor: McCullough, Elizabeth Ann, RN (Registered Nurse)
Related Notes: Original Note by McCullough, Elizabeth Ann, RN (Registered Nurse) filed at 08/16/16 2236

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Visible in milieu. Hygiene disheveled with messy hair and stained clothes. Refused shower this evening, stated he'd shower in AM. Provided with shower supplies. Expressed that he was very anxious earlier today, felt much better this evening. "Tonight is the first time I've felt like myself since I've been here." Thought process circumstantial. Restless, paced unit intermittently. Reported having trouble sleeping last night. Given Zyprexa 2.5 mg with bedtime medication for sleep. Social with select peers. Went for supervised walk. Ate 75% of dinner. Denied pain. Gait steady, no falls this shift.

Signed by McCullough, Elizabeth Ann, RN at 08/16/16 2236
Signed by McCullough, Elizabeth Ann, RN at 08/16/16 2249

CarePlan Notes by Scurry-Scott, Frazier M, RN at 08/17/16 0529

Author: Scurry-Scott, Frazier M, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/17/16 0640 | Note Time: 08/17/16 0529 | Status: Signed
Editor: Scurry-Scott, Frazier M, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Pt appears asleep at beginning of shift with eyes closed and breathing unlabored. Remained in bed throughout the night with no complaints. No signs or symptoms of acute psychological distress or physical discomfort observed or voiced. **Monitored for safety at least every 30 minutes.**

EVALYSIS

[ ]Day Shift [ ]PM Shift [X]Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS ACUITY	[ ]1	[X]2	[X]3	[ ]4
ADL: Independent	[ ]			
ADL: Partial assist / supervise		[X]	[X]	
ADL: Complete assist / supervise			[ ]	[ ]

Progress Notes (continued)

CarePlan Notes by Scurry-Scott, Frazier M, RN at 08/17/16 0529 (continued)

Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[ ]	[ ]	[ ]
Assess / Intervene: Above average			[X]	[X]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[X]	[X]
Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	1	2	3.5	2

Signed by Scurry-Scott, Frazier M, RN at 08/17/16 0640

Interdisciplinary Rounding Note by Kader, Paz T, RN at 08/17/16 1022

Author: Kader, Paz T, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/17/16 1024 | Note Time: 08/17/16 1022 | Status: Signed
Editor: Kader, Paz T, RN (Registered Nurse)

Patient is well connected with community services, referral to La Chieme for follow up. Continue to provide support and encourage groups.

	08/17/16 1021
Patient Assets/Stressors	
Patient Assets	general fund of knowledge;average or above intelligence;motivation for treatment/growth;capable of independent living;supportive family/friends;work skills;physical health;ability for insight;communication skills
Patient Stressors	medication change or non-compliance
Discharge Planning	

Progress Notes (continued)

Interdisciplinary Rounding Note by Kader, Paz T, RN at 08/17/16 1022 (continued)

Discharge Criteria	improved stabilization in mood, thinking and/or behavior;verbal commitment to aftercare and medication compliance
Recommended Discharge Plan	return to previous living environment;medication management with psychiatrist or other physician
Pt's Acceptance of Discharge Plan	yes
Why Continues to Need Hospitalization	severe impairment of level of functioning;danger to self or others;medication stabilization
Estimated Length of Stay	3-5 days
Provisional DSM 5 Diagnoses	
Problem Being Addressed	refer to problem list
Goal: Will work with social worker/treatment coordinator to develop safe discharge plan	
Goal Status	goal initiated
Goal: Will attend Occupational Therapy groups up to seven days weekly as tolerated	
Objectives	increase coping skills
Goal Status	progress made toward outcome
Treatment Plan Reviewed by	
Psychiatric Social Worker	Pauline
Registered Nurse	Kader
Nurse Manager	Han
Occupational Therapist	Edwards
Other	Leveton

Signed by Kader, Paz T, RN at 08/17/16 1024

Progress Notes (continued)

CarePlan Notes by Ellison, Ricky, RN at 08/17/16 1143

Author: Ellison, Ricky, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/17/16 1143 | Note Time: 08/17/16 1143 | Status: Signed
Editor: Ellison, Ricky, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Pts affect flat moods depressed and withdrawn at times and pt mopes around the unit with his head down.Pt declined to attend am groups because he said that he didn't sleep well last NOC.Pt continues to verbalize feeling depressed and overwhelmed at times and says that he wouldn't be safe at home because he would jump out of a window but feels safe here in the hospital.Pts appearance is still unkempt and di shelved and says he doesn't have energy to do his hygene

Signed by Ellison, Ricky, RN at 08/17/16 1143

Care Team Note by Allen, Donna E at 08/17/16 1100

Author: Allen, Donna E | Service: Pastoral | Author Type: Others
Filed: 08/17/16 1230 | Note Time: 08/17/16 1100 | Status: Signed
Editor: Allen, Donna E (Others)

ABSMC Chaplaincy Services 24/7 on call pager 510-801-5050
Spiritual Assessment and Patient Visit

PATIENT DID NOT ATTEND GROUP

Type of Visit: 60 minute inner peace group

Spiritual Care provided: Facilitated an inner peace group that included a guided meditation to de-stress, a directed conversation and reflection about achieving balance in life and how hope is an important part of being optimistic and positive regarding overall mental and physical wellness and ended group with a progressive muscle and calm breathening guided meditation.

Donna E Allen
8/17/2016 12:25 PM

Signed by Allen, Donna E at 08/17/16 1230

CarePlan Notes by Bailey, Peter Julian, OT at 08/17/16 1630

Author: Bailey, Peter Julian, OT | Service: Adult Mental Health | Author Type: Occupational Therapist
Filed: 08/17/16 1630 | Note Time: 08/17/16 1630 | Status: Signed
Editor: Bailey, Peter Julian, OT (Occupational Therapist)

Problem: Depression (Adult,Obstetrics,Pediatric)
Goal: Improved/Stable Mood
Outcome: Ongoing (interventions implemented as appropriate)

Progress Notes (continued)

CarePlan Notes by Bailey, Peter Julian, OT at 08/17/16 1630 (continued)

Alcoholics Anonymous
Group Start Time: 1400

Group lead by AA volunteer member(s) providing hospital and institution meetings for patients.

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

AFFECT: Flat

APPEARANCE/BEHAVIOR: disheveled, withdrawn, and anxious; pt attended group, but sat away from peers throughout. He appeared internally preoccupied. Pt did not share any information about self.

INTERVENTION/EDUCATION: Co-facilitated Alcoholics Anonymous 12-step oriented discussion group.
Prompted patient to participate and Provided support

4 of 4 units @ 15 min.

Signed by Bailey, Peter Julian, OT at 08/17/16 1630

Behavioral Health Note by Padrul, Pauline, LCSW at 08/17/16 1609

Author: Padrul, Pauline, LCSW | Service: Social Services | Author Type: Licensed Clinical Social Worker
Filed: 08/17/16 1637 | Note Time: 08/17/16 1609 | Status: Addendum
Editor: Padrul, Pauline, LCSW (Licensed Clinical Social Worker)
Related Notes: Original Note by Padrul, Pauline, LCSW (Licensed Clinical Social Worker) filed at 08/17/16 1619

LCSW met with patient to discuss discharge planning. Patient feels treatment team at Oakland Community Support has not been responsive to his needs; he is looking for psychiatric providers elsewhere. Discussed PHP; patient expresses much interest and is willing to make daily commitment. Patient is especially motivated for treatment given memories of molest that recently resurfaced; he will continue to engage in weekly therapy after conclusion of PHP. Patient is amenable to referral to Herrick and La Cheim PHPs. LCSW spoke with Herrick PHP intake staff; patient may be evaluated for transition day on Friday pending program has space and accepts medi/medi. Also LM for La Cheim PHP with plan to fax referral documents. Faxed initial H+P, ER notes, medicine consult and current medication regimen to David Beckerman at 510-596-8707.

Signed by Padrul, Pauline, LCSW at 08/17/16 1611
Signed by Padrul, Pauline, LCSW at 08/17/16 1619
Signed by Padrul, Pauline, LCSW at 08/17/16 1637

Progress Notes by Cruz, John Michael de Vera, MD at 08/17/16 0814

Author: Cruz, John Michael de Vera, MD | Service: Psychiatry | Author Type: Physician
Filed: 08/17/16 1928 | Note Time: 08/17/16 0814 | Status: Signed
Editor: Cruz, John Michael de Vera, MD (Physician)

PSYCHIATRY PROGRESS NOTE

Wednesday, August 17, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- Sleep - 7.5 hours
- Required PRN Buprenorphine 2 mg - 9:05
- Required PRN Olanzapine ODT 2.5 mg - 20:17
- Required PRN Gabapentin 300 mg - 9:01/ 9:37

In speaking to the psychiatrist, the patient states
- mood: "anxious and depressed" - worse than yesterday - because of the residual effects of his panic attack
- psychomotor retardation: "yes" - worse than yesterday - feels that his thinking has significantly slowed down
- anxiety: "yes" - worse than yesterday - had acute panic attack that started at 10:00am and peaked at 12:00pm requiring him to ask for PRN Gabapentin 600 mg which decreased his anxiety, but did not immediately remove it as it did yesterday
- psychomotor agitation: none
- sleep: "poor" - worse than night before - because has new roommate and people kept on coming into his room from 5:00am onwards to check on his roommate which woke up the patient
- energy: "low" and rates it a 3/10 (0 - poor, 10 - great) - worse than yesterday - because of lack of sleep, and worsening depression
- pain: denies
- self-esteem: "good"
- worthlessness: denies
- passive death wish: denies
- suicidal ideation: denies

- overall: His mood is not as depressed from when he first came in, but he continues to experience spontaneous anxiety.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 120/74 | Pulse 94 | Temp (Src) 98.5 °F (36.9 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 95%
Wt Readings from Last 3 Encounters:
08/09/16 : 58.514 kg (129 lb)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted

- Gait & Station: Gait: unassisted and stable
- AIMS: 0
- Orientation**:**Fully oriented
- Speech: soft and decreased rate
- Language: English speaking and WNL
- Affect:: Flat
- Mood: anxious and depressed
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Fair

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for:, depression, anxiety, panic attacks and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:
No results for input(s): WBC, HGB, HCT, PLT in the last 72 hours.
No results for input(s): NA, K, CL, CO2, BUN, CREATININE, GLU, CA, MG, PHOS in the last 72 hours.
No results for input(s): TBILI, AST, ALT, ALP, ALB in the last 72 hours.
No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/17/16 0814 (continued)

• gabapentin (NEURONTIN) Cap 600 mg	600 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD	
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 2,000 mg	2,000 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD	2,000 mg at 08/16/16 2018
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	7.5 mg at 08/15/16 2100
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD	10 mg at 08/16/16 0852
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD	30 mL at 08/16/16 2018
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD	17.2 mg at 08/16/16 2017
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD	
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD	2 Patch at 08/15/16 2100
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD	2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/16/16 0852
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/16/16 0853
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/16/16 2017

• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:
 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 2000 mg PO at bedtime
- f/ Valproic Acid trough level on Thursday night, goal between 50 - 125
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1

 # Post Traumatic Stress Disorder
- continue PRN Gabapentin 600 mg PO q4h for anxiety
- monitor for ongoing toxicity of Gabapentin that includes but are not limited to dizziness, somnolence, ataxia, worsening depression, increased suicidality and erythema multiforme, especially given recent increase
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:
- Gabapentin as above
- Exposure Response Prevention Therapy as outpatient

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)

- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 4 - 5 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Wednesday, August 17, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
mania
mood instability
extreme anxiety/panic

Intervention:
Increase awareness of emotional states/reality testing

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/17/16 0814 (continued)

Demonstrate interventions in thought-emotion-behavior triad
Increase insight into illness and treatment plan
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided positive reinforcement for being open with his feelings of anxiousness
- provided supportive psychotherapy and processed the following issues. He says that he feels depressed, but that his depression has decreased from when he first came in. In addition, he says that when he often feels depressed and anxious, all he wants to do is lay in bed. I encouraged him to engage in what we call behavioral activation which is to do things that are the opposite of what he wants to do. Specifically, when he wants to just lay in bed, he should go out of his room and socialize with others. I also told him that what he is experiencing is a current depressive episode and that often times depression and anxiety symptoms co-exist which may be a reason why he is experiencing panic attacks. He was told that I want to optimize treatment with Valproic Acid first, but if his depressive episodes continue, we can also start Lamotrigine which he says has helped him in the past.

ATTENDING PHYSICIAN:
John M Cruz, MD

Signed by Cruz, John Michael de Vera, MD at 08/17/16 1928

Behavioral Health Note by McCullough, Elizabeth Ann, RN at 08/17/16 2327

Author: McCullough, Elizabeth Ann, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/17/16 2328 | Note Time: 08/17/16 2327 | Status: Signed
Editor: McCullough, Elizabeth Ann, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☒PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐

Progress Notes (continued)

Behavioral Health Note by McCullough, Elizabeth Ann, RN at 08/17/16 2327 (continued)

Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	2	3.5	2

Signed by McCullough, Elizabeth Ann, RN at 08/17/16 2328

CarePlan Notes by McCullough, Elizabeth Ann, RN at 08/17/16 2332

Author: McCullough, Elizabeth Ann, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/17/16 2332 | Note Time: 08/17/16 2332 | Status: Signed
Editor: McCullough, Elizabeth Ann, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Visible in milieu. Hygiene disheveled. Stated that today was much more difficult than yesterday. "I had a really hard time today." Mood was reported as depressed and anxious. Denied suicidal ideation. Reported trouble sleeping last night. Given Zyprexa 2.5 mg this evening to assist with sleep. Spent a lot of time on the phone this evening. No falls this shift. Will continue to monitor.

Signed by McCullough, Elizabeth Ann, RN at 08/17/16 2332

CarePlan Notes by Scurry-Scott, Frazier M, RN at 08/18/16 0744

Author: Scurry-Scott, Frazier M, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/18/16 0744 | Note Time: 08/18/16 0744 | Status: Signed
Editor: Scurry-Scott, Frazier M, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Pt appears asleep at beginning of shift with eyes closed and breathing unlabored. Remained in bed throughout the night with no complaints. No signs or symptoms of acute psychological distress or physical discomfort observed or voiced.

EVALYSIS

[ ]Day Shift [ ]PM Shift [X]Noc Shift

PATIENT CARE INDICATORS	
CARE INDICATORS **ACUITY**	

Progress Notes (continued)

CarePlan Notes by Scurry-Scott, Frazier M, RN at 08/18/16 0744 (continued)

	[ ]1	[X]2	[ ]3	[ ]4
ADL: Independent	[X]			
ADL: Partial assist / supervise		[ ]	[ ]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[X]	[X]	[X]
Assess / Intervene: Above average			[ ]	[ ]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[ ]	[ ]
Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	2	2	1.5	1

Signed by Scurry-Scott, Frazier M, RN at 08/18/16 0744

Care Team Note by Parker, Dominique S, RD at 08/18/16 1112

Author: Parker, Dominique S, RD | Service: Nutrition | Author Type: Dietitian/Nutritionist
Filed: 08/18/16 1116 | Note Time: 08/18/16 1112 | Status: Signed
Editor: Parker, Dominique S, RD (Dietitian/Nutritionist)

Nutrition Follow Up

Pt presently in group, did not interrupt. Wt is up 1 lb 9.6 oz in past week and recorded PO shows 75-100% of meals. Ensure Plus is being provided. Updated labs reviewed. NO new nutrition problems identified.

Interventions

- Regular diet, Ensure Plus TID
- Honor food preferences - extra soup, yogurt TID

Date of Admission: 8/9/2016
Admission Dx: Mood disorder (HCC) [F39]

Height: 5' 7" 8/9/16
Admit wt: 58.5 kg (8/9/16)
Ideal Body Weight: 148 lbs. (± 10% to account for small to large framed individuals)./% Ideal Body Weight: 88.2%

Progress Notes (continued)

Care Team Note by Parker, Dominique S, RD at 08/18/16 1112 (continued)

Body Mass Index is 20.45 kg/m2. (Normal weight, BMI 19-25)
Wt Readings from Last 5 Encounters:
08/17/16 : 59.24 kg (130 lb 9.6 oz)

Energy needs per Mifflin St. Jeor Equation: ~1980 kcal/day (1.4 activity factor)
Protein: 59-70 g/day (1-1.2 g/kg)
Fluid: 1 mL/kcal or per MD
Needs based on: Admit weight: 58.5 kg

Nutrition Rx: Regular diet (generic menu provides ~2150 kcal, 118g protein per day) + Ensure Plus TID (each provides 350 kcal, 13 g protein)

PO Intake: Inadequate oral intake related to poor appetite as evidenced by 15 lb decrease x 2-3 weeks - 8/18: resolved

Nutrition Dx: Eating 75-100% of meals when recorded, drinking Ensure Plus TID

Interventions
- Regular diet, Ensure Plus TID
- Honor food preferences - extra soup, yogurt TID

Monitor/Evaluate/Goals
- Weight: Maintain weight within +/- 5% during admission
- PO adequacy: intake > 75% of meals and snacks daily
- Nutrition discharge plan: Continue supplements following discharge

Dominique S Parker, RD

Signed by Parker, Dominique S, RD at 08/18/16 1116

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/18/16 1100

Author: Marin, Lisa Nicole, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/18/16 1311 | Note Time: 08/18/16 1100 | Status: Addendum
Editor: Marin, Lisa Nicole, RN (Registered Nurse)
Related Notes: Original Note by Marin, Lisa Nicole, RN (Registered Nurse) filed at 08/18/16 1311

EVALYSIS

☒Day Shift ☐PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐

Progress Notes (continued)

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/18/16 1100 (continued)

Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	1	2.5	2

Signed by Marin, Lisa Nicole, RN at 08/18/16 1311
Signed by Marin, Lisa Nicole, RN at 08/18/16 1311

CarePlan Notes by Marin, Lisa Nicole, RN at 08/18/16 1439

Author: Marin, Lisa Nicole, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/18/16 1504 | Note Time: 08/18/16 1439 | Status: Addendum
Editor: Marin, Lisa Nicole, RN (Registered Nurse)
Related Notes: Original Note by Marin, Lisa Nicole, RN (Registered Nurse) filed at 08/18/16 1439

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Pt affect blunted with depressed and anxious mood. Pt denies current SI. Pt states he is feeling angry today because his job is in jeopardy d/t being admitted on a 5150. Pt works with firearms, and is now banned from owning one for 5 years. Pt informed he can contest this. Pt states he contacted someone about it, but that person told him they are very rarely over ruled. Pt encouraged to shower this shift, which he did, but he still looks disheveled, with messy hair. Pt intermittently restless, pacing in hallway. Pt speech pressured at times, and thought process mildly disorganized. No c/o pain or discomfort reported or noted this shift.

Later in the shift, Pt noted to be sitting on the floor in the hallway, holding his head in his hands. Pt helped up from the floor, and directed to sit in a chair in the hallway. Pt states he is "not doing good," stating he has been feeling depressed since he woke, and the intensity has not subsided, but denies SI. Pt states, "I'm seeing things in mono color. When I look out the window, everything is black and white." Pt states this happens when he is feeling very depressed. Dr. Cruz on the unit at the time, and notified of this. He is going to make med changes.

Signed by Marin, Lisa Nicole, RN at 08/18/16 1439
Signed by Marin, Lisa Nicole, RN at 08/18/16 1504

CarePlan Notes by Bailey, Peter Julian, OT at 08/18/16 1300

Author: Bailey, Peter Julian, OT | Service: Adult Mental Health | Author Type: Occupational Therapist
Filed: 08/18/16 1550 | Note Time: 08/18/16 1300 | Status: Addendum
Editor: Bailey, Peter Julian, OT (Occupational Therapist)
Related Notes: Original Note by Bailey, Peter Julian, OT (Occupational Therapist) filed at 08/18/16 1550

Problem: Depression (Adult,Obstetrics,Pediatric)
Goal: Improved/Stable Mood
Outcome: Ongoing (interventions implemented as appropriate)

Check-in (Community) Meeting
Group Start Time: 930

Group focused on review of program schedule and guidelines, identification of treatment issues, mood rating and identification and formulation of daily therapeutic goal(s).

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

AFFECT: blunted

APPEARANCE/BEHAVIOR: unkempt and withdrawn; pt sat in group with a blanket draped over head and wrapped around body. He identified mood as, "depressed, angry, and sad," due to, "medication management not his fault." He reported that he will lose his job because he is not allowed to have a 5150 on his record. He feels that because of circumstance outside of his control he has lost his employment. He states that he will try to, "let it go and forgive," to cope. His goal was to meditate. This is the first group that he sat amongst his peers for the duration.

COGNITION: circumstantial and perseverative

INTERVENTION: Unit orientation, Individual patient check-in, mood identification, goal setting. Prompted patient to participate, Provided support and Redirected patient
3 of 3 units @ 15 min.

Cognitive/Recreational Skills
Group Start Time: 1400

Recreational activity requiring basic understanding of simple and familiar game protocol, numbers recognition and ability to attend to verbal input of moderator and simple social skills.

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

AFFECT: blunted

APPEARANCE/BEHAVIOR: unkempt, withdrawn and disheveled; pt initially stated that he could not attend group because he was, "too depressed," but spontaneously presented to group. He appeared withdrawn, he did not engage with his peers, and put his head down on the table. During a short wait time during an activity he demonstrated a low frustration tolerance, which resulted him leaving the group and returning to his room.

COGNITION: circumstantial

INTERVENTION/EDUCATION: Facilitated interactive concept application. Prompted patient to participate, Provided support and Encouraged interaction with peers

2 of 4 units @ 15 min.

Signed by Bailey, Peter Julian, OT at 08/18/16 1300

Progress Notes (continued)

CarePlan Notes by Bailey, Peter Julian, OT at 08/18/16 1300 (continued)

Signed by Bailey, Peter Julian, OT at 08/18/16 1550
Signed by Bailey, Peter Julian, OT at 08/18/16 1550

Progress Notes by Cruz, John Michael de Vera, MD at 08/18/16 0827

Author: Cruz, John Michael de Vera, MD | Service: Psychiatry | Author Type: Physician
Filed: 08/18/16 2200 | Note Time: 08/18/16 0827 | Status: Signed
Editor: Cruz, John Michael de Vera, MD (Physician)

PSYCHIATRY PROGRESS NOTE

Thursday, August 18, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:

- Depressed
- Withdrawn
- Mopes around unit
- Sleep - 7.5 hours
- PRN Gabapentin 600 mg - 12:45
- PRN Olanzapine ODT 2.5 mg - 22:56

In speaking to the psychiatrist, the patient states

- mood: "depressed" - worse than yesterday - because he has lost his fire arms license for five years for being placed on a 5150
- interest: "low" - worse than yesterday - just wants to lay in his room and not go to groups
- psychomotor retardation: "slower" - worse than yesterday
- anxiety: "minimal" and rates it 1/10 (0 - none, 10 - great) - better than yesterday
- psychomotor agitation: "yes" - noticed to be laying in a fetal position in the hallway rocking himself back and forth
- sleep: "good" - better than night before
- energy: "good" - better than yesterday - despite feeling depressed
- pain: denies
- self-esteem: "very low" - worse than yesterday
- worthlessness: "yes"
- guilt: denies
- passive death wish: yes
- suicidal ideation: He feels safe in the hospital and comfortable talking to staff if his suicidal thoughts become worse. However, he states that if outside of the hospital, he would jump out of his window.
- racing thoughts: denies
- homicidal ideation: denies

- overall: Although his anxiety has improved, his depression has worsened.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 131/86 | Pulse 98 | Temp (Src) 97.7 °F (36.5 °C) (Oral) | Resp 17 | Ht 1.702 m (5' 7") | Wt 59.24 kg (130 lb 9.6 oz) | SpO2 98%
Wt Readings from Last 3 Encounters:
08/17/16 : 59.24 kg (130 lb 9.6 oz)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: 0
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Tearful
- Mood: depressed
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Fair

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for:, depression, tearful, lack of interest and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:
No results for input(s): WBC, HGB, HCT, PLT in the last 72 hours.
No results for input(s): NA, K, CL, CO2, BUN, CREATININE, GLU, CA, MG, PHOS in the last 72 hours.
No results for input(s): TBILI, AST, ALT, ALP, ALB in the last 72 hours.
No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• gabapentin (NEURONTIN) Cap 600 mg	600 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD		600 mg at 08/17/16 1254
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 2,000 mg	2,000 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		2,000 mg at 08/17/16 2209
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD		7.5 mg at 08/15/16 2100
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD		10 mg at 08/17/16 0832
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD		30 mL at 08/17/16 2209
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD		17.2 mg at 08/17/16 2209
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD		
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD		2 Patch at 08/15/16 2100
• buprenorphine SL	2 mg	Sublingual	Q6H PRN	Cruz, John		2 mg at

(SUBUTEX) Tab 2 mg				Michael de Vera, MD	08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/17/16 0832
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/16/16 0853
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/17/16 2256
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:
 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 2000 mg PO at bedtime
- f/ Valproic Acid trough level on Thursday night, goal between 50 - 125

- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- started Lurasidone 20 mg PO with dinner, titrate up as needed with max of 120 mg PO daily
- monitor for ongoing toxicity of Lurasidone that includes but are not limited to hypotension, syncope, extrapyramidal symptoms, somnolence, appetite, and fatigue
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1

 # Post Traumatic Stress Disorder
- continue PRN Gabapentin 600 mg PO q4h for anxiety
- monitor for ongoing toxicity of Gabapentin that includes but are not limited to dizziness, somnolence, ataxia, worsening depression, increased suicidality and erythema multiforme, especially given recent increase
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:
- Gabapentin as above
- Exposure Response Prevention Therapy as outpatient

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 7 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

Progress Notes by Cruz, John Michael de Vera, MD at 08/18/16 0827 (continued)

PSYCHOTHERAPY NOTE
Thursday, August 18, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
depression

Intervention:
Increase awareness of emotional states/reality testing
Demonstrate interventions in thought-emotion-behavior triad
Increase insight into illness and treatment plan
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided supportive psychotherapy and processed the following issues. He feels extremely sad because he was placed on a 5150 and now he has lost his firearms license for five years. He does not know how he will work or obtain money. He feels extremely depressed and cannot identify the reason. He said that he has been in a fetal position in the hallway rocking back and forth and crying. He knows that he is in a severe depressive episode because he started seeing things outside of the window in black and white and not in color. The last time that this occurred was 11 years ago when he was depressed. He was told that we will start him on Lurasidone which is a medication used to treat patients who have bipolar disorder type I and currently in a depressive phase as it seems that his depression has been worsening over the past few days. He understood. In addition, he was reminded that he was going to get his valproic acid trough level done tonight so that his Divalproex ER dosage could be appropriate adjusted.

ATTENDING PHYSICIAN:
John M Cruz, MD

Signed by Cruz, John Michael de Vera, MD at 08/18/16 2200

CarePlan Notes by Abend, Marquel Marie, RN at 08/19/16 0019

Progress Notes (continued)

CarePlan Notes by Abend, Marquel Marie, RN at 08/19/16 0019 (continued)

Author: Abend, Marquel Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/19/16 0019 | Note Time: 08/19/16 0019 | Status: Signed
Editor: Abend, Marquel Marie, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Pt denies SI/HI/AH/VH. He appears euthymic at this time. He reports having a severe episode of depression this am from 9-5 he describes it as the worse depression he has ever had and if he was not in the hospital he would have defiantly have checked himself in. He reports his mood in the am was a 0/10 with 10 being the best, then after 5 his mood went to a 9/10 with 10 being the best. Pt states he may have been triggered by a conversation he had with another pt where they both shared that having a 5150 is going to severely impact their life due to needing firearms for their work. Pt has been medication compliant with no complaints of side effects. Staff attempted to draw his valproic acid level this pm with no success. Pt may need a phlebotomist to come and draw his blood for ordered labs. Dr Cruz notified.

Signed by Abend, Marquel Marie, RN at 08/19/16 0019

Behavioral Health Note by Abend, Marquel Marie, RN at 08/19/16 0100

Author: Abend, Marquel Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/19/16 0100 | Note Time: 08/19/16 0100 | Status: Signed
Editor: Abend, Marquel Marie, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☒PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	2	2.5	2

Signed by Abend, Marquel Marie, RN at 08/19/16 0100

Progress Notes (continued)

CarePlan Notes by Abend, Marquel Marie, RN at 08/19/16 0512

Author: Abend, Marquel Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/19/16 0512 | Note Time: 08/19/16 0512 | Status: Signed
Editor: Abend, Marquel Marie, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Pt currently appears asleep and has appeared to sleep through the night. Pt is currently resting in bed with eyes closed in no apparent respiratory distress. Will continue to monitor.

Signed by Abend, Marquel Marie, RN at 08/19/16 0512

Behavioral Health Note by Abend, Marquel Marie, RN at 08/19/16 0516

Author: Abend, Marquel Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/19/16 0516 | Note Time: 08/19/16 0516 | Status: Signed
Editor: Abend, Marquel Marie, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☐PM Shift ☒Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	2	2.5	2

Signed by Abend, Marquel Marie, RN at 08/19/16 0516

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/19/16 0954

Author: Marin, Lisa Nicole, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/19/16 0955 | Note Time: 08/19/16 0954 | Status: Signed
Editor: Marin, Lisa Nicole, RN (Registered Nurse)

EVALYSIS

Progress Notes (continued)

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/19/16 0954 (continued)

☒Day Shift ☐PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	1	2.5	1

Signed by Marin, Lisa Nicole, RN at 08/19/16 0955

Interdisciplinary Rounding Note by Kader, Paz T, RN at 08/19/16 1100

Author: Kader, Paz T, RN
Filed: 08/19/16 1101
Editor: Kader, Paz T, RN (Registered Nurse)
Service: Adult Mental Health
Note Time: 08/19/16 1100
Author Type: Registered Nurse
Status: Signed
Cosigner: Cruz, John Michael de Vera, MD at 08/19/16 1150

More depressed,started on Latuda yesterday,awaiting trough level for Depakote so dosage can be adjusted

	08/19/16 1000
Patient Assets/Stressors	
Patient Assets	general fund of knowledge;average or above intelligence;motivation for treatment/growth;capable of independent living;supportive family/friends;work skills;physical health;ability for insight;communication skills
Patient Stressors	medication change or non-compliance

Progress Notes (continued)

Interdisciplinary Rounding Note by Kader, Paz T, RN at 08/19/16 1100 (continued)

Discharge Planning	
Discharge Criteria	improved stabilization in mood, thinking and/or behavior;verbal commitment to aftercare and medication compliance
Recommended Discharge Plan	return to previous living environment;medication management with psychiatrist or other physician
Pt's Acceptance of Discharge Plan	yes
Why Continues to Need Hospitalization	severe impairment of level of functioning;danger to self or others;medication stabilization
Estimated Length of Stay	3-5 days
Provisional DSM 5 Diagnoses	
Problem Being Addressed	refer to problem list
Goal: Will work with social worker/treatment coordinator to develop safe discharge plan	
Goal Status	goal initiated
Goal: Will attend Occupational Therapy groups up to seven days weekly as tolerated	
Objectives	increase coping skills
Goal Status	progress made toward outcome
Treatment Plan Reviewed by	
Psychiatric Social Worker	Guerian
Registered Nurse	Kader
Nurse Manager	Han
Occupational Therapist	Clare
Other	Leveton

Progress Notes (continued)

Interdisciplinary Rounding Note by Kader, Paz T, RN at 08/19/16 1100 (continued)

Signed by Kader, Paz T, RN at 08/19/16 1101
Signed by Cruz, John Michael de Vera, MD at 08/19/16 1150

CarePlan Notes by Marin, Lisa Nicole, RN at 08/19/16 1453

Author: Marin, Lisa Nicole, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/19/16 1453 | Note Time: 08/19/16 1453 | Status: Signed
Editor: Marin, Lisa Nicole, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Pt affect restricted with depressed and anxious mood. Pt denies current SI. Pt remains disheveled, dressed in hospital scrubs, with tangled messy hair. Pt attending some groups with encouragement. Pt states he is feeling more anxious today vs feeling more depressed yesterday. Pt states "I'm just tired of fighting. I don't know if I have it in me anymore." Pt encouraged to use coping skills other than medications to help keep his anxiety at bay. Pt states walking and deep breathing help, and he did both of these for about an hour before requesting a PRN dose of Gabapentin. Pt now attending Art Group. No further requests or reports of anxiety this shift.

Signed by Marin, Lisa Nicole, RN at 08/19/16 1453

CarePlan Notes by Colburn, Claire R, OT at 08/19/16 1610

Author: Colburn, Claire R, OT | Service: Adolescent Mental Health | Author Type: Occupational Therapist
Filed: 08/19/16 1642 | Note Time: 08/19/16 1610 | Status: Signed
Editor: Colburn, Claire R, OT (Occupational Therapist)

Check-in (Community) Meeting
Group Start Time: 9:30

Group focused on review of program schedule and guidelines, identification of treatment issues, mood rating and identification and formulation of daily therapeutic goal(s).

This group supports progress in ALL patients' OT Goals.

AFFECT: Flat
APPEARANCE/BEHAVIOR: unkempt:
COGNITION: concrete.

INTERVENTION: Unit orientation, Individual patient check-in, mood identification, goal setting. Prompted patient to participate and Provided support

PATIENT RESPONSE: Distracted/preoccupied

GOAL SET: set treatment goal for day - Pt. Described feeling sad, fearful and frustrated with his unstable moods. His goal is to pray.

2 of 2 units @ 15 min.

Group Therapy

Progress Notes (continued)

CarePlan Notes by Colburn, Claire R, OT at 08/19/16 1610 (continued)

Group Start Time: 11:00

Focused on increasing insight into illness and recovery needs, coping skills and support for positive problem solving.

This group supports progress in ALL patients' OT Goals.

AFFECT: Flat
APPEARANCE/BEHAVIOR: unkempt:
COGNITION: concrete.

INTERVENTION/EDUCATION: Group Topic: Anxiety, powerlessness, existential questions and self-care.

Prompted patient to participate and Provided support

PATIENT RESPONSE: Attentive/Engaged

COMMENTS: Pt. Listened to peers and thanked them for sharing their narratives. He kept his narrative to himself.

4 of 4 units @ 15 min.

Expressive Arts Therapy
Group Start Time: 14:00

Provide creative opportunities for expression of feelings, distraction from negative or stressful thoughts, and opportunities to incorporate movement, drama, art and music into their lives.

This group supports progress in ALL patients' OT Goals.

AFFECT: restricted.
APPEARANCE/BEHAVIOR: unkempt:
COGNITION: concrete.

INTERVENTION/EDUCATION: Use of imagery to explore and express experience. Prompted patient to participate and Provided support

PATIENT RESPONSE: Attentive/Engaged; Pt. Used the media and project to express his sadness.

4 of 4 units @ 15 min.

Signed by Colburn, Claire R, OT at 08/19/16 1642

Progress Notes by Cruz, John Michael de Vera, MD at 08/19/16 1010

Author: Cruz, John Michael de Vera, MD | Service: Psychiatry | Author Type: Physician
Filed: 08/19/16 1824 | Note Time: 08/19/16 1010 | Status: Signed
Editor: Cruz, John Michael de Vera, MD (Physician)

PSYCHIATRY PROGRESS NOTE

Friday, August 19, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- Sitting on floor with head in his hands rocking back and forth
- Mood improves in the evening
- Sleep - 7.5 hours
- PRN Gabapentin 600 mg - 15:00

In speaking to the psychiatrist, the patient states
- mood: "good" - better than yesterday where he was feeling extremely depressed
- interest: "okay" - better than yesterday - attending groups
- anxiety: "yes" - worse than yesterday - anxiety built up throughout the morning and went away by 10:00am
- psychomotor agitation: None observed
- sleep: "poor" - worse than night before - woke up at 3:00am because his roommate snores
- energy: "good" - better than yesterday - where he just wanted to lay in bed
- pain: denies
- self-esteem: good
- worthlessness: denies
- guilt: denies
- passive death wish: denies
- suicidal ideation: denies
- racing thoughts: "yes" - jumble of thoughts that occur right before he is trying to sleep

- overall: His depression has decreased, but his anxiety has increased from yesterday (although it is better from when he first came in).

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 136/83 | Pulse 81 | Temp (Src) 97.8 °F (36.6 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 59.24 kg (130 lb 9.6 oz) | SpO2 100%
Wt Readings from Last 3 Encounters:
08/17/16 : 59.24 kg (130 lb 9.6 oz)

MENTAL STATUS EXAM:

- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: 0
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: anxious
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Good

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for:, anxiety, sleeplessness and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:
No results for input(s): WBC, HGB, HCT, PLT in the last 72 hours.

Recent Labs

Lab	08/19/16 0734
NA	144
K	4.6
CL	108
CO2	29
BUN	18
CREATININE	0.83
GLU	75
CA	8.7

MG 2.4

Recent Labs

Lab	08/19/16 0734
TBILI	0.3
AST	30
ALT	72 H
ALP	85
ALB	3.3

No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• lurasidone (LATUDA) Tab 20 mg	20 mg	Oral	DAILY WITH DINNER	Cruz, John Michael de Vera, MD		20 mg at 08/18/16 1804
• gabapentin (NEURONTIN) Cap 600 mg	600 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD		600 mg at 08/18/16 1500
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 2,000 mg	2,000 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		2,000 mg at 08/18/16 2205
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD		7.5 mg at 08/15/16 2100
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD		10 mg at 08/19/16 0909
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD		30 mL at 08/19/16 0908
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD		17.2 mg at 08/18/16

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/19/16 1010 (continued)

					2120
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD	
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD	2 Patch at 08/15/16 2100
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD	2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/19/16 0909
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/16/16 0853
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/17/16 2256
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:

- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:

 # Bipolar Disorder Type I without Psychotic Features:

- continue Divalproex ER 2000 mg PO at bedtime
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- WEEKEND: F/u Valproic Acid trough level on Friday night, goal between 50 - 125
- WEEKEND: Adjust Divalproex ER dosage based on VPA trough level
- increased Lurasidone to 40 mg PO with dinner
- monitor for ongoing toxicity of Lurasidone that includes but are not limited to hypotension, syncope, extrapyramidal symptoms, somnolence, appetite, and fatigue
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1

 # Post Traumatic Stress Disorder

- continue PRN Gabapentin 600 mg PO q4h for anxiety
- monitor for ongoing toxicity of Gabapentin that includes but are not limited to dizziness, somnolence, ataxia, worsening depression, increased suicidality and erythema multiforme, especially given recent increase
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:

- Gabapentin as above
- Exposure Response Prevention Therapy as outpatient

 # Psoriasis

- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia

- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome

- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:

- Voluntary

 # Disposition:

- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 4 - 6 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Friday, August 19, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
mood instability
extreme anxiety/panic

Intervention:
Increase awareness of emotional states/reality testing
Increase insight into illness and treatment plan
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided supportive psychotherapy and processed the following issues. He states that he uses distraction and meditation when he feels anxious and I encouraged him to continue using those techniques. He and another patient commiserated as both of them now can not have firearms for the next 5 years because they have been placed on a 5150. I reflected back that like him there are other people that experience these symptoms as well. He said that he does not feel depressed today, but that he feels anxious. I reflected back to him that depression and anxiety often co occur with each other and that his anxiety symptoms may be a sign of a depressive episode. As a result, the Lurasidone that we started him on may be very helpful since it is FDA

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/19/16 1010 (continued)

approved to treat current depressive episodes in people who have Bipolar Disorder. I also told him that with time, his depression will improve especially with taking this medication. He says that he often wants to be by himself when he feels depressed and anxious. However, I encouraged him to engage in behavioral activation where people do the opposite of what they want to do and in his case, he should go to groups and surround himself by others.

ATTENDING PHYSICIAN:
John M Cruz, MD

Signed by Cruz, John Michael de Vera, MD at 08/19/16 1824

Behavioral Health Note by McCullough, Elizabeth Ann, RN at 08/19/16 1851

Author: McCullough, Elizabeth Ann, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/19/16 1853 | Note Time: 08/19/16 1851 | Status: Signed
Editor: McCullough, Elizabeth Ann, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☒PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	0	1	3.5	2

Signed by McCullough, Elizabeth Ann, RN at 08/19/16 1853

CarePlan Notes by McCullough, Elizabeth Ann, RN at 08/19/16 1912

Author: McCullough, Elizabeth Ann, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/19/16 2154 | Note Time: 08/19/16 1912 | Status: Addendum
Editor: McCullough, Elizabeth Ann, RN (Registered Nurse)
Related Notes: Original Note by McCullough, Elizabeth Ann, RN (Registered Nurse) filed at 08/19/16 1912

Problem: Patient Care Overview
Goal: Plan of Care Review

Progress Notes (continued)

CarePlan Notes by McCullough, Elizabeth Ann, RN at 08/19/16 1912 (continued)

Outcome: Ongoing (interventions implemented as appropriate)
Hygiene disheveled with messy hair and rumpled clothing. Pt refused shower this shift. Spent most of the evening in his room, out intermittently for meals and to see a friend who visited. When asked why he was isolating in his room, stated it was because he was trying to pay attention to his moods. "Today I feel anxious. Yesterday I was depressed, it was a terrible day for me." Stated that today has been an easier day because he isn't feeling depressed. Denied suicidal ideation. Expressed that he feels like his medications are working today. Reported trouble sleeping last night because his roommate was snoring. "I had ear plugs, but they didn't work." Moved to another room to assist with sleep. Stated that he over-ate for dinner-Pt ate 80%. Encouraged to hydrate. Gait steady, no falls this shift. Denied constipation. Will continue to monitor.

Addendum: Trough was drawn successfully. Per Dr Cruz, it's okay to send out with courier in AM. At 2100 Pt began complaining of extreme anxiety and restlessness. "This is how I felt the day I wanted to kill myself." Given bedtime medications along with Zyprexa 2.5 mg prn for sleep. Pt continued to pace the hall. He decided to take a shower and was making loud noises in the shower, when staff checked on him he said he was just breathing. Pt was given Neurontin 600 mg for anxiety at 2121. He continued to pace the hall stating that he was too anxious. Pt requested his next sleep prn. Given Zyprexa 2.5 mg at 2146.

Signed by McCullough, Elizabeth Ann, RN at 08/19/16 1912
Signed by McCullough, Elizabeth Ann, RN at 08/19/16 2154

Behavioral Health Note by Hima, Issaka, RN at 08/19/16 2353

Author: Hima, Issaka, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/19/16 2353 | Note Time: 08/19/16 2353 | Status: Signed
Editor: Hima, Issaka, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☐PM Shift ☒Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☒2	☐3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	2	1.5	1

Signed by Hima, Issaka, RN at 08/19/16 2353

Progress Notes (continued)

Behavioral Health Note by Hima, Issaka, RN at 08/19/16 2353 (continued)

CarePlan Notes by Hima, Issaka, RN at 08/20/16 0240

Author: Hima, Issaka, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/20/16 0713 | Note Time: 08/20/16 0240 | Status: Addendum
Editor: Hima, Issaka, RN (Registered Nurse)
Related Notes: Original Note by Hima, Issaka, RN (Registered Nurse) filed at 08/20/16 0240

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Patient is currently lying in bed, appears to be sleeping. No visible signs of distress or discomfort his breathing is even and unlabored. We will continue monitoring and offering a safe and supportive environment.
0710: Patient is still in bed.

Signed by Hima, Issaka, RN at 08/20/16 0240
Signed by Hima, Issaka, RN at 08/20/16 0713

Behavioral Health Note by Yerby, Derrick J, RN at 08/20/16 0948

Author: Yerby, Derrick J, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/20/16 0949 | Note Time: 08/20/16 0948 | Status: Signed
Editor: Yerby, Derrick J, RN (Registered Nurse)

EVALYSIS

☒Day Shift ☐PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	3	3.5	2

Signed by Yerby, Derrick J, RN at 08/20/16 0949

Care Team Note by SJAARDEMA-EVENHOUSE, GEORGIA at 08/20/16 0915

Author: SJAARDEMA-EVENHOUSE, GEORGIA | Service: Adult Mental Health | Author Type: Marriage,Family and Child Counselor
Filed: 08/20/16 1037 | Note Time: 08/20/16 0915 | Status: Signed
Editor: SJAARDEMA-EVENHOUSE, GEORGIA (Marriage,Family and Child Counselor)

Patient did not attend this group.

Progress Notes (continued)

Care Team Note by SJAARDEMA-EVENHOUSE, GEORGIA at 08/20/16 0915 (continued)

Signed by SJAARDEMA-EVENHOUSE, GEORGIA at 08/20/16 1037

CarePlan Notes by Elliott, Harold Edward, OT at 08/17/16 1600

Author: Elliott, Harold Edward, OT | Service: Occupational Therapy | Author Type: Occupational Therapist
Filed: 08/20/16 1245 | Note Time: 08/17/16 1600 | Status: Signed
Editor: Elliott, Harold Edward, OT (Occupational Therapist)

Check-in (Community) Meeting
8/17/16 Group Start Time: 9:30

Group focused on review of program schedule and guidelines, identification of treatment issues, mood rating and identification and formulation of daily therapeutic goal(s).

Patient did not attend this group.

0 of 3 units @ 15 min.

Life Skills Group – Inner Peace
8/17/16 Group Start Time: 11

Structured learning opportunities to improve skills in areas such as communication, stress management, and other areas related to daily living in patients' communities outside the hospital.

Patient did not attend this group.

0 of 4 units @ 15 min.

Signed by Elliott, Harold Edward, OT at 08/20/16 1245

Progress Notes by Hirschtritt, Matthew E, MD at 08/20/16 1401

Author: Hirschtritt, Matthew E, MD | Service: Psychiatry | Author Type: Physician
Filed: 08/20/16 1431 | Note Time: 08/20/16 1401 | Status: Signed
Editor: Hirschtritt, Matthew E, MD (Physician)

PSYCHIATRY PROGRESS NOTE
Saturday, August 20, 2016

Total Time Spent 40 Minutes.
Psychotherapy Time: 20 Minutes
E/M Time: 20 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT: hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes: patient has been "more depressed" over the past day, he stated yesterday, "I'm just tired of fighting. I don't know if I have it in me anymore." Benefited from deep breathing and use of PRN gabapentin. Last night was pacing the hall, was agitated, and endorsed insomnia, requested Zyprexa and fell asleep for several hours. Intermittent SI but no self-harm behavior noted, no aggression toward others.

PRN meds: gabapentin 600 x2, Zydis 2.5 x1

Med compliance: No missed doses

On interview, pt reports that he felt "extreme thoughts" of SI last night that "came from nowhere" although he denies any plan at the time. Zydis helped and he was able to sleep, and now feels calmer yet fatigued. He denies current SI/HI/AVH.

PAST FAMILY AND SOCIAL HISTORY: Unchanged, see H&P

VITAL SIGNS:

BP 101/70 | Pulse 64 | Temp (Src) 98 °F (36.7 °C) (Oral) | Resp 17 | Ht 1.702 m (5' 7") | Wt 59.24 kg (130 lb 9.6 oz) | SpO2 99%
Wt Readings from Last 3 Encounters:
08/17/16 : 59.24 kg (130 lb 9.6 oz)

MENTAL STATUS EXAM:

General Appearance: Lying supine in bed, sits up for interview, poor EC, appears somewhat disheveled.
Muscle Strength and Tone: No abnormalities noted
Gait & Station: Gait: unable to assess because pt remains in bed
Mental Status Examination:
Orientation: Fully oriented
Speech: normal rhythm and rate
Language: English speaking and WNL
Affect:: Dysphoric, somewhat anxious
Mood: "better but I was very anxious"
Suicidal ideation: No
Homicidal Ideation: No
Thought Process: Tangential
Thought Content: no evidence of abnormality
Attention & Concentration: Within Normal Limits;
Recent & Remote Memory: recent memory intact and remote memory intact;
Fund of Knowledge: Appropriate;
Judgment & Insight:
- Judgement: Fair
- Insight: Fair

APPEARANCE/BEHAVIOR:
SPEECH: nml rate, vol, tone
AFFECT:
MOOD:
THOUGHT FORM:
THOUGHT CONTENT:
SUICIDAL IDEATION:

HOMICIDAL/ASSAULTIVE IDEATION:
INSIGHT:
JUDGMENT:
ORIENTATION: Fully oriented
COGNITIVE FUNCTION: Grossly intact. Attentive. Appropriate memory and fund of knowldege
MOTOR: WNL. No abnormal movements. Gait steady and unremarkable

REVIEW OF SYSTEMS:
GENERAL: POSITIVE FOR: WEAKNESS, FATIGUE
NEURO: POSITIVE FOR: DIZZINESS
PSYCH: POSITIVE FOR: ANXIOUSNESS, NERVOUSNESS, DEPRESSED MOOD, TROUBLE CONCENTRATING, CHANGE IN SLEEP PATTERN . See interim history.

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:

Reviewed

Recent Labs

Lab	08/19/16 2025
WBC	4.3
HGB	12.7 L
HCT	39.0 L
PLT	143 L

Recent Labs

Lab	08/19/16 2025	08/19/16 0734
NA	--	144
K	--	4.6
CL	--	108
CO2	--	29
BUN	--	18
CREATININE	--	0.83
GLU	--	75
CA	--	8.7
MG	--	2.4
PHOS	3.6	--

Recent Labs

Lab	08/19/16 0734
TBILI	0.3
AST	30
ALT	72 H
ALP	85
ALB	3.3

Component	Latest Ref Rng	8/19/2016
Valproic Acid	50.0 - 100.0 ug/mL	89.4

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• lurasidone (LATUDA) Tab 40 mg	40 mg	Oral	DAILY WITH DINNER	Cruz, John Michael de Vera, MD		40 mg at 08/19/16 1802
• gabapentin (NEURONTIN) Cap 600 mg	600 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD		600 mg at 08/19/16 2121
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 2,000 mg	2,000 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		2,000 mg at 08/19/16 2056
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD		7.5 mg at 08/15/16 2100
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD		10 mg at 08/20/16 0947
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD		30 mL at 08/20/16 0900
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD		17.2 mg at 08/19/16 2056

Progress Notes (continued)

Progress Notes by Hirschtritt, Matthew E, MD at 08/20/16 1401 (continued)

• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD	
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD	2 Patch at 08/15/16 2100
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD	2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/20/16 0947
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/16/16 0853
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/19/16 2146
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/RESTRAINT:
None

DIAGNOSIS / PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:

- If discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- Pt requires locked, inpatient, psychiatric hospitalization for creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:

PSYCHIATRIC:
 # Bipolar Disorder Type I without Psychotic Features:
- **increase Divalproex ER from 2000 to 2250 mg PO at bedtime, starting tonight (8/20/16)**
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- **trough VPA level ordered for 8/23/16**
- continue Lurasidone 40 mg PO with dinner
- monitor for ongoing toxicity of Lurasidone that includes but are not limited to hypotension, syncope, extrapyramidal symptoms, somnolence, appetite, and fatigue
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1

 # Post Traumatic Stress Disorder
- continue PRN Gabapentin 600 mg PO q4h for anxiety
- monitor for ongoing toxicity of Gabapentin that includes but are not limited to dizziness, somnolence, ataxia, worsening depression, increased suicidality and erythema multiforme, especially given recent increase
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:
- Gabapentin as above
- Exposure Response Prevention Therapy as outpatient

MEDICAL:
Follow up labs/imaging

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

LEGAL STATUS: Voluntary

DISPOSITION:
Herrick PHP vs La Cheim

ELOS: 4-6d

PROCEDURE CODES:
E/M 99233
Psychotherapy90833

Matthew E Hirschtritt, MD

PSYCHOTHERAPY NOTE
Saturday, August 20, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

PSYCHOTHERAPY:
PSYCHOTHERAPY TYPE: CBT
Supportive

PROBLEM: mood instability
extreme anxiety/panic

INTERVENTION: Increase awareness of emotional states/reality testing
Improve treatment alliance

RESPONSE: Acknowledges intellectual understanding but emotionally struggles
Shows motivation to change

PLAN:
Continue current psychotherapeutic treatment approach
Work to reinforce insights/concepts/skills

NARRATIVE:
Patient discussed with me the distress of feeling sudden urge to harm himself last night, which left him feeling anxious and panicked. We discussed ways to deal with such powerful emotions, such as reaching out to support staff, deep breathing, and mindfulness. He endorsed understanding and stated that he would attempt these techniques in the future. He endorsed feeling somewhat calmer and less agitated after we spoke.

Matthew E Hirschtritt, MD

Progress Notes (continued)

Progress Notes by Hirschtritt, Matthew E, MD at 08/20/16 1401 (continued)

Signed by Hirschtritt, Matthew E, MD at 08/20/16 1431

Behavioral Health Note by Yerby, Derrick J, RN at 08/20/16 0949

Author: Yerby, Derrick J, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/20/16 1512 | Note Time: 08/20/16 0949 | Status: Signed
Editor: Yerby, Derrick J, RN (Registered Nurse)

Pt c/o of being very tired this morning because he had a difficult night last night. He reported that his troubles began late last evening when he started feeling extremely anxious, depressed, overwhelmed, and suicidal. He took two doses of Zyprexa last night which he states, "saved my life. It helped stop the negative thoughts, but I couldn't sleep and I'm tired today." He slept for the majority of the day today, he did not get up for breakfast or lunch, he only drank the juice that I brought him. He is med compliant. He did not go to any groups today, which is unusual for him. He offered no other complaints and continues resting/sleeping in his room. He appears in NAD.

Signed by Yerby, Derrick J, RN at 08/20/16 1512

Care Team Note by SJAARDEMA-EVENHOUSE, GEORGIA at 08/20/16 1100

Author: SJAARDEMA-EVENHOUSE, GEORGIA | Service: Adult Mental Health | Author Type: Marriage,Family and Child Counselor
Filed: 08/20/16 1519 | Note Time: 08/20/16 1100 | Status: Signed
Editor: SJAARDEMA-EVENHOUSE, GEORGIA (Marriage,Family and Child Counselor)

Patient did not attend this group.

Signed by SJAARDEMA-EVENHOUSE, GEORGIA at 08/20/16 1519

Care Team Note by SJAARDEMA-EVENHOUSE, GEORGIA at 08/20/16 1400

Author: SJAARDEMA-EVENHOUSE, GEORGIA | Service: Adult Mental Health | Author Type: Marriage,Family and Child Counselor
Filed: 08/20/16 1626 | Note Time: 08/20/16 1400 | Status: Signed
Editor: SJAARDEMA-EVENHOUSE, GEORGIA (Marriage,Family and Child Counselor)

Patient did not attend this group.

Signed by SJAARDEMA-EVENHOUSE, GEORGIA at 08/20/16 1626

CarePlan Notes by Abend, Marquel Marie, RN at 08/20/16 1825

Author: Abend, Marquel Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/20/16 2202 | Note Time: 08/20/16 1825 | Status: Signed
Editor: Abend, Marquel Marie, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Pt denies SI/HI/AH/VH. He appears depressed, anxious with restricted affect. He reports having the worse ever episode of depression last night stating it was worse than his suicide attempt. Pt thinks his body does not respond well to time release medications, he feels adding Lamictal might help due to past success. Pt reports feeling very tired, yet calm and sleeping for 14 hours. He states his mood now is a 7/10 with 10 being the best. He has been isolating towards himself in his room.

At 2000 pt reports feeling very restless, jumpy and having a hard time sitting still. It appears he may be having some akathisia from the Latuda which was started on Thursday at 20 mg and increased Friday to 40 mg. Pt

Progress Notes (continued)

CarePlan Notes by Abend, Marquel Marie, RN at 08/20/16 1825 (continued)

has concerns about continuing to take this medication. Pt is having a hard time sleeping due to these symptoms. Will continue to monitor.

Signed by Abend, Marquel Marie, RN at 08/20/16 2202

Progress Notes

CarePlan Notes by Scurry-Scott, Frazier M, RN at 08/21/16 0204

Author: Scurry-Scott, Frazier M, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/21/16 0650 | Note Time: 08/21/16 0204 | Status: Signed
Editor: Scurry-Scott, Frazier M, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Pt lying awake in bed, sleep disturbance due to roommate snoring and talking loudly in his sleep. Pt placed earplugs in and fell asleep. Will monitor of restlessness as pt c/o poor sleep last night. .**Slept 7.0 hrs**

EVALYSIS

[ ]Day Shift [ ]PM Shift [X]Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS ACUITY	[ ]1	[ ]2	[ ]3	[ ]4
ADL: Independent	[X]			
ADL: Partial assist / supervise		[ ]	[ ]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[X]	[X]	[X]
Assess / Intervene: Above average			[ ]	[ ]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[X]	[X]
Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	2	2	2.5	2

Signed by Scurry-Scott, Frazier M, RN at 08/21/16 0650

Progress Notes (continued)

CarePlan Notes by Britt, Julia Anna, RN at 08/21/16 1139

Author: Britt, Julia Anna, RN | Service: Adolescent Mental Health | Author Type: Registered Nurse
Filed: 08/21/16 1139 | Note Time: 08/21/16 1139 | Status: Signed
Editor: Britt, Julia Anna, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
This shift Vincent appeared cooperative with mild anxiety related to restlessness/akathesia from taking his latuda (per pt). He requested and was given cogentin prn 1mg this morning. He denies feeling anxious today but states he has an inner restlessness. Pt requesting to go on unit walk with staff today as he felt this would be helpful for his restlessness, order received from covering psychiatrist for patient to be allowed to go on unit walks. Pt went on unit walk this shift. No unsafe behaviors observed today. He denies SI, HI or a/v hallucinations. Will continue to monitor.

EVALYSIS

PATIENT CARE INDICATORS				
CARE INDICATORS ACUITY	DAY			
	[ ]1	[ ]2	[X]3	[ ]4
ADL: Independent	[ ]			
ADL: Partial assist / supervise		[X]	[X]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[ ]	[ ]	[ ]
Assess / Intervene: Above average			[X]	[X]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[X]	[X]
Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	1	2	3.5	2

Signed by Britt, Julia Anna, RN at 08/21/16 1139

CarePlan Notes by Britt, Julia Anna, RN at 08/21/16 1139 (continued)

Progress Notes by Hirschtritt, Matthew E, MD at 08/21/16 1200

Author: Hirschtritt, Matthew E, MD | Service: Psychiatry | Author Type: Physician
Filed: 08/21/16 1223 | Note Time: 08/21/16 1200 | Status: Signed
Editor: Hirschtritt, Matthew E, MD (Physician)

PSYCHIATRY PROGRESS NOTE

Sunday, August 21, 2016

Total Time Spent 40 Minutes.
Psychotherapy Time: 20 Minutes
E/M Time: 20 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT: hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes: pt appears depressed, anxious, disheveled on unit; however, is participating in grps and expressing his concerns to nursing and OT staff. He consistently denies SI and reports a mood of 7/10 with 10 being the best. In between grps, he has been isolating himself in his room. He reported extreme restlessness last night, that he attributes to Latuda and derived some benefit from the adjunctive Zyprexa to address akathisia. Slept 7.0 hours. He engaged in a unit walk this morning, which was beneficial to address restlessness.

PRN meds: Cogentin 1mg PO x1, Zydis 2.5mg PO x2

Med compliance: No missed doses

On interview, pt reports "akathesia" last night that he attributes to Latuda and claims that his mood was "fine" before starting the Latuda, and that the Zyprexa monotherapy has helped in the past with low mood and anxiety. He is feeling somewhat more hopeful and upbeat today, and identifies medication and journaling as coping strategies. He denies SI/HI/AVH. He wants to engage in the hospital PHP following discharge to build on the improvements he's made in the hospital over the past several days.

PAST FAMILY AND SOCIAL HISTORY: Unchanged, see H&P

VITAL SIGNS:

BP 103/76 | Pulse 74 | Temp (Src) 97.9 °F (36.6 °C) (Oral) | Resp 17 | Ht 1.702 m (5' 7") | Wt 59.24 kg (130 lb 9.6 oz) | SpO2 99%
Wt Readings from Last 3 Encounters:
08/17/16 : 59.24 kg (130 lb 9.6 oz)

MENTAL STATUS EXAM:

Progress Notes (continued)

Progress Notes by Hirschtritt, Matthew E, MD at 08/21/16 1200 (continued)

General Appearance: Lying supine in bed, sits up for interview, later observed walking without assistance in hallway, good EC, appears somewhat disheveled, is mildly malodorous
Muscle Strength and Tone: No abnormalities noted
Gait & Station: Gait: unassisted and stable
Mental Status Examination:
Orientation: Fully oriented
Speech: normal rhythm and rate
Language: English speaking and WNL
Affect:: Dysphoric, somewhat anxious
Mood: "fine"
Suicidal ideation: No
Homicidal Ideation: No
Thought Process: More linear compared to yesterday
Thought Content: no evidence of abnormality
Attention & Concentration: Within Normal Limits;
Recent & Remote Memory: recent memory intact and remote memory intact;
Fund of Knowledge: Appropriate;
Judgment & Insight:
- Judgement: Fair
- Insight: Fair

REVIEW OF SYSTEMS:
GENERAL: POSITIVE FOR: WEAKNESS, FATIGUE
NEURO: POSITIVE FOR: RESTLESSNESS
PSYCH: POSITIVE FOR: ANXIOUSNESS, NERVOUSNESS, DEPRESSED MOOD, TROUBLE CONCENTRATING, CHANGE IN SLEEP PATTERN . See interim history.

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:

No labs in past 24h

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• benztropine (COGENTIN) Tab 1 mg	1 mg	Oral	ONCE	Trautner, Rick Jeffrey, MD		
• benztropine (COGENTIN) Tab 1	1 mg	Oral	Q4H PRN	Trautner, Rick Jeffrey, MD		1 mg at 08/21/16

Progress Notes (continued)

Progress Notes by Hirschtritt, Matthew E, MD at 08/21/16 1200 (continued)

mg					0859
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 2,250 mg	2,250 mg	Oral	Q BEDTIME	Hirschtritt, Matthew E, MD	2,250 mg at 08/20/16 2009
• lurasidone (LATUDA) Tab 40 mg	40 mg	Oral	DAILY WITH DINNER	Cruz, John Michael de Vera, MD	40 mg at 08/20/16 1840
• gabapentin (NEURONTIN) Cap 600 mg	600 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD	600 mg at 08/19/16 2121
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	7.5 mg at 08/15/16 2100
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD	10 mg at 08/21/16 0900
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD	30 mL at 08/21/16 0830
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD	17.2 mg at 08/20/16 2009
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD	
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD	2 Patch at 08/15/16 2100
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD	2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/21/16 0830
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/16/16 0853
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/20/16 2134
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/RESTRAINT:
None

DIAGNOSIS / PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- If discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- Pt requires locked, inpatient, psychiatric hospitalization for creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:

PSYCHIATRIC:
 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 2250 mg PO at bedtime, increased from 2000mg on 8/20/16
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- **trough VPA level ordered for 8/23/16**
- decrease Lurasidone from 40 mg to 20mg PO with dinner to reduce risk of akathisia; may slowly increase if tolerated over several days
- monitor for ongoing toxicity of Lurasidone that includes but are not limited to hypotension, syncope, extrapyramidal symptoms, somnolence, appetite, and fatigue
- continue PRN Olanzapine ODT 2.5mg PO at bedtime for insomnia, may repeat x 1

 # Post Traumatic Stress Disorder
- continue PRN Gabapentin 600 mg PO q4h for anxiety
- monitor for ongoing toxicity of Gabapentin that includes but are not limited to dizziness, somnolence, ataxia, worsening depression, increased suicidality and erythema multiforme, especially given recent increase
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:
- Gabapentin as above
- Exposure Response Prevention Therapy as outpatient

MEDICAL:
Follow up labs/imaging

 # Psoriasis

- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

LEGAL STATUS: Voluntary

DISPOSITION:
Herrick PHP vs La Cheim

ELOS: 4-6d

PROCEDURE CODES:
E/M 99233
Psychotherapy90833

Matthew E Hirschtritt, MD

PSYCHOTHERAPY NOTE
Sunday, August 21, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

PSYCHOTHERAPY:
PSYCHOTHERAPY TYPE: CBT
Supportive

PROBLEM: mood instability
extreme anxiety/panic

INTERVENTION: Increase awareness of emotional states/reality testing
Improve treatment alliance

Progress Notes by Hirschtritt, Matthew E, MD at 08/21/16 1200 (continued)

RESPONSE: Acknowledges intellectual understanding but emotionally struggles
Shows motivation to change

PLAN:
Continue current psychotherapeutic treatment approach
Work to reinforce insights/concepts/skills

NARRATIVE:
We discussed ways to anticipate and deal with anxiety/distress and suicidal ideation, including medication, journaling, and reaching out for assistance and advice from peers and staff. He endorsed understanding and requested to walk outside of the unit to reduce feeling of restlessness. We also discussed ways to continue the skills he has learned during this hospitalization in PHP or a residential tx setting.

Matthew E Hirschtritt, MD

Signed by Hirschtritt, Matthew E, MD at 08/21/16 1223

CarePlan Notes by Bailey, Peter Julian, OT at 08/21/16 1018

Author: Bailey, Peter Julian, OT | Service: Adult Mental Health | Author Type: Occupational Therapist
Filed: 08/21/16 1714 | Note Time: 08/21/16 1018 | Status: Addendum
Editor: Bailey, Peter Julian, OT (Occupational Therapist)
Related Notes: Original Note by Bailey, Peter Julian, OT (Occupational Therapist) filed at 08/21/16 1018

Problem: Depression (Adult,Obstetrics,Pediatric)
Goal: Improved/Stable Mood
Outcome: Ongoing (interventions implemented as appropriate)

Check-in (Community) Meeting
Group Start Time: 930

Group focused on review of program schedule and guidelines, identification of treatment issues, mood rating and identification and formulation of daily therapeutic goal(s).

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

AFFECT: blunted

APPEARANCE/BEHAVIOR: unkempt, disheveled and internally preoccupied. Pt identified mood as, "miserable, confused, worried," because he is, "confused about medications affects, feels like I'm going backwards, and worried it won't all work." To cope, he identified, participating on the walk, stating that he has been isolating for the previous 2 days.

COGNITION: circumstantial

INTERVENTION: Unit orientation, Individual patient check-in, mood identification, goal setting. Prompted patient to participate, Provided support and Encouraged interaction with peers

3 of 3 units @ 15 min.

Focal Group

Progress Notes (continued)

CarePlan Notes by Bailey, Peter Julian, OT at 08/21/16 1018 (continued)

Group Start Time: 1115

Group focused on promotion of improved communication and positive, interpersonal experiences—generalizable to relationships outside of the program—to provide opportunity for verbal expression and processing, group co-facilitated by mental health specialist and occupational therapist.

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

AFFECT: Flat

APPEARANCE/BEHAVIOR: unkempt, guarded and internally preoccupied. Pt sat with group, frequently with his eyes closed. Pt shared about childhood sexual abuse, the emotional experience of knowing that his abuser could have also abused his father. Stated that he did not date until he was 27 as result of the abuse. Pt did not interact with peers, except for during this exchange, where he connected with a peer on the shared experience of childhood abuse.

COGNITION: coherent and goal directed

INTERVENTION/EDUCATION: Prompted patient to participate, Provided support and Encouraged interaction with peers
3 of 3 units @ 15 min.

Expressive Arts Therapy
Group Start Time: 1400

Provide creative opportunities for expression of feelings, distraction from negative or stressful thoughts, and opportunities to incorporate movement, drama, art and music into their lives.

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

Pt arrived late to group, he had difficulty initiating activity on a collage and became distracted by the materials. Pt composed a simple collage of animals that he felt a connection to, he selected a baby fox and a baby wild cat. Pt stated to OT, that he is trying very hard to connect with peers and attend group, but his depression makes it very difficult.
2 of 4 units @ 15 min.

Signed by Bailey, Peter Julian, OT at 08/21/16 1018
Signed by Bailey, Peter Julian, OT at 08/21/16 1714

CarePlan Notes by Rowny, Katharine Lynne, RN at 08/21/16 2318

Author: Rowny, Katharine Lynne, RN | Service: Adolescent Mental Health | Author Type: Registered Nurse
Filed: 08/21/16 2318 | Note Time: 08/21/16 2318 | Status: Signed
Editor: Rowny, Katharine Lynne, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)

Progress Notes (continued)

CarePlan Notes by Rowny, Katharine Lynne, RN at 08/21/16 2318 (continued)

Patient presented as anxious and slightly restless, walking slowing around the unit. He was pleasant and cooperative with staff, social with a few peers, and participated in groups during this shift.

The patient reports his mood as "ok" although noted some mood swings in the past several days. The patient spent time reporting on details leading up to his recent hospitalization, noting that a provider in the community weaned him off of his psychiatric medications. The patient stated, "she told me I didn't have bipolar disorder. Before that, I was on Seroquel 25mg , Lamictal 400mg, and Paxil 30mg, and was pretty stable on that for 7 years." Prior to being taken off of medication, the patient explained, he was fairly stable and had been looking for employment with the intent of getting off of SSDI

The patient denied any homicidal or suicidal ideation. He denied any perceptual distortions. No unsafe behavior was observed during this shift.

EVALYSIS

PATIENT CARE INDICATORS				
CARE INDICATORS ACUITY	EVENING 1500			
	[ ]1	[ ]2	[X]3	[ ]4
ADL: Independent	[ ]			
ADL: Partial assist / supervise		[X]	[X]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[ ]	[ ]	[ ]
Assess / Intervene: Above average			[X]	[X]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[X]	[X]
Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	1	2	3.5	2

,

Progress Notes (continued)

CarePlan Notes by Rowny, Katharine Lynne, RN at 08/21/16 2318 (continued)

Signed by Rowny, Katharine Lynne, RN at 08/21/16 2318

CarePlan Notes by Scurry-Scott, Frazier M, RN at 08/22/16 0702

Author: Scurry-Scott, Frazier M, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/22/16 0702 | Note Time: 08/22/16 0702 | Status: Signed
Editor: Scurry-Scott, Frazier M, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Received in bed and appeared asleep @ beginning of shift. Remained in bed throughout the night woth no signs/sx of distress or discomfort. Slept soudly and continues to be asleep. **Slept 7.5 hrs. No falls/injury/trauma observed or reported.**

EVALYSIS

[ ]Day Shift [ ]PM Shift [X]Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS ACUITY	[ ]1	[ ]2	[X]3	[ ]4
ADL: Independent	[X]			
ADL: Partial assist / supervise		[ ]	[ ]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[X]	[X]	[X]
Assess / Intervene: Above average			[ ]	[ ]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[X]	[X]	[X]
Behavior: Moderately unpredictable			[ ]	[ ]
Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	2	2	2.5	2

Progress Notes (continued)

CarePlan Notes by Scurry-Scott, Frazier M, RN at 08/22/16 0702 (continued)

Signed by Scurry-Scott, Frazier M, RN at 08/22/16 0702

Behavioral Health Note by Edwards, Sarah C, RN at 08/22/16 1002

Author: Edwards, Sarah C, RN | Service: Adolescent Mental Health | Author Type: Registered Nurse
Filed: 08/22/16 1003 | Note Time: 08/22/16 1002 | Status: Signed
Editor: Edwards, Sarah C, RN (Registered Nurse)

EVALYSIS

☒Day Shift ☐PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	2	3.5	2

Signed by Edwards, Sarah C, RN at 08/22/16 1003

Interdisciplinary Rounding Note by Ellison, Ricky, RN at 08/22/16 1046

Author: Ellison, Ricky, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/22/16 1047 | Note Time: 08/22/16 1046 | Status: Signed
Editor: Ellison, Ricky, RN (Registered Nurse)

Referred to Herrick PHP once stable, continue medication management and provide support.

	08/22/16 0929
Patient Assets/Stressors	
Patient Assets	general fund of knowledge;average or above

Progress Notes (continued)

Interdisciplinary Rounding Note by Ellison, Ricky, RN at 08/22/16 1046 (continued)

	intelligence;motivation for treatment/growth;capable of independent living;supportive family/friends;work skills;physical health;ability for insight;communication skills
Patient Stressors	medication change or non-compliance
Discharge Planning	
Discharge Criteria	improved stabilization in mood, thinking and/or behavior;verbal commitment to aftercare and medication compliance
Recommended Discharge Plan	return to previous living environment;medication management with psychiatrist or other physician
Pt's Acceptance of Discharge Plan	yes
Why Continues to Need Hospitalization	severe impairment of level of functioning;danger to self or others;medication stabilization
Estimated Length of Stay	3-5 days
Provisional DSM 5 Diagnoses	
Problem Being Addressed	refer to problem list
Goal: Will work with social worker/treatment coordinator to develop safe discharge plan	
Goal Status	goal initiated
Goal: Will attend Occupational Therapy groups up to seven days weekly as tolerated	
Objectives	increase coping skills
Goal Status	progress made toward

Progress Notes (continued)

Interdisciplinary Rounding Note by Ellison, Ricky, RN at 08/22/16 1046 (continued)

	outcome
Treatment Plan Reviewed by	
Physician	Cruz, Schumm
Psychiatric Social Worker	Bathick
Registered Nurse	Ellison
Nurse Manager	Han
Occupational Therapist	Peter
Other	Silverman

Signed by Ellison, Ricky, RN at 08/22/16 1047

Progress Notes by Cruz, John Michael de Vera, MD at 08/22/16 1142

Author: Cruz, John Michael de Vera, MD | Service: Psychiatry | Author Type: Physician
Filed: 08/22/16 1142 | Note Time: 08/22/16 1142 | Status: Signed
Editor: Cruz, John Michael de Vera, MD (Physician)

MEDICARE 1st RE-CERTIFICATION, DAY 12

Due date: August 20, 2016

I certify that the inpatient psychiatric hospital services furnished since the previous certification was and continues to be medically necessary for either treatment which would reasonably be expected to improve the patient's condition or diagnostic study and the hospital records indicate that the services furnished were either intensive treatment services, admission and related services necessary for diagnostic study or equivalent services.

I estimate 7 days of hospitalization is necessary for proper treatment of the patient. My plans for post-hospital care for this patient are coordinating with outpatient provider.

Signed by Cruz, John Michael de Vera, MD at 08/22/16 1142

CarePlan Notes by Edwards, Sarah C, RN at 08/22/16 1414

Author: Edwards, Sarah C, RN | Service: Adolescent Mental Health | Author Type: Registered Nurse
Filed: 08/22/16 1447 | Note Time: 08/22/16 1414 | Status: Addendum
Editor: Edwards, Sarah C, RN (Registered Nurse)
Related Notes: Original Note by Edwards, Sarah C, RN (Registered Nurse) filed at 08/22/16 1414

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Pt attending groups, interacts minimally with peers . Pt continues disheveled, bx is bizarre @ times. Pt reports feeling mood is improved, states mood is "level", no racing thoughts this shift.Pt denies restlessness or akathisia @ this time.Pt denies SI.

Signed by Edwards, Sarah C, RN at 08/22/16 1414

Progress Notes (continued)

CarePlan Notes by Edwards, Sarah C, RN at 08/22/16 1414 (continued)

Signed by Edwards, Sarah C, RN at 08/22/16 1447

CarePlan Notes by Bailey, Peter Julian, OT at 08/22/16 1311

Author: Bailey, Peter Julian, OT | Service: Adult Mental Health | Author Type: Occupational Therapist
Filed: 08/22/16 1707 | Note Time: 08/22/16 1311 | Status: Addendum
Editor: Bailey, Peter Julian, OT (Occupational Therapist)
Related Notes: Original Note by Bailey, Peter Julian, OT (Occupational Therapist) filed at 08/22/16 1311

Problem: Depression (Adult,Obstetrics,Pediatric)
Goal: Improved/Stable Mood
Outcome: Ongoing (interventions implemented as appropriate)

Check-in (Community) Meeting
Group Start Time: 930

Group focused on review of program schedule and guidelines, identification of treatment issues, mood rating and identification and formulation of daily therapeutic goal(s).

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

AFFECT: Restricted

APPEARANCE/BEHAVIOR: agitated and unkempt; pt identified mood as, "anxious, and confused," due to somatic symptoms he is attributing to medication. He stated his goal for the day was to read, stating that it has been challenging to maintain his concentration long enough to successfully read a page. During group patient was attempting to remove knotted hair by hand, occasionally throwing excess floor to the ground.

COGNITION: coherent and goal directed

INTERVENTION: Unit orientation, Individual patient check-in, mood identification, goal setting. Prompted patient to participate, Provided support and Encouraged interaction with peers

3 of 3 units @ 15 min.

Introduction to DBT
Group Start Time: 1100

Review of the cognitive modes as it relates to psychological well-being; practice utilizing thought records, activity schedules and other coping skills for symptom management. Group co-facilitated by Mental Health Specialist and occupational therapists. Introduction to mindfulness, distress tolerance, interpersonal effectiveness and emotional regulation. Discussion in group to facilitate functional application of skills to improve daily life.
This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

AFFECT: Restricted

APPEARANCE/BEHAVIOR: appropriate and alert; pt attended group, he asked appropriate clarifying questions, sat amongst peers, and kept his eyes open throughout the discussion.

COGNITION: coherent and goal directed

CarePlan Notes by Bailey, Peter Julian, OT at 08/22/16 1311 (continued)

4 of 4 units @ 15 min.

Pet Therapy
Group Start Time: 1400

Provide creative opportunities for expression of feelings, distraction from negative or stressful thoughts, to decrease stress, isolation and increase socialization. Provide, opportunity to assess cognitive abilities.

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

AFFECT: Flat

APPEARANCE/BEHAVIOR: restless, malodorous, and somatically focused; pt continually joined and left group. He interacted with peers minimally, he held a dog for a brief period. He expressed feeling frequent needs to have a bowel movement. Pt stated that he has a cat at home that is very comforting to him. His affect became brighter while holding the dog, and also when he spoke of his cat.

COGNITION: coherent and goal directed

2 of 2 units @ 15 min.

Signed by Bailey, Peter Julian, OT at 08/22/16 1311
Signed by Bailey, Peter Julian, OT at 08/22/16 1707

Progress Notes by Cruz, John Michael de Vera, MD at 08/22/16 0913

Author: Cruz, John Michael de Vera, MD | Service: Psychiatry | Author Type: Physician
Filed: 08/22/16 2101 | Note Time: 08/22/16 0913 | Status: Addendum
Editor: Cruz, John Michael de Vera, MD (Physician)
Related Notes: Original Note by Cruz, John Michael de Vera, MD (Physician) filed at 08/22/16 2055

PSYCHIATRY PROGRESS NOTE

Monday, August 22, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:

- Sleep - 7.25 hours

- PRN Benztropine 1 mg - 8:59/ 21:09
- PRN Olanzapine 2.5 mg - 21:20/ 23:14

In speaking to the psychiatrist, the patient states
- mood: Depressed - same as yesterday - because he did not get good sleep
- interest: "poor" - taking part in groups, but requires a lot of effort.
- appetite: "good" - same as yesterday - eating three meals a day with snacks
- anxiety: none
- psychomotor agitation: Reports that he felt inner restlessness when he took Lurasidone and even when it was decreased to lower dose.,
- sleep: "poor" - worse than the night before - feels that the Lurasidone kept him up
- energy: "poor" - worse than yesterday - because he did not sleep
- pain: denies
- passive death wish: denies
- suicidal ideation: denies
- racing thoughts: denies
- homicidal ideation: denies

- overall: He states that the Lurasidone made him feel very restless inside and made it difficult for him to fall asleep even with the PRN dose of the Olanzapine.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 128/71 | Pulse 86 | Temp (Src) 97.8 °F (36.6 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 59.24 kg (130 lb 9.6 oz) | SpO2 100%
Wt Readings from Last 3 Encounters:
08/17/16 : 59.24 kg (130 lb 9.6 oz)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: 0
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: anxious and depressed
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired

- Judgement: Fair
- Insight: Fair

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for:, depression, anxiety, sleeplessness and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:

Recent Labs

Lab	08/19/16 2025
WBC	4.3
HGB	12.7 L
HCT	39.0 L
PLT	143 L

Recent Labs

Lab	08/19/16 2025
PHOS	3.6

No results for input(s): TBILI, AST, ALT, ALP, ALB in the last 72 hours.
No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• lurasidone	20 mg	Oral	DAILY WITH	Hirschtritt,		20 mg at

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/22/16 0913 (continued)

(LATUDA) Tab 20 mg			DINNER	Matthew E, MD	08/21/16 2056
• benztropine (COGENTIN) Tab 1 mg	1 mg	Oral	ONCE	Trautner, Rick Jeffrey, MD	
• benztropine (COGENTIN) Tab 1 mg	1 mg	Oral	Q4H PRN	Trautner, Rick Jeffrey, MD	1 mg at 08/21/16 2109
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 2,250 mg	2,250 mg	Oral	Q BEDTIME	Hirschtritt, Matthew E, MD	2,250 mg at 08/21/16 2055
• gabapentin (NEURONTIN) Cap 600 mg	600 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD	600 mg at 08/19/16 2121
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	7.5 mg at 08/15/16 2100
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD	10 mg at 08/21/16 0900
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD	30 mL at 08/22/16 0900
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD	17.2 mg at 08/21/16 2056
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD	
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD	2 Patch at 08/15/16 2100
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD	2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/22/16 0836
• magnesium hydroxide (MILK OF	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	

MAGNESIA/MOM) Oral Susp 30 mL					
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/16/16 0853
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/21/16 2314
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:
 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 2250 mg PO at bedtime
- f/u VPA trough level on 8/23 at bedtime
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- discontinued Lurasidone given reports of akathisia and restlessness
- *started Olanzapine 5 mg PO at bedtime instead*
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1
- *started PRN Olanzapine ODT 2.5 mg PO q4h for anxiety*
- monitor for ongoing toxicity of Olanzapine that includes but are not limited to hypotension, syncope, extrapyramidal symptoms, somnolence, appetite, and fatigue

 # Post Traumatic Stress Disorder
- discontinued PRN Gabapentin 600 mg PO q4h for anxiety given ineffectiveness
- started PRN Olanzapine 2.5 mg PO q4h for anxiety
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:
- PRN Olanzapine ODT as above
- Exposure Response Prevention Therapy as outpatient

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mL PO BID

 # Gastroesophageal Reflux:
- Pantoprazole 40 mg PO daliy

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 4 - 6 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Monday, August 22, 2016

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/22/16 0913 (continued)

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
mania
mood instability
extreme anxiety/panic

Intervention:
Increase awareness of emotional states/reality testing
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided supportive psychotherapy and processed the following issues. He states that the Lurasidone made him feel very restless and prevented him from sleeping. As a result, it was discontinued. We brainstormed about various medications that have helped him in the past. He stated that Olanzapine has helped with insomnia and anxiety. He also stated that Quetiapine helped with his depression. I told him that I would prefer that he not be on two neuroleptics and instead, if given a choice which one would he prefer based on its efficacy in the past. He states that since Olanzapine has helped both his insomnia and anxiety, he would like to continue with that medications. He was also told that we would be starting the Olanzapine to help stabilize his depression and anxiety as the medication does both. He agreed. I thanked him for being open and honest with his feelings and for keeping such good notes on his psychiatric state and the side effects from the medications that he takes. He was also encouraged to continue going to all groups and to go out on the walks to get some fresh air which he did.

ATTENDING PHYSICIAN:
John M Cruz, MD

Signed by Cruz, John Michael de Vera, MD at 08/22/16 2055
Signed by Cruz, John Michael de Vera, MD at 08/22/16 2101

Behavioral Health Note by Abend, Marquel Marie, RN at 08/22/16 2118

Author: Abend, Marquel Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/22/16 2119 | Note Time: 08/22/16 2118 | Status: Signed
Editor: Abend, Marquel Marie, RN (Registered Nurse)

Progress Notes (continued)

Behavioral Health Note by Abend, Marquel Marie, RN at 08/22/16 2118 (continued)

EVALYSIS

☐Day Shift ☒PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☐3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	2	2.5	2

Signed by Abend, Marquel Marie, RN at 08/22/16 2119

CarePlan Notes by Abend, Marquel Marie, RN at 08/22/16 2124

Author: Abend, Marquel Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/22/16 2124 | Note Time: 08/22/16 2124 | Status: Signed
Editor: Abend, Marquel Marie, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Pt denies SI/HI/AH/VH. He appears anxious, depressed and unkept, isolating towards himself in his room and the day room. He had complaints of anxiety at the beginning of the shift received prn gabapentin which was effective. He reports not sleeping well last noc due to akathisia. He has had no complaints of akathisia or any other side effects this shift. He is medication compliant. Will continue to monitor.

Signed by Abend, Marquel Marie, RN at 08/22/16 2124

CarePlan Notes by Smith, Hilda, RN at 08/23/16 0531

Author: Smith, Hilda, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/23/16 0645 | Note Time: 08/23/16 0531 | Status: Signed
Editor: Smith, Hilda, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)

Progress Notes (continued)

CarePlan Notes by Smith, Hilda, RN at 08/23/16 0531 (continued)

Received sleeping and has continued to do so this shift. Head at the end but he is sleeping. Respiration is even, unlabored but snoring loud. Has not voiced any concerns related to pain or discomfort. No falls or injuries thus far this shift.

0605 Awaken for lab draw and he stated that he had slept for nine hours. Apparently he slept hard, his eyes appeared to be swollen. Venipuncture done per MD order, per aseptic technique, using 23,3/4 gage needle x 1 successfully to Left AC. Patient tolerated well, no excess bleeding or bruising. Hands washed before and after venipuncture.
Blood specimen tube labeled/dated/timed and initials, prepared for processing. All sharps and soiled items disposed properly. Will continue to monitor for safety and support.

Back to bed and went to sleep.

EVALYSIS

☐Day Shift ☐PM Shift ☒Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	2	3.5	2

Signed by Smith, Hilda, RN at 08/23/16 0645

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/23/16 1100

Author: Marin, Lisa Nicole, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/23/16 1238 | Note Time: 08/23/16 1100 | Status: Signed
Editor: Marin, Lisa Nicole, RN (Registered Nurse)

EVALYSIS

☒Day Shift ☐PM Shift ☐Noc Shift

Progress Notes (continued)

Behavioral Health Note by Marin, Lisa Nicole, RN at 08/23/16 1100 (continued)

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☒3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☒	☒
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	1	2.5	2

Signed by Marin, Lisa Nicole, RN at 08/23/16 1238

CarePlan Notes by Marin, Lisa Nicole, RN at 08/23/16 1412

Author: Marin, Lisa Nicole, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/23/16 1419 | Note Time: 08/23/16 1412 | Status: Signed
Editor: Marin, Lisa Nicole, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Pt affect restricted with anxious and depressed mood. Pt denies current SI. Pt remains disheveled, although he is showering, his how is messy and tangled. Pt states he is starting to feel improvement, and states yesterday was the first day he felt his mood start to stabilize. Pt states he still does not feel ready to discharge because he is worried his mood will still go up and down, and wants to have a few days where is mood is not so labile.

Signed by Marin, Lisa Nicole, RN at 08/23/16 1419

CarePlan Notes by Bailey, Peter Julian, OT at 08/23/16 1244

Author: Bailey, Peter Julian, OT | Service: Adult Mental Health | Author Type: Occupational Therapist
Filed: 08/23/16 1637 | Note Time: 08/23/16 1244 | Status: Addendum
Editor: Bailey, Peter Julian, OT (Occupational Therapist)
Related Notes: Original Note by Bailey, Peter Julian, OT (Occupational Therapist) filed at 08/23/16 1244

Problem: Depression (Adult,Obstetrics,Pediatric)
Goal: Improved/Stable Mood
Outcome: Ongoing (interventions implemented as appropriate)

Check-in (Community) Meeting
Group Start Time: 930

Group focused on review of program schedule and guidelines, identification of treatment issues, mood rating

and identification and formulation of daily therapeutic goal(s).

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

AFFECT: Flat

APPEARANCE/BEHAVIOR: drowsy and withdrawn; pt identified mood as, "lethargic, undecided and lonely," pt reported feeling his body adjust to new medication. Pt also made comments stating that he does not have an adequate support system. He feels like there are few people that he can turn to for support.

COGNITION: circumstantial

INTERVENTION: Unit orientation, Individual patient check-in, mood identification, goal setting. Prompted patient to participate, Provided support and Encouraged interaction with peers

3 of 3 units @ 15 min.

Life Skills Group
Group Start Time: 1100

Structured learning opportunities to improve skills in areas such as communication, stress management, and other areas related to daily living in patients' communities outside the hospital.

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

Pt arrived late to group, he sat away from his peers with eyes closed. He appeared anxious (continually bouncing his leg while sitting) and internally preoccupied (sitting with eyes closed). Pt stated that the group was helpful for him, although he did not participate in discussion.

3 of 4 units @ 15 min.

Expressive Arts Therapy
Group Start Time: 1400

Provide creative opportunities for expression of feelings, distraction from negative or stressful thoughts, and opportunities to incorporate movement, drama, art and music into their lives.

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

AFFECT: Guarded

APPEARANCE/BEHAVIOR: withdrawn and contemplative. Pt joined group late, he appeared somewhat restless, occasionally getting up to pace around the unit. Pt demonstrated good planning, organizing and sequencing skills while working on bracelet. He asked for help appropriately from staff. Pt only interacted with peers and staff when prompted.

Progress Notes (continued)

CarePlan Notes by Bailey, Peter Julian, OT at 08/23/16 1244 (continued)

INTERVENTION/EDUCATION: Use of imagery to explore and express experience. Prompted patient to participate, Provided support and Encouraged interaction with peers

PATIENT RESPONSE: Distracted/preoccupied

2 of 3 units @ 15 min.

Signed by Bailey, Peter Julian, OT at 08/23/16 1244
Signed by Bailey, Peter Julian, OT at 08/23/16 1637

Behavioral Health Note by Senior, Adolfo A, RN at 08/23/16 1658

Author: Senior, Adolfo A, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/23/16 1700 | Note Time: 08/23/16 1658 | Status: Signed
Editor: Senior, Adolfo A, RN (Registered Nurse)

EVALYSIS

PATIENT CARE INDICATORS				
CARE INDICATORS → / ACUITY ↓	☐1	☒2	☐3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	2	1.5	1

Signed by Senior, Adolfo A, RN at 08/23/16 1700

Progress Notes by Cruz, John Michael de Vera, MD at 08/23/16 0843

Author: Cruz, John Michael de Vera, MD | Service: Psychiatry | Author Type: Physician
Filed: 08/23/16 1943 | Note Time: 08/23/16 0843 | Status: Signed
Editor: Cruz, John Michael de Vera, MD (Physician)

PSYCHIATRY PROGRESS NOTE

Tuesday, August 23, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:

47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- Sleep - 7 hours

In speaking to the psychiatrist, the patient states
- mood: "much better" - better than yesterday - he has had no depression
- interest: "good" - better than yesterday - he is attending all groups and finishes his group projects early
- anxiety: none
- psychomotor agitation: none
- sleep: "great" - better than night before - easily feel asleep, stayed asleep and woke up feeling refreshed
- energy: "good" - better than night before - because he got good sleep
- pain: denies
- worthlessness: denies
- guilt: denies
- passive death wish: denies
- suicidal ideation: denies
- racing thoughts: denies

- overall: His depression has decreased, his anxiety has decreased and his sleep is better.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 112/79 | Pulse 79 | Temp (Src) 97.6 °F (36.4 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 59.24 kg (130 lb 9.6 oz) | SpO2 100%
Wt Readings from Last 3 Encounters:
08/17/16 : 59.24 kg (130 lb 9.6 oz)

MENTAL STATUS EXAM:
- General Appearance**:** appropriate
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: 0
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: euthymic
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused

- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Fair

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for: and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:
No results for input(s): WBC, HGB, HCT, PLT in the last 72 hours.
No results for input(s): NA, K, CL, CO2, BUN, CREATININE, GLU, CA, MG, PHOS in the last 72 hours.
No results for input(s): TBILI, AST, ALT, ALP, ALB in the last 72 hours.
No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q Monday	Cruz, John Michael de Vera, MD		2 Patch at 08/22/16 1202
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD		
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 5 mg	5 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		5 mg at 08/22/16 2006

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/23/16 0843 (continued)

• pantoprazole (PROTONIX) Tab 40 mg	40 mg	Oral	AC 30 MIN BKFST	Cruz, John Michael de Vera, MD	40 mg at 08/23/16 0829
• benztropine (COGENTIN) Tab 1 mg	1 mg	Oral	Q4H PRN	Trautner, Rick Jeffrey, MD	1 mg at 08/21/16 2109
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 2,250 mg	2,250 mg	Oral	Q BEDTIME	Hirschtritt, Matthew E, MD	2,250 mg at 08/22/16 2006
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	7.5 mg at 08/22/16 2114
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD	10 mg at 08/21/16 0900
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD	30 mL at 08/22/16 2100
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD	17.2 mg at 08/22/16 2005
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD	
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD	2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/23/16 0829
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/16/16 0853
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/21/16 2314
• phenazopyridine	200 mg	Oral	Q8H PRN	Cruz, John	200 mg

(PYRIDIUM) Tab 200 mg	Michael de Vera, MD	at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Acid reflux disease [K21.9]	08/22/2016
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:
 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 2250 mg PO at bedtime
- f/u VPA trough level on 8/23 at bedtime
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- discontinued Lurasidone given reports of akathisia and restlessness
- continue Olanzapine 5 mg PO at bedtime instead
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1
- continue PRN Olanzapine ODT 2.5 mg PO q4h for anxiety
- monitor for ongoing toxicity of Olanzapine that includes but are not limited to hypotension, syncope, extrapyramidal symptoms, somnolence, appetite, and fatigue

 # Post Traumatic Stress Disorder
- continue PRN Olanzapine 2.5 mg PO q4h for anxiety
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:
- PRN Olanzapine ODT as above
- Exposure Response Prevention Therapy as outpatient

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mL PO BID

 # Gastroesophageal Reflux:
- Pantoprazole 40 mg PO daliy

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 4 - 6 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Tuesday, August 23, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/23/16 0843 (continued)

mood instability
extreme anxiety/panic

Intervention:
Increase awareness of emotional states/reality testing
Increase insight into illness and treatment plan
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided supportive psychotherapy and processed the following issues. He states that he has been attending all groups and going on all walks. I encouraged him to keep up this healthy behavior. In addition, as he often tends to spend time in his room laying on his bed with the drapes closed, I encouraged him to stay in the day area as much as possible so that he can continue to socialize with other people and not be isolated to his room. I also explained to him the treatment plan. Specifically, he would be getting his Valproic Acid trough level drawn today, that we would be splitting up the Divalproex into a morning and a night dose as he has difficulties swallowing the big pills and from tonight's lab draw, we will determine whether the dosage should be adjusted. In addition, he was also reminded that he can take PRN Olanzapine 2.5 mg for anxiety and insomnia. He understood.

ATTENDING PHYSICIAN:
John M Cruz, MD

Signed by Cruz, John Michael de Vera, MD at 08/23/16 1943

CarePlan Notes by Senior, Adolfo A, RN at 08/23/16 2017

Author: Senior, Adolfo A, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/23/16 2225 | Note Time: 08/23/16 2017 | Status: Addendum
Editor: Senior, Adolfo A, RN (Registered Nurse)
Related Notes: Original Note by Senior, Adolfo A, RN (Registered Nurse) filed at 08/23/16 2017

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Patient doing better, denies new symptoms,more hopeful,taking medications,tolerating them well, getting a Depakote level this evening before his next schedule dose at bed time, denies s/i.

2000- patient state his overall status improved after being hospitalized where his mental condition his but remain cautiously hopeful.

Signed by Senior, Adolfo A, RN at 08/23/16 2017
Signed by Senior, Adolfo A, RN at 08/23/16 2225

Progress Notes (continued)

Behavioral Health Note by Richardson, Cleo, RN at 08/24/16 0226

Author: Richardson, Cleo, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/24/16 0227 | Note Time: 08/24/16 0226 | Status: Signed
Editor: Richardson, Cleo, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☐PM Shift ☒Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☒2	☐3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	2	1.5	1

Signed by Richardson, Cleo, RN at 08/24/16 0227

Care Team Note by Richardson, Cleo, RN at 08/24/16 0608

Author: Richardson, Cleo, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/24/16 0611 | Note Time: 08/24/16 0608 | Status: Signed
Editor: Richardson, Cleo, RN (Registered Nurse)

Pt in bed eyes closed no apparent discomfort noted when observed on safety checks. Breathing even and unlabored, Pt able to sleep throughout this shift. No c/o, NADN, will continue to monitor pt for safety.

Signed by Richardson, Cleo, RN at 08/24/16 0611

Behavioral Health Note by Edwards, Sarah C, RN at 08/24/16 1029

Author: Edwards, Sarah C, RN | Service: Adolescent Mental Health | Author Type: Registered Nurse
Filed: 08/24/16 1031 | Note Time: 08/24/16 1029 | Status: Signed
Editor: Edwards, Sarah C, RN (Registered Nurse)

EVALYSIS

☒Day Shift ☐PM Shift ☐Noc Shift

PATIENT CARE INDICATORS

Progress Notes (continued)

Behavioral Health Note by Edwards, Sarah C, RN at 08/24/16 1029 (continued)

CARE INDICATORS → ACUITY ↓	☐1	☐2	☒3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☒	☒
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	2	2.5	1

Signed by Edwards, Sarah C, RN at 08/24/16 1031

Interdisciplinary Rounding Note by Kader, Paz T, RN at 08/24/16 1037

Author: Kader, Paz T, RN
Filed: 08/24/16 1038
Editor: Kader, Paz T, RN (Registered Nurse)
Service: Adult Mental Health
Note Time: 08/24/16 1037
Author Type: Registered Nurse
Status: Cosign Needed
Cosign Required: Yes

Possible discharge tomorrow,will do an intake with Herrick PHP OR La Cheim

	08/24/16 1000
Patient Assets/Stressors	
Patient Assets	general fund of knowledge;average or above intelligence;motivation for treatment/growth;capable of independent living;supportive family/friends;work skills;physical health;ability for insight;communication skills
Patient Stressors	medication change or non-compliance
Discharge Planning	
Discharge Criteria	improved stabilization in mood, thinking and/or behavior;verbal commitment to aftercare

Progress Notes (continued)

Interdisciplinary Rounding Note by Kader, Paz T, RN at 08/24/16 1037 (continued)

	and medication compliance
Recommended Discharge Plan	return to previous living environment;medication management with psychiatrist or other physician
Pt's Acceptance of Discharge Plan	yes
Why Continues to Need Hospitalization	severe impairment of level of functioning;danger to self or others;medication stabilization
Estimated Length of Stay	3-5 days
Provisional DSM 5 Diagnoses	
Problem Being Addressed	refer to problem list
Goal: Will work with social worker/treatment coordinator to develop safe discharge plan	
Goal Status	goal initiated
Goal: Will attend Occupational Therapy groups up to seven days weekly as tolerated	
Objectives	increase coping skills
Goal Status	progress made toward outcome
Treatment Plan Reviewed by	
Physician	Cruz, Schumm
Psychiatric Social Worker	Himot
Registered Nurse	Kader
Occupational Therapist	Edward

Signed by Kader, Paz T, RN at 08/24/16 1038

Care Team Note by Allen, Donna E at 08/24/16 1100

Author: Allen, Donna E
Filed: 08/24/16 1213
Editor: Allen, Donna E (Others)
Service: Pastoral
Note Time: 08/24/16 1100
Author Type: Others
Status: Signed

ABSMC Chaplaincy Services 24/7 on call pager 510-801-5050

Progress Notes (continued)

Care Team Note by Allen, Donna E at 08/24/16 1100 (continued)

Spiritual Assessment and Patient Visit

Type of Visit: Inner Peace Group

Spiritual Care provided: Facilitated a group that included: guided meditation to de-stress, check in with images of lighthouses, reflection on the song "I am Light" and brief positive statements about forgiveness. Patient participated in group.

Donna E Allen
8/24/2016 12:06 PM

Signed by Allen, Donna E at 08/24/16 1213

CarePlan Notes by Edwards, Sarah C, RN at 08/24/16 1454

Author: Edwards, Sarah C, RN | Service: Adolescent Mental Health | Author Type: Registered Nurse
Filed: 08/24/16 1509 | Note Time: 08/24/16 1454 | Status: Addendum
Editor: Edwards, Sarah C, RN (Registered Nurse)
Related Notes: Original Note by Edwards, Sarah C, RN (Registered Nurse) filed at 08/24/16 1454

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Pt reports mood has been improved & stable x 2-3 days, feels good. Pt attending groups, continues isolative @ other times.Pt seems somewhat confused @ times.Pt met with PHP staff, may transition Thursday or Friday.

Signed by Edwards, Sarah C, RN at 08/24/16 1454
Signed by Edwards, Sarah C, RN at 08/24/16 1509

Behavioral Health Note by Walter, Willa, MFT at 08/24/16 1546

Author: Walter, Willa, MFT | Service: Mental Health | Author Type: Marriage and Family Therapist
Filed: 08/24/16 1550 | Note Time: 08/24/16 1546 | Status: Signed
Editor: Walter, Willa, MFT (Marriage and Family Therapist)

PHP Assessment
Reviewed chart, spoke with staff and met with patient per Dr. Cruz's request. Reviewed Insurance benefit information with patient.

Provided schedule and answered any questions patient had about PHP. Pt shared that he feels that he has been stable in his mood for the past two days and feels ready to try a transition day in the next day or two. Pt shared that he would like to work on managing his emotions around recent and historical traumas in his life. Pt denied SI, intent or plan.

Assessment: Patient is appropriate for PHP transition day. **Pt will transition on Friday rather then tomorrow because there is not room in ADH tomorrow for another transition.**

Behavioral Health Note by Walter, Willa, MFT at 08/24/16 1546 (continued)

Plan: Patient will transition on FRIDAY to the ADH program, room J.
Patient will attend group from 9-11:45am, come to the unit for lunch and return for groups from 12:30-3:30pm.

Patient has agreed to stay within the physical boundaries of the 3rd Floor PHP Program during their transition day. He/she will not leave the premises of the program without being attended by staff. He/she will let the group leader know if he/she needs to return to the unit for any reason.

Before discharge from hospital, patient should have been given PHP admission paperwork to take home and fill out.
Patient should arrive at 8:30 and proceed to Admitting Office on first floor. After registering for PHP at Admitting Office, take elevator B to PHP Intake Office on 3rd Floor, Room 3388.

Signed by Walter, Willa, MFT at 08/24/16 1550

Progress Notes by Cruz, John Michael de Vera, MD at 08/24/16 0822

Author: Cruz, John Michael de Vera, MD | Service: Psychiatry | Author Type: Physician
Filed: 08/24/16 2150 | Note Time: 08/24/16 0822 | Status: Signed
Editor: Cruz, John Michael de Vera, MD (Physician)

PSYCHIATRY PROGRESS NOTE
Wednesday, August 24, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- Restricted affect
- Depressed affect
- Sleep - 7.5 hours
- Required PRN Olanzapine ODT 2.5 mg - 22:40

In speaking to the psychiatrist, the patient states
- mood: "great" - better than day before - because got good sleep
- interest: "good" - better than day before - attending all groups
- appetite: "good" - same as day before - eating all three meals with snacks
- concentration: "good" - same as day before - able to concentrate in groups
- psychomotor retardation: denies
- anxiety: none
- psychomotor agitation: denies
- sleep: "great" - better than night before - because of the Olanzapine ODT

- energy: "great" - better than night before - because he got good sleep
- pain: denies
- self-esteem: "great" - better than night before
- worthlessness: denies
- guilt: denies
- passive death wish: denies
- suicidal ideation: denies
- homicidal ideation: denies

- overall: He feels tremendously better than the day before because the Olanzapine has done a great job at boosting up his mood and decreasing his anxiety.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 119/64 | Pulse 79 | Temp (Src) 98.4 °F (36.9 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 59.24 kg (130 lb 9.6 oz) | SpO2 100%
Wt Readings from Last 3 Encounters:
08/17/16 : 59.24 kg (130 lb 9.6 oz)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: 0
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: euthymic
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Good
- Insight: Good

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: negative for:, depression, panic attacks and sleeplessness

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:
No results for input(s): WBC, HGB, HCT, PLT in the last 72 hours.

Recent Labs

Lab	08/23/16 0605
NA	146 H
K	4.6
CL	108 H
CO2	33 H
BUN	21
CREATININE	1.06
GLU	69 L
CA	8.6

Recent Labs

Lab	08/23/16 0605
TBILI	0.3
AST	26
ALT	75 H
ALP	90
ALB	3.4

No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• divalproex 12Hr-DR (DEPAKOTE) Tab	1,000 mg	Oral	DAILY	Cruz, John Michael de Vera,		

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/24/16 0822 (continued)

1,000 mg				MD	
• divalproex 12Hr-DR (DEPAKOTE) Tab 1,000 mg	1,000 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD	
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q Monday	Cruz, John Michael de Vera, MD	2 Patch at 08/22/16 1202
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD	
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 5 mg	5 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD	5 mg at 08/23/16 2108
• pantoprazole (PROTONIX) Tab 40 mg	40 mg	Oral	AC 30 MIN BKFST	Cruz, John Michael de Vera, MD	40 mg at 08/24/16 0755
• benztropine (COGENTIN) Tab 1 mg	1 mg	Oral	Q4H PRN	Trautner, Rick Jeffrey, MD	1 mg at 08/21/16 2109
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	7.5 mg at 08/22/16 2114
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD	10 mg at 08/21/16 0900
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD	30 mL at 08/23/16 2105
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD	17.2 mg at 08/23/16 2107
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD	
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD	2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/23/16 0829
• magnesium hydroxide (MILK OF	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	

MAGNESIA/MOM) Oral Susp 30 mL					
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/23/16 0913
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/23/16 2240
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Acid reflux disease [K21.9]	08/22/2016
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:
 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 2250 mg PO at bedtime
- *f/u VPA trough level on 8/23 - 97.8*
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- *increase Olanzapine to 7.5 mg PO at bedtime*
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1
- continue PRN Olanzapine ODT 2.5 mg PO q4h for anxiety
- monitor for ongoing toxicity of Olanzapine that includes but are not limited to hypotension, syncope, extrapyramidal symptoms, somnolence, appetite, and fatigue

 # Post Traumatic Stress Disorder
- continue PRN Olanzapine 2.5 mg PO q4h for anxiety
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:
- PRN Olanzapine ODT as above
- Exposure Response Prevention Therapy as outpatient

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mL PO BID

 # Gastroesophageal Reflux:
- Pantoprazole 40 mg PO daliy

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- 8/26 - Herrick PHP Transition Day/ Discharge from Hospital
- 8/29 - Start Herrick PHP Full Time

 # Estimated Length of Stay
- ~ 2 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Wednesday, August 24, 2016

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/24/16 0822 (continued)

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
mood instability
extreme anxiety/panic

Intervention:
Demonstrate interventions in thought-emotion-behavior triad
Increase insight into illness and treatment plan
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided supportive psychotherapy and processed the following issues. He is extremely happy that he has felt good for two days straight He has not felt this good since March 2016. He states that it feels as if he is back on Lamotrigine. I continued to thank him for his patience and reflected back how much better he looks even from two days ago as his mood is good, he has no anxiety and his sleep is very restful. In addition, I also informed him about the tentative plan for discharge. On Friday, he will have a transition day to Herrick PHP with discharge from the hospital. On Monday, he will start the Herrick PHP program full time. In addition, he was reminded that sleep is very important. Should he have difficulties sleeping tonight even with the increased dosage of Olanzapine ODT, he should ask for the PRN Olanzapine ODT 2.5 mg to help him sleep. He voiced that he has a difficult time swallowing the Divalproex DR tabs. As a result, he was transitioned to Divalproex Sprinkles. I thanked him for making his needs known.

ATTENDING PHYSICIAN:
John M Cruz, MD

Signed by Cruz, John Michael de Vera, MD at 08/24/16 2150

CarePlan Notes by Scurry-Scott, Frazier M, RN at 08/24/16 2245

Author: Scurry-Scott, Frazier M, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/24/16 2245 | Note Time: 08/24/16 2245 | Status: Signed
Editor: Scurry-Scott, Frazier M, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review

Progress Notes (continued)

CarePlan Notes by Scurry-Scott, Frazier M, RN at 08/24/16 2245 (continued)

Outcome: Ongoing (interventions implemented as appropriate)
Visible on unit, social with select peers. States no depression or anxiety for past 36 hours. Anticipating transition to PHP and has a plan for participation once discharged. Med compliant. Monitored for safety every 30 minutes.

EVALYSIS

[ ]Day Shift [X]PM Shift [ ]Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS ACUITY	[ ]1	[X]2	[ ]3	[ ]4
ADL: Independent	[X]			
ADL: Partial assist / supervise		[ ]	[ ]	
ADL: Complete assist / supervise			[ ]	[ ]
Assess / Intervene: Minimal	[ ]			
Assess / Intervene: Average		[X]	[X]	[X]
Assess / Intervene: Above average			[ ]	[ ]
Assess / Intervene: Almost constant				[ ]
Resistant to treatment modalities		[ ]	[ ]	[ ]
Behavior: Moderately unpredictable			[ ]	[ ]
Behavior: Very unpredictable				[ ]
Weighing factors	1	1	0.5	0
Total	2	2	1.5	1

Signed by Scurry-Scott, Frazier M, RN at 08/24/16 2245

Behavioral Health Note by Richardson, Cleo, RN at 08/25/16 0042

Author: Richardson, Cleo, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/25/16 0043 | Note Time: 08/25/16 0042 | Status: Signed
Editor: Richardson, Cleo, RN (Registered Nurse)

Progress Notes (continued)

Behavioral Health Note by Richardson, Cleo, RN at 08/25/16 0042 (continued)

EVALYSIS

☐Day Shift ☐PM Shift ☒Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☒2	☐3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	2	1.5	1

Signed by Richardson, Cleo, RN at 08/25/16 0043

Care Team Note by Richardson, Cleo, RN at 08/25/16 0553

Author: Richardson, Cleo, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/25/16 0555 | Note Time: 08/25/16 0553 | Status: Signed
Editor: Richardson, Cleo, RN (Registered Nurse)

Pt in bed eyes closed no apparent discomfort noted when observed on safety checks. Breathing even and unlabored, PTable to sleep throughout this shift. No c/o, NADN. will continue to monitor pt for safety.

Signed by Richardson, Cleo, RN at 08/25/16 0555

Behavioral Health Note by Edwards, Sarah C, RN at 08/25/16 1033

Author: Edwards, Sarah C, RN | Service: Adolescent Mental Health | Author Type: Registered Nurse
Filed: 08/25/16 1034 | Note Time: 08/25/16 1033 | Status: Signed
Editor: Edwards, Sarah C, RN (Registered Nurse)

EVALYSIS

☒Day Shift ☐PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☒2	☐3	☐4

Progress Notes (continued)

Behavioral Health Note by Edwards, Sarah C, RN at 08/25/16 1033 (continued)

ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☐	☐	☐
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	2	1.5	0

Signed by Edwards, Sarah C, RN at 08/25/16 1034

Care Team Note by Allen, Donna E at 08/25/16 1129

Author: Allen, Donna E | Service: Pastoral | Author Type: Others
Filed: 08/25/16 1131 | Note Time: 08/25/16 1129 | Status: Signed
Editor: Allen, Donna E (Others)

ABSMC Chaplaincy Services 24/7 on call pager 510-801-5050
Spiritual Assessment and Patient Visit

Type of Visit: follow-up

Spiritual Care provided: this morning made a second attempt to visit with Vincent he declined. He has stated that he wants to visit with a chaplain but continues to put off the visitation.

Spiritual Care Plan: Follow up later this afternoon as agreed by patient.

Donna E Allen
8/25/2016 11:29 AM

Signed by Allen, Donna E at 08/25/16 1131

CarePlan Notes by Edwards, Sarah C, RN at 08/25/16 1404

Author: Edwards, Sarah C, RN | Service: Adolescent Mental Health | Author Type: Registered Nurse
Filed: 08/25/16 1404 | Note Time: 08/25/16 1404 | Status: Signed
Editor: Edwards, Sarah C, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)

Progress Notes (continued)

CarePlan Notes by Edwards, Sarah C, RN at 08/25/16 1404 (continued)

Pt attending groups, continues to interact minimally with peers @ other times.Pt reports mood remains stable & improved, denies SI.Pt states he will transition to PHP tomorrow, hopes to be discharged after that.Pt remains disheveled, appears to be his baseline.

Signed by Edwards, Sarah C, RN at 08/25/16 1404

CarePlan Notes by Bailey, Peter Julian, OT at 08/25/16 1018

Author: Bailey, Peter Julian, OT | Service: Adult Mental Health | Author Type: Occupational Therapist
Filed: 08/25/16 1601 | Note Time: 08/25/16 1018 | Status: Addendum
Editor: Bailey, Peter Julian, OT (Occupational Therapist)
Related Notes: Original Note by Bailey, Peter Julian, OT (Occupational Therapist) filed at 08/25/16 1018

Problem: Depression (Adult,Obstetrics,Pediatric)
Goal: Improved/Stable Mood
Outcome: Ongoing (interventions implemented as appropriate)

Check-in (Community) Meeting
Group Start Time: 930

Group focused on review of program schedule and guidelines, identification of treatment issues, mood rating and identification and formulation of daily therapeutic goal(s).

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

AFFECT: Flat

APPEARANCE/BEHAVIOR: alert and unkempt. Pt reported mood as, "calm, undecided and hopeful," because he will be transitioning into the PHP program tomorrow. His goal for the day was to contact friends to help him feel more supported, before starting this new phase of recovery. He sat outside of the check-in circle, but faced peers and volunteered to check-in first.

COGNITION: coherent and goal directed

INTERVENTION: Unit orientation, Individual patient check-in, mood identification, goal setting. Prompted patient to participate, Provided support and Encouraged interaction with peers

2 of 3 units @ 15 min.

Life Skills Group
Group Start Time: 1100

Structured learning opportunities to improve skills in areas such as communication, stress management, and other areas related to daily living in patients' communities outside the hospital.

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

CarePlan Notes by Bailey, Peter Julian, OT at 08/25/16 1018 (continued)

AFFECT: Flat

APPEARANCE/BEHAVIOR: alert and withdrawn. Pt attended group, he sat with his peers and was attentive to discussion around early warning signs and the need to make changes. He took notes on a paper, but did not offer any personal examples or situations, even when prompted by facilitator. Pt was somewhat restless, he left and rejoined group 3x.

COGNITION: could not assess, pt made few statements in group.

INTERVENTION/EDUCATION: Facilitated interactive exercise(s) for relaxation, distraction and socialization. Prompted patient to participate, Provided support and Encouraged interaction with peers

3 of 4 units @ 15 min.

Cognitive/Recreational Skills
Group Start Time: 1400

Recreational activity requiring basic understanding of simple and familiar game protocol, numbers recognition and ability to attend to verbal input of moderator and simple social skills.

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

AFFECT: Appropriate

APPEARANCE/BEHAVIOR: alert and engaged. Pt demonstrated somewhat slowed cognitive processing, he was able to participate when given extra time. He listened to peers, provided appropriate responses, laughed appropriately, and followed all rules. He appeared more relaxed and comfortable around others, than he had during previous groups.

COGNITION: coherent and goal directed

INTERVENTION/EDUCATION: Facilitated interactive concept application. Prompted patient to participate, Provided support and Encouraged interaction with peers
2 of 3 units @ 15 min.

Signed by Bailey, Peter Julian, OT at 08/25/16 1018
Signed by Bailey, Peter Julian, OT at 08/25/16 1601

Behavioral Health Note by McCullough, Elizabeth Ann, RN at 08/25/16 1637

Author: McCullough, Elizabeth Ann, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/25/16 1638 | Note Time: 08/25/16 1637 | Status: Signed
Editor: McCullough, Elizabeth Ann, RN (Registered Nurse)

EVALYSIS

Progress Notes (continued)

Behavioral Health Note by McCullough, Elizabeth Ann, RN at 08/25/16 1637 (continued)

☐Day Shift ☒PM Shift ☐Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☒2	☐3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	3	2.5	1

Signed by McCullough, Elizabeth Ann, RN at 08/25/16 1638

Progress Notes by Cruz, John Michael de Vera, MD at 08/25/16 0824

Author: Cruz, John Michael de Vera, MD | Service: Psychiatry | Author Type: Physician
Filed: 08/25/16 1757 | Note Time: 08/25/16 0824 | Status: Signed
Editor: Cruz, John Michael de Vera, MD (Physician)

PSYCHIATRY PROGRESS NOTE

Thursday, August 25, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- Slept - 7.5 hours
- No over night events

In speaking to the psychiatrist, the patient states
- mood: "good" - same as yesterday - because he likes the combination of the medications he takes
- interest: "good" - same as yesterday - actively taking part in groups
- anxiety: none

- psychomotor agitation: None
- sleep: "great" - same as night before - easily fell asleep, stayed asleep and woke up feeling refreshed
- energy: "good" - same as day before - because he got good sleep
- pain: denies
- passive death wish: denies
- suicidal ideation: denies
- racing thoughts: denies

- overall: His mood, anxiety and sleep have been constant since yesterday.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 123/73 | Pulse 83 | Temp (Src) 98.1 °F (36.7 °C) (Oral) | Resp 17 | Ht 1.702 m (5' 7") | Wt 59.24 kg (130 lb 9.6 oz) | SpO2 98%
Wt Readings from Last 3 Encounters:
08/17/16 : 59.24 kg (130 lb 9.6 oz)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: 0
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: euthymic
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Fair

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for: and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:

Recent Labs

Lab	08/23/16 2330
WBC	3.9 L
HGB	12.5 L
HCT	38.4 L
PLT	100 L

Recent Labs

Lab	08/23/16 0605
NA	146 H
K	4.6
CL	108 H
CO2	33 H
BUN	21
CREATININE	1.06
GLU	69 L
CA	8.6

Recent Labs

Lab	08/23/16 0605
TBILI	0.3
AST	26
ALT	75 H
ALP	90
ALB	3.4

No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/25/16 0824 (continued)

Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• divalproex DR (DEPAKOTE SPRINKLE) Cap 1,000 mg	1,000 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		1,000 mg at 08/24/16 2109
• divalproex DR (DEPAKOTE SPRINKLE) Cap 1,000 mg	1,000 mg	Oral	DAILY	Cruz, John Michael de Vera, MD		
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 7.5 mg	7.5 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		7.5 mg at 08/24/16 2116
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q Monday	Cruz, John Michael de Vera, MD		2 Patch at 08/22/16 1202
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD		
• pantoprazole (PROTONIX) Tab 40 mg	40 mg	Oral	AC 30 MIN BKFST	Cruz, John Michael de Vera, MD		40 mg at 08/25/16 0745
• benztropine (COGENTIN) Tab 1 mg	1 mg	Oral	Q4H PRN	Trautner, Rick Jeffrey, MD		1 mg at 08/21/16 2109
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD		7.5 mg at 08/22/16 2114
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD		10 mg at 08/21/16 0900
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD		30 mL at 08/24/16 0836
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD		17.2 mg at 08/24/16 2112
• aluminum/magnesium hydroxide/simethicon	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD		

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/25/16 0824 (continued)

e (MYLANTA) Oral Susp 30 mL					
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD	2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/24/16 0836
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/23/16 0913
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/23/16 2240
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Acid reflux disease [K21.9]	08/22/2016
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:

 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex DR 1000 mg PO qam/ 1000 mg PO at bedtime
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- continue Olanzapine 7.5 mg PO at bedtime
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1
- continue PRN Olanzapine ODT 2.5 mg PO q4h for anxiety
- monitor for ongoing toxicity of Olanzapine that includes but are not limited to hypotension, syncope, extrapyramidal symptoms, somnolence, appetite, and fatigue

 # Post Traumatic Stress Disorder
- continue PRN Olanzapine 2.5 mg PO q4h for anxiety
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:
- PRN Olanzapine ODT as above
- Exposure Response Prevention Therapy as outpatient

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mL PO BID

 # Gastroesophageal Reflux:
- Pantoprazole 40 mg PO daliy

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- 8/26 - Herrick PHP Transition Day/ Discharge from Hospital
- 8/29 - Start Herrick PHP Full Time

 # Estimated Length of Stay
- ~ 2 days

PROCEDURE CODES:
E/M 99233

Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Thursday, August 25, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
mania
mood instability

Intervention:
Demonstrate interventions in thought-emotion-behavior triad
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided supportive psychotherapy and processed the following issues. He feels tremendously worried that because he was placed on a 5150, he will not be able to have a firearms for the next five years. He does not know how he will have an income. He is considering writing a letter to the national team to see they would be willing to support his ability to use firearms again. Since he no longer has a roommate, he does not know if he will be able to afford the apartment where he lives. He also said that he feels tremendously disappointed in the people at Oakland Community Support Center because they took him off all of his medications and he "fell through the cracks." In addition, I reflected back to him about how well he has done. His sleep is better, he is no longer having panic attacks, his mood is better, and he feels more motivated.

ATTENDING PHYSICIAN:
John M Cruz, MD

Signed by Cruz, John Michael de Vera, MD at 08/25/16 1757

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/25/16 0824 (continued)

CarePlan Notes by McCullough, Elizabeth Ann, RN at 08/25/16 1646

Author: McCullough, Elizabeth Ann, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/25/16 2250 | Note Time: 08/25/16 1646 | Status: Addendum
Editor: McCullough, Elizabeth Ann, RN (Registered Nurse)
Related Notes: Original Note by McCullough, Elizabeth Ann, RN (Registered Nurse) filed at 08/25/16 1646

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Visible in milieu. Hygiene disheveled with tangled hair and slight malodor. Stated he would shower later. Paced unit intermittently. Reported feeling better today. "I still have a little bit of panic, but I think the meds are working. I feel more like myself." Denied suicidal thoughts. Agreeable to going to PHP tomorrow. "I think that will work for me." Reported sleeping well. Denied pain. No falls this shift. Went for the supervised walk. Will continue to monitor.

Pt took Zydis 2.5 mg at 2250 for sleep.

Signed by McCullough, Elizabeth Ann, RN at 08/25/16 1646
Signed by McCullough, Elizabeth Ann, RN at 08/25/16 2250

Behavioral Health Note by Richardson, Cleo, RN at 08/26/16 0124

Author: Richardson, Cleo, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/26/16 0126 | Note Time: 08/26/16 0124 | Status: Signed
Editor: Richardson, Cleo, RN (Registered Nurse)

EVALYSIS

☐Day Shift ☐PM Shift ☒Noc Shift

PATIENT CARE INDICATORS				
CARE INDICATORS → **ACUITY** ↓	☐1	☐2	☐3	☐4
ADL: Independent	☐			
ADL: Partial assist / supervise		☒	☒	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	1	3	2.5	1

Signed by Richardson, Cleo, RN at 08/26/16 0126

Progress Notes (continued)

Care Team Note by Richardson, Cleo, RN at 08/26/16 0655

Author: Richardson, Cleo, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/26/16 0659 | Note Time: 08/26/16 0655 | Status: Signed
Editor: Richardson, Cleo, RN (Registered Nurse)

Pt in bed eyes closed no apparent discomfort noted when observed on safety checks. Breathing even and unlabored, pt able to sleep this shift with the aide of PRN Zyprexa Zydis tab.2.5mg (see MAR) no further c/o NADN. will continue to monitor pt for safety.

Signed by Richardson, Cleo, RN at 08/26/16 0659

Behavioral Health Note by Harris, Stephanie, RN at 08/26/16 0959

Author: Harris, Stephanie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/26/16 0959 | Note Time: 08/26/16 0959 | Status: Signed
Editor: Harris, Stephanie, RN (Registered Nurse)

	08/26/16 0900
Legal Status	
Legal status	1 - voluntary
Pain Assessment: Number Scale (0-10)	
Pain Rating (0-10): Rest	0
Pain Rating (0-10): Activity	0
Comfort/Acceptable Pain Level	3
Skin WDL	
Skin WDL	WDL
Precautions/Isolation	
Precautions (displays in banner)	1
Precautions Interventions	
Interventions Performed	yes
Level of Observation	every 30 minutes
Activities of Daily Living	
ADL's (WDL)	WDL
Mental Status	
Orientation	oriented x 4
Level Of Consciousness	alert
General Appearance WDL	ex
General Appearance	body odor;unkempt

Progress Notes (continued)

Behavioral Health Note by Harris, Stephanie, RN at 08/26/16 0959 (continued)

Mood	anxious;hopeful
Mood/Behavior/ Affect WDL	WDL
Behavior (WDL)	WDL
Mood/Behavior	appropriate
Speech	WDL
Speech	clear
Judgment and Insight	insight appropriate to situation
Insight	fair
Concentration	fair
Memory Deficit	intact
Thought (WDL)	WDL
Coping/Psychosocial Response	
Observed Emotional State	accepting;anxious;cooperative;hopeful
Verbalized Emotional State	acceptance;anxiety;hopefulness
Coping/Psychosocial Response Interventions	
Family/Support System Care	self-care encouraged
Plan Of Care Reviewed With	patient
Supportive Measures	decision-making supported
Psychiatric Symptoms	
Anxiety Symptoms (WDL)	Ex
Anxiety Symptoms	generalized
Manic Symptoms (WDL)	WDL
Psychotic symptoms (WDL)	WDL
Danger to Self	
Danger to Self (WDL)	WDL
Danger to Others	
Danger to Others (WDL)	WDL

Progress Notes (continued)

Behavioral Health Note by Harris, Stephanie, RN at 08/26/16 0959 (continued)

Signed by Harris, Stephanie, RN at 08/26/16 0959

Care Team Note by Harris, Stephanie, RN at 08/26/16 0959

Author: Harris, Stephanie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/26/16 0959 | Note Time: 08/26/16 0959 | Status: Signed
Editor: Harris, Stephanie, RN (Registered Nurse)

EVALYSIS

PATIENT CARE INDICATORS				
CARE INDICATORS → / ACUITY ↓	☐1	☒2	☐3	☐4
ADL: Independent	☒			
ADL: Partial assist / supervise		☐	☐	
ADL: Complete assist / supervise			☐	☐
Assess / Intervene: Minimal	☐			
Assess / Intervene: Average		☒	☒	☒
Assess / Intervene: Above average			☐	☐
Assess / Intervene: Almost constant				☐
Resistant to treatment modalities		☐	☐	☐
Behavior: Moderately unpredictable			☐	☐
Behavior: Very unpredictable				☐
Weighing factors	1	1	0.5	0
Total	2	2	1.5	1

Signed by Harris, Stephanie, RN at 08/26/16 0959

Interdisciplinary Rounding Note by Yerby, Derrick J, RN at 08/26/16 1032

Author: Yerby, Derrick J, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/26/16 1033 | Note Time: 08/26/16 1032 | Status: Cosign Needed
Editor: Yerby, Derrick J, RN (Registered Nurse) | Cosign Required: Yes

php transition today, then discharge after the progrqm

	08/26/16 1000
Patient Assets/Stressors	
Patient Assets	general fund of knowledge;average or above intelligence;motivation for treatment/growth;capable of independent living;supportive family/friends;work skills;physical

Progress Notes (continued)

Interdisciplinary Rounding Note by Yerby, Derrick J, RN at 08/26/16 1032 (continued)

	health;ability for insight;communication skills
Patient Stressors	medication change or non-compliance
Discharge Planning	
Discharge Criteria	improved stabilization in mood, thinking and/or behavior;verbal commitment to aftercare and medication compliance
Recommended Discharge Plan	return to previous living environment;medication management with psychiatrist or other physician
Pt's Acceptance of Discharge Plan	yes
Why Continues to Need Hospitalization	severe impairment of level of functioning;danger to self or others;medication stabilization
Estimated Length of Stay	3-5 days
Provisional DSM 5 Diagnoses	
Problem Being Addressed	refer to problem list
Goal: Will work with social worker/treatment coordinator to develop safe discharge plan	
Goal Status	goal initiated
Goal: Will attend Occupational Therapy groups up to seven days weekly as tolerated	
Objectives	increase coping skills
Goal Status	progress made toward outcome
Treatment Plan Reviewed by	
Physician	Cruz, Schumm
Psychiatric Social Worker	Himot
Registered Nurse	yerby

Progress Notes (continued)

Interdisciplinary Rounding Note by Yerby, Derrick J, RN at 08/26/16 1032 (continued)

Occupational Therapist	Edward

Signed by Yerby, Derrick J, RN at 08/26/16 1033

CarePlan Notes by Elliott, Harold Edward, OT at 08/24/16 1500

Author: Elliott, Harold Edward, OT | Service: Occupational Therapy | Author Type: Occupational Therapist
Filed: 08/26/16 1224 | Note Time: 08/24/16 1500 | Status: Signed
Editor: Elliott, Harold Edward, OT (Occupational Therapist)

Check-in (Community) Meeting
8/24/16 Group Start Time: 9:30

Group focused on review of program schedule and guidelines, identification of treatment issues, mood rating and identification and formulation of daily therapeutic goal(s).

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

AFFECT: blunted

APPEARANCE/BEHAVIOR: withdrawn

COGNITION: perseverated

INTERVENTION/EDUCATION: Unit orientation, Individual patient check-in, mood identification, goal setting. Prompted patient to participate, Provided support, Redirected patient and Encouraged interaction with peers

PATIENT RESPONSE: Withdrawn, stated feeling "hopeful/ calm/ undecided"

GOAL SET: set treatment goal for day, to "read one chapter of a book".

3 of 3 units @ 15 min.

Life Skills Group – Inner Peace
8/24/16 Group Start Time: 11

Structured learning opportunities to improve skills in areas such as communication, stress management, and other areas related to daily living in patients' communities outside the hospital.

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

AFFECT: blunted

APPEARANCE/BEHAVIOR: withdrawn from main group body, did not participate verbally

COGNITION: perseverated

CarePlan Notes by Elliott, Harold Edward, OT at 08/24/16 1500 (continued)

INTERVENTION/EDUCATION: Co-facilitated interactive discussion and exercise for emotional management and development of coping skills. Prompted patient to participate, Provided support, Redirected patient and Encouraged interaction with peers

PATIENT RESPONSE: Withdrawn, but engaged in mindfulness activity.

4 of 4 units @ 15 min.

Life Skills Group
8/24/16 Group Start Time: 14

Structured learning opportunities to improve skills in areas such as communication, stress management, and other areas related to daily living in patients' communities outside the hospital.

This group supports progress in patient's
OT Treatment Plan Goal(s) #1,2,3,4

AFFECT: blunted

APPEARANCE/BEHAVIOR: withdrawn from main group body, engaged verbally only with strong inquiry by therapist

COGNITION: coherent, perseverated

INTERVENTION/EDUCATION: Facilitated interactive discussion for development of coping skills. Prompted patient to participate, Provided support, Redirected patient and Encouraged interaction with peers

PATIENT RESPONSE: Resistant and Withdrawn, but did engage after heavy redirect, mostly listening.

4 of 4 units @ 15 min.

Signed by Elliott, Harold Edward, OT at 08/26/16 1224

CarePlan Notes by Himot, Craig at 08/26/16 1240

Author: Himot, Craig | Service: Social Services | Author Type: Others
Filed: 08/26/16 1240 | Note Time: 08/26/16 1240 | Status: Signed
Editor: Himot, Craig (Others)

Problem: Patient Care Overview
Goal: Discharge Needs Assessment
Outcome: Ongoing (interventions implemented as appropriate)
T/C to pt's pt's Oakland Community Support Case Manager, Al Boozer at 510-777-3800. Left voice mail message that pt is attending PHP transition day and will be discharged after the program this afternoon. Pt states that his IHSS, Willie Franklin at 510-355-5016 or 834-4148 will be providing transportation upon discharge.

Signed by Himot, Craig at 08/26/16 1240

Progress Notes (continued)

CarePlan Notes by Harris, Stephanie, RN at 08/26/16 1359

Author: Harris, Stephanie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/26/16 1359 | Note Time: 08/26/16 1359 | Status: Signed
Editor: Harris, Stephanie, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Ongoing (interventions implemented as appropriate)
Vincent went to PHP at 0900. Rec'd order to discharge pt. Pt was calm, ready for PHP this am after breakfast. At approx 1010, Scott from PHP called to say pt had fibromyalgia pain, and wanted a prn pain med. Went to PHP and escorted pt back to floor, where he received 2 mg sublingual; escorted back to PHP. When he arrived ack on the floor for lunch, he stated the med helped a lot. He gathered his belongings together in a bag in anticipation of discharging this afternoon, then returned to PHP.

PLAN: Discharge after PHP.

Signed by Harris, Stephanie, RN at 08/26/16 1359

Behavioral Health Note by Harris, Stephanie, RN at 08/26/16 1401

Author: Harris, Stephanie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/26/16 1402 | Note Time: 08/26/16 1401 | Status: Signed
Editor: Harris, Stephanie, RN (Registered Nurse)

	08/26/16 1300
Assessment Type	
Assessment timing	Discharge
Suicide Risk Assessment- Mood	
Agitation	None
Anxiety or Fearfulness	None
Loss of Pleasure or Interest	None
Depression or Sadness	None
Suicide Plan for Today	None
Hopeless or Overwhelmed	None
Suicide Risk Assessment - Thinking	
Sleep Disturbances	None
Cognition Problems	None
Psychotic	None

Progress Notes (continued)

Behavioral Health Note by Harris, Stephanie, RN at 08/26/16 1401 (continued)

Symptoms	
Suicide Risk Assessment-Behavior	
Withholding Information	None
Resistance to Treatment	None
Impulsivity	None
Aggressive towards self/others	None
Suicide Risk Assessment- Health	
Pain, real or perceived	Moderate
Perceived Loss of Health	Moderate
Suicide Risk Assessment-Discharge (for hospitalized patients only)	
Suicide Plan outside of Hospital	None
Lack of Support if Discharged	None
Pessimism if Discharged	None
Suicidal Inquiry	
Suicide Ideation for Today	None
Behavior congruent with Verbal and Non-Verbal	Yes
Assessment of Current Suicide Risk	
Assessment of Current Suicide Risk	Low

Signed by Harris, Stephanie, RN at 08/26/16 1402

Care Team Note by Harris, Stephanie, RN at 08/26/16 1439

Progress Notes (continued)

Care Team Note by Harris, Stephanie, RN at 08/26/16 1439 (continued)

Author: Harris, Stephanie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/26/16 1439 | Note Time: 08/26/16 1439 | Status: Signed
Editor: Harris, Stephanie, RN (Registered Nurse)

Notify attending physician before patient is discharged home.

DR. CRUZ

Signed by Harris, Stephanie, RN at 08/26/16 1439

CarePlan Notes by Abend, Marquel Marie, RN at 08/26/16 1652

Author: Abend, Marquel Marie, RN | Service: Adult Mental Health | Author Type: Registered Nurse
Filed: 08/26/16 1652 | Note Time: 08/26/16 1652 | Status: Signed
Editor: Abend, Marquel Marie, RN (Registered Nurse)

Problem: Patient Care Overview
Goal: Plan of Care Review
Outcome: Outcome(s) Achieved **Date Met:** 08/26/16
Pt discharged to self in lobby with friend waiting to pick him up at 1615. Pt discharge aftercare plan and medications reviewed with pt, pt verbalized understanding. Pt own medications returned to pt per md order. Pt belongings and valuables returned to pt. Pt will be following up with PHP

Signed by Abend, Marquel Marie, RN at 08/26/16 1652

Progress Notes

CarePlan Notes by Himot, Craig at 08/26/16 1646

Author: Himot, Craig | Service: Social Services | Author Type: Others
Filed: 08/26/16 1653 | Note Time: 08/26/16 1646 | Status: Signed
Editor: Himot, Craig (Others)

Intra-Facility Transfer of Care document completed to facilitate continuity of care upon transition to PHP. Treatment Coordinator also coordinated with PHP Intake Department regarding treatment and discharge planning needs.

Mental Health Services
Intra-Hospital Transfer of Care
Partial Hospitalization Programs and Inpatient Services

The following information and documentation must accompany the patient for a complete intra-hospital transfer. Please note any information that is not available or not applicable to this situation.

Date of Transfer: 8/29/16
From: ☐ PHP ☐ UNIT 3EA ☐ UNIT 3EB ☒ UNIT 4EA ☐ UNIT 4EB

Legal Status: ☒ Voluntary ☐ 5150 ☐ 5250 ☐ OTHER:

Diagnosis: Bipolar

☒ Suicidal ☐ Assaultive ☐ Abuse Victim ☐ Elopement ☐ Falls

Treatment Issues: Referred by his outpatient psychiatrist secondary to acute SI. Pt was having thoughts/urges to jump out of a window. He called his friend who stopped him from jumping. Pt became increasingly depressed after stopping Paxil rx two months ago.

Recent Changes: **Narrative**:
- provided supportive psychotherapy and processed the following issues. He feels tremendously worried that because he was placed on a 5150, he will not be able to have a firearms for the next five years. He does not know how he will have an income. He is considering writing a letter to the national team to see they would be willing to support his ability to use firearms again. Since he no longer has a roommate, he does not know if he will be able to afford the apartment where he lives. He also said that he feels tremendously disappointed in the people at Oakland Community Support Center because they took him off all of his medications and he "fell through the cracks." In addition, I reflected back to him about how well he has done. His sleep is better, he is no longer having panic attacks, his mood is better, and he feels more motivated.

Status Since Admission: Some Improvement (Little/Some/Much)

Discharge Plans: To return home. He lives alone in Alameda. He has IHSS (Willie Franklin at 355-5016 or 834-4148. His IHSS provider will provide transportation to and from Herrick PHP program

Reason for Transfer: Discharged on 8/26/16

Signed by Himot, Craig at 08/26/16 1653

CarePlan Notes by Himot, Craig at 08/26/16 1654

Progress Notes (continued)

CarePlan Notes by Himot, Craig at 08/26/16 1654 (continued)

Author: Himot, Craig | Service: Social Services | Author Type: Others
Filed: 08/26/16 1656 | Note Time: 08/26/16 1654 | Status: Signed
Editor: Himot, Craig (Others)

Patient anticipated to discharge to current residence in Alameda, on 8/26/16. Treatment Coordinator informed outpatient team of discharge date and discharge/safety plan. Per Alta Bates Summit Medical Center policy and to ensure continuity of care, the following documentation was faxed to outpatient provider/s: Oakland Community Support Center. Herrick PHP has access to these records via EPIC

After Visit Summary
Psychiatric Admission Note
Psychiatric Discharge Note (not available. Faxed recent progress note)
Internal Medicine Consult
Recent Labs

Signed by Himot, Craig at 08/26/16 1656

Care Team Note by Himot, Craig at 08/26/16 1656

Author: Himot, Craig | Service: Social Services | Author Type: Others
Filed: 08/26/16 1657 | Note Time: 08/26/16 1656 | Status: Signed
Editor: Himot, Craig (Others)

ABSMC Behavioral Health Therapy
2001 Dwight Way
Berkeley CA, 94704

Discharge Summary
8/9/2016

Vincent Ho | MRN: : 50553672

Basic Information

Date Of Birth	Sex	Race	Ethnicity	Preferred Language
11/6/1968	Male	Other Asian	Non Hispanic	ENGLISH

About your hospitalization

You were admitted on: August 9, 2016
You were discharged on: August 26, 2016

Treatment Team

Provider	Role
Stanger, Michael Terence, MD	Attending Provider
Cruz, John Michael de Vera, MD	Attending Provider

Why you were hospitalized

Your primary diagnosis was: Not on File
Your diagnoses also included: Fibromyalgia, Psoriasis, Chronic Pelvic Pain In Male, Bipolar I Disorder, Most Recent Episode Depressed (Hcc), Acid Reflux Disease

General Information

Allergies as of 8/26/2016

Reviewed on: **8/16/2016**

No Known Allergies

Vital Signs

BP	Pulse	Temp(Src)	Resp	Ht	Wt
153/95 mmHg	80	97.5 °F (36.4 °C) (Oral)	16	1.702 m (5' 7")	59.24 kg (130 lb 9.6 oz)

BMI	SpO2
20.45 kg/m2	98%

Current Immunizations

Reviewed on 8/9/2016

No immunizations on file.

Appointments for Next 30 Days

None

Discharge Instructions

Ho, Vincent (MR # 50553672)

About your Medication List

This list is based on information given by or verified by you (patient) and your family or other sources. It is not meant to substitute for advice/directions given by the prescribing physician, your pharmacist or primary care physician. Please contact them with questions.

Please keep a copy of this list with you and bring to all appointments. Discard old lists and update any records with all medication providers or retail pharmacies. Check with your physician before continuing over-the-counter medications, herbals and/or supplements.

If your prescriptions were sent electronically they were sent to the pharmacy listed below.

Pharmacy

No Pharmacy

Medication List

START taking these medications

	Prescription	Morning	Afternoon	Evening	As Needed	Other
divalproex 12Hr-DR 250mg Tab Dose: 1000 mg Take 4 Tabs by mouth twice daily. Take 1000 mg PO qam/ 1000 mg PO qhs Commonly known as: DEPAKOTE Last time this was given: 1,000 mg on 8/24/2016 8:36 AM For diagnoses: Bipolar I Disorder, Most Recent Episode Depressed (Hcc) When to take next dose: Today	Quantity: 240 Tab Refills: 0	✓		✓		
foLIC acid 1mg Tabs Tab Dose: 1 mg Take 1 Tab by mouth daily. Last time this was given: 1 mg on 8/26/2016 8:28 AM For diagnoses: Psoriasis When to take next dose: Today	Quantity: 30 Tab Refills: 0	✓				
*** OLANZapine ODT 5mg Solutab** Dose: 2.5 mg Take 0.5 Tabs by mouth every 6 hours as needed (insomnia, anxiety). Commonly known as: zyPREXA ZYDIS	Quantity: 28 Tab Refills: 0				✓	

Progress Notes (continued)

Care Team Note by Himot, Craig at 08/26/16 1656 (continued)

Last time this was given: 2.5 mg on 8/25/2016 10:49 PM For diagnoses: Bipolar I Disorder, Most Recent Episode Depressed (Hcc)						
*** OLANZapine ODT 5mg Solutab** Dose: 7.5 mg Take 1.5 Tabs by mouth daily at bedtime. Commonly known as: zyPREXA ZYDIS Last time this was given: 2.5 mg on 8/25/2016 10:49 PM For diagnoses: Bipolar I Disorder, Most Recent Episode Depressed (Hcc) When to take next dose: Today	Quantity: 45 Tab Refills: 0			✓		
pantoprazole 40mg EC Tab Dose: 40 mg Take 1 Tab by mouth daily 30 minutes before breakfast. Commonly known as: PROTONIX Last time this was given: 40 mg on 8/26/2016 8:08 AM For diagnoses: Gastroesophageal Reflux Disease Without Esophagitis When to take next dose: Resume Tomorrow	Quantity: 30 Tab Refills: 0	✓				
sennosides 8.6mg Dose: 2 Tab Take 2 Tabs by mouth daily at bedtime.	Quantity: 60 Tab Refills: 0			✓		

Progress Notes (continued)

Care Team Note by Himot, Craig at 08/26/16 1656 (continued)

Commonly known as: SENOKOT Last time this was given: 17.2 mg on 8/25/2016 9:00 PM For diagnoses: Chronic Pelvic Pain In Male When to take next dose: Today						

* Notice: **This list has 2 medication(s) that are the same as other medications prescribed for you. Read the directions carefully, and ask your doctor or other care provider to review them with you.**

CHANGE how you take these medications

	Prescription	Morning	Afternoon	Evening	As Needed	Other
lactulose 10g/15mL Oral Soln Dose: 30 mL Take 30 mL by mouth twice daily. What changed: **- when to take this** **- additional instructions** Commonly known as: ENULOSE Last time this was given: 30 mL on 8/26/2016 8:34 AM For diagnoses: Chronic Pelvic Pain In Male	Quantity: 1800 mL Refills: 0	✓		✓		
*** methotrexate 5mg Tab** Dose: 5 mg Take 1 Tab by mouth every 7 days. What changed: **- medication strength** **- when to take**	Refills: 0					

Progress Notes (continued)

Care Team Note by Himot, Craig at 08/26/16 1656 (continued)

this Last time this was given: 5 mg on 8/23/2016 9:13 AM						
*** methotrexate 7.5mg Tab** Dose: 7.5 mg Take 1 Tab by mouth every 7 days. What changed: **You were already taking a medication with the same name, and this prescription was added. Make sure you understand how and when to take each.** Last time this was given: 5 mg on 8/23/2016 9:13 AM	Refills: 0					

* Notice: **This list has 2 medication(s) that are the same as other medications prescribed for you. Read the directions carefully, and ask your doctor or other care provider to review them with you.**

CONTINUE taking these medications

	Prescription	Morning	Afternoon	Evening	As Needed	Other
buprenorphine SL 2mg Dose: 2 mg Apply/place 2 mg under the tongue every 6 hours as needed. Not to exceed two dosages/ 24 hour Indications: Chronic Pelvic Pain Syndrome, Fibromyalgia Syndrome For: Chronic Pelvic	Refills: 0				✓	

Progress Notes (continued)

Care Team Note by Himot, Craig at 08/26/16 1656 (continued)

Pain Syndrome, Fibromyalgia Syndrome Commonly known as: SUBUTEX Last time this was given: 2 mg on 8/26/2016 10:28 AM						
BUTRANS 10mcg/hr Topical Patch Refills: 0 Dose: 1 Patch Generic drug: buprenorphine 1 Patch to affected area(s) every 7 days.						
HYDROcodone/acetaminophen 10mg/325mg Tab Refills: 0 Dose: 1 Tab Take 1 Tab by mouth every 24 hours as needed for Pain. Commonly known as: NORCO 10				✓		
phenazopyridine 200mg Tab Refills: 0 Dose: 200 mg Take 200 mg by mouth three times daily as needed for urinary pain. Commonly known as: PYRIDIUM Last time this was given: 200 mg on 8/13/2016 10:08 AM				✓		

STOP taking these medications

DIAZEPAM PO

methotrexate (anti-rheumatic) 2.5 MG Tab
Commonly known as: RHEUMATREX

PAXIL PO

Where to Get Your Medications

You need to pick up these prescriptions. We sent them to a specific pharmacy, so go there to get them.

WELLSPRING PHARMACY - 4184C Piedmont Ave Phone: 510-428-1559

OAKLAND, CA - 4184C PIEDMONT AVE Oakland CA 94611

- divalproex 12Hr-DR 250mg Tab
- foLIC acid 1mg Tabs Tab
- lactulose 10g/15mL Oral Soln
- OLANZapine ODT 5mg Solutab
- OLANZapine ODT 5mg Solutab
- pantoprazole 40mg EC Tab
- sennosides 8.6mg

Discharge Instructions

The following are after care appointments and resources to support your recovery and ongoing treatment after discharge. If possible, please follow up with appointments within one week.

If you feel you are in crisis, please go to the nearest emergency room or contact crisis support hotline: 1-800-273-TALK (8255).

Herrick PHP Program
2001 Dwight Way, Third Floor
Berkeley, Ca
510-204-4569
Date: 8/29/16 Patient should arrive at 8:30 and proceed to Admitting Office on first floor. After registering for PHP at Admitting Office, take elevator B to PHP Intake Office on 3rd Floor, Room 3388. The program begins at 9 am.

Oakland Community Support Center
7200 Bancroft Ave.
510-777-3800
With: Al Boozer (case manager). Call Al to schedule next appointment.

IHSS Provider (Willie Franklin) at 510-355-5016 will assist you with transportation to and from the Herrick PHP program.

How can I reduce the risk of suicide and/or rehospitalization?
Though not all suicides or rehospitalization can be prevented, some strategies can help reduce the risk. All of these factors are linked to well-being. These strategies include:

- Keeping scheduled after care appointments
- Taking medications as prescribed.
- Seeking treatment, care and support for mental health concerns—and building a good relationship with a doctor or other health professionals
- Building social support networks, such as family, friends, a peer support or support group, or connections with a cultural or faith community

- Learning good coping skills to deal with problems, and trusting in coping abilities
- Calling a crisis telephone support line
- Connecting with family, friends, or a support group. It can be helpful to talk with others who have experienced thoughts of suicide to learn about their coping strategies
- Activities that calm you or take your mind off your thoughts
- Your own reasons for living
- Key people to call if you're worried about your safety
- Phone numbers for local crisis or suicide prevention helplines
- A list of safe places to go if you don't feel safe at home

Tips for family/friends to keep loved ones safe upon return home from the hospital:

- Support scheduled mental health after care appointments (offer assistance for transport or scheduling if needed)
- Ask directly if he or she is thinking about suicide.
- Eliminate access to firearms
- Focus on your concern for their wellbeing and avoid being accusatory.
- Remain calm and listen. Do not judge.
- Reassure them that there is help and they will not feel like this forever.
- Provide constant supervision if possible.
- If possible, remove means for self-harm from the home (secure over the counter and prescription medications, alcohol, etc.).
- If medications are prescribed, offer to maintain and supervise administration of medications
-

Follow-up with these providers

Robinson, Mark D, MD
Specialty: Internal Medicine
Relationship: PCP - General

10700 MACARTHUR BLVD
STE 14B
OAKLAND CA 94605
Phone: 510-563-4300

ABSMC HERRICK PARTIAL HOSPITAL PROGRAM

2001 DWIGHT WAY
BERKELEY CA 94704

Phone: 204-4569

PUBLIC SERVICE INFORMATION:

CHILD SAFETY LAWS
California Law (SB 929) requires any child under the age of 8 or less than 4 feet 9 inches tall to be restrained in a federally approved car safety seat whenever traveling in a motor vehicle.

IF YOU SMOKE
Stopping smoking is one of the most important steps you can take to improve your

health. Please call 1-800-NO-BUTTS (800-662-8887) for information on stopping smoking.

SUICIDE PREVENTION
You can contact a suicide hotline, crisis center, or local suicide prevention center for help right away:
1-800-273-TALK (1-800-273-8255) in the United States.
1-800-SUICIDE (1-800-784-2433) in the United States.
1-888-628-9454 in the United States for Spanish-speaking counselors.
1-800-799-4TTY (1-800-799-4889) in the United States for TTY users.

Tests, Procedures, and Treatments

Lab Tests performed during your visit

Procedure/Test	Number of Times Performed
ADD ON LAB TEST	1
CBC WITH AUTOMATED DIFFERENTIAL	4
COMPREHENSIVE METABOLIC PANEL W GFR	3
FOLATE (FOLIC ACID)	1
HEMOGLOBIN A1C	1
HEPATITIS ACUTE PANEL	1
HIV 1 & 2 AB AG SCREEN W/ REFLEXES	1
LIPASE	1
LIPID PROFILE	1
MAGNESIUM	2
PHOSPHORUS	2
RPR	1
THYROID STIMULATING HORMONE (TSH)	1
URINALYSIS & CULT IF INDICATED	1
VALPROIC ACID	4
VITAMIN B12	1

Electronic Discharge Instructions

Your discharge instructions, test results, and other information is available electronically on Sutter's online patient portal, My Health Online (MHO). Before you can use My Health Online, you must register and create an account using the unique Access Code below. To register for a new My Health Online account:
- In your web browser, visit myhealthonline.sutterhealth.org
- In the bottom-right corner of the screen, click the **Activate Your Account** link.
- In the **Access Code** field, enter 5ZTGV-TFSM8.
- Follow the instructions on-screen to complete your registration and access your account.

Care Team Note by Himot, Craig at 08/26/16 1656 (continued)

Note: Your unique **Access Code** expires on **9/25/2016**. If that date has passed and you would like to register for a new account, please contact the My Health Online Service Desk at 1-866-978-8837 to request a new Access Code.

Patient Signature:

_____

Date: _____

WELFARE AND INSTITUTIONS CODE 5531

No person may be presumed to be incompetent because he or she has been evaluated or treated for mental disorder or chronic alcoholism, regardless of whether such evaluation or treatment was voluntarily or involuntarily received.

Any person who leaves a public or private mental health facility following evaluation or treatment for mental disorder or chronic alcoholism, regardless of whether that evaluation or treatment was voluntarily or involuntarily received, shall be given a statement of California law as stated in this paragraph.

Signed by Himot, Craig at 08/26/16 1657

Behavioral Health Note by Weber, Scott A, LCSW at 08/26/16 1704

Author: Weber, Scott A, LCSW | Service: Mental Health | Author Type: Licensed Clinical Social Worker
Filed: 08/26/16 1706 | Note Time: 08/26/16 1704 | Status: Signed
Editor: Weber, Scott A, LCSW (Licensed Clinical Social Worker)

BEHAVIORAL HEALTH HAND OFF COMMUNICATION TOOL (PHP)

☐ UNIT 3EA ☐ UNIT 3EB ☒ UNIT 4EA ☐ UNIT 4EB ☐ OTHER _____

S = SITUATION

Patient attended groups in PHP for transition day.

B = BACKGROUND

Special Needs: ☐Vision ☐Hearing ☐Language(specify):

Mobility: ☐With Assistance ☒Without Assistance ☐Total Assistance Needed
Type of assistive device used:

Abnormal / significant lab or test results:

Abnormal / significant vital signs:

Progress Notes (continued)

Behavioral Health Note by Weber, Scott A, LCSW at 08/26/16 1704 (continued)

Infection control: ☐ Contact ☐ Airborne ☐ Droplet ☐ Other(Specify):

A = ASSESSMENT: *Assessment about the patient situation.*

Current mental status: Oriented X4

Current Behavior: Pt. Participated well in groups throughout the day. He appropriately asked about what to do if feeling triggered in the group. Focused on triggers and past traumatic events.

Active Medical Problems:

Skin:

Restraints: N/A

Has the client been searched? ☐ Yes ☒ No

Medication received: None

Pain status / intensity (1 – 10):
Location:
Last pain med given at:: N/A
Name of med: N/A

R = RECOMMENDATION

Comments:
☒ Patient is appropriate for PHP.
☐ Second transition day recommended.
☐ Patient is not appropriate for PHP and Doctor notified.
Comments:

Signed by Weber, Scott A, LCSW at 08/26/16 1706

Progress Notes by Cruz, John Michael de Vera, MD at 08/26/16 0824

Author: Cruz, John Michael de Vera, MD | Service: Psychiatry | Author Type: Physician
Filed: 08/26/16 2046 | Note Time: 08/26/16 0824 | Status: Signed
Editor: Cruz, John Michael de Vera, MD (Physician)

PSYCHIATRY PROGRESS NOTE

Friday, August 26, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:

47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:

hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- Sleep - 7 hours
- PRN Olanzapine 2.5 mg PO - 22:49 - insomnia

In speaking to the psychiatrist, the patient states
- mood: "good" - same as yesterday - feels even
- interest: "good" - same as yesterday - enjoys attending PHP group
- appetite: "good" - same as yesterday - eating three meals a day with snacks
- concentration: "good" - same as yesterday - able to comprehend what was being said in PHP group
- psychomotor retardation: denies
- anxiety: denies
- psychomotor agitation: denies
- sleep: "great" - same as yesterday - no difficulties falling asleep or staying asleep
- energy: "great" - same as yesterday - because of getting good sleep
- pain: denies
- self-esteem: "good" - same as yesterday - believes that he is a good person
- worthlessness: denies
- guilt: denies
- passive death wish: denies
- suicidal ideation: denies

- overall: His mood and cognition seem even better than yesterday.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged.

VITAL SIGNS:
BP 134/74 | Pulse 85 | Temp (Src) 98.6 °F (37 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 59.24 kg (130 lb 9.6 oz) | SpO2 98%
Wt Readings from Last 3 Encounters:
08/17/16 : 59.24 kg (130 lb 9.6 oz)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: 0
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: euthymic
- Suicidal ideation: No
- Homicidal Ideation: No

- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Fair

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for: and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:

Recent Labs

Lab	08/23/16 2330
WBC	3.9 L
HGB	12.5 L
HCT	38.4 L
PLT	100 L

No results for input(s): NA, K, CL, CO2, BUN, CREATININE, GLU, CA, MG, PHOS in the last 72 hours.
No results for input(s): TBILI, AST, ALT, ALP, ALB in the last 72 hours.
No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• divalproex DR	1,000	Oral	Q BEDTIME	Cruz, John		1,000

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/26/16 0824 (continued)

(DEPAKOTE SPRINKLE) Cap 1,000 mg	mg			Michael de Vera, MD	mg at 08/25/16 2100
• divalproex DR (DEPAKOTE SPRINKLE) Cap 1,000 mg	1,000 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1,000 mg at 08/25/16 0937
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 7.5 mg	7.5 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD	7.5 mg at 08/25/16 2100
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q Monday	Cruz, John Michael de Vera, MD	2 Patch at 08/22/16 1202
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD	
• pantoprazole (PROTONIX) Tab 40 mg	40 mg	Oral	AC 30 MIN BKFST	Cruz, John Michael de Vera, MD	40 mg at 08/26/16 0808
• benztropine (COGENTIN) Tab 1 mg	1 mg	Oral	Q4H PRN	Trautner, Rick Jeffrey, MD	1 mg at 08/21/16 2109
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	7.5 mg at 08/22/16 2114
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD	10 mg at 08/25/16 0936
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD	30 mL at 08/25/16 2100
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD	17.2 mg at 08/25/16 2100
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD	
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD	2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John	1 mg at

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/26/16 0824 (continued)

				Michael de Vera, MD	08/25/16 0937
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/23/16 0913
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/25/16 2249
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Acid reflux disease [K21.9]	08/22/2016
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- Discharge today

PLAN:
 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex DR 1000 mg PO qam/ 1000 mg PO at bedtime
- continue Olanzapine 7.5 mg PO at bedtime
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1
- continue PRN Olanzapine ODT 2.5 mg PO q4h for anxiety

 # Post Traumatic Stress Disorder

- continue PRN Olanzapine 2.5 mg PO q4h for anxiety
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:
- PRN Olanzapine ODT as above
- Exposure Response Prevention Therapy as outpatient

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mL PO BID

 # Gastroesophageal Reflux:
- Pantoprazole 40 mg PO daliy

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- 8/26 - Herrick PHP Transition Day/ Discharge from Hospital
- 8/29 - Start Herrick PHP Full Time

 # Estimated Length of Stay
- discharge today

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Friday, August 26, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce

Progress Notes (continued)

Progress Notes by Cruz, John Michael de Vera, MD at 08/26/16 0824 (continued)

symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
mood instability

Intervention:
Demonstrate interventions in thought-emotion-behavior triad
Increase insight into illness and treatment plan
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided supportive psychotherapy and processed the following issues. He states that he is very sad for losing his job because he will miss working with the children. He will ask the national coach of the junior olympics to write a letter for him so that he can attempt to get his fire arms license sooner as opposed to waiting for five years In PHP today, he said that he started to have panic attacks because another patient reminded him of the person that broke into his apartment. In addition, he also started to feel anxious when he saw one of the group leaders shaking her legs because it reminded him of his mother who used to shake her legs and who used to physically abuse him. He says that he has learned many things from PHP. He recognizes that there are stimuli that can trigger trauma that has happened to him in the past, but by trying to figure out what stimuli is being triggered, he can then work on decreasing the anxiety that he is feeling.

ATTENDING PHYSICIAN:
John M Cruz, MD

Signed by Cruz, John Michael de Vera, MD at 08/26/16 2046

Scans

Encounter-Level Documents - 08/09/2016:

BH Consent - Scan on 8/22/2016 0000 by Scan, Onbase Inf : OLANZAPINE (below)

INFORMED CONSENT FOR
PSYCHOTROPIC MEDICATION

A separate informed consent must be obtained for each prescribed medication.

I have reviewed with the patient named below the following information:

1. The nature of the patient's mental condition.
2. The reasons for taking the recommended medication, including the likelihood of improving or not improving without this medication.
3. The patient's consent, once given, may be withdrawn at any time by the patient's stating such intention to any member of the treating staff.
4. The reasonable alternative treatments available, if any.
5. The type, range of frequency and amount (including use of PRN orders), method (oral or injection), and duration of taking this medicine.
6. The probable side effects of this medication known to occur commonly, and any particular side effects likely to occur.
7. The possible additional side effects which may occur to patients taking this medication beyond three months.

I recommend that the patient take: olanzapine

with a daily dose of: 40 to 20 mg.: (circle one) oral intramuscular

Date: 8/22 Time: 4:40 AM/PM Physician's signature: [signature]

(Print) Physician's name: John M. Cruz, MD

I acknowledge that I have had a discussion with my physician named above concerning my taking the recommended medication to assist in my treatment and that I understand the risks and benefits. I understand that I have the right to refuse this medication until I have spoken with my physician and given my consent to it. Furthermore, I understand that I may seek further information at any time by telling my physician or the nursing staff.

I hereby give my consent to start this medication regimen with the medication indicated above.
Date: 8/22 **Time:** 4:40 **AM/PM** **Patient's signature:** [signature]
(patient/parent/conservator/guardian)

If signed by other than patient, indicate relationship: _____
Date: ___ **Time:** _____
AM/PM **Witness:** _____

☐ Consent given verbally only. Date _____ Time _____
Explanation of verbal consent: _____

Physician's Signature _____ ABSMC
Witness _____

NS-34451-ABSMC (01/13) v6

200025 CONSENT FORM DOCUMENTATION

Alta Bates Summit Medical Center

INFORMED CONSENT FOR PSYCHOTROPIC MEDICATION

page 1 of 2

COPIES: WHITE-MEDICAL RECORDS YELLOW-PATIENT COPY

Ho, Vincent

MRN: 50553672 CRUZ, JOHN MICHAEL DE VERA
11/6/1968 47 yrs MICHEL, CHRISTOPHER S
SEX: M Adult Mental Health 8/9/2016
MEDS,LABS CSN: 820425781

Scans (continued)

INFORMED CONSENT FOR PSYCHOTROPIC MEDICATION

RESPIRATORY AND CEREBRAL STIMULANTS

	BRAND NAME
____dextroamphetamine	Biphetamine / Dexedrine
methylphenidate	Ritalin

ANTI-MANIC MEDICATION

carbamazepine	Tegretol
valproic acid	Depakote

BH Insurance - Scan on 8/9/2016 by Baingul, Vicki : MEDI-CAL ELIGIBILITY RESPONSE (below)

Medi-Cal: Eligibility Response

Department of Health Care Services Medi-Cal

Home » Transaction Services

Eligibility Response

Eligibility transaction performed by provider: 1013906221
on Wednesday, August 10, 2016 at 11:04:47 AM

Name: **HO, VINCENT**		
Subscriber ID: **98633469E**		
Service Date: **08/09/2016**	Subscriber Birth Date: **11/06/1968**	Issue Date: **08/10/2016**
Primary Aid Code: **6H**	First Special Aid Code: **80**	
Second Special Aid Code:	Third Special Aid Code:	
Subscriber County: **01 - Alameda**	HIC Number: **224572556A**	
Primary Care Physician Phone #:	Service Type: **R**	
Trace Number (Eligibility Verification Confirmation (EVC) Number): **9758CPB3J5**		
Eligibility Message: **SUBSCRIBER LAST NAME: HO . EVC #: 9758CPB3J5. CNTY CODE: 01. PRMY AID CODE: 6H. 1ST SPECIAL AID CODE: 80. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: PHP-ALAMEDA ALLIANCE FOR HLTH: MEDICAL CALL (510)747-4500. PART A, B AND D MEDICARE COV W/HIC #224572556A . MEDICARE PART A AND B COVERED SVCS MUST BE BILLED TO MEDICARE BEFORE BILLING MEDI-CAL.MEDICARE PART D COVERED DRUGS MUST BE BILLED TO THE PART D CARRIER BEFORE BILLING MEDI-CAL. CARRIER NAME: CIGNA HEALTH CARE. COV: R.**		

Server:www.medi-cal.ca.gov |File:/Eligibility/EligResp.asp |Last Modified:1/23/2015 3:24:28 PM

Ho, Vincent

MRN: 50553672 CRUZ, JOHN MICHAEL DE VERA
11/6/1968 47 yrs STANGER, MICHAEL TERENCE
SEX: M Adult Mental Healt8/9/2016
MEDS,LABS CSN: 820425781

Medicare Message Form - Scan on 8/9/2016 by Robertson, William B, RN : message from Medicare (below)

Alta Bates Summit Medical Center
A Sutter Health Affiliate

Patient Name: Ho, Vincent
Date Of Birth: 11/6/1968
MR# 50553672
CSN: 820425781

Steps To Appeal Your Discharge

- **Step 1:** You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  - Here is the contact information for the QIO:

    Name of QIO (in bold)

    Livanta BFCC - QIO

    Telephone Number of QIO

    PHONE: 1-877-588-1123 or TTY 1-855-887-6668
  - You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun.**
  - Ask the hospital if you need help contacting the QIO.
  - The name of this hospital is: Alta Bates Medical Center

Summit: 50043	Ashby/Herrick: 50305

- **Step 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- **Step 3:** The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
- **Step 4:** The QIO will review your medical records and other important information about your case.
- **Step 5:** The QIO will notify you of its decision within 1 day after it receives all necessary information.
  - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  - If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

If You Miss The Deadline To Appeal, You Have Other Appeal Rights:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call the QIO listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Additional Information:

Alta Bates Summit Medical Center
A Sutter Health Affiliate

Patient Name: Ho, Vincent
Date Of Birth: 11/6/1968
MR# 50553672
CSN: 820425781

Department of Health & Human Services
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

An Important Message From Medicare About Your Rights

As A Hospital Inpatient, You Have The Right To:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

Name of QIO
Livanta BFCC - QIO

Telephone Number of QIO
PHONE: 1-877-588-1123 or TTY 1-855-887-6668

Your Medicare Discharge Rights

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  - **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- Step by step instructions for calling the QIO and filing an appeal are on page 2.

To speak with someone at the hospital about this notice, call: Summit Campus: (510) 869 – 6173
Ashby/Herrick: (510) 204 - 2064

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative	Date/Time
	8/10/2016 1305

1

200070

BH Documentation - Scan on 8/9/2016 by Monk, Diana M : Patient diary (below)

Ho, Vincent

MRN: 50553672 STANGER, MICHAEL TERENCE
11/6/1968 47 yrs STANGER, MICHAEL TERENCE
SEX: M Adult Mental Health
MEDS,LABS CSN: 820425781

mental

Chronic Pelvic Pain Syndrome (since 2003, disability 2005): Sinquan 25mg Diazepam 1mg Phenazopydirean 200mg
Fibromyalgia (2009): none.
Psoriasis: Methotrexate 2.5mgx5/week
Painkillers: Norco 10/325 (30), Butran 10mcg/h week Butran 2mg (60)
Diazpepam 10mg ~~PRN zyprexa zydis 5mg PRN~~
Original Paxil dosage:
2013 40mg 2014 30mg 2015 20mg October 10mg 2016 January 5 mg April 2.5mg May 0.mg
Seroquel 25mg, Lamictal 100mg all ends at the end of 2015. No manic episode since mid 2012.

5/1 First day without paxil.
6/6 (first one ever, the monday moving back, called coach and denise, ZZ). Low level panic attack on the morning or woke up by one for 4 weeks except in SoCal
6/8 (second one)
6-9-13 off to LA. mood great. no attack!
6/24 Friday, first one in slrr, left range (ZZ home).
6/28 fibro starts
6/29 first minor attack from fibro; constant minor, until end of fibro 7/13?
7/1 (significanr major, ZZ)
7/4 (significant major, out with katy, tamescal lake, no meds),
7/5 (door repair, major, ZZ), then "11 day break with no major".
7/16 (major, ZZ)
7/21 (medium diazepam), back to 2.5mg
7/22 (medium-major, leave richmond early for k31 diazepam)
7/26 (minnor, at home only, diazepam)
7/28 (super minor, after talking to new ex, triggered).
7/30 2.5mg begin:
8/1 (moderate, woken up by panic--slight tint of depreession) - complete disaster - saulson creek
8/6 2.5mg+5mngSevere depression, Headache, Panic attack. ZZ. SUICIDAL. passed out around 3pm.
8/7 woke up 5mg only. brain zaps.
8/8 5am Super panic attack, chills, heart rate increase, dry heave, depression, short breathing, diazepamn, lasts for more than an hour.
8/9 5am Panic attack. Chills, Brain Zaps

Oakland Community Support Center (510)777-3800 After Hours Emergency (1800)769-1312

Al Boozer 1(510)777-3820 521-6445 Case Manager Maureen Costello 1(510)777-3850
Department Head James Hinson 1(510)777-3847 Doctor
Medical: Highland Pain Clinic (510)437-8552 Amy Smith (510)437-8377 Pain Management N.P.
Lifelong Medical Care (510)430-8740 Dr. Mark Robinson G.P. Bill Littman (510)652-8091 Dermatologist
Emergency Contact: Katy Kaminski (510)816-6963 Will Franklin (510)355-5016

Page 1

Ho, Vincent

MRN: 50553672 STANGER, MICHAEL TERENCE
11/6/1968 47 yrs STANGER, MICHAEL TERENCE
SEX: M Adult Mental Health
MEDS,LABS CSN: 820425781

72 Hour Hold Patient Rights - Scan on 8/9/2016 by Monk, Diana M : 5150 (below)

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

APPLICATION FOR ASSESSMENT, EVALUATION, AND CRISIS INTERVENTION OR PLACEMENT FOR EVALUATION AND TREATMENT

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

Welfare and Institutions Code (W&I Code), Section 5150(f) and (g), require that each person, when first detained for psychiatric evaluation, be given certain specific information orally and a record be kept of the advisement by the evaluating facility.

☒ **Advisement Complete** ☐ **Advisement Incomplete**

Good Cause for Incomplete Advisement

Advisement Completed By	Position	Language or Modality Used	Date of Advisement
BROWN, STEPHANIE	MD	ENGLISH	8-9-16

DETAINMENT ADVISEMENT

My name is_____.
I am a (peace officer/mental health professional) with (name of agency). You are not under criminal arrest, but I am taking you for examination by mental health professionals at (name of facility).

You will be told your rights by the mental health staff.

If taken into custody at his or her residence, the person shall also be told the following information:

You may bring a few personal items with you, which I will have to approve. Please inform me if you need assistance turning off any appliance or water. You may make a phone call and leave a note to tell your friends or family where you have been taken.

To (name of 5150 designated facility) ALTA BATES SUMMIT MEDICAL CENTER

Application is hereby made for the assessment and evaluation of Ho, VINCENT

Residing at _____, California, for up to 72- hour assessment, evaluation and crisis intervention or placement for evaluation and treatment at a designated facility pursuant to Section 5150, et seq. (adult) or Section 5585 et seq. (minor), of the W&I Code. If a minor, authorization for voluntary treatment is not available and to the best of my knowledge, the legally responsible party appears to be / is: (Circle one) Parent; Legal Guardian; Juvenile Court under W&I Code 300; Juvenile Court under W&I Code 601/602; Conservator. If known, provide names, address and telephone number:

The above person's condition was called to my attention under the follow

Ho, Vincent
MRN: 50553672 BROWN, STEPHANIE YVONNE
11/6/1968 47 yrs
SEX: M 8/9/2016
MEDS,LABS CSN: 820327096

I have probable cause to believe that the person is, as a result of a mental health disorder, a danger to others, or to himself/ herself, or gravely disabled because: (state specific facts)
jump out of a window over weekend, tried to
Bipolar depression off of Paxil

Based upon the above information, there is probable cause to believe that said person is, as a result of mental health disorder:
☒ **A danger to himself/herself.** ☐ **A danger to others.** ☐ **Gravely disabled adult.** ☐ **Gravely disabled minor.**

Signature, title and badge number of peace officer, professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, designated members of a mobile crisis team, or professional person designated by the county.	Date 8-9-16 Time 0935	Phone
Stephanie M.D.		

Name of Law Enforcement Agency or Evaluation Facility/Person	Address of Law Enforcement Agency or Evaluation Facility/Person

NOTIFICATIONS TO BE PROVIDED TO LAW ENFORCEMENT AGENCY

Notify (officer/unit & telephone #) _____

NOTIFICATION OF PERSON'S RELEASE IS REQUESTED BY THE REFERRING PEACE OFFICER BECAUSE:
☐ The person has been referred to the facility under circumstances which, based upon an allegation of facts regarding actions witnessed by the officer or another person, would support the filing of a criminal complaint.

☐ Weapon was confiscated pursuant to Section 8102 W&I Code. Upon release, facility is required to provide notice to the person regarding the procedure to obtain return of any confiscated firearm pursuant to Section 8102 W&I Code.

SEE REVERSE SIDE REFERENCES AND DEFINITIONS

DHCS 1801 (07/2014) Page 1 of 2

APPLICATION FOR ASSESSMENT, EVALUATION AND CRISIS INTERVENTION OR PLACEMENT FOR EVALUATION AND TREATMENT

REFERENCES AND DEFINITIONS

"Gravely Disabled" means a condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing and shelter. SECTION 5008(h) W&I Code.

"Gravely Disabled Minor" means a minor who, as a result of a mental disorder, is unable to use the elements of life which are essential to health, safety, and development, including food, clothing, and shelter, even though provided to the minor by others. Intellectual disability, epilepsy, or other developmental disabilities, alcoholism, other drug abuse, or repeated antisocial behavior do not, by themselves, constitute a mental disorder. SECTION 5585.25 W&I Code.

"Peace officer" means a duly sworn peace officer as that term is defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code who has completed the basic training course established by the Commission on Peace Officer Standards and Training, or any parole officer or probation officer specified in Section 830.5 of the Penal Code when acting in relation to cases for which he or she has a legally mandated responsibility. SECTION 5008(i) W&I Code.

Section 5152.1 W&I Code

The professional person in charge of the facility providing 72-hour evaluation and treatment, or his or her designee, shall notify the county mental health director or the director's designee and the peace officer who makes the written application pursuant to Section 5150 or a person who is designated by the law enforcement agency that employs the peace officer, when the person has been released after 72-hour detention, when the person is not detained, or when the person is released before the full period of allowable 72-hour detention if all of the conditions apply:

(a) The peace officer requests such notification at the time he or she makes the application and the peace officer certifies at that time in writing that the person has been referred to the facility under circumstances which, based upon an allegation of facts regarding actions witnessed by the officer or another person, would support the filing of a criminal complaint.
(b) The notice is limited to the person's name, address, date of admission for 72-hour evaluation and treatment, and date of release.

If a police officer, law enforcement agency, or designee of the law enforcement agency, possesses any record of information obtained pursuant to the notification requirements of this section, the officer, agency, or designee shall destroy that record two years after receipt of notification.

Section 5152.2 W&I Code

Each law enforcement agency within a county shall arrange with the county mental health director a method for giving prompt notification to peace officer pursuant to Section 5152.1 W&I Code.

Section 5585.50 W&I Code

The facility shall make every effort to notify the minor's parent or legal guardian as soon as possible after the minor is detained. Section 5585.50 W&I Code.

A minor under the jurisdiction of the Juvenile Court under Section 300 W&I Code is due to abuse, neglect, or exploitation.

A minor under the jurisdiction of the Juvenile Court under Section 601 W&I Code is due to being adjudged a ward of the court as a result of being out of parental control.

A minor under the jurisdiction of the Juvenile Court under Section 602 W&I Code is due to being adjudged a ward of the court because of crimes committed.

Section 8102 W&I Code (EXCERPTS FROM)

(a) Whenever a person who has been detained or apprehended for examination of his or her mental condition or who is a person described in Section 8100 or 8103, is found to own, have in his or her possession or under his or her control, any firearm whatsoever, or any other deadly weapon, the firearm or other deadly weapon shall be confiscated by any law enforcement agency or peace officer, who shall retain custody of the firearm or other deadly weapon.
"Deadly weapon," as used in this section, has the meaning prescribed by Section 8100.
(b)(1) Upon confiscation of any firearm or other deadly weapon from a person who has been detained or apprehended for examination of his or her mental condition, the peace officer or law enforcement agency shall issue a receipt describing the deadly weapon or any firearm and listing any serial number or other identification on the firearm and shall notify the person of the procedure for the return, sale, transfer, or destruction of any firearm or other deadly weapon which has been confiscated. A peace officer or law enforcement agency that provides the receipt and notification described in Section 33800 of the Penal Code satisfies the receipt and notice requirements.
(2) If the person is released, the professional person in charge of the facility, or his or her designee, shall notify the person of the procedure for the return of any firearm or other deadly weapon which may have been confiscated.
(3) Health facility personnel shall notify the confiscating law enforcement agency upon release of the detained person, and shall make a notation to the effect that the facility provided the required notice to the person regarding the procedure to obtain return of any confiscated firearm.

BH Consent - Scan on 8/9/2016 by Monk, Diana M : Advisements (below)

(Any Staff) LEGAL

ADVISEMENTS

You have been admitted to the Alta Bates Summit Medical Center, Herrick Campus, 2001 Dwight Way, Berkeley, CA 94704

☒ **5150 INVOLUNTARY HOLD ADVISEMENT:**

My name is Amy, my position here is RN.

You are being held on the psychiatric unit because it is the opinion of duly designated mental health professionals or peace officers that, as a result of mental disorder, inebriation, or use of narcotics or restricted drugs, you are likely to:

☒ harm yourself, ☐ harm others, or ☐ be unable to take care of your own needs for food, shelter or clothing.

Document specific evidence which substantiates reason for hold:

We feel this is true because you tried to jump out of window last weekend - Severe depression - off your anti depressant Rx.

Your 72 hour hold STARTED (date/time) 8/9/16 0925 and will END (date/time) 8/12/16 0925

During this time you will be evaluated by the hospital staff, and you may be given treatment, including medications. It is possible for you to be released sooner, if the staff decide this is safe. If the staff decide 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 a lawyer, one will be provided free. State law says that no person may be presumed to be incompetent because he or she has been evaluated or treated for mental disorder or chronic alcoholism, regardless of whether such evaluation or treatment was voluntarily or involuntarily received. Welfare and Institutions Code Section 5157 c & d.

☒ **FIREARM PROHIBITION:** If this 5150 (72 hour) involuntary hold is because you are thought to be a risk to harm yourself or others, you are now prohibited by state law from possessing or purchasing a firearm for 5-years. You have the right to appeal this prohibition. Should you be placed on a 5250 (14 day) involuntary hold and this hold is upheld at a hearing, you will be subject to a lifetime firearm prohibition, which is not appealable. Welfare and Institutions Code Section 8103 AB1587

☒ **ADVANCE DIRECTIVES AND YOUR RIGHT TO MAKE DECISIONS ABOUT MEDICAL TREATMENT:**

☒ Yes, ☐ No. YOU HAVE RECEIVED THE INFORMATION ABOUT "Your Right to Make Decisions about Medical Treatment" (Reverse side of this page) For more information you may call Social Services at Ext. 2064

☐ Yes, ☒ No. DO YOU HAVE AN ADVANCE DIRECTIVE for Health Care? (i.e., a Durable Power of Attorney for Health Care, a Declaration, or a Living Will)

☐ Yes, ☒ No. DO YOU HAVE AN ADVANCE DIRECTIVE for Mental Health?

☐ Yes, ☒ No. HAS ABSMC RECEIVED A CURRENT COPY of your Advance Directive for Health Care for this admission? You understand it is your responsibility to present a current copy on each admission to the hospital.

☐ Yes, ☒ No. HAS ABSMC RECEIVED A CURRENT COPY of your Advance Directive for Mental Health for this admission? You understand it is your responsibility to present a current copy on each admission to the hospital.

☒ You have received COMPLAINT AND GRIEVANCE PROCEDURES FOR MENTAL HEALTH PATIENTS

☒ You have received a copy of the PATIENT RIGHTS HANDBOOK. Any patient who believes a right of his or hers has been abused, punitively withheld, or unreasonably denied may file a complaint with the Patient's Rights Advocacy Office by calling

1-800-734-2504

Good cause for incomplete advisement:

For the above reason, patient has not yet been given all Rights and Advisements; Another attempt will be made tomorrow. Signature/Title: Date/Time:

Patient given all the above Patients' Rights and Advisements by Signature/Title: Amy Date/Time: 8/9/16 2140

I have received all the above Rights and Advisements: Patient: Date/Time: 8/9/16 2140

60514 (03/13) v10 EPIC

200227 BH CONSENT

Sutter Health Alta Bates Summit Medical Center

ADVISEMENTS

COPIES: WHITE-MEDICAL RECORD YELLOW-PATIENT COPY

Ho, Vincent

MRN: 50553672 STANGER, MICHAEL TERENCE
11/6/1968 47 yrs STANGER, MICHAEL TERENCE
SEX: M Adult Mental Health
MEDS,LABS CSN: 820425781

Your Right to Make Decisions about Medical Treatment

Who decides about my treatment?
Your doctors will give you information and advice about treatment. You have the right to choose. You can say "yes" to treatments you want. You can say "no" to treatments you don't want — even if the treatment might keep you alive longer.

How do I know what I want? Your doctor must tell you about your medical condition and about what different treatments can do for you. Many treatments have "side effects." Your doctor must offer you information about any serious problems that medical treatment is likely to cause. Often, more than one treatment might help you — and people have different ideas about which is best. You doctor can tell you which treatments are available to you, but your doctor can't choose for you. That choice depends on what is important to you.

What if I'm too sick to decide? If you can't make treatment decisions, your doctor will ask your closest available relative or friend to help decide what is best for you. Most of the time that works. But sometimes everyone doesn't agree about what to do. That's why it is helpful if you say in advance what you want to happen if you can't speak for yourself. There are several kinds of "advance directives" that you can use to say what you want and who you want to speak for you. One kind of advance directive under California law lets you name someone to make health care decisions when you can't. This form is called a ***Durable Power of Attorney for Health Care***.

Who can fill out this form? You can if you are 18 years or older and of sound mind. You do not need a lawyer to fill it out.

Who can I name to make medical treatment decisions when I'm unable to do so?
You can choose an adult relative or friend you trust as your "agent" to speak for you when you're too sick to make your own decisions.

How does this person know what I would want?
After you choose someone, talk to that person about what you want. You can also write down in the ***Durable Power of Attorney for Health Care*** form when you would or wouldn't want medical treatment. Talk to your doctor about what you want and give your doctor a copy of the form. Give another copy to the person named as your agent. And take a copy with you when you go into a hospital or other treatment facility. Sometimes treatment decisions are hard to make and it truly helps your family and your doctors if they know what you want. The ***Durable Power of Attorney for Health Care*** form also gives them legal protection when they follow your wishes.

What if I don't have anybody to make decisions for me?
You can use another kind of advance directive to write down your wishes about treatment. This is often called a "living will" because it takes effect while you are still alive but have become unable to speak for yourself. The California Natural Death Act lets you sign a living will called a ***Declaration***. Anyone 18 years or older and of sound mind can sign one.
When you sign a ***Declaration*** it tells your doctors that you don't want any treatment that would only prolong your dying. All life-sustaining treatment would be stopped if you were terminally ill and your death was expected soon or if you were permanently unconscious. You would still receive treatment to keep you comfortable, however.
The doctors must follow your wishes about limiting treatment or turn your care over to another doctor who will. Your doctors are also legally protected when they follow your wishes.

Are there other living wills I can use?
Instead of using the ***Declaration*** in the Natural Death Act, you can use any of the available living will forms. You can use a ***Durable Power of Attorney for Health Care*** form without naming an agent. Or you can just write down your wishes on a piece of paper. Your doctors and family can use what you write in deciding about your treatment. But living wills that don't meet the requirements of the Natural Death Act don't give as much legal protection for your doctors if a disagreement arises about following your wishes.

What if I change my mind?
You can change or revoke any of these documents at any time as long as you can communicate your wishes.

Do I have to fill out one of these forms?
No, you don't have to fill out any of these forms if you don't want to. You can just talk with your doctors and ask them to write down what you've said in your medical chart. And you can talk with your family. But people will be more clear about your treatment wishes if you write them down. And your wishes are more likely to be followed if you write them down.

Will I still be treated if I don't fill out these forms?
Absolutely. You will still get medical treatment. We just want you to know that, if you become too sick to make decisions, someone else will have to make them for you. Remember that:
✓ A ***Durable Power of Attorney for Health Care*** lets you name someone to make treatment decisions for you. That person can make most medical decisions — not just those about life-sustaining treatment — when you can't speak for yourself. Besides naming an agent, you can also use the form to say when you would and wouldn't want particular kinds of treatment.
✓ If you don't have someone you want to name to make decisions when you can't, you can sign a ***Natural Death Act Declaration***. This ***Declaration*** says that you do not want life-prolonging treatment if you are terminally ill or permanently unconscious.
The California Consortium on Patient Self-Determination prepared the preceding text, which has been adopted by the California Department of Health Services to implement Public Law 101-508.

How can I get more information about advance directives?
1. Ask the admitting clerk or your nurse for an additional informative brochure called "Making an Advance Directive."
2. Contact your doctor or nurse or Social Services, 204-2064

All of us at Alta Bates Summit Medical Center want our patients to understand their rights to make medical treatment decisions. The Medical Center complies with California Laws and court decisions on advance directives. We do not condition the provision of care or otherwise discriminate against anyone based on whether or not you have executed an advance directive. We have formal policies to ensure that your wishes about treatment will be followed. We also have an ethics committee that can help if any questions arise about your treatment wishes. It is your responsibility to provide a copy of your advance directive to the hospital so that it can be kept with your records.

60514 (03/13) v10 EPIC

Give to Patient on Admission

BH Consent - Scan on 8/9/2016 by Monk, Diana M : Release of information (below)

Staff cannot give out any information about you or even acknowledge that you are here without your consent, unless someone is in danger of being hurt or killed, a child or elder is in danger of being abused, molested or abandoned, or we receive a court order.

PLEASE SIGN YOUR *INITIALS* WHERE YOU ARE GIVING YOUR CONSENT AND SIGN YOUR *FULL NAME* AT THE BOTTOM.

Who do you want to know that you are here? ☒ Patient will call. ☐ Staff has called. Name and phone:	Initials/Signature:
Staff may acknowledge I am here and give the patient phone number out if someone calls for me or comes to the door and asks for me. Staff will not call anyone to let them know you are here unless you ask them to.	Initials/Signature:

Staff may talk to the following people about my illness and my discharge plans:

Relationship	Name	Phone	Initials
Physician Psych	James Hinson	777-3847	
Therapist Case Manger	Al Booger	777 3820	
Spouse Emegency Contact	Katy Kaminski	816 - 6963	
Friend IHHS	Will Franklin	355-5016	
Cat Sitter	Gesine Lohr	205-9895	
Best Friend	Veronika Alexander	(401)481-8685	
Friend	David Van Ness	525-9659	
Friend	Denise Rovetti	(415)305-0789	
Priest	John's Milene Rawlinson	882-2367	
Parents	L.K (Nick)'s Susie Ho	(011)(852)9492-1713	
Sister	Penny Ho	(650)703-9549	
Professional Advisor	Dan Subia	(602)315-3594	
Boss	Al Tyner	(510)755-4334	

Date/Time:	Staff Signatures:	Patient or Guardian:
8/10/16 1715	Myra Romanenko	NA

80263 (04/13) v2 EPIC

200227 BH CONSENT

Sutter Health
Alta Bates Summit
Medical Center

BEHAVIORAL HEALTH SERVICES
RELEASE OF INFORMATION

Ho, Vincent

MRN: 50553672 CRUZ, JOHN MICHAEL DE VERA
11/6/1968 47 yrs STANGER, MICHAEL TERENCE
SEX: M Adult Mental Health 8/9/2016
MEDS,LABS CSN: 820425781

Staff cannot give out any information about you or even acknowledge that you are here without your consent, unless someone is in danger of being hurt or killed, a child or elder is in danger of being abused, molested or abandoned, or we receive a court order.

PLEASE SIGN YOUR *INITIALS* WHERE YOU ARE GIVING YOUR CONSENT AND SIGN YOUR *FULL NAME* AT THE BOTTOM.

Who do you want to know that you are here? ☒ Patient will call. ☐ Staff has called. Name and phone:	Initials/Signature: vh
Staff may acknowledge I am here and give the patient phone number out if someone calls for me or comes to the door and asks for me. Staff will not call anyone to let them know you are here unless you ask them to.	Initials/Signature: vh

Staff may talk to the following people about my illness and my discharge plans:

Relationship	Name	Phone	Initials
Physician	James Hinson MD	510 777-3847	vh
Therapist			
Spouse			
Friend			
Highland Pain Clinic	Amy Smith	510 437-8552 or 437-8377	
Case Manager	Al Brazer	510 777-3820	vh
Friend	Katy Kamiuski	510 816-6963	
In homehealth support	Will Franklin	510 355-5016	

Date/Time:	Staff Signatures:	Patient or Guardian:
8/9/16 2140	Amy Stinson	

80263 (04/13) v2 EPIC

200227 BH CONSENT

Sutter Health
Alta Bates Summit
Medical Center

BEHAVIORAL HEALTH SERVICES
RELEASE OF INFORMATION

Ho, Vincent
MRN: 50553672
11/6/1968 47 yrs
SEX: M
MEDS,LABS
STANGER, MICHAEL TERENCE
STANGER, MICHAEL TERENCE
Adult Mental Health
CSN: 820425781

Patient Valuables - Scan on 8/9/2016 by Monk, Diana M : Property list (below)

PROPERTY LIST

VALUABLES:

The hospital is not responsible for the loss of money, credit cards, jewelry, the keys to your car or home, or any other valuables you keep with you on the unit.

If you are unable to send these items home, they must be stored in the safe.

☑ YES ☐ NO
☐ YES ☐ NO

Valuables have been sent to SAFE
Valuables have been sent to HOME with:_____

☑ YES ☐ NO
☐ YES ☐ NO

Medications sent to Pharmacy:
Medications have been sent Home with:_____

KEEP AT BEDSIDE (at your own risk):

Describe (number, color, brand, etc.)

- ✓ glasses
- ____ contact lenses
- ____ hearing aid
- ____ prosthesis
- ____ dentures
- 2 shirts
- 1 pants Black
- ____ shoes w/o shoe string
- ____ dresses
- ____ jacket/coat
- Money: $_____
- ____ phone card
- ____ watch
- ____ rings
- 1 Socks
- ____
- ____
- ____
- ____ battery clock
- ____ battery radio, no wires

PATIENT SIGNATURE: _____ DATE: 8/9/16 TIME: 22:10

KEPT LOCKED IN "CUBICLES"

May be used with staff supervision:

- ____ safety razor
- ____ battery electric razor
- ____ glass toiletries
- ____ shoes with shoe strings
- ____
- OTHER:_____

STORED (LOCKED) ON UNIT:

*These may **NOT** be used in the hospital.*

***Please send these items home if possible.** The hospital **cannot guarantee** the safety of these items even though they have been stored on the unit. For reasons of confidentiality, on recording devices are permitted.*

- ____ elec. appliances
- ____ tape recorder
- ____ computer
- 2 cell phone Samsung (Valuable Envelope)
- ____ pager
- ____ pocket knife
- ____ suit case
- ____ backpack
- 1 walking cane
- ✓ belts
- ____ clothes with cords
- ____ hair dryer, curling iron
- ____ perfumes
- Shoestlaces
- green/yellow/Blue Bag
- Bible
- ~~Red Checkers~~
- ~~Keys~~

METHOD OF SEARCH:

☒ CLOTHING Searched by: _____ PN 2200 Date: 8/9/16
(Staff signature and title) (Time)

☒ PATIENT SEARCHED Searched by: _____ RN 2135 Date: 8-9-16
(Staff signature and title) (Time)

☒ METAL DETECTOR (WAND) Searched by: _____ RN 2135 Date 8-9-16
(Staff signature and title) (Time)

80265 (03/13) v1 EPIC

200092 PATIENT VALUABLES

Sutter Health
Alta Bates Summit
Medical Center

PROPERTY LIST

Ho, Vincent
MRN: 50553672
11/6/1968 47 yrs
SEX: M
MEDS,LABS
STANGER, MICHAEL TERENCE
STANGER, MICHAEL TERENCE
Adult Mental Health
CSN: 820425781

Patient Valuables - Scan on 8/9/2016 by Monk, Diana M : Patient valuables envelope #071698 (below)

Sutter Health
Alta Bates Summit
Medical Center

PATIENT VALUABLES ENVELOPE

☐ Alta Bates Campus ☐ Summit Campus ☒ Herrick Campus

Addressograph or Write-in

Ho, Vincent

MRN: 50553672 STANGER, MICHAEL TERENCE
11/6/1968 47 yrs STANGER, MICHAEL TERENCE
SEX: M Adult Mental Health
MEDS,LABS CSN: 820425781

No. 071698

CONTENTS OF ENVELOPE

TAKE VALUABLES OUT OF WALLETS DEPOSITED WITH HOSPITAL

NEGOTIABLES:	JEWELRY (DESCRIPTION)
☐ COINS	☐ RINGS
☐ BILLS	☒ WATCH
☒ TOTAL CASH $43.00 $44.12	☐ NECKLACE
☐ CHECKS $	☐ BRACELET
☒ CHECKBOOK	☐ EARRINGS
☒ CREDIT CARDS (1) PayPal MasterCard (2) Chase Debit (3) Manhattan Visa (4) BOA visa	☐ OTHER JEWELRY
☒ keys	☒ phone (1) Black Samsung (2) white/black Samsung
☒ Black wallet	☒ white charger cord
☒ Medicare card; Benefits card ID	☒ ~~Black wallet~~ empty
☐	☐
☐	☐

THIS HOSPITAL MAINTAINS A SAFE FOR THE STORAGE OF MONEY AND VALUABLES DURING YOUR STAY IN THE HOSPITAL BUT ASSUMES NO LIABILITY FOR THE LOSS OF, OR DAMAGE TO, ANY MONEY, JEWELRY, DOCUMENTS FURS, OR OTHER ITEMS OF VALUE NOT DEPOSITED IN THAT SAFE.

I HAVE CHECKED THE ABOVE AND ACKNOWLEDGE THE LISTS TO BE CORRECT. I, THE PATIENT, OR THE RESPONSIBLE PARTY ASSUME FULL RESPONSIBILITY FOR THOSE ITEMS RETAINED IN MY POSSESSION DURING MY HOSPITALIZATION OR BROUGHT TO PATIENT AFTER SIGNATURES HAVE BEEN OBTAINED.

SIGNATURE	DATE	TIME		SIGNATURE NOT OBTAINED
X	8/9/16	2210	☒ PATIENT ☐ RESPONSIBLE PARTY	☐ PATIENT COMATOSE ☐ DOA

	DATE	TIME	RECEIVED BY	WITNESSED BY *
ADMITTING DEPT. USE ▶				
EMERGENCY ROOM USE ▶	DATE	TIME	PROPERTY COLLECTED BY	WITNESSED BY *
NURSING UNIT USE ▶	DATE 8/9/16	TIME 2200	PROPERTY COLLECTED BY	WITNESSED BY *

* Obtain a witness signature if Patient is unable to sign.

2000092 PATIENT VALUABLES

CHART

Patient Valuables - Scan on 8/9/2016 by Monk, Diana M : Patient valuables envelope #070227 (below)

Sutter Health
Alta Bates Summit
Medical Center

PATIENT VALUABLES ENVELOPE

☐ Alta Bates Campus ☐ Summit Campus ☑ Herrick Campus

Addressograph: Ho, Vincent
MRN: 50553672 CRUZ, JOHN MICHAEL DE VERA
11/6/1968 47 yrs MICHEL, CHRISTOPHER S
SEX: M Adult Mental Health 8/9/2016
MEDS,LABS CSN: 820425781

Admission Date: 8/9/16

No. 070227

CONTENTS OF ENVELOPE

TAKE VALUABLES OUT OF WALLETS DEPOSITED WITH HOSPITAL

NEGOTIABLES:	JEWELRY (DESCRIPTION)
☐ COINS	☐ RINGS
☑ BILLS $44.02	☐ WATCH
☐ TOTAL CASH	☐ NECKLACE
☐ CHECKS $	☐ BRACELET
☐ CHECKBOOK	☐ EARRINGS
☐ CREDIT CARDS Paypal, Master card	☐ OTHER JEWELRY
☐ Chase USA, Mainstreet [illegible]	☑ white charger cord
☑ 4 keys	☑ White Metal wallet
☑ Black wallet	☐
☐ Medicare card, Benefit card	☐
☐ (2) phone Black Samsung / white and black Samsung	☐

THIS HOSPITAL MAINTAINS A SAFE FOR THE STORAGE OF MONEY AND VALUABLES DURING YOUR STAY IN THE HOSPITAL BUT ASSUMES NO LIABILITY FOR THE LOSS OF, OR DAMAGE TO, ANY MONEY, JEWELRY, DOCUMENTS FURS, OR OTHER ITEMS OF VALUE NOT DEPOSITED IN THAT SAFE.

I HAVE CHECKED THE ABOVE AND ACKNOWLEDGE THE LISTS TO BE CORRECT. I, THE PATIENT, OR THE RESPONSIBLE PARTY ASSUME FULL RESPONSIBILITY FOR THOSE ITEMS RETAINED IN MY POSSESSION DURING MY HOSPITALIZATION OR BROUGHT TO PATIENT AFTER SIGNATURES HAVE BEEN OBTAINED.

SIGNATURE	DATE	TIME		SIGNATURE NOT OBTAINED
X			☐ PATIENT ☐ RESPONSIBLE PARTY	☐ PATIENT COMATOSE ☐ DOA

	DATE	TIME		WITNESSED BY *
ADMITTING DEPT. USE			RECEIVED BY	
EMERGENCY ROOM USE			PROPERTY COLLECTED BY	
NURSING UNIT USE	8/10/16	0311	PROPERTY COLLECTED BY: [signature]	Bill Robertson RN

* Obtain a witness signature if Patient is unable to sign.

200092 PATIENT VALUABLES

CHART

Medication - Scan on 8/9/2016 by Monk, Diana M : Patient's own medications stored in pharmacy (below)

Sutter Health
Alta Bates Summit
Medical Center

Ho, Vincent
MRN: 50553672
11/6/1968 47 yrs
SEX: M
MEDS,LABS
STANGER, MICHAEL TERENCE
STANGER, MICHAEL TERENCE
Adult Mental Health
CSN: 820425781

PATIENT'S OWN MEDICATIONS STORED IN PHARMACY

(Original form goes to pharmacy with meds; copy stays with patient belongings)

Date Received in Pharmacy:_____

Patient (print name/signature):_____ verified medication count

Patient unable to participate in medication count due to:_____

Counted and Delivered by RN (print name/signature): Amy Silver / [illegible]

Count Verified and Received by Pharmacist (print name/signature)_____

Patient Pharmacy (from med bottle(s)):_____ Phone #:_____

Medication / Strength	Quantity (approx) *RN to count exact quantity for controlled substances*	Pharmacy Count Verification (Controlled Substances only) Print Name	Signature
Paroxetine Hcl 10mg	9 pills		
Hydrocodone 10-325 mg	6 Pills	Amy Silver	[signature]
Diazepam 2 mg	#31 light blue/white	1/2 dark blue Amy Silver	[signature]
Butrans patch 10mcg	1 patch	Amy Silver	[signature]
Zyprexa 5 mg	2 packets (5mg)		

****Any discrepancy between RN and Pharmacy count for controlled substances must be resolved immediately****

Medications Picked up by:

(Pharmacist and Nurse to verify medications at the time of pick up - approx quantity for non-controlled; exact quantity for controlled substances)

Name/Title:_____ Date_____

Relationship to Patient_____ Pharmacist signature_____

Please Note: All medications not picked up in 90 days will be destroyed in compliance with State and Federal Regulations and OSHA requirements.

Date Destroyed_____

First Witness_____ Second Witness_____

This form is to be stored with the patient's medications until they are picked up or destroyed. Then it is to be placed in the Patient's Own Medications Log/File alphabetically according to last name. Records are kept for 3 years.

200073 MEDICATIONS

80326 v4 EPIC
(03/14)

COPIES: WHITE-PHARMACY YELLOW-MEDICAL RECORD PINK-RECEIPT CLAIM (STORE WITH PATIENT BELONGINGS)

BH Documentation - Scan on 8/9/2016 by Monk, Diana M : Grievances (below)

GRIEVANCES

IF YOU HAVE A COMPLAINT, YOU CAN CONTACT:

Your Service Provider:
If you are having trouble getting your needs met or you are concerned about the care you are receiving, you can speak directly to your doctor, your social worker, and the nurse assigned to you. If they are unable to satisfy you, ask for the Unit Manager or Medical Director for your unit. You may also call the Patient Relations Representative at Alta Bates Medical Center at (510) 204-4689.

The Patients' Rights Advocate:
If your complaint has to do with a denial of your patients' rights or if you need help to determine whether it is a patients' rights issue, call the Patients' Rights Advocate at (800) 734-2504. This is a 24-hour toll-free number with an answering machine after office hours.

Grievance Procedures:
Each health care provider has a different process for resolving disputes and misunderstandings. They all have both an informal verbal complaint procedure and a formal written grievance procedure. At any time during this complaint/grievance process, you have the right to authorize another person to act on your behalf. After your informal oral complaint or formal written complaint or grievance has been received, the people who receive it will try to resolve it, and you will be notified promptly of the results. All complaints are kept confidential within your health care provider, and consumers are not subject to discrimination or any other penalty for filing an appeal, complaint, or grievance.

Kaiser Insurance:
For information about your health plan benefits call (800) 464-4000 or the number on your Kaiser Health Plan card. You may also call their Customer Service Office in Oakland (800) 464-4000.

Medi-Care Beneficiaries:
You may call the Medi-Care Rights Center at (888) 466-9050 or the Insurance Counseling and Assistance Program at (800) 434-0222. If you have received a NOTICE OF NON-COVERAGE from the hospital and wish a review by a Peer Review Organization, you must call before noon on the next working day (800) 841-1602. If you have not already received the information Your Rights While You Are A Medi-Care Patient, it is available in the Admissions office.

Medi-Cal Beneficiaries:
Each county has a Mental Health Plan that contracts with hospitals to provide acute inpatient mental health services. In most cases, the Mental Health Plan will be the county mental health department. The Alameda County Behavioral Health Care Services Mental Health Plan (ACBHC-MHP) is located at 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606. The Alameda County Consumer Assistance Desk is (800) 779-0787.

Your pre-planned admission to a hospital for psychiatric services must be approved in advance by the Mental Health Plan. Generally, your admission must be to a contract hospital of your Mental Health Plan. However, your Plan can authorize admission to a non-contract hospital if specialized services are needed.

If you are hospitalized on an emergency basis, advanced approval is not required, and you may be admitted to any hospital which participates in the Medi-Cal program. However, when your condition allows, the Mental Health Plan may seek to transfer you to a hospital under contract to them. You still have the right to choose your own doctor.

The County Consumer Assistance Desk:
If you prefer or if you are still not satisfied, you can make an informal verbal complaint by calling the County Consumer Assistance Desk at (800) 779-0787 or fax to (510) 567-8137. The Consumer Assistance Desk can give you a copy of the Consumer Complaint Form and can help you fill it out. You can also submit a written formal grievance at anytime to the Consumer Assistance Desk. If the grievance is not resolved to your satisfaction, the Consumer Assistance Desk is also available to assist you in filing an appeal to the Grievance/Appeal Committee at 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606.

The State Fair Hearing:
If you are a Medi-Cal beneficiary and receive a Notice of Action from the ACBHC-MHP that you are being denied services or that services you have been receiving are to be reduced or terminated, you have the right to a State Fair Hearing. In most cases, you must request a hearing *within 10 days of receiving a notice of reduction*, denial or termination of services to continue your inpatient hospital stay until your hearing or until your doctor decides your stay is no longer necessary. To request a hearing, complete the Request for State Fair Hearing form, or call the Public Inquiry and Response Unit at (800) 952-5254. You may also send your hearing request to Administrative Adjudications Division, 744 P Street, Mail Station 19-37, Sacramento, CA 95814.

Acknowledgment of Receipt: *My signature only acknowledges that I have received a copy of this page.*

Staff witnessing patient's receipt of this page: Patient or person acting on patient's behalf: Date:

X Amy Stiver 8/9/16 2140

80264 (03/12) v3 EPIC

200014 BH DOCUMENTATION

Sutter Health
Alta Bates Summit
Medical Center

Ho, Vincent

MRN: 50553672 STANGER, MICHAEL TERENCE
11/6/1968 47 yrs STANGER, MICHAEL TERENCE
SEX: M Adult Mental Health
MEDS,LABS CSN: 820425781

GRIEVANCES

COMPLAINT AND GRIEVANCE PROCEDURES FOR MENTAL HEALTH PATIENTS

CONCERNS	EXAMPLES	WHERE TO TAKE YOUR COMPLAINT			
You are unsatisfied and want to complain to your service provider.	You spoke to your doctor, your social worker, and your nurse and you are still not satisfied.	Ask the nurse to call the Unit Manager or Medical Director for your unit. You may also call the Patient Relations Representative at Alta Bates Medical Center (510) 204-1515			
Patient's Rights Denial You feel that one (or more) of your rights as a mental health patient is being denied.	You were put in restraints and you do not think the facility had good cause to do this. You were hospitalized against your will and you do not understand why or what your options are.	Call the Patients' Rights Advocate at (800) 734-2504. This is a 24-hour number with an answering machine after hours. Collect calls are accepted. You should have received on admission a Patient Rights Handbook and, if you are being held involuntarily, an explanation of your hold. Please ask the nurse if you do not have these. CDRP: Patients who are part of the Chemical Dependency Recovery Program (who were NOT admitted with a psychiatric diagnosis) should register complaints with the Department of Licensing and Certification, Department of Health Services, 2151 Berkeley Way, Berkeley CA (510) 540-2417.			
Unsatisfactory Service You are not getting the kind of service you want, or you are getting poor quality service, or you are being treated unfairly.	You feel you need therapy, but you are only getting medication. Your out-patient appointments or referrals are not adequate or are not at good times for you.	**MEDI-CAL BENEFICIARIES** Call the Consumer Assistance Desk at (888) 779-0787. Your complaint can be informal or you can make a formal, written grievance. Complaint forms and envelopes should be available on your unit - if you do not see them, ask for them.	**MEDI-CARE** You may call the Medi-Care Rights Center (888) 466-9050 or the Insurance Counseling and Assistance Program (800) 434-0222	**KAISER** Call the Customer Service Office (800) 464-4000, or write Customer Service, 280 West MacArthur Boulevard 94611	**OTHER** Ask for the Customer Service Office at your insurance provider. There is usually a customer service number to call on your health card.
Denial of Inpatient Service You are told that you are being denied a service, or that a service that you are currently receiving is being terminated or reduced.	*You go to a hospital and ask to be admitted for inpatient services; and the hospital refuses to admit you.* Your doctor requests that you continue to be hospitalized; but your insurance (or County Medi-Cal authorization office) denies this request.	You can request a State Fair Hearing. This must be done in a timely fashion, and within 10 days if you are to continue receiving a service pending the hearing. To request a hearing, complete the Request for a State Hearing form or call the Public Inquiry and Response Unit at (800) 952-5253	Before noon on the next working day, request a Peer Review Organization review by calling (800) 841-1602 Detailed instructions for grievance procedures are available at the Admissions Office.	For information about your health plan benefits, call (800) 464-4000. You can request a "Demand for Arbitration" form from Kaiser Regional Legal Department, PO Box 12916, Oakland, CA 94604	Ask for the grievance procedure to be faxed to you at the hospital. It is important that you make your complaint promptly. If in doubt, the Patient Rights Advocate can help you decide what action to take.
Denial of Outpatient (Non-Hospital) Services	Your insurance provider (or ACBHCS ACCESS for Medi-Cal recipients) denies admission to non-hospital services.	You can appeal this denial with the Director of ACCESS (Level I appeal) and if there is no resolution, a second appeal (Level II) can be presented to the Adult NON-Hospital Services Appeal Committee.			

BH Documentation - Scan on 8/9/2016 by Monk, Diana M : Philosophy regarding aggression (below)

PATIENT INFORMATION AND ADVISEMENTS

PHILOSOPHY REGARDING AGGRESSION

It is the policy of ABSMC Behavioral Health Services to provide a safe, compassionate treatment environment where patients begin to understand their illnesses and start the recovery process.

In order to do this everyone must work to handle stresses and crisis without threatening or injuring others and without destroying the property of the hospital or other persons. It is the policy of this facility that when a person is stressed or angry that they should take time to him/herself (time-out) until they are able to calmly discuss the problem with staff and work out a solution *without* being violent.

Patients who become agitated and attempt to harm others or destroy hospital property will be encouraged to calm down. If that fails, such persons will be subject to removal to a safe seclusion room, or, if violent, may be restrained, if such action is determined to be necessary by hospital staff.

Any patient who assaults others (patient or staff), or who destroys property, may be subject to legal prosecution to the full extent of the law, if that is felt appropriate for their behavior and treatment, or for their own safety, or the safety of others.

THE PATIENT/FAMILY MEMBER IDENTIFIES THE FOLLOWING ALTERNATIVES TO SECLUSION AND RESTRAINT:

- ☒ 1:1 Intervention
- ☒ Activities: games, music
- ☒ Time alone/time out
- ☒ Medication
- ☐ Patient declines to state
- Other: _____

I have read this statement or I have had this statement read to me. I understand it and will follow the expectations for my treatment, my safety and the safety of others.

Give to Patient on Admission

Patient: _____ *Date* 8/9/16 *Time* 2130

Staff Signature: _____ RN *Title:* RN *Date* 8/9/16 *Time* 2130

60516 (02/13) v11 EPIC

200014 BH DOCUMENTATION

Alta Bates Summit Medical Center

BEHAVIORAL HEALTH SERVICES
PHILOSOPHY REGARDING AGGRESSION

page 1 of 1

COPIES: WHITE-PATIENT YELLOW-MEDICAL RECORD

Ho, Vincent

MRN: 50553672 STANGER, MICHAEL TERENCE
11/6/1968 47 yrs STANGER, MICHAEL TERENCE
SEX: M Adult Mental Health
MEDS,LABS CSN: 820425781

BH Documentation - Scan on 8/9/2016 by Monk, Diana M : 4East Guidelines (below)

4 EAST B UNIT GUIDELINES / RULES FOR SAFETY:

- NO PHYSICAL OR SEXUAL CONTACT- No touching, kissing, sexual acts or other inappropriate behavior
- APPROPRIATE CLOTHING WORN AT ALL TIMES WHILE IN PUBLIC PLACES: no bare midriffs, shirts worn at all times, chest covered
- THERE IS NO SMOKING ANYWHERE IN THE HOSPITAL- please do not have visitors bring in cigarettes, matches, lighters
- NO CONTRABAND: drugs, alcohol, caffeine, cigarettes, medications not prescribed by your 4 North Physician
- NO GLASS, SHARP OBJECTS, STRINGS, soda cans, razors, scissors, etc
- YOU MAY NOT GO INTO ANOTHER PATIENT'S ROOM
- YOU MUST KEEP THE DOOR TO YOUR ROOM OPEN AT ALL TIMES (EXCEPT NIGHTS) UNLESS YOU HAVE PERMISSION FROM STAFF
- For the health & safety of all patients, there is NO FOOD ALLOWED IN PATIENT ROOMS
- PLEASE WEAR SHOES OR COVER FEET AT ALL TIMES
- ELECTRONIC DEVICES are not allowed on the unit.

I received a copy of these rules:

Patient Signature: _____ 8/9/16

Ho, Vincent
MRN: 50553672 STANGER, MICHAEL TERENCE
11/6/1968 47 yrs STANGER, MICHAEL TERENCE
SEX: M Adult Mental Health
MEDS LABS CSN: 820425781

Consent Form Documentation - Scan on 8/9/2016 by Monk, Diana M : Consent for voluntary admission (below)

The therapeutic treatment approach is that of team collaboration. Therapeutic issues are discussed between members of the treatment team. As a client, I am also a vital member of my treatment team and my active input about goals and discharge planning is essential. I understand that personal information which I disclose to one staff member may be shared with the other members of the treatment team in order to best address my goals and therapeutic issues. I understand that all personal information disclosed by me to the treatment team will remain confidential within the Alta Bates Summit Medical Center program and will not be shared with any other parties, unless the following exceptions apply.

1. I have signed a consent form to release information about my personal health status to another treating health professional or facility, for the purposes of coordinating my treatment in this program.
2. Symptoms are seen which indicate a risk of my being suicidal or dangerous to myself.
3. Symptoms are seen which indicate a risk of my being dangerous to other people.
4. Symptoms are seen which indicate a risk of my being gravely disabled due to a mental condition and unable to reasonably care for myself independently.
5. Information is disclosed whereby there is reasonable suspicion to believe that physical or sexual abuse or severe neglect endangering a child has occurred, perpetrated by another identifiable person or myself. This information shall be reported to the Department of Child Protective Services.
6. Information is disclosed whereby there is reasonable suspicion to believe that physical or adult abuse or severe neglect endangering a senior citizen or dependant adult has occurred, perpetrated by another identifiable person or myself. This may include situations of abuse where I am the victim. This information shall be reported to the Department of Adult Protective Services.

I have read and understand this agreement. *The RISKS AND BENEFITS REGARDING VOLUNTARY ADMISSION TO THIS PROGRAM HAVE BEEN EXPLAINED TO ME BY:* _____.

_____	8/10/16	_____	8/10/16
Patient (Guardian) Signature	Date	Witness Signature	Date

60711 (01/13) v5 EPIC

200025 CONSENT FORM DOCUMENTATION

Alta Bates Summit Medical Center
Alta Bates Campus

ALTA BATES SUMMIT MEDICAL CENTER
INPATIENT ADULT MENTAL HEALTH SERVICES
CONSENT FOR VOLUNTARY ADMISSION page 1 of 2

COPIES: WHITE-MEDICAL RECORD YELLOW-PATIENT COPY

Ho, Vincent

MRN: 50553672 CRUZ, JOHN MICHAEL DE VERA
11/6/1968 47 yrs MICHEL, CHRISTOPHER S
SEX: M Adult Mental Health8/9/2016
MEDS,LABS CSN: 820425781

ALTA BATES SUMMIT MEDICAL CENTER
INPATIENT ADULT MENTAL HEALTH SERVICES
CONSENT FOR VOLUNTARY ADMISSION

I hereby request admission to the Inpatient Adult Mental Health Services, Alta Bates Summit Medical Center, Herrick Campus. This includes the Adult Intensive Unit, the Dual Diagnosis Unit and the Gero-psychiatry unit. I consent to the care and treatment as ordered by the Physicians assigned to my care and delivered by the Mental Health Services staff.

Treatment for psychiatric illnesses often results in a number of benefits, including (but not limited to) decrease in your specific illness symptoms, decrease in suicidal thoughts, urges and actions, abstinence from drugs and/or alcohol, improved interpersonal relationships, improved mood symptoms, improved daily functioning and resolution of the specific concerns that led to the need to seek hospitalization. Other benefits may include increased understanding of your illness that prompted you to need hospitalization and/or use drugs or alcohol and improved ability to cope with symptoms. I understand that working toward these benefits requires effort on my part, both during the time I'm in the hospital but also in the months following my discharge, as I participate in my discharge plan, take my medications and work with my out-patient providers. I understand that I will receive the most benefits from being in the hospital if I am actively involved, honest, and open in order to make changes to thoughts, feelings, and/or behavior.

I also understand that treatment may also involve risks. Hospitalization may involve remembering or talking about unpleasant behaviors, events, feelings, or thoughts which may result in experiencing considerable discomfort or strong feelings. I may be challenged to examine assumptions or perceptions or be given a different way of looking at, thinking about, and/or handling certain situations and feelings, particularly ones that led to my increased illness symptoms, relationship problems, or alcohol and/or drug abuse. Attempting to resolve issues that brought me to treatment in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Participation in the treatment program may result in decisions about housing or relationships. Sometimes a decision that is positive for one family member is viewed differently or negatively by another family member, which may lead to increased conflict. Change will sometimes be experienced as easy and rapid, but more often it may be slow or even frustrating.

Although there is no guarantee that inpatient treatment at ABSMC will yield positive or intended results, I understand that an important variable in my recovery is my level of motivation and willingness to follow the recommendations my treatment team. Factors that correlate positively with improved levels of functioning after hospitalization includes: adherence to recommendations for therapy and/or the medication regime as prescribed by my physician(s) and active involvement with my outpatient support team.

Conditions of Admission (COA) - Scan on 8/9/2016 by Monk, Diana M : COA (below)

Alta Bates Summit Medical Center
A Sutter Health Affiliate

Patient Name: Ho, Vincent
Date Of Birth: 11/6/1968
MR# 50553672
CSN: 820425781

CONDITIONS OF ADMISSION AND/OR REGISTRATION

Please review these Conditions of Admission/Registration carefully. This is a legal agreement that affects your rights and provides important information about Alta Bates Summit Medical Center (Hereafter "Hospital").

CONSENT TO TREATMENT: I consent to the performance of all routine hospital and medical care and treatment including, but not limited to, emergency treatment or procedures, laboratory and radiological tests and procedures, supportive and rehabilitative therapies, medication administration and/or other hospital services that may be provided or performed under the general and special instructions of my physician, surgeon and/or other authorized healthcare provider(s). I understand that my care and treatment may involve the taking of photographs using various imaging technologies to assist in my diagnosis or treatment, or as necessary for the hospital's operations, including healthcare quality and patient safety programs.

NOTICE OF CLINICAL TRAINING: I understand that the Hospital may participate in advanced teaching programs through which physician residents, fellows, medical students, student nurses, and/or students in other health care fields receive in-hospital training and experience as part of their education. Whenever a participant in any of these programs takes part in my/the patient's care, he/she will do so only under the direct supervision of his/her assigned faculty or other licensed clinical professional. Physician residents may assist in surgery only under the immediate supervision of a staff physician.

NOTICE OF ELECTRONIC INTENSIVE CARE UNIT (EICU): The Hospital may utilize certain electronic technologies to communicate between health care providers and monitor patients receiving care in the Intensive Care Unit.

LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS: I understand that all physicians providing health care services to me/the patient, including but not limited to, radiologists, pathologists, anesthesiologists, hospitalists, surgeons, emergency physicians and on-call specialists are independent contractors and are not employees or agents of the Hospital. I understand that I am/the patient is under the care and supervision of my/the patient's attending physician, and it is the responsibility of hospital staff to carry out his/her instructions. I understand that it is the responsibility of my/the patient's physician, surgeon or other authorized healthcare provider to obtain my informed consent for surgical or complex medical treatment, special diagnostic or therapeutic procedures, investigational treatment or procedures, and/or other specialized hospital services.

PATIENT RIGHTS & RESPONSIBILITIES: The Hospital is committed to treating every patient with respect, dignity, and concern. We consider you a partner in your hospital care. When you are well-informed, participate in treatment decisions, and communicate openly with your doctor

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and other health care professionals, you help to make your health care as effective as possible. Please review the Patient's Rights & Responsibilities handout that has been prepared by the Hospital. It contains important information about your rights.

PATIENT'S PERSONAL PROPERTY: I understand that I should not keep valuables in my room and that I should either send them home if possible or ask that they be placed in the Hospital's fireproof safe. The Hospital will not be responsible for, or liable to me for the loss of, or damage to, any money, jewelry, documents, or any other articles of unusual value and small size, unless they have been placed in the Hospital's safe at my request. The Hospital shall also not be responsible for or liable to me for the loss or damage of any other personal property, such as dentures, hearing aids, glasses, etc., unless deposited with the Hospital for safekeeping. I understand that the liability of the Hospital for loss of any personal property that is deposited with it for safekeeping is limited by California law to five hundred dollars ($500) unless I obtain a written receipt for a greater amount from the Hospital.

DIRECTORY INFORMATION: I understand that unless I object, information such as my name, room, facility location, general condition (fair, critical, stable, etc.) and religious affiliation may be disclosed to individuals who visit or call to inquire about my stay.

Object to Directory: Patient/Representative Initials_____

MATERNITY PATIENTS ONLY: If I deliver an infant(s) while a patient in this Hospital, I understand that these same Conditions of Admissions apply to the infant(s).

I have read the foregoing and I consent to treatment as described in the above Conditions of Admission/Registration.

8/10/16 1650 X _____

Date Time Signature (Patient/Representative)

If signed by other than patient, print name and relationship:

_____ _____

Name (Please print) Relationship

Witnesses (required only for telephone consent, physical inability to sign, or signature by mark):

_____ _____ _____ _____

Date Time Witness name (please print) Witness signature

_____ _____ _____ _____

Date Time Witness name (please print) Witness signature

If an interpreter provided assistance with this form, please print name and sign below:

_____ _____

Name (please print) Signature

(00179324-9) v.1

Alta Bates Summit Medical Center
A Sutter Health Affiliate

Patient Name: Ho, Vincent
Date Of Birth: 11/6/1968
MR# 50553672
CSN: 820425781

FINANCIAL AGREEMENT

Please review this Financial Agreement carefully. This is a legal agreement that affects your rights. The Hospital provides advice and counseling for patients who request assistance in understanding their health care coverage and financial obligations for hospital services, including copayments and/or coinsurance, government health care program eligibility, charity care, and uninsured and prompt payment discount and installment programs. If you have questions regarding your financial obligation for hospital services, please request an appointment with a Patient Financial Services Counselor through the Hospital's admitting office.

HOSPITAL CHARGES: The Hospital's charges for care and services are calculated in accordance with its Charge Description Master ("CDM") in effect at the time services are provided. If you would like to review the CDM charges, please request an appointment with a Patient Financial Services Counselor. You can also view the Hospital's CDM on line at: www.oshpd.ca.gov

PHYSICIAN FEES: I understand that all physicians furnishing health care services to me, including but not limited to surgeons, radiologists, pathologists, anesthesiologists, hospitalists, emergency room physicians and on call specialists, are independent contractors and are not employees or agents of the Hospital, and they will bill me separately for their services. I also understand that the physician(s) who provide services to me at the Hospital may not contract with my health plan and it is not the Hospital's responsibility to determine if they do, and if I need that information I can obtain it from the physician or my health plan. I authorize payment of insurance benefits otherwise payable to me under any policy, plan or program directly to the Hospital based physicians for any health care services provided by them. If I have questions about which services are physician services and which are Hospital services, I can make an appointment to discuss my questions with a Patient Financial Services Counselor.

SELF PAY: I agree to pay all of the individual charges calculated in accordance with the Hospital's Charge Description Master (CDM), for the services and items provided to me, less the Hospital's uninsured discount and, if applicable, a prompt pay discount, unless I qualify for charity care under the Hospital's Financial Assistance Policy. I understand that the individual charges for the services and items provided by the Hospital are reflected in the Hospital's current CDM, which is available for my review in the Hospital's business office. These charges are subject to change from time to time. I understand that the Hospital maintains a Financial Assistance policy and that, depending on my financial condition, the cost of my hospital care may be reduced or even eliminated under this policy. I also understand that Patient Financial Services Counselors are available to: help me understand whether I qualify for government health care programs, charity care, and uninsured and prompt pay discounts; answer any questions I may have about this financial agreement; estimate my financial responsibility for the Hospital's services; and establish a reasonable payment plan should I desire one. I understand that, if permitted by law, delinquent accounts shall bear interest at the legal rate.

MANAGED CARE (HMO) AND PREFERRED PROVIDER ORGANIZATION (PPO) HEALTH PLANS: The Hospital maintains a list of health plans with which it contracts. A list of such plans is available upon request from a Patient Financial Services Counselor.

- If the Hospital currently has a contract with my HMO or PPO health plan, I understand that I am responsible to pay directly to the Hospital any deductible, co-payment or cost share as determined by my health plan policy, as well as all charges for services and items that are not covered by my health plan policy terms. I understand that I may be eligible for a discount for services and items that are not covered by my health plan policy terms under the Hospital's Financial Assistance policy. Nothing in this agreement shall preclude the Hospital from seeking reimbursement from other responsible third parties--including, but not limited to, health plans, auto and liability insurers, third party administrators, or government healthcare programs--for any amounts that may be due from them up to the total of all of the Hospital's charges for the services and items provided to me calculated in accordance with the Hospital's CDM.

- If the Hospital does not have a contract with my HMO or PPO health plan, I agree to pay all of the Hospital's charges calculated in accordance with the hospital's CDM, for the services and items provided to me without reduction or discount, unless the services and items provided are not covered by my health plan, in which case I may be eligible for a discount under the Hospital's Financial Assistance policy. As a courtesy, the Hospital will first bill my health plan. If the health plan does not pay all of the Hospital's charges without reduction or discount, I agree to pay the unpaid balance (except for any unpaid balances owed for emergency services covered by my health plan). I agree to irrevocably assign my rights against the health plan to the Hospital if requested, and I agree to cooperate with the Hospital in its efforts to collect from my health plan. I understand that, if permitted by law, delinquent accounts shall bear interest at the legal rate.

INDEMNITY AND OTHER INSURANCE: I direct my insurance to pay directly to the Hospital all insurance benefits otherwise payable to me for the services and items provided to me, without reduction or discount. If my insurance does not pay all of the Hospital's charges calculated in accordance with the Hospital's CDM, for the services and items provided to me, I agree to pay the unpaid balance. If my insurance fails to pay any amount, I understand that I may be required to pay the bill in full. I understand that if permitted by law, delinquent accounts shall bear interest at the legal rate.

MEDICARE/MEDICAID/MEDI-CAL: The Hospital is a Medicare and Medi-Cal provider. I understand that I am responsible to pay directly to the Hospital any cost share or co-payment due from me under these programs, as well as any charges for treatment or services not covered by these programs that I have requested and agreed, in advance, to be provided.

BENEFITS REVIEW: The Hospital provides advice and counseling for patients who request assistance in understanding insurance, government healthcare eligibility, charity care, uninsured and prompt payment discounts, and installment programs. Please request an appointment with a Patient

Alta Bates Summit Medical Center
A Sutter Health Affiliate

Patient Name: Ho, Vincent
Date Of Birth: 11/6/1968
MR# 50553672
CSN: 820425781

Financial Services Counselor if you need assistance in understanding your financial obligations for hospital services.

NOTICE THAT THE HOSPITAL VERIFIES FINANCIAL INFORMATION: The Hospital may use outside agencies that verify the information I have provided, including my income and credit information. The Hospital uses this information to assist it with identifying potential sources of payment for my healthcare services, obtaining payment for healthcare services, and assessing my eligibility for Financial Assistance.

AMENDMENTS TO THE CONDITIONS OF ADMISSION/REGISTRATION AND FINANCIAL AGREEMENT: To be valid and enforceable, any amendment or modification to this agreement must be approved in writing by me and an authorized agent of the Hospital.

AUTHORIZATION: I have read the information noted above and have been given the opportunity to have my questions answered fully and to my satisfaction, and have been offered a copy of this agreement.

8/10/16 1650 _____
Date Time Signature (Patient/Representative)

If signed by other than patient, print name and relationship:

_____ _____
Name Relationship

Witnesses (required only for telephone consent, physical inability to sign, or signature by mark:

_____ _____ _____ _____
Date Time Witness name (please print) Witness signature

_____ _____ _____ _____
Date Time Witness name (please print) Witness signature

If an interpreter provided assistance with this form, please print name and sign below:

_____ _____ _____
Date Name (please print) Signature

(00179324-9) v.1

Consent Form Documentation - Scan on 8/9/2016 by Monk, Diana M : Divalproex (below)

INFORMED CONSENT FOR
PSYCHOTROPIC MEDICATION

A separate informed consent must be obtained for each prescribed medication.

I have reviewed with the patient named below the following information:

1. The nature of the patient's mental condition.
2. The reasons for taking the recommended medication, including the likelihood of improving or not improving without this medication.
3. The patient's consent, once given, may be withdrawn at any time by the patient's stating such intention to any member of the treating staff.
4. The reasonable alternative treatments available, if any.
5. The type, range of frequency and amount (including use of PRN orders), method (oral or injection), and duration of taking this medicine.
6. The probable side effects of this medication known to occur commonly, and any particular side effects likely to occur.
7. The possible additional side effects which may occur to patients taking this medication beyond three months.

I recommend that the patient take: Divalproex

with a daily dose of: 40 to 4000 mg.: (circle one) (oral) intramuscular

Date: 8/10 Time: 4:21 AM/PM Physician's signature: [signature]

(Print) Physician's name: John M. Cruz, MD

I acknowledge that I have had a discussion with my physician named above concerning my taking the recommended medication to assist in my treatment and that I understand the risks and benefits. I understand that I have the right to refuse this medication until I have spoken with my physician and given my consent to it. Furthermore, I understand that I may seek further information at any time by telling my physician or the nursing staff.

I hereby give my consent to start this medication regimen with the medication indicated above.
Date: 8/10/2016 **Time:** 4 24 **AM/PM** **Patient's signature:** [signature]
(patient/parent/conservator/guardian)

If signed by other than patient, indicate relationship: _____
Date: ___ **Time:** _____
AM/PM **Witness:**

☐ Consent given verbally only. Date _____ Time_____
Explanation of verbal consent:_____

Physician's Signature _____ ABSMC
Witness _____

NS-34451-ABSMC (01/13) v6

200025 CONSENT FORM DOCUMENTATION

Alta Bates Summit Medical Center

INFORMED CONSENT FOR PSYCHOTROPIC MEDICATION

page 1 of 2

COPIES: WHITE-MEDICAL RECORDS YELLOW-PATIENT COPY

Ho, Vincent
MRN: 50553672 CRUZ, JOHN MICHAEL DE VERA
11/6/1968 47 yrs MICHEL, CHRISTOPHER S
SEX: M Adult Mental Health 8/9/2016
MEDS,LABS CSN: 820425781

INFORMED CONSENT FOR PSYCHOTROPIC MEDICATION

RESPIRATORY AND CEREBRAL STIMULANTS

	BRAND NAME
dextroamphetamine	Biphetamine / Dexedrine
methylphenidate	Ritalin

ANTI-MANIC MEDICATION

carbamazepine	Tegretol
valproic acid	Depakote

Consent Form Documentation - Scan on 8/9/2016 by Monk, Diana M : Lurasidone (below)

INFORMED CONSENT FOR
PSYCHOTROPIC MEDICATION

A separate informed consent must be obtained for each prescribed medication.

I have reviewed with the patient named below the following information:

1. The nature of the patient's mental condition.
2. The reasons for taking the recommended medication, including the likelihood of improving or not improving without this medication.
3. The patient's consent, once given, may be withdrawn at any time by the patient's stating such intention to any member of the treating staff.
4. The reasonable alternative treatments available, if any.
5. The type, range of frequency and amount (including use of PRN orders), method (oral or injection), and duration of taking this medicine.
6. The probable side effects of this medication known to occur commonly, and any particular side effects likely to occur.
7. The possible additional side effects which may occur to patients taking this medication beyond three months.

I recommend that the patient take: Lurasidone

with a daily dose of: up to 160 mg.: (circle one) (oral) intramuscular

Date: 8/10 Time: 2:56 AM/PM Physician's signature:

(Print) Physician's name: John M. Cruz, MD

I acknowledge that I have had a discussion with my physician named above concerning my taking the recommended medication to assist in my treatment and that I understand the risks and benefits. I understand that I have the right to refuse this medication until I have spoken with my physician and given my consent to it. Furthermore, I understand that I may seek further information at any time by telling my physician or the nursing staff.

I hereby give my consent to start this medication regimen with the medication indicated above.
Date: 8/10 **Time:** 2:57 **AM/PM** **Patient's signature:**
(patient/parent/conservator/guardian)

If signed by other than patient, indicate relationship:
Date: **Time:**
AM/PM **Witness:**

☐ Consent given verbally only. Date Time
Explanation of verbal consent:

Physician's Signature ABSMC
Witness

NS-34451-ABSMC (01/13) v6

200025 CONSENT FORM DOCUMENTATION

Alta Bates Summit Medical Center

INFORMED CONSENT FOR PSYCHOTROPIC MEDICATION

page 1 of 2

COPIES: WHITE-MEDICAL RECORDS YELLOW-PATIENT COPY

Ho, Vincent

MRN: 50553672 CRUZ, JOHN MICHAEL DE VERA
11/6/1968 47 yrs MICHEL, CHRISTOPHER S
SEX: M Adult Mental Health 8/9/2016
MEDS,LABS CSN: 820425781

INFORMED CONSENT FOR PSYCHOTROPIC MEDICATION

RESPIRATORY AND CEREBRAL STIMULANTS

	BRAND NAME
____dextroamphetamine	Biphetamine / Dexedrine
methylphenidate	Ritalin

ANTI-MANIC MEDICATION

carbamazepine	Tegretol
valproic acid	Depakote

Sutter Health
With You. For Life.

ALTA BATES SUMMIT - HERRICK
2001 Dwight Way
Berkeley CA 94704
IP/OBS/SDS Legal Rec

HO,VINCENT
MRN: 50553672
DOB: 11/6/1968, Sex: M
Adm: 8/9/2016, D/C: 8/26/2016

Order-Level Documents:

There are no order-level documents.

Call Documentation

Cruz, John Michael de Vera, MD at 08/26/16 0824
Status: Signed

PSYCHIATRY PROGRESS NOTE

Friday, August 26, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- Sleep - 7 hours
- PRN Olanzapine 2.5 mg PO - 22:49 - insomnia

In speaking to the psychiatrist, the patient states
- mood: "good" - same as yesterday - feels even
- interest: "good" - same as yesterday - enjoys attending PHP group
- appetite: "good" - same as yesterday - eating three meals a day with snacks
- concentration: "good" - same as yesterday - able to comprehend what was being said in PHP group
- psychomotor retardation: denies
- anxiety: denies
- psychomotor agitation: denies
- sleep: "great" - same as yesterday - no difficulties falling asleep or staying asleep
- energy: "great" - same as yesterday - because of getting good sleep
- pain: denies
- self-esteem: "good" - same as yesterday - believes that he is a good person
- worthlessness: denies
- guilt: denies
- passive death wish: denies
- suicidal ideation: denies

- overall: His mood and cognition seem even better than yesterday.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged.

VITAL SIGNS:
BP 134/74 | Pulse 85 | Temp (Src) 98.6 °F (37 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 59.24 kg (130 lb 9.6 oz) | SpO2 98%
Wt Readings from Last 3 Encounters:
08/17/16 : 59.24 kg (130 lb 9.6 oz)

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/26/16 0824 (continued)

MENTAL STATUS EXAM:

- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: 0
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: euthymic
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Fair

REVIEW OF SYSTEMS:

- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for: and difficulty coping

ADDITIONAL DATA REVIEWED:

I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:

Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:

Reviewed

LAB VALUES:

Recent Labs

Lab	08/23/16 2330
WBC	3.9 L
HGB	12.5 L
HCT	38.4 L
PLT	100 L

No results for input(s): NA, K, CL, CO2, BUN, CREATININE, GLU, CA, MG, PHOS in the last 72 hours.

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/26/16 0824 (continued)

No results for input(s): TBILI, AST, ALT, ALP, ALB in the last 72 hours.
No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• divalproex DR (DEPAKOTE SPRINKLE) Cap 1,000 mg	1,000 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		1,000 mg at 08/25/16 2100
• divalproex DR (DEPAKOTE SPRINKLE) Cap 1,000 mg	1,000 mg	Oral	DAILY	Cruz, John Michael de Vera, MD		1,000 mg at 08/25/16 0937
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 7.5 mg	7.5 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		7.5 mg at 08/25/16 2100
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q Monday	Cruz, John Michael de Vera, MD		2 Patch at 08/22/16 1202
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD		
• pantoprazole (PROTONIX) Tab 40 mg	40 mg	Oral	AC 30 MIN BKFST	Cruz, John Michael de Vera, MD		40 mg at 08/26/16 0808
• benztropine (COGENTIN) Tab 1 mg	1 mg	Oral	Q4H PRN	Trautner, Rick Jeffrey, MD		1 mg at 08/21/16 2109
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD		7.5 mg at 08/22/16 2114
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD		10 mg at 08/25/16 0936
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD		30 mL at 08/25/16 2100

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/26/16 0824 (continued)

• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD	17.2 mg at 08/25/16 2100
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD	
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD	2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/25/16 0937
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/23/16 0913
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/25/16 2249
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Acid reflux disease [K21.9]	08/22/2016
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- Discharge today

PLAN:
 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex DR 1000 mg PO qam/ 1000 mg PO at bedtime
- continue Olanzapine 7.5 mg PO at bedtime
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1
- continue PRN Olanzapine ODT 2.5 mg PO q4h for anxiety

 # Post Traumatic Stress Disorder
- continue PRN Olanzapine 2.5 mg PO q4h for anxiety
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:
- PRN Olanzapine ODT as above
- Exposure Response Prevention Therapy as outpatient

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mL PO BID

 # Gastroesophageal Reflux:
- Pantoprazole 40 mg PO daliy

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- 8/26 - Herrick PHP Transition Day/ Discharge from Hospital
- 8/29 - Start Herrick PHP Full Time

 # Estimated Length of Stay
- discharge today

PROCEDURE CODES:

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/26/16 0824 (continued)

E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Friday, August 26, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
mood instability

Intervention:
Demonstrate interventions in thought-emotion-behavior triad
Increase insight into illness and treatment plan
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided supportive psychotherapy and processed the following issues. He states that he is very sad for losing his job because he will miss working with the children. He will ask the national coach of the junior olympics to write a letter for him so that he can attempt to get his fire arms license sooner as opposed to waiting for five years In PHP today, he said that he started to have panic attacks because another patient reminded him of the person that broke into his apartment. In addition, he also started to feel anxious when he saw one of the group leaders shaking her legs because it reminded him of his mother who used to shake her legs and who used to physically abuse him. He says that he has learned many things from PHP. He recognizes that there are stimuli that can trigger trauma that has happened to him in the past, but by trying to figure out what stimuli is being triggered, he can then work on decreasing the anxiety that he is feeling.

ATTENDING PHYSICIAN:
John M Cruz, MD

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/26/16 0824 (continued)

Cruz, John Michael de Vera, MD at 08/25/16 0824
Status: Signed

PSYCHIATRY PROGRESS NOTE
Thursday, August 25, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- Slept - 7.5 hours
- No over night events

In speaking to the psychiatrist, the patient states
- mood: "good" - same as yesterday - because he likes the combination of the medications he takes
- interest: "good" - same as yesterday - actively taking part in groups
- anxiety: none
- psychomotor agitation: None
- sleep: "great" - same as night before - easily fell asleep, stayed asleep and woke up feeling refreshed
- energy: "good" - same as day before - because he got good sleep
- pain: denies
- passive death wish: denies
- suicidal ideation: denies
- racing thoughts: denies

- overall: His mood, anxiety and sleep have been constant since yesterday.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 123/73 | Pulse 83 | Temp (Src) 98.1 °F (36.7 °C) (Oral) | Resp 17 | Ht 1.702 m (5' 7") | Wt 59.24 kg (130 lb 9.6 oz) | SpO2 98%
Wt Readings from Last 3 Encounters:
08/17/16 : 59.24 kg (130 lb 9.6 oz)

MENTAL STATUS EXAM:

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/25/16 0824 (continued)

- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: 0
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: euthymic
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Fair

REVIEW OF SYSTEMS:

- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for: and difficulty coping

ADDITIONAL DATA REVIEWED:

I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:

Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:

Reviewed

LAB VALUES:

Recent Labs

Lab	08/23/16 2330
WBC	3.9 L
HGB	12.5 L
HCT	38.4 L
PLT	100 L

Recent Labs

Lab	08/23/16

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/25/16 0824 (continued)

	0605
NA	146 H
K	4.6
CL	108 H
CO2	33 H
BUN	21
CREATININE	1.06
GLU	69 L
CA	8.6

Recent Labs

Lab	08/23/16 0605
TBILI	0.3
AST	26
ALT	75 H
ALP	90
ALB	3.4

No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• divalproex DR (DEPAKOTE SPRINKLE) Cap 1,000 mg	1,000 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		1,000 mg at 08/24/16 2109
• divalproex DR (DEPAKOTE SPRINKLE) Cap 1,000 mg	1,000 mg	Oral	DAILY	Cruz, John Michael de Vera, MD		
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 7.5 mg	7.5 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		7.5 mg at 08/24/16 2116
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q Monday	Cruz, John Michael de Vera, MD		2 Patch at 08/22/16 1202

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/25/16 0824 (continued)

• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD	
• pantoprazole (PROTONIX) Tab 40 mg	40 mg	Oral	AC 30 MIN BKFST	Cruz, John Michael de Vera, MD	40 mg at 08/25/16 0745
• benztropine (COGENTIN) Tab 1 mg	1 mg	Oral	Q4H PRN	Trautner, Rick Jeffrey, MD	1 mg at 08/21/16 2109
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	7.5 mg at 08/22/16 2114
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD	10 mg at 08/21/16 0900
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD	30 mL at 08/24/16 0836
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD	17.2 mg at 08/24/16 2112
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD	
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD	2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/24/16 0836
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/23/16 0913
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/23/16 2240
• phenazopyridine (PYRIDIUM) Tab	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera,	200 mg at

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/25/16 0824 (continued)

200 mg	MD	08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Acid reflux disease [K21.9]	08/22/2016
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:
 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex DR 1000 mg PO qam/ 1000 mg PO at bedtime
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- continue Olanzapine 7.5 mg PO at bedtime
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1
- continue PRN Olanzapine ODT 2.5 mg PO q4h for anxiety
- monitor for ongoing toxicity of Olanzapine that includes but are not limited to hypotension, syncope, extrapyramidal symptoms, somnolence, appetite, and fatigue

 # Post Traumatic Stress Disorder
- continue PRN Olanzapine 2.5 mg PO q4h for anxiety
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:
- PRN Olanzapine ODT as above
- Exposure Response Prevention Therapy as outpatient

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/25/16 0824 (continued)

- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mL PO BID

 # Gastroesophageal Reflux:
- Pantoprazole 40 mg PO daliy

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- 8/26 - Herrick PHP Transition Day/ Discharge from Hospital
- 8/29 - Start Herrick PHP Full Time

 # Estimated Length of Stay
- ~ 2 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Thursday, August 25, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
mania
mood instability

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/25/16 0824 (continued)

Intervention:
Demonstrate interventions in thought-emotion-behavior triad
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided supportive psychotherapy and processed the following issues. He feels tremendously worried that because he was placed on a 5150, he will not be able to have a firearms for the next five years. He does not know how he will have an income. He is considering writing a letter to the national team to see they would be willing to support his ability to use firearms again. Since he no longer has a roommate, he does not know if he will be able to afford the apartment where he lives. He also said that he feels tremendously disappointed in the people at Oakland Community Support Center because they took him off all of his medications and he "fell through the cracks." In addition, I reflected back to him about how well he has done. His sleep is better, he is no longer having panic attacks, his mood is better, and he feels more motivated.

ATTENDING PHYSICIAN:
John M Cruz, MD

Cruz, John Michael de Vera, MD at 08/24/16 0822

Status: Signed

PSYCHIATRY PROGRESS NOTE
Wednesday, August 24, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- Restricted affect
- Depressed affect
- Sleep - 7.5 hours
- Required PRN Olanzapine ODT 2.5 mg - 22:40

In speaking to the psychiatrist, the patient states
- mood: "great" - better than day before - because got good sleep
- interest: "good" - better than day before - attending all groups
- appetite: "good" - same as day before - eating all three meals with snacks
- concentration: "good" - same as day before - able to concentrate in groups
- psychomotor retardation: denies
- anxiety: none
- psychomotor agitation: denies
- sleep: "great" - better than night before - because of the Olanzapine ODT
- energy: "great" - better than night before - because he got good sleep
- pain: denies
- self-esteem: "great" - better than night before
- worthlessness: denies
- guilt: denies
- passive death wish: denies
- suicidal ideation: denies
- homicidal ideation: denies

- overall: He feels tremendously better than the day before because the Olanzapine has done a great job at boosting up his mood and decreasing his anxiety.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 119/64 | Pulse 79 | Temp (Src) 98.4 °F (36.9 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 59.24 kg (130 lb 9.6 oz) | SpO2 100%
Wt Readings from Last 3 Encounters:
08/17/16 : 59.24 kg (130 lb 9.6 oz)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: 0
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: euthymic
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/24/16 0822 (continued)

- Fund of Knowledge: Impaired
- Judgement: Good
- Insight: Good

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: negative for:, depression, panic attacks and sleeplessness

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:
No results for input(s): WBC, HGB, HCT, PLT in the last 72 hours.

Recent Labs

Lab	08/23/16 0605
NA	146 H
K	4.6
CL	108 H
CO2	33 H
BUN	21
CREATININE	1.06
GLU	69 L
CA	8.6

Recent Labs

Lab	08/23/16 0605
TBILI	0.3
AST	26
ALT	75 H
ALP	90
ALB	3.4

No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/24/16 0822 (continued)

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• divalproex 12Hr-DR (DEPAKOTE) Tab 1,000 mg	1,000 mg	Oral	DAILY	Cruz, John Michael de Vera, MD		
• divalproex 12Hr-DR (DEPAKOTE) Tab 1,000 mg	1,000 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q Monday	Cruz, John Michael de Vera, MD		2 Patch at 08/22/16 1202
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD		
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 5 mg	5 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		5 mg at 08/23/16 2108
• pantoprazole (PROTONIX) Tab 40 mg	40 mg	Oral	AC 30 MIN BKFST	Cruz, John Michael de Vera, MD		40 mg at 08/24/16 0755
• benztropine (COGENTIN) Tab 1 mg	1 mg	Oral	Q4H PRN	Trautner, Rick Jeffrey, MD		1 mg at 08/21/16 2109
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD		7.5 mg at 08/22/16 2114
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD		10 mg at 08/21/16 0900
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD		30 mL at 08/23/16 2105
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD		17.2 mg at 08/23/16 2107
• aluminum/magnesium hydroxide/simethicon	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD		

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/24/16 0822 (continued)

e (MYLANTA) Oral Susp 30 mL					
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD	2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/23/16 0829
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/23/16 0913
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/23/16 2240
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Acid reflux disease [K21.9]	08/22/2016
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/24/16 0822 (continued)

PLAN:

 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 2250 mg PO at bedtime
- *f/u VPA trough level on 8/23 - 97.8*
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- *increase Olanzapine to 7.5 mg PO at bedtime*
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1
- continue PRN Olanzapine ODT 2.5 mg PO q4h for anxiety
- monitor for ongoing toxicity of Olanzapine that includes but are not limited to hypotension, syncope, extrapyramidal symptoms, somnolence, appetite, and fatigue

 # Post Traumatic Stress Disorder
- continue PRN Olanzapine 2.5 mg PO q4h for anxiety
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:
- PRN Olanzapine ODT as above
- Exposure Response Prevention Therapy as outpatient

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mL PO BID

 # Gastroesophageal Reflux:
- Pantoprazole 40 mg PO daliy

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- 8/26 - Herrick PHP Transition Day/ Discharge from Hospital
- 8/29 - Start Herrick PHP Full Time

 # Estimated Length of Stay
- ~ 2 days

PROCEDURE CODES:

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/24/16 0822 (continued)

E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Wednesday, August 24, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
mood instability
extreme anxiety/panic

Intervention:
Demonstrate interventions in thought-emotion-behavior triad
Increase insight into illness and treatment plan
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided supportive psychotherapy and processed the following issues. He is extremely happy that he has felt good for two days straight He has not felt this good since March 2016. He states that it feels as if he is back on Lamotrigine. I continued to thank him for his patience and reflected back how much better he looks even from two days ago as his mood is good, he has no anxiety and his sleep is very restful. In addition, I also informed him about the tentative plan for discharge. On Friday, he will have a transition day to Herrick PHP with discharge from the hospital. On Monday, he will start the Herrick PHP program full time. In addition, he was reminded that sleep is very important. Should he have difficulties sleeping tonight even with the increased dosage of Olanzapine ODT, he should ask for the PRN Olanzapine ODT 2.5 mg to help him sleep. He voiced that he has a difficult time swallowing the Divalproex DR tabs. As a result, he was transitioned to Divalproex Sprinkles. I thanked him for making his needs known.

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/24/16 0822 (continued)

ATTENDING PHYSICIAN:
John M Cruz, MD

Cruz, John Michael de Vera, MD at 08/23/16 0843

Status: Signed

PSYCHIATRY PROGRESS NOTE

Tuesday, August 23, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- Sleep - 7 hours

In speaking to the psychiatrist, the patient states
- mood: "much better" - better than yesterday - he has had no depression
- interest: "good" - better than yesterday - he is attending all groups and finishes his group projects early
- anxiety: none
- psychomotor agitation: none
- sleep: "great" - better than night before - easily feel asleep, stayed asleep and woke up feeling refreshed
- energy: "good" - better than night before - because he got good sleep
- pain: denies
- worthlessness: denies
- guilt: denies
- passive death wish: denies
- suicidal ideation: denies
- racing thoughts: denies

- overall: His depression has decreased, his anxiety has decreased and his sleep is better.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 112/79 | Pulse 79 | Temp (Src) 97.6 °F (36.4 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 59.24 kg (130 lb 9.6 oz) | SpO2 100%
Wt Readings from Last 3 Encounters:
08/17/16 : 59.24 kg (130 lb 9.6 oz)

MENTAL STATUS EXAM:
- General Appearance**:** appropriate
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: 0
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: euthymic
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Fair

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for: and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:
No results for input(s): WBC, HGB, HCT, PLT in the last 72 hours.
No results for input(s): NA, K, CL, CO2, BUN, CREATININE, GLU, CA, MG, PHOS in the last 72 hours.
No results for input(s): TBILI, AST, ALT, ALP, ALB in the last 72 hours.
No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/23/16 0843 (continued)

Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q Monday	Cruz, John Michael de Vera, MD		2 Patch at 08/22/16 1202
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD		
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 5 mg	5 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		5 mg at 08/22/16 2006
• pantoprazole (PROTONIX) Tab 40 mg	40 mg	Oral	AC 30 MIN BKFST	Cruz, John Michael de Vera, MD		40 mg at 08/23/16 0829
• benztropine (COGENTIN) Tab 1 mg	1 mg	Oral	Q4H PRN	Trautner, Rick Jeffrey, MD		1 mg at 08/21/16 2109
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 2,250 mg	2,250 mg	Oral	Q BEDTIME	Hirschtritt, Matthew E, MD		2,250 mg at 08/22/16 2006
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD		7.5 mg at 08/22/16 2114
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD		10 mg at 08/21/16 0900
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD		30 mL at 08/22/16 2100
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD		17.2 mg at 08/22/16 2005
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD		
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD		2 mg at 08/16/16 0905

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/23/16 0843 (continued)

• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/23/16 0829
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/16/16 0853
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/21/16 2314
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Acid reflux disease [K21.9]	08/22/2016
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:
 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 2250 mg PO at bedtime
- f/u VPA trough level on 8/23 at bedtime
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias,

tremor, polyuria, and polydipsia especially given recent increase
- discontinued Lurasidone given reports of akathisia and restlessness
- continue Olanzapine 5 mg PO at bedtime instead
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1
- continue PRN Olanzapine ODT 2.5 mg PO q4h for anxiety
- monitor for ongoing toxicity of Olanzapine that includes but are not limited to hypotension, syncope, extrapyramidal symptoms, somnolence, appetite, and fatigue

 # Post Traumatic Stress Disorder
- continue PRN Olanzapine 2.5 mg PO q4h for anxiety
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:
- PRN Olanzapine ODT as above
- Exposure Response Prevention Therapy as outpatient

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mL PO BID

 # Gastroesophageal Reflux:
- Pantoprazole 40 mg PO daliy

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 4 - 6 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/23/16 0843 (continued)

PSYCHOTHERAPY NOTE
Tuesday, August 23, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
mood instability
extreme anxiety/panic

Intervention:
Increase awareness of emotional states/reality testing
Increase insight into illness and treatment plan
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided supportive psychotherapy and processed the following issues. He states that he has been attending all groups and going on all walks. I encouraged him to keep up this healthy behavior. In addition, as he often tends to spend time in his room laying on his bed with the drapes closed, I encouraged him to stay in the day area as much as possible so that he can continue to socialize with other people and not be isolated to his room. I also explained to him the treatment plan. Specifically, he would be getting his Valproic Acid trough level drawn today, that we would be splitting up the Divalproex into a morning and a night dose as he has difficulties swallowing the big pills and from tonight's lab draw, we will determine whether the dosage should be adjusted. In addition, he was also reminded that he can take PRN Olanzapine 2.5 mg for anxiety and insomnia. He understood.

ATTENDING PHYSICIAN:
John M Cruz, MD

Cruz, John Michael de Vera, MD at 08/22/16 1142

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/22/16 1142 (continued)
Status: Signed

MEDICARE 1st RE-CERTIFICATION, DAY 12

Due date: August 20, 2016

I certify that the inpatient psychiatric hospital services furnished since the previous certification was and continues to be medically necessary for either treatment which would reasonably be expected to improve the patient's condition or diagnostic study and the hospital records indicate that the services furnished were either intensive treatment services, admission and related services necessary for diagnostic study or equivalent services.

I estimate 7 days of hospitalization is necessary for proper treatment of the patient. My plans for post-hospital care for this patient are coordinating with outpatient provider.

Cruz, John Michael de Vera, MD at 08/22/16 0913
Status: Addendum

PSYCHIATRY PROGRESS NOTE
Monday, August 22, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- Sleep - 7.25 hours
- PRN Benztropine 1 mg - 8:59/ 21:09
- PRN Olanzapine 2.5 mg - 21:20/ 23:14

In speaking to the psychiatrist, the patient states
- mood: Depressed - same as yesterday - because he did not get good sleep
- interest: "poor" - taking part in groups, but requires a lot of effort.
- appetite: "good" - same as yesterday - eating three meals a day with snacks
- anxiety: none
- psychomotor agitation: Reports that he felt inner restlessness when he took Lurasidone and even when it was decreased to lower dose.,
- sleep: "poor" - worse than the night before - feels that the Lurasidone kept him up
- energy: "poor" - worse than yesterday - because he did not sleep
- pain: denies

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/22/16 0913 (continued)

- passive death wish: denies
- suicidal ideation: denies
- racing thoughts: denies
- homicidal ideation: denies

- overall: He states that the Lurasidone made him feel very restless inside and made it difficult for him to fall asleep even with the PRN dose of the Olanzapine.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 128/71 | Pulse 86 | Temp (Src) 97.8 °F (36.6 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 59.24 kg (130 lb 9.6 oz) | SpO2 100%
Wt Readings from Last 3 Encounters:
08/17/16 : 59.24 kg (130 lb 9.6 oz)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: 0
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: anxious and depressed
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Fair

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for:, depression, anxiety, sleeplessness and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/22/16 0913 (continued)

Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:

Recent Labs

Lab	08/19/16 2025
WBC	4.3
HGB	12.7 L
HCT	39.0 L
PLT	143 L

Recent Labs

Lab	08/19/16 2025
PHOS	3.6

No results for input(s): TBILI, AST, ALT, ALP, ALB in the last 72 hours.
No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• lurasidone (LATUDA) Tab 20 mg	20 mg	Oral	DAILY WITH DINNER	Hirschtritt, Matthew E, MD		20 mg at 08/21/16 2056
• benztropine (COGENTIN) Tab 1 mg	1 mg	Oral	ONCE	Trautner, Rick Jeffrey, MD		
• benztropine (COGENTIN) Tab 1 mg	1 mg	Oral	Q4H PRN	Trautner, Rick Jeffrey, MD		1 mg at 08/21/16 2109
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 2,250 mg	2,250 mg	Oral	Q BEDTIME	Hirschtritt, Matthew E, MD		2,250 mg at 08/21/16 2055

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/22/16 0913 (continued)

• gabapentin (NEURONTIN) Cap 600 mg	600 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD	600 mg at 08/19/16 2121
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	7.5 mg at 08/15/16 2100
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD	10 mg at 08/21/16 0900
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD	30 mL at 08/22/16 0900
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD	17.2 mg at 08/21/16 2056
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD	
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD	2 Patch at 08/15/16 2100
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD	2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/22/16 0836
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/16/16 0853
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/21/16 2314
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:
 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 2250 mg PO at bedtime
- f/u VPA trough level on 8/23 at bedtime
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- discontinued Lurasidone given reports of akathisia and restlessness
- *started Olanzapine 5 mg PO at bedtime instead*
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1
- *started PRN Olanzapine ODT 2.5 mg PO q4h for anxiety*
- monitor for ongoing toxicity of Olanzapine that includes but are not limited to hypotension, syncope, extrapyramidal symptoms, somnolence, appetite, and fatigue

 # Post Traumatic Stress Disorder
- discontinued PRN Gabapentin 600 mg PO q4h for anxiety given ineffectiveness
- started PRN Olanzapine 2.5 mg PO q4h for anxiety
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:
- PRN Olanzapine ODT as above
- Exposure Response Prevention Therapy as outpatient

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/22/16 0913 (continued)

- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mL PO BID

 # Gastroesophageal Reflux:
- Pantoprazole 40 mg PO daliy

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 4 - 6 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Monday, August 22, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
mania
mood instability

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/22/16 0913 (continued)

extreme anxiety/panic

Intervention:
Increase awareness of emotional states/reality testing
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided supportive psychotherapy and processed the following issues. He states that the Lurasidone made him feel very restless and prevented him from sleeping. As a result, it was discontinued. We brainstormed about various medications that have helped him in the past. He stated that Olanzapine has helped with insomnia and anxiety. He also stated that Quetiapine helped with his depression. I told him that I would prefer that he not be on two neuroleptics and instead, if given a choice which one would he prefer based on its efficacy in the past. He states that since Olanzapine has helped both his insomnia and anxiety, he would like to continue with that medications. He was also told that we would be starting the Olanzapine to help stabilize his depression and anxiety as the medication does both. He agreed. I thanked him for being open and honest with his feelings and for keeping such good notes on his psychiatric state and the side effects from the medications that he takes. He was also encouraged to continue going to all groups and to go out on the walks to get some fresh air which he did.

ATTENDING PHYSICIAN:
John M Cruz, MD

Revision History

	Date/Time	User	Action
>	08/22/16 2101	Cruz, John Michael de Vera, MD	Addend
	08/22/16 2055	Cruz, John Michael de Vera, MD	Sign

Hirschtritt, Matthew E, MD at 08/21/16 1200

Status: Signed

PSYCHIATRY PROGRESS NOTE
Sunday, August 21, 2016

Total Time Spent 40 Minutes.
Psychotherapy Time: 20 Minutes
E/M Time: 20 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT: hospital care and psychotherapy + E&M

Call Documentation (continued)

Hirschtritt, Matthew E, MD at 08/21/16 1200 (continued)

INTERIM HISTORY:
Nursing notes: pt appears depressed, anxious, disheveled on unit; however, is participating in grps and expressing his concerns to nursing and OT staff. He consistently denies SI and reports a mood of 7/10 with 10 being the best. In between grps, he has been isolating himself in his room. He reported extreme restlessness last night, that he attributes to Latuda and derived some benefit from the adjunctive Zyprexa to address akathisia. Slept 7.0 hours. He engaged in a unit walk this morning, which was beneficial to address restlessness.

PRN meds: Cogentin 1mg PO x1, Zydis 2.5mg PO x2

Med compliance: No missed doses

On interview, pt reports "akathesia" last night that he attributes to Latuda and claims that his mood was "fine" before starting the Latuda, and that the Zyprexa monotherapy has helped in the past with low mood and anxiety. He is feeling somewhat more hopeful and upbeat today, and identifies medication and journaling as coping strategies. He denies SI/HI/AVH. He wants to engage in the hospital PHP following discharge to build on the improvements he's made in the hospital over the past several days.

PAST FAMILY AND SOCIAL HISTORY: Unchanged, see H&P

VITAL SIGNS:

BP 103/76 | Pulse 74 | Temp (Src) 97.9 °F (36.6 °C) (Oral) | Resp 17 | Ht 1.702 m (5' 7") | Wt 59.24 kg (130 lb 9.6 oz) | SpO2 99%
Wt Readings from Last 3 Encounters:
08/17/16 : 59.24 kg (130 lb 9.6 oz)

MENTAL STATUS EXAM:

General Appearance: Lying supine in bed, sits up for interview, later observed walking without assistance in hallway, good EC, appears somewhat disheveled, is mildly malodorous
Muscle Strength and Tone: No abnormalities noted
Gait & Station: Gait: unassisted and stable
Mental Status Examination:
Orientation: Fully oriented
Speech: normal rhythm and rate
Language: English speaking and WNL
Affect:: Dysphoric, somewhat anxious
Mood: "fine"
Suicidal ideation: No
Homicidal Ideation: No
Thought Process: More linear compared to yesterday
Thought Content: no evidence of abnormality
Attention & Concentration: Within Normal Limits;
Recent & Remote Memory: recent memory intact and remote memory intact;
Fund of Knowledge: Appropriate;

Call Documentation (continued)

Hirschtritt, Matthew E, MD at 08/21/16 1200 (continued)

Judgment & Insight:
- Judgement: Fair
- Insight: Fair

REVIEW OF SYSTEMS:
GENERAL: POSITIVE FOR: WEAKNESS, FATIGUE
NEURO: POSITIVE FOR: RESTLESSNESS
PSYCH: POSITIVE FOR: ANXIOUSNESS, NERVOUSNESS, DEPRESSED MOOD, TROUBLE CONCENTRATING, CHANGE IN SLEEP PATTERN . See interim history.

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:

No labs in past 24h

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• benztropine (COGENTIN) Tab 1 mg	1 mg	Oral	ONCE	Trautner, Rick Jeffrey, MD		
• benztropine (COGENTIN) Tab 1 mg	1 mg	Oral	Q4H PRN	Trautner, Rick Jeffrey, MD		1 mg at 08/21/16 0859
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 2,250 mg	2,250 mg	Oral	Q BEDTIME	Hirschtritt, Matthew E, MD		2,250 mg at 08/20/16 2009
• lurasidone (LATUDA) Tab 40 mg	40 mg	Oral	DAILY WITH DINNER	Cruz, John Michael de Vera, MD		40 mg at 08/20/16 1840
• gabapentin (NEURONTIN) Cap 600 mg	600 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD		600 mg at 08/19/16 2121
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD		7.5 mg at 08/15/16 2100
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD		10 mg at 08/21/16 0900
• lactulose (ENULOSE)	30 mL	Oral	BID	Sharma, Kanika, MD		30 mL at

Call Documentation (continued)

Hirschtritt, Matthew E, MD at 08/21/16 1200 (continued)

Oral Soln 30 mL					08/21/16 0830
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD	17.2 mg at 08/20/16 2009
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD	
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD	2 Patch at 08/15/16 2100
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD	2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/21/16 0830
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/16/16 0853
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/20/16 2134
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/RESTRAINT:

None

DIAGNOSIS / PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:

- If discharged, patient is at acute risk of self harm and for decompensation and rehospitalization

Call Documentation (continued)

Hirschtritt, Matthew E, MD at 08/21/16 1200 (continued)

- Pt requires locked, inpatient, psychiatric hospitalization for creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:

PSYCHIATRIC:
 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 2250 mg PO at bedtime, increased from 2000mg on 8/20/16
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- **trough VPA level ordered for 8/23/16**
- decrease Lurasidone from 40 mg to 20mg PO with dinner to reduce risk of akathisia; may slowly increase if tolerated over several days
- monitor for ongoing toxicity of Lurasidone that includes but are not limited to hypotension, syncope, extrapyramidal symptoms, somnolence, appetite, and fatigue
- continue PRN Olanzapine ODT 2.5mg PO at bedtime for insomnia, may repeat x 1

 # Post Traumatic Stress Disorder
- continue PRN Gabapentin 600 mg PO q4h for anxiety
- monitor for ongoing toxicity of Gabapentin that includes but are not limited to dizziness, somnolence, ataxia, worsening depression, increased suicidality and erythema multiforme, especially given recent increase
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:
- Gabapentin as above
- Exposure Response Prevention Therapy as outpatient

MEDICAL:
Follow up labs/imaging

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

LEGAL STATUS: Voluntary

DISPOSITION:
Herrick PHP vs La Cheim

Call Documentation (continued)

Hirschtritt, Matthew E, MD at 08/21/16 1200 (continued)

ELOS: 4-6d

PROCEDURE CODES:
E/M 99233
Psychotherapy90833

Matthew E Hirschtritt, MD

PSYCHOTHERAPY NOTE
Sunday, August 21, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

PSYCHOTHERAPY:
PSYCHOTHERAPY TYPE: CBT
Supportive

PROBLEM: mood instability
extreme anxiety/panic

INTERVENTION: Increase awareness of emotional states/reality testing
Improve treatment alliance

RESPONSE: Acknowledges intellectual understanding but emotionally struggles
Shows motivation to change

PLAN:
Continue current psychotherapeutic treatment approach
Work to reinforce insights/concepts/skills

NARRATIVE:
We discussed ways to anticipate and deal with anxiety/distress and suicidal ideation, including medication, journaling, and reaching out for assistance and advice from peers and staff. He endorsed understanding and requested to walk outside of the unit to reduce feeling of restlessness. We also discussed ways to continue the skills he has learned during this hospitalization in PHP or a residential tx setting.

Matthew E Hirschtritt, MD

Hirschtritt, Matthew E, MD at 08/20/16 1401

Call Documentation (continued)

Hirschtritt, Matthew E, MD at 08/20/16 1401 (continued)

Status: Signed

PSYCHIATRY PROGRESS NOTE
Saturday, August 20, 2016

Total Time Spent 40 Minutes.
Psychotherapy Time: 20 Minutes
E/M Time: 20 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT: hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes: patient has been "more depressed" over the past day, he stated yesterday, "I'm just tired of fighting. I don't know if I have it in me anymore." Benefited from deep breathing and use of PRN gabapentin. Last night was pacing the hall, was agitated, and endorsed insomnia, requested Zyprexa and fell asleep for several hours. Intermittent SI but no self-harm behavior noted, no aggression toward others.

PRN meds: gabapentin 600 x2, Zydis 2.5 x1

Med compliance: No missed doses

On interview, pt reports that he felt "extreme thoughts" of SI last night that "came from nowhere" although he denies any plan at the time. Zydis helped and he was able to sleep, and now feels calmer yet fatigued. He denies current SI/HI/AVH.

PAST FAMILY AND SOCIAL HISTORY: Unchanged, see H&P

VITAL SIGNS:

BP 101/70 | Pulse 64 | Temp (Src) 98 °F (36.7 °C) (Oral) | Resp 17 | Ht 1.702 m (5' 7") | Wt 59.24 kg (130 lb 9.6 oz) | SpO2 99%
Wt Readings from Last 3 Encounters:
08/17/16 : 59.24 kg (130 lb 9.6 oz)

MENTAL STATUS EXAM:

General Appearance: Lying supine in bed, sits up for interview, poor EC, appears somewhat disheveled.
Muscle Strength and Tone: No abnormalities noted
Gait & Station: Gait: unable to assess because pt remains in bed
Mental Status Examination:
Orientation: Fully oriented
Speech: normal rhythm and rate
Language: English speaking and WNL
Affect:: Dysphoric, somewhat anxious

Call Documentation (continued)

Hirschtritt, Matthew E, MD at 08/20/16 1401 (continued)

Mood: "better but I was very anxious"
Suicidal ideation: No
Homicidal Ideation: No
Thought Process: Tangential
Thought Content: no evidence of abnormality
Attention & Concentration: Within Normal Limits;
Recent & Remote Memory: recent memory intact and remote memory intact;
Fund of Knowledge: Appropriate;
Judgment & Insight:
- Judgement: Fair
- Insight: Fair

APPEARANCE/BEHAVIOR:
SPEECH: nml rate, vol, tone
AFFECT:
MOOD:
THOUGHT FORM:
THOUGHT CONTENT:
SUICIDAL IDEATION:
HOMICIDAL/ASSAULTIVE IDEATION:
INSIGHT:
JUDGMENT:
ORIENTATION: Fully oriented
COGNITIVE FUNCTION: Grossly intact. Attentive. Appropriate memory and fund of knowldege
MOTOR: WNL. No abnormal movements. Gait steady and unremarkable

REVIEW OF SYSTEMS:
GENERAL: POSITIVE FOR: WEAKNESS, FATIGUE
NEURO: POSITIVE FOR: DIZZINESS
PSYCH: POSITIVE FOR: ANXIOUSNESS, NERVOUSNESS, DEPRESSED MOOD, TROUBLE CONCENTRATING, CHANGE IN SLEEP PATTERN . See interim history.

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:

Reviewed

Recent Labs

Lab	08/19/16 2025

Call Documentation (continued)

Hirschtritt, Matthew E, MD at 08/20/16 1401 (continued)

WBC 4.3
HGB 12.7 L
HCT 39.0 L
PLT 143 L

Recent Labs

Lab	08/19/16 2025	08/19/16 0734
NA	--	144
K	--	4.6
CL	--	108
CO2	--	29
BUN	--	18
CREATININE	--	0.83
GLU	--	75
CA	--	8.7
MG	--	2.4
PHOS	3.6	--

Recent Labs

Lab	08/19/16 0734
TBILI	0.3
AST	30
ALT	72 H
ALP	85
ALB	3.3

Component	Latest Ref Rng	8/19/2016
Valproic Acid	50.0 - 100.0 ug/mL	89.4

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• lurasidone (LATUDA) Tab 40 mg	40 mg	Oral	DAILY WITH DINNER	Cruz, John Michael de Vera, MD		40 mg at 08/19/16 1802
• gabapentin (NEURONTIN) Cap 600 mg	600 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD		600 mg at 08/19/16

Call Documentation (continued)

Hirschtritt, Matthew E, MD at 08/20/16 1401 (continued)

					2121
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 2,000 mg	2,000 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD	2,000 mg at 08/19/16 2056
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	7.5 mg at 08/15/16 2100
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD	10 mg at 08/20/16 0947
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD	30 mL at 08/20/16 0900
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD	17.2 mg at 08/19/16 2056
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD	
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD	2 Patch at 08/15/16 2100
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD	2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/20/16 0947
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/16/16 0853
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/19/16 2146
• phenazopyridine (PYRIDIUM) Tab	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera,	200 mg at

Call Documentation (continued)

Hirschtritt, Matthew E, MD at 08/20/16 1401 (continued)

200 mg	MD	08/13/16 1008

SECLUSION/RESTRAINT:
None

DIAGNOSIS / PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- If discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- Pt requires locked, inpatient, psychiatric hospitalization for creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:

PSYCHIATRIC:
 # Bipolar Disorder Type I without Psychotic Features:
- **increase Divalproex ER from 2000 to 2250 mg PO at bedtime, starting tonight (8/20/16)**
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- **trough VPA level ordered for 8/23/16**
- continue Lurasidone 40 mg PO with dinner
- monitor for ongoing toxicity of Lurasidone that includes but are not limited to hypotension, syncope, extrapyramidal symptoms, somnolence, appetite, and fatigue
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1

 # Post Traumatic Stress Disorder
- continue PRN Gabapentin 600 mg PO q4h for anxiety
- monitor for ongoing toxicity of Gabapentin that includes but are not limited to dizziness, somnolence, ataxia, worsening depression, increased suicidality and erythema multiforme, especially given recent increase
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:
- Gabapentin as above
- Exposure Response Prevention Therapy as outpatient

Call Documentation (continued)

Hirschtritt, Matthew E, MD at 08/20/16 1401 (continued)

MEDICAL:
Follow up labs/imaging

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

LEGAL STATUS: Voluntary

DISPOSITION:
Herrick PHP vs La Cheim

ELOS: 4-6d

PROCEDURE CODES:
E/M 99233
Psychotherapy90833

Matthew E Hirschtritt, MD

PSYCHOTHERAPY NOTE
Saturday, August 20, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

PSYCHOTHERAPY:
PSYCHOTHERAPY TYPE: CBT
Supportive

PROBLEM: mood instability
extreme anxiety/panic

Call Documentation (continued)

Hirschtritt, Matthew E, MD at 08/20/16 1401 (continued)

INTERVENTION: Increase awareness of emotional states/reality testing
Improve treatment alliance

RESPONSE: Acknowledges intellectual understanding but emotionally struggles
Shows motivation to change

PLAN:
Continue current psychotherapeutic treatment approach
Work to reinforce insights/concepts/skills

NARRATIVE:
Patient discussed with me the distress of feeling sudden urge to harm himself last night, which left him feeling anxious and panicked. We discussed ways to deal with such powerful emotions, such as reaching out to support staff, deep breathing, and mindfulness. He endorsed understanding and stated that he would attempt these techniques in the future. He endorsed feeling somewhat calmer and less agitated after we spoke.

Matthew E Hirschtritt, MD

Cruz, John Michael de Vera, MD at 08/19/16 1010

Status: Signed

PSYCHIATRY PROGRESS NOTE
Friday, August 19, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- Sitting on floor with head in his hands rocking back and forth
- Mood improves in the evening
- Sleep - 7.5 hours
- PRN Gabapentin 600 mg - 15:00

In speaking to the psychiatrist, the patient states
- mood: "good" - better than yesterday where he was feeling extremely depressed

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/19/16 1010 (continued)

- interest: "okay" - better than yesterday - attending groups
- anxiety: "yes" - worse than yesterday - anxiety built up throughout the morning and went away by 10:00am
- psychomotor agitation: None observed
- sleep: "poor" - worse than night before - woke up at 3:00am because his roommate snores
- energy: "good" - better than yesterday - where he just wanted to lay in bed
- pain: denies
- self-esteem: good
- worthlessness: denies
- guilt: denies
- passive death wish: denies
- suicidal ideation: denies
- racing thoughts: "yes" - jumble of thoughts that occur right before he is trying to sleep

- overall: His depression has decreased, but his anxiety has increased from yesterday (although it is better from when he first came in).

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 136/83 | Pulse 81 | Temp (Src) 97.8 °F (36.6 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 59.24 kg (130 lb 9.6 oz) | SpO2 100%
Wt Readings from Last 3 Encounters:
08/17/16 : 59.24 kg (130 lb 9.6 oz)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: 0
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: anxious
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Good

REVIEW OF SYSTEMS:
- General: negative for: and change in energy

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/19/16 1010 (continued)

- Neuro: negative for:, headaches and weakness
- Psych: positive for:, anxiety, sleeplessness and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:
No results for input(s): WBC, HGB, HCT, PLT in the last 72 hours.

Recent Labs

Lab	08/19/16 0734
NA	144
K	4.6
CL	108
CO2	29
BUN	18
CREATININE	0.83
GLU	75
CA	8.7
MG	2.4

Recent Labs

Lab	08/19/16 0734
TBILI	0.3
AST	30
ALT	72 H
ALP	85
ALB	3.3

No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/19/16 1010 (continued)

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• lurasidone (LATUDA) Tab 20 mg	20 mg	Oral	DAILY WITH DINNER	Cruz, John Michael de Vera, MD		20 mg at 08/18/16 1804
• gabapentin (NEURONTIN) Cap 600 mg	600 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD		600 mg at 08/18/16 1500
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 2,000 mg	2,000 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		2,000 mg at 08/18/16 2205
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD		7.5 mg at 08/15/16 2100
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD		10 mg at 08/19/16 0909
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD		30 mL at 08/19/16 0908
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD		17.2 mg at 08/18/16 2120
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD		
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD		2 Patch at 08/15/16 2100
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD		2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD		1 mg at 08/19/16 0909
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD		
• methotrexate Tab 5	5 mg	Oral	Q7 DAYS	Cruz, John		5 mg at

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/19/16 1010 (continued)

mg				Michael de Vera, MD	08/16/16 0853
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/17/16 2256
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:
 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 2000 mg PO at bedtime
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- WEEKEND: F/u Valproic Acid trough level on Friday night, goal between 50 - 125
- WEEKEND: Adjust Divalproex ER dosage based on VPA trough level
- increased Lurasidone to 40 mg PO with dinner
- monitor for ongoing toxicity of Lurasidone that includes but are not limited to hypotension, syncope, extrapyramidal symptoms, somnolence, appetite, and fatigue
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1

 # Post Traumatic Stress Disorder
- continue PRN Gabapentin 600 mg PO q4h for anxiety
- monitor for ongoing toxicity of Gabapentin that includes but are not limited to dizziness, somnolence, ataxia,

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/19/16 1010 (continued)

worsening depression, increased suicidality and erythema multiforme, especially given recent increase
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:
- Gabapentin as above
- Exposure Response Prevention Therapy as outpatient

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 4 - 6 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Friday, August 19, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/19/16 1010 (continued)

Interpersonal
Supportive

Problem:
mood instability
extreme anxiety/panic

Intervention:
Increase awareness of emotional states/reality testing
Increase insight into illness and treatment plan
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided supportive psychotherapy and processed the following issues. He states that he uses distraction and meditation when he feels anxious and I encouraged him to continue using those techniques. He and another patient commiserated as both of them now can not have firearms for the next 5 years because they have been placed on a 5150. I reflected back that like him there are other people that experience these symptoms as well. He said that he does not feel depressed today, but that he feels anxious. I reflected back to him that depression and anxiety often co occur with each other and that his anxiety symptoms may be a sign of a depressive episode. As a result, the Lurasidone that we started him on may be very helpful since it is FDA approved to treat current depressive episodes in people who have Bipolar Disorder. I also told him that with time, his depression will improve especially with taking this medication. He says that he often wants to be by himself when he feels depressed and anxious. However, I encouraged him to engage in behavioral activation where people do the opposite of what they want to do and in his case, he should go to groups and surround himself by others.

ATTENDING PHYSICIAN:
John M Cruz, MD

Cruz, John Michael de Vera, MD at 08/18/16 0827

Status: Signed

PSYCHIATRY PROGRESS NOTE
Thursday, August 18, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/18/16 0827 (continued)

47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- Depressed
- Withdrawn
- Mopes around unit
- Sleep - 7.5 hours
- PRN Gabapentin 600 mg - 12:45
- PRN Olanzapine ODT 2.5 mg - 22:56

In speaking to the psychiatrist, the patient states
- mood: "depressed" - worse than yesterday - because he has lost his fire arms license for five years for being placed on a 5150
- interest: "low" - worse than yesterday - just wants to lay in his room and not go to groups
- psychomotor retardation: "slower" - worse than yesterday
- anxiety: "minimal" and rates it 1/10 (0 - none, 10 - great) - better than yesterday
- psychomotor agitation: "yes" - noticed to be laying in a fetal position in the hallway rocking himself back and forth
- sleep: "good" - better than night before
- energy: "good" - better than yesterday - despite feeling depressed
- pain: denies
- self-esteem: "very low" - worse than yesterday
- worthlessness: "yes"
- guilt: denies
- passive death wish: yes
- suicidal ideation: He feels safe in the hospital and comfortable talking to staff if his suicidal thoughts become worse. However, he states that if outside of the hospital, he would jump out of his window.
- racing thoughts: denies
- homicidal ideation: denies

- overall: Although his anxiety has improved, his depression has worsened.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 131/86 | Pulse 98 | Temp (Src) 97.7 °F (36.5 °C) (Oral) | Resp 17 | Ht 1.702 m (5' 7") | Wt 59.24 kg (130 lb 9.6 oz) | SpO2 98%
Wt Readings from Last 3 Encounters:
08/17/16 : 59.24 kg (130 lb 9.6 oz)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/18/16 0827 (continued)

- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: 0
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Tearful
- Mood: depressed
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Fair

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for:, depression, tearful, lack of interest and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:
No results for input(s): WBC, HGB, HCT, PLT in the last 72 hours.
No results for input(s): NA, K, CL, CO2, BUN, CREATININE, GLU, CA, MG, PHOS in the last 72 hours.
No results for input(s): TBILI, AST, ALT, ALP, ALB in the last 72 hours.
No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last	Last

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/18/16 0827 (continued)

					Rate	Dose
• gabapentin (NEURONTIN) Cap 600 mg	600 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD		600 mg at 08/17/16 1254
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 2,000 mg	2,000 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		2,000 mg at 08/17/16 2209
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD		7.5 mg at 08/15/16 2100
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD		10 mg at 08/17/16 0832
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD		30 mL at 08/17/16 2209
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD		17.2 mg at 08/17/16 2209
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD		
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD		2 Patch at 08/15/16 2100
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD		2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD		1 mg at 08/17/16 0832
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD		
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD		5 mg at 08/16/16 0853
• OLANZapine ODT (zyPREXA ZYDIS)	2.5 mg	Oral	BEDTIME PRN MAY	Cruz, John Michael de Vera,		2.5 mg at

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/18/16 0827 (continued)

Solutab 2.5 mg			REPEAT X 1	MD	08/17/16 2256
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:
 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 2000 mg PO at bedtime
- f/ Valproic Acid trough level on Thursday night, goal between 50 - 125
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- started Lurasidone 20 mg PO with dinner, titrate up as needed with max of 120 mg PO daily
- monitor for ongoing toxicity of Lurasidone that includes but are not limited to hypotension, syncope, extrapyramidal symptoms, somnolence, appetite, and fatigue
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1

 # Post Traumatic Stress Disorder
- continue PRN Gabapentin 600 mg PO q4h for anxiety
- monitor for ongoing toxicity of Gabapentin that includes but are not limited to dizziness, somnolence, ataxia, worsening depression, increased suicidality and erythema multiforme, especially given recent increase
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:
- Gabapentin as above

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/18/16 0827 (continued)

- Exposure Response Prevention Therapy as outpatient

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 7 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Thursday, August 18, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
depression

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/18/16 0827 (continued)

Intervention:
Increase awareness of emotional states/reality testing
Demonstrate interventions in thought-emotion-behavior triad
Increase insight into illness and treatment plan
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided supportive psychotherapy and processed the following issues. He feels extremely sad because he was placed on a 5150 and now he has lost his firearms license for five years. He does not know how he will work or obtain money. He feels extremely depressed and cannot identify the reason. He said that he has been in a fetal position in the hallway rocking back and forth and crying. He knows that he is in a severe depressive episode because he started seeing things outside of the window in black and white and not in color. The last time that this occurred was 11 years ago when he was depressed. He was told that we will start him on Lurasidone which is a medication used to treat patients who have bipolar disorder type I and currently in a depressive phase as it seems that his depression has been worsening over the past few days. He understood. In addition, he was reminded that he was going to get his valproic acid trough level done tonight so that his Divalproex ER dosage could be appropriate adjusted.

ATTENDING PHYSICIAN:
John M Cruz, MD

Cruz, John Michael de Vera, MD at 08/17/16 0814
Status: Signed

PSYCHIATRY PROGRESS NOTE
Wednesday, August 17, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/17/16 0814 (continued)

- Sleep - 7.5 hours
- Required PRN Buprenorphine 2 mg - 9:05
- Required PRN Olanzapine ODT 2.5 mg - 20:17
- Required PRN Gabapentin 300 mg - 9:01/ 9:37

In speaking to the psychiatrist, the patient states
- mood: "anxious and depressed" - worse than yesterday - because of the residual effects of his panic attack
- psychomotor retardation: "yes" - worse than yesterday - feels that his thinking has significantly slowed down
- anxiety: "yes" - worse than yesterday - had acute panic attack that started at 10:00am and peaked at 12:00pm requiring him to ask for PRN Gabapentin 600 mg which decreased his anxiety, but did not immediately remove it as it did yesterday
- psychomotor agitation: none
- sleep: "poor" - worse than night before - because has new roommate and people kept on coming into his room from 5:00am onwards to check on his roommate which woke up the patient
- energy: "low" and rates it a 3/10 (0 - poor, 10 - great) - worse than yesterday - because of lack of sleep, and worsening depression
- pain: denies
- self-esteem: "good"
- worthlessness: denies
- passive death wish: denies
- suicidal ideation: denies

- overall: His mood is not as depressed from when he first came in, but he continues to experience spontaneous anxiety.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 120/74 | Pulse 94 | Temp (Src) 98.5 °F (36.9 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 95%
Wt Readings from Last 3 Encounters:
08/09/16 : 58.514 kg (129 lb)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: 0
- Orientation**:**Fully oriented
- Speech: soft and decreased rate
- Language: English speaking and WNL
- Affect:: Flat
- Mood: anxious and depressed
- Suicidal ideation: No
- Homicidal Ideation: No

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/17/16 0814 (continued)

- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Fair

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for:, depression, anxiety, panic attacks and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:
No results for input(s): WBC, HGB, HCT, PLT in the last 72 hours.
No results for input(s): NA, K, CL, CO2, BUN, CREATININE, GLU, CA, MG, PHOS in the last 72 hours.
No results for input(s): TBILI, AST, ALT, ALP, ALB in the last 72 hours.
No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• gabapentin (NEURONTIN) Cap 600 mg	600 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD		
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 2,000 mg	2,000 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		2,000 mg at 08/16/16 2018
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera,		7.5 mg at

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/17/16 0814 (continued)

				MD	08/15/16 2100
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD	10 mg at 08/16/16 0852
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD	30 mL at 08/16/16 2018
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD	17.2 mg at 08/16/16 2017
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD	
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD	2 Patch at 08/15/16 2100
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD	2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/16/16 0852
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/16/16 0853
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/16/16 2017
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/17/16 0814 (continued)

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:

- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:

 # Bipolar Disorder Type I without Psychotic Features:

- continue Divalproex ER 2000 mg PO at bedtime
- f/ Valproic Acid trough level on Thursday night, goal between 50 - 125
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1

 # Post Traumatic Stress Disorder

- continue PRN Gabapentin 600 mg PO q4h for anxiety
- monitor for ongoing toxicity of Gabapentin that includes but are not limited to dizziness, somnolence, ataxia, worsening depression, increased suicidality and erythema multiforme, especially given recent increase
- consider Exposure Response Prevention Therapy as outpatient

 # Panic Attacks:

- Gabapentin as above
- Exposure Response Prevention Therapy as outpatient

 # Psoriasis

- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia

- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/17/16 0814 (continued)

- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 4 - 5 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Wednesday, August 17, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
mania
mood instability
extreme anxiety/panic

Intervention:
Increase awareness of emotional states/reality testing
Demonstrate interventions in thought-emotion-behavior triad
Increase insight into illness and treatment plan
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/17/16 0814 (continued)

Narrative:
- provided positive reinforcement for being open with his feelings of anxiousness
- provided supportive psychotherapy and processed the following issues. He says that he feels depressed, but that his depression has decreased from when he first came in. In addition, he says that when he often feels depressed and anxious, all he wants to do is lay in bed. I encouraged him to engage in what we call behavioral activation which is to do things that are the opposite of what he wants to do. Specifically, when he wants to just lay in bed, he should go out of his room and socialize with others. I also told him that what he is experiencing is a current depressive episode and that often times depression and anxiety symptoms co-exist which may be a reason why he is experiencing panic attacks. He was told that I want to optimize treatment with Valproic Acid first, but if his depressive episodes continue, we can also start Lamotrigine which he says has helped him in the past.

ATTENDING PHYSICIAN:
John M Cruz, MD

Cruz, John Michael de Vera, MD at 08/16/16 0908
Status: Signed

PSYCHIATRY PROGRESS NOTE
Tuesday, August 16, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- Had panic attack
- Felt hopeless
- Slept - 8 hours

In speaking to the psychiatrist, the patient states
- mood: "anxious and depressed" - worse than yesterday - woke up feeling this way
- anxiety: "extremely high" - worse than yesterday - woke up feeling extremely anxious, was curled up in fetal position on his bed and tapping his leg on his bad. His anxiety did not go away with PRN Gabapentin 300 mg. He required a second dosage of PRN Gabapentin 300 to help him feel better.
- sleep: "poor" - worse than yesterday - because he worried whether people were going to draw his blood tonight
- energy: "poor" - worse than yesterday - feels wiped out from the "panic attack"
- pain: denes

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/16/16 0908 (continued)

- passive death wish: denies
- suicidal ideation: If he experienced this level of panic outside of the hospital, he states that he definitely would have jumped out of the window of his apartment.
- racing thoughts: "yes" - same as yesterday - thoughts go through his mind so fast and makes him feel anxious
- psychomotor agitation: "yes" - worse than yesterday - was pacing up and down the hallway and jumping up and down in the day area during the panic attack
- homicidal ideation: denies

- overall: Patient continues to have break through panic attacks which worsens his depression and intensifies his anxiety

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 134/72 | Pulse 84 | Temp (Src) 98.4 °F (36.9 °C) (Oral) | Resp 18 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 99%
Wt Readings from Last 3 Encounters:
08/09/16 : 58.514 kg (129 lb)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: Not applicable
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: anxious and depressed
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Good

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for:, depression, anxiety, panic attacks and difficulty coping

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/16/16 0908 (continued)

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:

Recent Labs

Lab	08/13/16 1044
WBC	3.8 L
HGB	14.6
HCT	43.7
PLT	229

Recent Labs

Lab	08/13/16 1044
NA	142
K	4.1
CL	102
CO2	34 H
BUN	16
CREATININE	0.98
GLU	107 H
CA	9.1

Recent Labs

Lab	08/13/16 1044
TBILI	0.3
AST	62 H
ALT	126 H
ALP	103
ALB	4.0

No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/16/16 0908 (continued)

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 2,000 mg	2,000 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		2,000 mg at 08/15/16 2039
• gabapentin (NEURONTIN) Cap 300 mg	300 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD		300 mg at 08/16/16 0901
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD		7.5 mg at 08/15/16 2100
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD		10 mg at 08/16/16 0852
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD		30 mL at 08/15/16 2043
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD		17.2 mg at 08/14/16 2124
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD		
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD		2 Patch at 08/15/16 2100
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD		2 mg at 08/16/16 0905
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD		1 mg at 08/16/16 0852
• magnesium hydroxide (MILK OF MAGNESIA/MOM)	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD		

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/16/16 0908 (continued)

Oral Susp 30 mL					
• methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	5 mg at 08/16/16 0853
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/14/16 2124
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:
 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER to 200 mg PO at bedtime
- f/ Valproic Acid trough level on Thursday night, goal between 50 - 125
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime for insomnia, may repeat x 1

 # Post Traumatic Stress Disorder
- increased PRN Gabapentin to 600 mg PO q4h for anxiety
- monitor for ongoing toxicity of Gabapentin that includes but are not limited to dizziness, somnolence, ataxia, worsening depression, increased suicidality and erythema multiforme, especially given recent increase
- consider Exposure Response Prevention Therapy as outpatient

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/16/16 0908 (continued)

 # Panic Attacks:
- Gabapentin as above
- Exposure Response Prevention Therapy as outpatient

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 3 - 5 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Tuesday, August 16, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/16/16 0908 (continued)

Problem:
mood instability
extreme anxiety/panic

Intervention:
Increase awareness of emotional states/reality testing
Increase insight into illness and treatment plan
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided supportive psychotherapy and processed the following issues. I told him that I am glad that the Gabapentin is working for him and that we will increase his PRN dosages since 600 mg was effective at breaking his panic attack. In addition, I also told him that I do not like placing my patients on benzodiazepines as these medications can be extremely habit forming, often requiring higher and higher dosages for effectiveness. I also spoke to him about the course of treatment for bipolar disorder which is that with treatment, the range between his manic and depressive episodes will ideally decrease so the point where his mood is just even (not feeling manic nor depressed).

ATTENDING PHYSICIAN:
John M Cruz, MD

Cruz, John Michael de Vera, MD at 08/15/16 0828
Status: Signed

PSYCHIATRY PROGRESS NOTE
Monday, August 15, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:

- No over night events
- Sleep - 7.25 hours

In speaking to the psychiatrist, the patient states
- mood: Depressed in the morning, but improves gradually throughout the afternoon - worse than yesterday - because had panic attack in the afternoon
- appetite: good
- psychomotor retardation: "yes" - worse than yesterday - feels that the PRN Gabapentin slowed his mind down too much.
- anxiety: "yes" - worse than yesterday - had a panic attack in the afternoon where he was stomping on the ground and dissipated after he took PRN Gabapentin 300 mg PO x 1
- psychomotor agitation: "yes" - worse than yesterday - was stomping on the ground when he was feeling anxious
- sleep: "good" - same as yesterday - easily fell asleep, slept throughout the night and woke up feeling rested
- energy: "good" - same as yesterday - because got good sleep
- passive death wish: denies
- suicidal ideation: denies

- overall: Although his mood is better, his anxiety was worse today when he had a panic attack.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 132/72 | Pulse 90 | Temp (Src) 98.2 °F (36.8 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 100%
Wt Readings from Last 3 Encounters:
08/09/16 : 58.514 kg (129 lb)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: Not applicable
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Flat
- Mood: anxious and depressed
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired

- Judgement: Fair
- Insight: Fair

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for:, anxiety, panic attacks and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
WBC	3.8 L	3.3 L
HGB	14.6	13.8
HCT	43.7	41.1
PLT	229	224

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
NA	142	--
K	4.1	--
CL	102	--
CO2	34 H	--
BUN	16	--
CREATININE	0.98	--
GLU	107 H	--
CA	9.1	--
MG	--	2.5 H
PHOS	--	2.9

Recent Labs

Lab	08/13/16

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/15/16 0828 (continued)

	1044
TBILI	0.3
AST	62 H
ALT	126 H
ALP	103
ALB	4.0

No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• clonAZEPAM (klonoPIN) Tab 0.5 mg	0.5 mg	Oral	BID PRN	Schumm, Derek Daniel, MD		
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD		10 mg at 08/14/16 0857
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD		30 mL at 08/14/16 2123
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD		17.2 mg at 08/14/16 2124
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD		
• buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD		
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD		2 mg at 08/12/16 1844
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 1,500 mg	1,500 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		1,500 mg at 08/14/16 2123
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John		1 mg at

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/15/16 0828 (continued)

				Michael de Vera, MD	08/14/16 0857
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• [START ON 8/16/2016] methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	
• methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/14/16 2124
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:
 # Bipolar Disorder Type I without Psychotic Features:
- increased Divalproex ER to 200 mg PO at bedtime

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/15/16 0828 (continued)

- f/ Valproic Acid trough level on Thursday night, goal between 50 - 125
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent increase
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime, may repeat x 1

 # Post Traumatic Stress Disorder
- continue PRN Gabapentin 300 mg PO q4h for anxiety
- f/u with outpatient therapy

 # Panic Attacks:
- continue PRN Gabapentin 300 mg PO q4h for anxiety

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 4 - 7 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Monday, August 15, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/15/16 0828 (continued)

modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
extreme anxiety/panic

Intervention:
Increase awareness of emotional states/reality testing
Increase insight into illness and treatment plan
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided positive reinforcement for being open with his feelings of anxiety.
- provided supportive psychotherapy and processed the following issues. He said that his anxiety today was very high. He said that taking the Neurontin seemed to have slowed down his thoughts too much. He was told that with his anxiety being so high and his thoughts going so fast, that when his thoughts do slow down after taking the Neurontin, they may feel especially slow. In addition, I provided him psychoeducation about the treatment of bipolar disorder. Specifically, I told him that with Bipolar Disorder, a person's mood goes up and down, but that the goal of bipolar disorder is to get the range to be smaller and smaller until there is minimal range between his elevated moods and depressed moods.

ATTENDING PHYSICIAN:
John M Cruz, MD

Sharma, Kanika, MD at 08/14/16 2034

Status: Signed

HOSPITALIST PROGRESS NOTE 8/14/2016

DOA: 8/9/2016

SUBJECTIVE:
F/U abdominal pain.

Call Documentation (continued)

Sharma, Kanika, MD at 08/14/16 2034 (continued)

Patient had a good BM early this AM.
He feels much better after that.
No nausea, no emesis. He was able to eat today.

OBJECTIVE:
BP 132/72 | Pulse 90 | Temp (Src) 98.2 °F (36.8 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 100%

Temp (36hrs), Avg:98.4 °F (36.9 °C), Min:98.1 °F (36.7 °C), Max:98.7 °F (37.1 °C)

Systolic (36hrs), Avg:123 mmHg, Min:109 mmHg, Max:145 mmHg
Diastolic (36hrs), Avg:74 mmHg, Min:68 mmHg, Max:80 mmHg

PE
General: No acute distress,
Neck: No JVD, No masses, Supple,
Respiratory: good inspiratory effort, No wheezes, No rales (crackles) and No rhonchi
Cardiovacular: Regular rhythm, Normal heart sounds, No murmur. No edema, peripheral pulses intact.
GI: Soft, Non-tender,Non-distended, Normal bowel sounds, no hepatosplenomegaly.
Musculoskeletal: muscle strength and tone normal, No muscle atrophy. Joint range of motion normal.
Neuro: Awake, Alert, Conversant, CN intact, Motor intact.
Skin: No Decubital ulcer, No rash.
Psych: Normal affect

Labs

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
WBC	3.8 L	3.3 L
HGB	14.6	13.8
HCT	43.7	41.1
PLT	229	224

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
NA	142	--
K	4.1	--
CL	102	--
CO2	34 H	--

Call Documentation (continued)

Sharma, Kanika, MD at 08/14/16 2034 (continued)

BUN	16	--
CREATININE	0.98	--
GLU	107 H	--
CA	9.1	--
MG	--	2.5 H
PHOS	--	2.9

Recent Labs

Lab	08/13/16 1044
TBILI	0.3
AST	62 H
ALT	126 H
ALP	103
ALB	4.0

Medications

bisacodyl	10 mg	DAILY
lactulose	30 mL	BID
sennosides	17.2 mg	Q BEDTIME
[START ON 8/15/2016] buprenorphine	2 Patch	Q7 DAYS
divalproex 24Hr-ER	1,500 mg	Q BEDTIME
foLIC acid	1 mg	DAILY
[START ON 8/16/2016] methotrexate	5 mg	Q7 DAYS
[START ON 8/15/2016] methotrexate	7.5 mg	Q7 DAYS

Review of patient's allergies indicates no known allergies.

ASSESSMENT and PLAN:

Nausea and vomiting
-improved with bowel regimen

Transaminitis
-monitor
-check Hepatitis panel

Chronic pain syndrome with chronic pelvic pain and fibromyalgia.
-followed by the Highland General Hospital Pain Clinic
-Butrans patch
-Subutex

Call Documentation (continued)

Sharma, Kanika, MD at 08/14/16 2034 (continued)

-Neurontin
-Pyridium.

Psoriasis.
-Methotrexate.

Bipolar affective disorder and posttraumatic stress disorder
-treatment as per psych

Kanika Sharma, MD
510-393-1453

Schumm, Derek Daniel, MD at 08/14/16 1544

Status: Signed

PSYCHIATRY PROGRESS NOTE
8/13/16

Total Time Spent: 35 Minutes.

Hospital Care

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:

8/14: Reports having 2 panic attacks today. Unclear about precipitants. Did describe racing thoughts on Friday which "frightened," him. Most of Saturday was spent getting medically well. Depakote level not drawn last night. Notes moderate (6/10) degrees of depression. Requests prn clonazepam for panic. Does not feel that gabapentin has been useful. Remains disheveled and malodorous.

Per RN: Mostly isolative to room. Attended 1100 group but left group early. Endorsed depressed and anxious mood. Guarded during interaction. Stated he would use "meditation" to help manage his anxiety. Disheveled, unkempt appearance. Refused shower this shift, stated he showered last night. Reported eating only 2 sausage links at breakfast and refused lunch.
1415: Continues to c/o high anxiety. Visited with friend this afternoon. Declined gabapentin when offered, stated doctor offered to order Klonopin. Stated he will wait for order to come through.
1430: Patient re-approached RN and requested gabapentin PRN. Stated he would still like to take Klonopin when ordered.

Call Documentation (continued)

Schumm, Derek Daniel, MD at 08/14/16 1544 (continued)

8/13: Reports acute onset 9/10 R upper quadrant abdominal pain that started about 10 minutes after breakfast. In room using toilet and also "trying to vomit." Apparently dry heaved several times. Reported to nursing above and that I was worried about gall bladder dysfunctions. Vitals are normal. No other associated sx. Pt himself feels that he has food poisoning. Denies any current SI. Compliant w/ tx plan.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 111/80 | Pulse 100 | Temp (Src) 98.6 °F (37 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 100%
Wt Readings from Last 3 Encounters:
08/09/16 : 58.514 kg (129 lb)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: Not applicable
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: anxious
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Good

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for: and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
WBC	3.8 L	3.3 L
HGB	14.6	13.8
HCT	43.7	41.1
PLT	229	224

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
NA	142	--
K	4.1	--
CL	102	--
CO2	34 H	--
BUN	16	--
CREATININE	0.98	--
GLU	107 H	--
CA	9.1	--
MG	--	2.5 H
PHOS	--	2.9

Recent Labs

Lab	08/13/16 1044
TBILI	0.3
AST	62 H
ALT	126 H
ALP	103
ALB	4.0

No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Call Documentation (continued)

Schumm, Derek Daniel, MD at 08/14/16 1544 (continued)

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• bisacodyl (DULCOLAX) Supp 10 mg	10 mg	Rectal	DAILY	Sharma, Kanika, MD		10 mg at 08/14/16 0857
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	BID	Sharma, Kanika, MD		30 mL at 08/14/16 0857
• sennosides (SENOKOT) Tab 17.2 mg	17.2 mg	Oral	Q BEDTIME	Sharma, Kanika, MD		17.2 mg at 08/13/16 2047
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD		
• [START ON 8/15/2016] buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD		
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD		2 mg at 08/12/16 1844
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 1,500 mg	1,500 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		1,500 mg at 08/13/16 2048
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD		1 mg at 08/14/16 0857
• gabapentin (NEURONTIN) Cap 300 mg	300 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD		300 mg at 08/14/16 1432
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD		
• [START ON 8/16/2016] methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD		
• [START ON 8/15/2016] methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD		
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD		2.5 mg at 08/13/16 0258
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD		200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:

- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:

 # Acute abdominal pain - screening labs ordered by IM. May need RUQ ultrasound - defer to IM. Vitals stable

 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 1500 mg PO at bedtime
- check Depakote level tonight
- WEEKEND: Adjust Divalproex ER dosage based on trough level
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent initiation
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime, may repeat x 1

 # Post Traumatic Stress Disorder
- continue PRN Gabapentin 300 mg PO q4h for anxiety
- f/u with outpatient therapy

 # Panic Attacks:
-stop gabapentin; start clonazepam 0.5mg po bid prn panic

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

Call Documentation (continued)

Schumm, Derek Daniel, MD at 08/14/16 1544 (continued)

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 4 - 7 days

PROCEDURE CODES:
E/M 99233

ATTENDING PHYSICIAN:
Derek D Schumm

—

Sharma, Kanika, MD at 08/13/16 1944
Status: Signed

HOSPITALIST PROGRESS NOTE 8/13/2016

DOA: 8/9/2016

SUBJECTIVE:
RN asked me to eval patient for nausea and vomiting

Patient states that at 3AM last night, he took zyprexa for sleep. He ate breakfast this AM. 10 minutes after breakfast he had nausea and vomiting with a sharp stabbing pan in his stomach and intestines. The pain was so severe that he was down on the floor in a fetal position. He was given zofran and pyridium. He felt better and slept for most of the afternoon. He did not eat lunch. When I saw him he felt better with no abdominal pain. He is having trouble with severe constipation and thinks this may be contributing to his symptoms.

OBJECTIVE:
BP 145/79 | Pulse 115 | Temp (Src) 98.7 °F (37.1 °C) (Oral) | Resp 17 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 100%

Temp (36hrs), Avg:98.2 °F (36.8 °C), Min:97.9 °F (36.6 °C), Max:98.7 °F (37.1 °C)

Systolic (36hrs), Avg:128 mmHg, Min:109 mmHg, Max:145 mmHg

Call Documentation (continued)

Sharma, Kanika, MD at 08/13/16 1944 (continued)

Diastolic (36hrs), Avg:78 mmHg, Min:68 mmHg, Max:88 mmHg

PE

General: No acute distress,
Neck: No JVD, No masses, Supple,
Respiratory: good inspiratory effort, No wheezes, No rales (crackles) and No rhonchi
Cardiovacular: Regular rhythm, Normal heart sounds, No murmur. No edema, peripheral pulses intact.
GI: Soft, Non-tender,Non-distended, Normal bowel sounds, no hepatosplenomegaly.
Musculoskeletal: muscle strength and tone normal, No muscle atrophy. Joint range of motion normal.
Neuro: Awake, Alert, Conversant, CN intact, Motor intact.
Skin: psoriatatic rash on abdomen and legs
Psych: Normal affect

Labs

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
WBC	3.8 L	3.3 L
HGB	14.6	13.8
HCT	43.7	41.1
PLT	229	224

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
NA	142	--
K	4.1	--
CL	102	--
CO2	34 H	--
BUN	16	--
CREATININE	0.98	--
GLU	107 H	--
CA	9.1	--
MG	--	2.5 H
PHOS	--	2.9

Recent Labs

Lab	08/13/16 1044
TBILI	0.3
AST	62 H
ALT	126 H

Call Documentation (continued)

Sharma, Kanika, MD at 08/13/16 1944 (continued)

ALP 103
ALB 4.0

Medications

bisacodyl	10 mg	DAILY
lactulose	30 mL	BID
sennosides	17.2 mg	Q BEDTIME
[START ON 8/15/2016] buprenorphine	2 Patch	Q7 DAYS
divalproex 24Hr-ER	1,500 mg	Q BEDTIME
foLIC acid	1 mg	DAILY
[START ON 8/16/2016] methotrexate	5 mg	Q7 DAYS
[START ON 8/15/2016] methotrexate	7.5 mg	Q7 DAYS

Review of patient's allergies indicates no known allergies.

ASSESSMENT and PLAN:

Nausea and vomiting
-probably secondary to obstipation
-increase bowel regimen

Transaminitis
-monitor
-check Hepatitis panel

Chronic pain syndrome with chronic pelvic pain and fibromyalgia.
-followed by the Highland General Hospital Pain Clinic
-Butrans patch
-Subutex
-Neurontin
-Pyridium.

Psoriasis.
-Methotrexate.

Bipolar affective disorder and posttraumatic stress disorder
-treatment as per psych

Kanika Sharma, MD
510-393-1453

Call Documentation (continued)

Sharma, Kanika, MD at 08/13/16 1944 (continued)

Schumm, Derek Daniel, MD at 08/13/16 1344

Status: Signed

PSYCHIATRY PROGRESS NOTE

8/13/16

Total Time Spent: 35 Minutes.

Hospital Care

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY: Reports acute onset 9/10 R upper quadrant abdominal pain that started about 10 minutes after breakfast. In room using toilet and also "trying to vomit." Apparently dry heaved several times. Reported to nursing above and that I was worried about gall bladder dysfunctions. Vitals are normal. No other associated sx. Pt himself feels that he has food poisoning. Denies any current SI. Compliant w/ tx plan.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 120/71 | Pulse 87 | Temp (Src) 98.1 °F (36.7 °C) (Oral) | Resp 20 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 100%
Wt Readings from Last 3 Encounters:
08/09/16 : 58.514 kg (129 lb)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: Not applicable
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: anxious
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality

Call Documentation (continued)

Schumm, Derek Daniel, MD at 08/13/16 1344 (continued)

- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Good

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for: and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
WBC	3.8 L	3.3 L
HGB	14.6	13.8
HCT	43.7	41.1
PLT	229	224

Recent Labs

Lab	08/13/16 1044	08/12/16 1015
NA	142	--
K	4.1	--
CL	102	--
CO2	34 H	--
BUN	16	--
CREATININE	0.98	--
GLU	107 H	--
CA	9.1	--
MG	--	2.5 H
PHOS	--	2.9

Recent Labs

Call Documentation (continued)

Schumm, Derek Daniel, MD at 08/13/16 1344 (continued)

Lab	08/13/16 1044
TBILI	0.3
AST	62 H
ALT	126 H
ALP	103
ALB	4.0

No results for input(s): GLUCAP in the last 72 hours.
No results for input(s): TSH in the last 72 hours.

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD		
• [START ON 8/15/2016] buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD		
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD		2 mg at 08/12/16 1844
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 1,500 mg	1,500 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		1,500 mg at 08/12/16 2106
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD		1 mg at 08/12/16 0826
• gabapentin (NEURONTIN) Cap 300 mg	300 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD		300 mg at 08/12/16 1205
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	Q BEDTIME	Sharma, Kanika, MD		30 mL at 08/12/16 2106
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD		
• [START ON 8/16/2016] methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD		
• [START ON 8/15/2016] methotrexate Tab 7.5	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD		

Call Documentation (continued)

Schumm, Derek Daniel, MD at 08/13/16 1344 (continued)

mg					
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	2.5 mg at 08/13/16 0258
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	200 mg at 08/13/16 1008

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:

 # Acute abdominal pain - screening labs ordered by IM. May need RUQ ultrasound - defer to IM. Vitals stable

 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 1500 mg PO at bedtime
- f/ Valproic Acid trough level on Saturday night, goal between 50 - 125
- WEEKEND: Adjust Divalproex ER dosage based on trough level
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent initiation
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime, may repeat x 1

 # Post Traumatic Stress Disorder
- continue PRN Gabapentin 300 mg PO q4h for anxiety
- f/u with outpatient therapy

 # Panic Attacks:
- continue PRN Gabapentin 300 mg PO q4h for anxiety

Call Documentation (continued)

Schumm, Derek Daniel, MD at 08/13/16 1344 (continued)

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 4 - 7 days

PROCEDURE CODES:
E/M 99233

ATTENDING PHYSICIAN:
Derek D Schumm

—

Cruz, John Michael de Vera, MD at 08/12/16 0830

Status: Signed

PSYCHIATRY PROGRESS NOTE
Friday, August 12, 2016

Total Time Spent: 50 Minutes.
Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- Learned of roommate's death
- Slept - 7.5 hours
- PRN Gabapentin 300 mg - 9:50

In speaking to the psychiatrist, the patient states
- mood: "sad and relief" - better than yesterday - because of learning of roommate's death. Roommate in the past trashed his apartment causing him to buy new furniture and asking his father for help.
- appetite: "good" - same as yesterday - eating solid foods and three meals a day with snacks
- anxiety: "yes" and had a panic attack earlier this morning, but the panic attack was much lower than yesterday - better than yesterday - because Gabapentin helps
- psychomotor agitation: denies
- sleep: "great" and slept 10 hours - better than the night before - because Divalproex is working
- energy: "very good" - better than yesterday - as a result of getting a good night's sleep.
- pain: "yes" and has a headache and rates it a 3/10 (0 - none, 10 - severe) - worse than yesterday
- passive death wish: denies
- suicidal ideation: denies

- energy: "good" - rates it 50/100 (0 - poor, 10 - too high) - same as yesterday
- homicidal ideation: denies

- overall: Feels calmer and recognizes that his thinking is slowing down and becoming more focused

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 136/88 | Pulse 78 | Temp (Src) 98.2 °F (36.8 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 96%
Wt Readings from Last 3 Encounters:
08/09/16 : 58.514 kg (129 lb)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: Not applicable
- Orientation**:**Fully oriented
- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: anxious and depressed
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/12/16 0830 (continued)

- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Good

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for: and difficulty coping

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:

Recent Labs

Lab	08/09/16 1025
WBC	2.2 L
HGB	13.3 L
HCT	40.2
PLT	233

Recent Labs

Lab	08/09/16 1025
NA	144
K	4.0
CL	106
CO2	32
BUN	18
CREATININE	0.93
GLU	100 H
CA	9.1

Recent Labs

Lab	08/09/16

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/12/16 0830 (continued)

	1025
TBILI	0.8
AST	39 H
ALT	61 H
ALP	103
ALB	4.0

No results for input(s): GLUCAP in the last 72 hours.

Recent Labs

Lab	08/09/16 1025
TSH	0.67

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD		
• [START ON 8/15/2016] buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD		
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD		
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 1,500 mg	1,500 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		1,500 mg at 08/11/16 2059
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD		1 mg at 08/12/16 0826
• gabapentin (NEURONTIN) Cap 300 mg	300 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD		300 mg at 08/11/16 0950

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/12/16 0830 (continued)

• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	Q BEDTIME	Sharma, Kanika, MD	30 mL at 08/11/16 2100
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• [START ON 8/16/2016] methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	
• [START ON 8/15/2016] methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:
- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations

PLAN:
 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 1500 mg PO at bedtime

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/12/16 0830 (continued)

- f/ Valproic Acid trough level on Saturday night, goal between 50 - 125
- WEEKEND: Adjust Divalproex ER dosage based on trough level
- monitor for toxicity of Divalproex which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia especially given recent initiation
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime, may repeat x 1

 # Post Traumatic Stress Disorder
- continue PRN Gabapentin 300 mg PO q4h for anxiety
- f/u with outpatient therapy

 # Panic Attacks:
- continue PRN Gabapentin 300 mg PO q4h for anxiety

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP vs. La Cheim

 # Estimated Length of Stay
- ~ 4 - 7 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

PSYCHOTHERAPY NOTE
Friday, August 12, 2016

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/12/16 0830 (continued)

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
mania
social conflict/stressors

Intervention:
Increase awareness of emotional states/reality testing
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided positive reinforcement for being open with his feelings especially regarding his roommate's death.
- provided supportive psychotherapy and processed the following issues. He finds it strange that his roommate who harassed him so much is now dead. He feels sad for the ending of her life, but relief that she will no longer harass him and that his superintendent will be relieved as well. He said that he was experiencing a migraine with aura. He wonders whether this is due to the medication or a sign of Paroxetine withdrawal. He was told that it might not be due to anything, but a psychological relief from his roommate's death. It is unlikely to be Paroxetine withdrawal since the last time he took Paroxetine was on Monday. In addition, he was told that Divalproex does not necessarily cause migraines, and is in fact a medication that is often used as prophylactic for migraines. He was reminded that he will be getting his Divalproex level checked on Saturday and from there, medication changes, most likely an increase, will be done.

ATTENDING PHYSICIAN:
John M Cruz, MD

Cruz, John Michael de Vera, MD at 08/11/16 0823

Status: Signed

PSYCHIATRY PROGRESS NOTE

Thursday, August 11, 2016

Total Time Spent: 50 Minutes.

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/11/16 0823 (continued)

Psychotherapy Time: 40 Minutes
E/M Time: 10 Minutes

CHIEF COMPLAINT:
47 year old male being treated for bipolar disorder without psychotic features.

TREATMENT:
hospital care and psychotherapy + E&M

INTERIM HISTORY:
Nursing notes state:
- Slept - 5 hours
- Failed blood draw

In speaking to the psychiatrist, the patient states
- mood: "little depressed" - slightly better than yesterday though
- appetite: "good" and eating solid foods now - better than yesterday
- anxiety: Had a panic attack in the middle of group today and the panic attack decreased and stopped after taking the PRN Gabapentin 300 mg
- psychomotor agitation: denies
- sleep: "good" and had no difficulties falling asleep or staying asleep and slept until 7:00am this morning and woke up feeling rested - better than yesterday
- energy: "good" and rates it 40/100 (0 - poor, 100 - too elevated) - better than yesterday
- pain: denies
- passive death wish: denies
- suicidal ideation: denies
- racing thoughts: denies
- psychomotor agitation: denies
- homicidal ideation: denies

- overall: His depressive states are not as intense as they used to be.

PAST FAMILY AND SOCIAL HISTORY:
- Unchanged

VITAL SIGNS:
BP 117/70 | Pulse 77 | Temp (Src) 98.1 °F (36.7 °C) (Oral) | Resp 16 | Ht 1.702 m (5' 7") | Wt 58.514 kg (129 lb) | SpO2 98%
Wt Readings from Last 3 Encounters:
08/09/16 : 58.514 kg (129 lb)

MENTAL STATUS EXAM:
- General Appearance**:** unkempt
- Muscle Strength and Tone**:** No abnormalities noted
- Gait & Station: Gait: unassisted and stable
- AIMS: Not applicable
- Orientation**:**Fully oriented

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/11/16 0823 (continued)

- Speech: normal rhythm and rate
- Language: English speaking and WNL
- Affect:: Appropriate
- Mood: euthymic
- Suicidal ideation: No
- Homicidal Ideation: No
- Thought Process: Focused
- Thought Content: no evidence of abnormality
- Attention & Concentration: Impaired
- Recent & Remote Memory: recent memory fair and remote memory fair
- Fund of Knowledge: Impaired
- Judgement: Fair
- Insight: Good

REVIEW OF SYSTEMS:
- General: negative for: and change in energy
- Neuro: negative for:, headaches and weakness
- Psych: positive for:, anxiety and panic attacks

ADDITIONAL DATA REVIEWED:
I have reviewed all pertinent notes, lab and imaging studies since last encounter.

COORDINATION OF CARE:
Coordination activities since last encounter: Nurse
Social Worker

DIAGNOSTIC STUDIES:
Reviewed

LAB VALUES:

Recent Labs

Lab	08/09/16 1025
WBC	2.2 L
HGB	13.3 L
HCT	40.2
PLT	233

Recent Labs

Lab	08/09/16 1025
NA	144
K	4.0
CL	106
CO2	32

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/11/16 0823 (continued)

BUN	18
CREATININE	0.93
GLU	100 H
CA	9.1

Recent Labs

Lab	08/09/16 1025
TBILI	0.8
AST	39 H
ALT	61 H
ALP	103
ALB	4.0

No results for input(s): GLUCAP in the last 72 hours.

Recent Labs

Lab	08/09/16 1025
TSH	0.67

MEDICATIONS:
Reviewed
Discussed A/E's

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• aluminum/magnesium hydroxide/simethicone (MYLANTA) Oral Susp 30 mL	30 mL	Oral	Q4H PRN	Michel, Christopher S, MD		
• [START ON 8/15/2016] buprenorphine (BUTRANS) 5mcg/hr 2 Patch	2 Patch	Transdermal	Q7 DAYS	Cruz, John Michael de Vera, MD		
• buprenorphine SL (SUBUTEX) Tab 2 mg	2 mg	Sublingual	Q6H PRN	Cruz, John Michael de Vera, MD		
• divalproex 24Hr-ER (DEPAKOTE ER) Tab 1,500 mg	1,500 mg	Oral	Q BEDTIME	Cruz, John Michael de Vera, MD		1,500 mg at 08/10/16

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/11/16 0823 (continued)

					2108
• foLIC acid Tab 1 mg	1 mg	Oral	DAILY	Cruz, John Michael de Vera, MD	1 mg at 08/10/16 1700
• gabapentin (NEURONTIN) Cap 300 mg	300 mg	Oral	Q4H PRN	Cruz, John Michael de Vera, MD	
• lactulose (ENULOSE) Oral Soln 30 mL	30 mL	Oral	Q BEDTIME	Sharma, Kanika, MD	30 mL at 08/10/16 2110
• magnesium hydroxide (MILK OF MAGNESIA/MOM) Oral Susp 30 mL	30 mL	Oral	BEDTIME PRN	Michel, Christopher S, MD	
• [START ON 8/16/2016] methotrexate Tab 5 mg	5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	
• [START ON 8/15/2016] methotrexate Tab 7.5 mg	7.5 mg	Oral	Q7 DAYS	Cruz, John Michael de Vera, MD	
• OLANZapine ODT (zyPREXA ZYDIS) Solutab 2.5 mg	2.5 mg	Oral	BEDTIME PRN MAY REPEAT X 1	Cruz, John Michael de Vera, MD	
• phenazopyridine (PYRIDIUM) Tab 200 mg	200 mg	Oral	Q8H PRN	Cruz, John Michael de Vera, MD	

SECLUSION/ RESTRAINT:
None

DIAGNOSIS/ PROBLEM LIST:

Active Hospital Problems

Diagnosis	Date Noted
• Fibromyalgia [M79.7]	08/10/2016
• Psoriasis [L40.9]	08/10/2016
• Chronic pelvic pain in male [R10.2, G89.29]	08/10/2016
• Bipolar I disorder, most recent episode depressed (HCC) [F31.30]	08/10/2016

Resolved Hospital Problems

Diagnosis	Date Noted

No resolved problems to display.

ASSESSMENT AND REASON FOR CONTINUED HOSPITALIZATION:

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/11/16 0823 (continued)

- if discharged, patient is at acute risk of self harm and for decompensation and rehospitalization
- in midst of creating and coordinating a safe and therapeutic discharge plan to decrease future inpatient psychiatric hospitalizations
- monitor for toxicity of Divalproex ER which include but are not limited to coma, seizures, ventricular arrhythmias, tremor, polyuria, and polydipsia

PLAN:

 # Bipolar Disorder Type I without Psychotic Features:
- continue Divalproex ER 1500 mg PO at bedtime
- f/ Valproic Acid trough level on Saturday night, adjusting level to reach goal between 50 - 125
- continue PRN Olanzapine ODT 2.5 mg PO at bedtime, may repeat x 1

 # Post Traumatic Stress Disorder
- continue PRN Gabapentin 300 mg PO q4h for anxiety
- f/u with outpatient therapy

 # Panic Attacks:
- continue PRN Gabapentin 300 mg PO q4h for anxiety

 # Psoriasis
- continue Methotrexate 7.5 mg PO at bedtime q7days (Mondays)
- continue Methotrexate 5 mg PO qam q7days (Tuesdays)
- continue Folic Acid 1 mg PO daily

 # Fibromyalgia
- continue Butran Patch 10 mcg/ hr 1 Patch TD at bedtime q7days (Mondays)
- continue PRN Buprenorphine SL 2 mg q6h for pain (not to exceed two dosages per day)
- holding PRN Hydrocodone/ Acetaminophen 10 mg/ 325 mg for pain to prevent polypharmacy
- continue Lactulose 30 mg PO qhs

 # Chronic Pelvic Pain Syndrome
- continue PRN Phenazopyridine 200 mg q8h for pelvic pain

 # Legal Issues:
- Voluntary

 # Disposition:
- Herrick PHP

 # Estimated Length of Stay
- ~ 5 - 8 days

PROCEDURE CODES:
E/M 99233
Psychotherapy90836

ATTENDING PHYSICIAN:
John M Cruz, MD

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/11/16 0823 (continued)

PSYCHOTHERAPY NOTE
Thursday, August 11, 2016

Patient was assessed as appropriate for psychotherapy with potential to benefit from evidence based modalities. Psychotherapy is provided in conjunction with and in addition to E/M evaluation in order to reduce symptomatology and improve adherence with psychopharmacologic interventions.

Psychotherapy Type:
CBT
Interpersonal
Supportive

Problem:
mood instability

Intervention:
Increase awareness of emotional states/reality testing
Demonstrate interventions in thought-emotion-behavior triad
Motivational interviewing to assess/assist readiness to change
Increase insight into illness and treatment plan
Improve treatment alliance

Response:
Acknowledges intellectual understanding but emotionally struggles

Plan:
Continue current psychotherapeutic treatment approach

Narrative:
- provided positive reinforcement for being honestly reporting his mental state. Provided psychoeducation about the projected course of treatment of bipolar disorder which is that a person's moods will swing between being extremely elevated to being extremely depressed, but once treatment is initiated, the range between these two poles will be much less. He understood. In addition, I also explained that the panic attack that he felt this morning was most likely a component of a depressive episode that he is currently experiencing. He voiced understanding.

ATTENDING PHYSICIAN:
John M Cruz, MD

Cruz, John Michael de Vera, MD at 08/10/16 0831

Status: Signed

INITIAL CERTIFICATION FOR MEDICARE

Call Documentation (continued)

Cruz, John Michael de Vera, MD at 08/10/16 0831 (continued)

Due date: 8/9/2016

I certify that the inpatient psychiatric hospital admission was medically necessary for psychiatric treatment which would necessarily be expected to improve the patient's condition.

I estimate 7 days of hospitalization is necessary for proper treatment of the patient. My plans for post-hospital care for this patient are coordinating with outpatient provider.

Medical History

Past Medical History	Date	Comments
Unspecified mental or behavioral problem [IMO0002]		depression/bipolar

Surgical History

Surgical History

Past Surgical History	Laterality	Last Occurrence	Comments
HX APPENDECTOMY [HX0023]			
HX Transurethral Resect/Destruct Pros [HX00537]		2004	

Birth **None**

Family History

Family History

Family history is unknown by patient.

Social History

Social History

Category	History
Smoking Tobacco Use	Never Smoker
Smokeless Tobacco Use	Unknown
Tobacco Comment	
Alcohol Use	No
Drug Use	No
Sexual Activity	Not Asked
ADL	Not Asked

Immunizations

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

Multi-Disciplinary Problems (from)

Active Problems

Not on file

Immunizations (continued)

Multi-Disciplinary Problems (continued) (from)

Resolved Problems

Problem: Patient Care Overview (Priority: --) (Start Date: 08/09/16) (Resolve Date: 08/26/16)

Goal	Priority	Disciplines	Start Date	Expected End Date	End Date
Plan of Care Review (RESOLVED)	--	Interdisciplinary	08/09/16	--	08/26/16
Goal	**Priority**	**Disciplines**	**Start Date**	**Expected End Date**	**End Date**
Individualization and Mutuality (RESOLVED)	--	Interdisciplinary, Nursing	08/09/16	--	08/26/16
Goal	**Priority**	**Disciplines**	**Start Date**	**Expected End Date**	**End Date**
Discharge Needs Assessment (RESOLVED)	--	Interdisciplinary	08/09/16	--	08/26/16

Problem: Depression (Adult,Obstetrics,Pediatric) (Priority: --) (Start Date: 08/09/16) (Resolve Date: 08/26/16)

Goal	Priority	Disciplines	Start Date	Expected End Date	End Date
Identify Related Risk Factors and Signs and Symptoms (RESOLVED)	--	Interdisciplinary	08/09/16	--	08/09/16

Goal Details: Related risk factors and signs and symptoms are identified upon initiation of Human Response Clinical Practice Guideline (CPG)

Goal	Priority	Disciplines	Start Date	Expected End Date	End Date
Establish/Maintain Self-Care Routine (RESOLVED)	--	Interdisciplinary	08/09/16	--	08/26/16

Goal Details: Patient will demonstrate the desired outcomes by discharge/transition of care.

Goal	Priority	Disciplines	Start Date	Expected End Date	End Date
Improved/Stable Mood (RESOLVED)	--	Interdisciplinary	08/09/16	--	08/26/16

Goal Details: Patient will demonstrate the desired outcomes by discharge/transition of care.

Prob Intervention	Frequency	Disciplines	Start Date	End Date
Monitor/Manage Signs of Depression	Per CPG	Interdisciplinary	08/09/16	08/26/16

Intervention Details: Assess for suicidal ideation/thoughts
Evaluate need for additional safety measures/psychiatric consult
Provide opportunity for patient/family/caregiver to express feelings, stressors and self-perception
Evaluate current coping strategies/assist with developing new
Mutually develop realistic, attainable short and long term goals
Recognize achievements/successes/personal strengths
Empower active participation planning care/activities and treatment decisions.
Encourage self-care
Determine available resources for support

Problem: Suicide Risk (Adult,Obstetrics,Pediatric) (Priority: --) (Start Date: 08/09/16) (Resolve Date: 08/26/16)

Goal	Priority	Disciplines	Start Date	Expected End Date	End Date
Identify Related Risk Factors and Signs and Symptoms (RESOLVED)	--	Interdisciplinary	08/09/16	--	08/09/16

Goal Details: Related risk factors and signs and symptoms are identified upon initiation of Human Response Clinical Practice Guideline (CPG)

Goal	Priority	Disciplines	Start Date	Expected End Date	End Date
Strength-Based Wellness/Recovery (RESOLVED)	--	Interdisciplinary	08/09/16	--	08/18/16

Goal Details: Patient will demonstrate the desired outcomes by discharge/transition of care.

Goal	Priority	Disciplines	Start Date	Expected End Date	End Date
Physical Safety (RESOLVED)	--	Interdisciplinary	08/09/16	--	08/18/16

Goal Details: Patient will demonstrate the desired outcomes by discharge/transition of care.

Prob Intervention	Frequency	Disciplines	Start Date	End Date
Promote/Enhance Psychosocial Well-being	Per CPG	Interdisciplinary	08/09/16	08/26/16

Intervention Details: Listen, use calm, nonjudgmental approach
Explore patient's present perception/reality
Discuss precipitating events, stressors, warning signs and potential alternative solutions

Immunizations (continued)

Multi-Disciplinary Problems (continued) (from)

Evaluate current coping strategies, assist with developing new
Explore personal strengths/protective factors and methods to enhance/utilize them
Mutually identify available resources for support
Discuss and implement constructive methods to decrease/channel hopelessness and to increase self-esteem
Evaluate the need for a psychiatric consult

Prob Intervention	Frequency	Disciplines	Start Date	End Date
Assess Risk to Self/Maintain Safety	Per CPG	Interdisciplinary	08/09/16	08/26/16

Intervention Details: Assess suicidal ideation/intention
Advocate for/implement suicide risk precautions
Evaluate need for additional safety measures considering level of suicidality
Remove stimuli/object(s) from environment that may precipitate potentially destructive behavior/self-harm
Set limits that are clear and specific

Problem: Fall Risk (Adult) (Priority: --) (Start Date: 08/11/16) (Resolve Date: 08/26/16)

Goal	Priority	Disciplines	Start Date	Expected End Date	End Date
Identify Related Risk Factors and Signs and Symptoms (RESOLVED)	--	Interdisciplinary	08/11/16	--	08/18/16

Goal Details: Related risk factors and signs and symptoms are identified upon initiation of Human Response Clinical Practice Guideline (CPG)

Goal	Priority	Disciplines	Start Date	Expected End Date	End Date
Absence of Falls (RESOLVED)	--	Interdisciplinary	08/11/16	--	08/26/16

Goal Details: Patient will demonstrate the desired outcomes by discharge/transition of care.

Prob Intervention	Frequency	Disciplines	Start Date	End Date
Monitor/Assist with Self Care	Per CPG	Interdisciplinary	08/11/16	08/26/16

Intervention Details: Provide a safe, barrier-free environment that encourages independent activity
Keep care area uncluttered
Keep needed items within reach (e.g., call light, personal items)
Promote use of personal vision/auditory aids (e.g., glasses, hearing aids)
Assess assistance level required for safe/effective self-care
Encourage functional activity performance with appropriate level of assistance based upon level of ability

Prob Intervention	Frequency	Disciplines	Start Date	End Date
Reduce Risk/Promote Restraint Free Environment	Per CPG	Interdisciplinary	08/11/16	08/26/16

Intervention Details: Reassess fall risk frequently and with change in status/transfer to another level of care
Communicate fall/injury risk to interprofessional health care team
Determine need for increased observation, or bed/chair alarms
Assess equipment /environmental modification needs (e.g., low bed, signage, nonskid footwear)
Define behavior and activity limits to patient/family
Perform regular intentional rounding to assess need for position change, pain assessment, personal needs

Prob Intervention	Frequency	Disciplines	Start Date	End Date
Review Medications/Identify Contributors to Fall Risk	Per CPG	Interdisciplinary	08/11/16	08/26/16

Intervention Details: Regularly review medication contribution to fall risk
Consider risk related to polypharmacy and age
Balance adequate pain management with potential for oversedation
Schedule medication administration times to minimize fall risk (e.g., avoid diuretics in pm)
High-risk medications related to falls include; narcotics, sedatives, diuretics, laxatives, hypnotic agents, insulin/oral hypoglycemics, regional blocks, recent anesthesia/sedation and cardiovascular drugs

Problem: Pain, Acute (Adult) (Priority: --) (Start Date: 08/13/16) (Resolve Date: 08/14/16)

Goal	Priority	Disciplines	Start Date	Expected End Date	End Date
Identify Related Risk Factors and Signs and Symptoms (RESOLVED)	--	Interdisciplinary	08/13/16	--	08/14/16

Goal Details: Related risk factors and signs and symptoms are identified upon initiation of Human Response Clinical Practice Guideline (CPG)

Goal	Priority	Disciplines	Start Date	Expected End Date	End Date
Acceptable Pain Control/Comfort Level (RESOLVED)	--	Interdisciplinary	08/13/16	--	08/14/16

Goal Details: Patient will demonstrate the desired outcomes by discharge/transition of care.

Prob Intervention	Frequency	Disciplines	Start Date	End Date

Immunizations (continued)

Multi-Disciplinary Problems (continued) (from)

Monitor/Manage Analgesia	Per CPG	Interdisciplinary	08/13/16	08/14/16

Intervention Details: Use a multimodal approach (more than one type/route of medication)
Titrate medications to patient response
Utilize around-the-clock dosing the first 24 to 48 hours post injury/surgery
Pre-medicate for anticipated procedures
Consider the presence of pre-existing chronic pain; adjust medications appropriately
Monitor for signs of tolerance (increased dose/frequency to reach desired effect)
Prevent/manage medication effects Opioids: initiate prophylactic bowel regimen
Prevent/manage medication effects Non-opioids: monitor for gastrointestinal symptoms, prolonged bleeding, renal/liver dysfunction
Advocate for gradual weaning to prevent physical withdrawal symptoms

Prob Intervention	Frequency	Disciplines	Start Date	End Date
Mutually Develop/Implement Acute Pain Management Plan	Per CPG	Interdisciplinary	08/13/16	08/14/16

Intervention Details: Mutually determine pain management plan/review regularly
Identify successful past strategies
Assume pain is present during painful activity/procedures if unable to respond
Utilize cutaneous stimulation (e.g., heat/cold, vibration)
Provide physical medicine & rehabilitation techniques (e.g., gait aids, support devices/garments, ultrasound, therapeutic exercise) as indicated
Coordinate/cluster activity/ modify environment to enhance rest/sleep

Prob Intervention	Frequency	Disciplines	Start Date	End Date
Support/Optimize Psychosocial Response to Acute Pain	Per CPG	Interdisciplinary	08/13/16	08/14/16

Intervention Details: Pain is what the patient says it is (subjective, not objective)
Acknowledge emotional response, explore/promote coping strategies
Allow choices in care, schedule and pain control methods
Assess/modify barriers to successful coping
Utilize distraction, behavioral therapy, relaxation techniques

Problem: Constipation (Adult) (Priority: --) (Start Date: 08/14/16) (Resolve Date: 08/26/16)

Goal	Priority	Disciplines	Start Date	Expected End Date	End Date
Identify Related Risk Factors and Signs and Symptoms (RESOLVED)	--	Interdisciplinary	08/14/16	--	08/18/16

Goal Details: Related risk factors and signs and symptoms are identified upon initiation of Human Response Clinical Practice Guideline (CPG)

Goal	Priority	Disciplines	Start Date	Expected End Date	End Date
Effective Bowel Elimination (RESOLVED)	--	Interdisciplinary	08/14/16	--	08/26/16

Goal Details: Patient will demonstrate the desired outcomes by discharge/transition of care.

Goal	Priority	Disciplines	Start Date	Expected End Date	End Date
Comfort (RESOLVED)	--	Interdisciplinary	08/14/16	--	08/26/16

Goal Details: Patient will demonstrate the desired outcomes by discharge/transition of care.

Prob Intervention	Frequency	Disciplines	Start Date	End Date
Promote Effective Bowel Elimination	Per CPG	Interdisciplinary	08/14/16	08/26/16

Intervention Details: Encourage adequate hydration/fiber intake
Promote activity/mobility within prescribed limits and as tolerated
Establish regular, unhurried time for elimination
Promote privacy, comfort and position to promote defecation process
Monitor of stool quantity, frequency, length of time required for defecation, patient expression of symptoms/relief

Reviewed By

Britt, Julia Anna, RN	08/21/16 0745
Cruz, John Michael de Vera, MD	08/10/16 0858
Cruz, John Michael de Vera, MD	08/10/16 0858
Cruz, John Michael de Vera, MD	08/10/16 0858

Education

Title: Generic Teaching Goals/Outcomes (Active)

Points For This Title

Immunizations (continued)

Education (continued)

Point: OT MH Group Participation (Resolved)
Description: Attend and participate in OT mental health educational groups including CBT/DBT, social skills, expressive arts, movement, and relapse prevention. See patient's presentation, behavior and response to education in patient's daily Care Plan Progress Notes.

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	C,E	NR	Attended 1 of 2 OT groups today.	HE 08/11/16 1739	Active
	Nonacceptance	E,D	NE	Attended 1 of 2 OT groups today.	PB 08/15/16 1726	Active
	Refuses	C,E,D	R	Did not attend 3 of 3 OT groups today.	PB 08/16/16 1655	Active
	Refuses	C,E	R	Attended 0 of 2 AM OT groups today.	HE 08/17/16 1244	Active
	Nonacceptance	E,C	NR	Attended 1 of 1 PM OT groups.	PB 08/17/16 1631	Active
	Acceptance	E,D	NR	Attended 5 of 7 OT group units	PB 08/18/16 1703	Active
	Acceptance	E,D	NR	Attended 8 of 10 OT group units today.	PB 08/21/16 1714	Active
	Acceptance	E,D,C	NR	Attended 3 of 3 OT groups	PB 08/22/16 1707	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	L,E,D	NR	Attended 3 of 3 OT groups	PB 08/23/16 1638	Active
	Acceptance	C,E	NR	Attended 3 of 3 OT groups today.	HE 08/24/16 1224	Active
	Acceptance	E,D,C,L	NR	Attended 8 of 10 Ot group units.	PB 08/25/16 1601	Active

Point: Room/Orientation (Active)
Description: Room/Orientation

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU		AS 08/09/16 2209	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Pain and Pain Management (Active)
Description: Pain and Pain Management

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU		AS 08/09/16 2209	Done
	Acceptance	E	VU		JB 08/21/16 0950	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Medications (Done)
Description: Medications

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU		AS 08/09/16 2209	Done
	Acceptance	E	VU,NR		EM 08/16/16 2231	Done
	Acceptance	E	VU,NR		EM 08/17/16 2326	Done
	Acceptance	E	VU,NR		LM 08/18/16 1424	Done
	Acceptance	E	VU,NR		EM 08/19/16 1849	Done
	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	VU		JB 08/21/16 0950	Done
	Acceptance	E	VU,NR		KR 08/21/16 1650	Done
	Acceptance	E	NR		SE 08/22/16 1037	Active
	Acceptance	E	NR		SE 08/22/16 1128	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	VU,NR		LM 08/23/16 1238	Done
	Acceptance	E	VU		AS1 08/23/16 2017	Done
	Acceptance	E	NR		SE 08/24/16 1039	Active
	Acceptance	E	NR		SE 08/25/16 1151	Active
	Acceptance	E	VU,NR		EM 08/25/16 1639	Done

Immunizations (continued)

Education (continued)

	Acceptance	E	VU		SH 08/26/16 1004	Done

Point: Diagnostic Tests/Procedures (Active)
Description: Diagnostic Tests/Procedures

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Dietary Modifications (Active)
Description: Dietary Modifications

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Hygiene/Infection Prevention - Click Hyperlink to Print Patient Handouts (Active)
Description: Hygiene/Infection Prevention - Click Hyperlink to Print Patient Handouts

Frequent hand washing, oral care, toileting

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		LM 08/19/16 0955	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Rehabilitation (Active)
Description: Rehabilitation

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Medical Equipment/Supplies (Active)
Description: Medical Equipment/Supplies

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Tobacco Cessation (Active)
Description: Tobacco Cessation

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Resources for Support (Active)
Description: Resources for Support

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		SE 08/22/16 1037	Active
	Acceptance	E	NR		SE 08/22/16 1128	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	NR		SE 08/24/16 1039	Active
	Acceptance	E	NR		SE 08/25/16 1151	Active

Title: Functional Deficit (Adult,Obstetrics,Pediatric) (Resolved)

Points For This Title

Point: Functional Deficit Overview (Resolved)
Description: Functional Deficit Overview [e.g., description, anatomy, physiology, cause(s)]

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active

Immunizations (continued)

Education (continued)

Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Modifiable Risk Factors/Triggers (Resolved)
Description: Modifiable Risk Factors/Triggers (e.g., trauma, fracture, brain injury, deconditioning following surgery or medical illness)

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Signs/Symptoms (Resolved)
Description: Signs/Symptoms (e.g., unable to function at the level of the whole person, including physical actions, tasks or activities)

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	VU		JB 08/21/16 0950	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: When To Seek Medical Attention (Resolved)
Description: When To Seek Medical Attention (e.g., initial presence of symptoms, persistent or worsening symptoms)

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	NR		SE 08/22/16 1037	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Self-Management (Resolved)
Description: Self-Management (e.g., rehabilitation schedule, adaptive equipment, balance rest and activity, skin breakdown prevention, safety precautions, pain management prior to activity)

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	VU,NR		EM 08/16/16 2231	Done
	Acceptance	E	VU,NR		LM 08/18/16 1424	Done
	Acceptance	E	VU,NR		LM 08/19/16 0955	Done
	Acceptance	E	VU,NR		EM 08/19/16 1849	Done
	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		SE 08/22/16 1128	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	VU,NR		LM 08/23/16 1238	Done
	Acceptance	E	VU		AS1 08/23/16 2017	Done
	Acceptance	E	NR		SE 08/24/16 1039	Active
	Acceptance	E	VU,NR		EM 08/25/16 1639	Done

Point: Treatment Plan (Resolved)
Description: Treatment Plan (e.g., MEDICATIONS: analgesics, antispasmodics; TREATMENT: therapeutic exercise)

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	VU		JB 08/21/16 0950	Done
	Acceptance	E	VU,NR		KR 08/21/16 1650	Done
	Acceptance	E	NR		SE 08/22/16 1128	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	NR		SE 08/25/16 1151	Active

Point: Rehabilitation To Improve Functional Independence (Resolved)
Description: Rehabilitation To Improve Functional Independence [e.g., therapeutic exercise techniques (isometric training, isotonic training, isokinetic training, muscle/tissue stretching exercises, joint mobilization, balance training, proprioceptive neuromuscular facilitation)]

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	VU,NR		EM 08/19/16 1849	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active

Immunizations (continued)

Education (continued)

Point: Pt safety (Resolved)
Description: The patient has received and reviewed the “guide to patient safety”.

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	VU,NR		EM 08/17/16 2326	Done
	Acceptance	E	VU,NR		EM 08/19/16 1849	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: HEP (Resolved)
Description: Instructed patient in home exercise program (e.g. behavioral training techniques for bowel/bladder control/function, bladder/bowel health, pelvic floor muscle recruitment/activation/coordination, down-training of pelvic floor muscles and/or nervous system, dietary changes, etc.) Handouts provided.

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Title: Pain, Acute (Adult) (Resolved)

Topic: Acute Pain: Personal Risk Factors and Signs/Symptoms (Resolved)

Point: Personal Risk Factors (Resolved)
Description: Personal Risk Factors

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Signs/Symptoms Related to Acute Pain (Resolved)
Description: Signs/Symptoms Related to Acute Pain

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		EM 08/16/16 2231	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active

Topic: Treatment Plan (Resolved)

Point: Medication: Analgesics (Resolved)
Description: Medication: Analgesics

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Medication: Pain Control Strategies (Resolved)
Description: Medication: Pain Control Strategies

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		SE 08/22/16 1037	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	NR		SE 08/25/16 1151	Active

Point: Medication: Factors That Aggravate/Relieve Pain (Resolved)
Description: Medication: Factors That Aggravate/Relieve Pain

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Medication: Family Participation In Plan (Resolved)
Description: Medication: Family Participation In Plan

Immunizations (continued)

Education (continued)

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Activity: Nonpharmacologic Pain Control Methods (Resolved)
Description: Activity: Nonpharmacologic Pain Control Methods

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Activity: Self-Advocacy Techniques (Resolved)
Description: Activity: Self-Advocacy Techniques

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Topic: Self-Management (Resolved)

Point: Medication Management (Resolved)
Description: Medication Management

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		EM 08/17/16 2326	Done
	Acceptance	E	VU,NR		EM 08/19/16 1849	Done
	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		SE 08/22/16 1128	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	VU		SH 08/26/16 1004	Done

Point: Use of Assistive Devices (Resolved)
Description: Use of Assistive Devices

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Modification to Activities of Daily Living (Resolved)
Description: Modification to Activities of Daily Living

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	NR		SE 08/24/16 1039	Active

Point: Nonpharmacologic Pain Methods (Resolved)
Description: Nonpharmacologic Pain Methods

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Mobility/Physical Activity Restrictions (Resolved)
Description: Mobility/Physical Activity Restrictions

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	VU,NR		LM 08/23/16 1238	Done

Point: Sleep/Rest (Resolved)
Description: Sleep/Rest

Learning Progress Summary

Immunizations (continued)

Education (continued)

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		LM 08/18/16 1424	Done
	Acceptance	E	VU,NR		LM 08/19/16 0955	Done
	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	VU,NR		EM 08/25/16 1639	Done

Point: Stress Management (Resolved)
Description: Stress Management

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		EM 08/16/16 2231	Done
	Acceptance	E	VU,NR		EM 08/17/16 2326	Done
	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Impact On Employment (Resolved)
Description: Impact On Employment

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Topic: When to Seek Medical Attention (Resolved)

Point: Negative Impact On Physical or Psychosocial Well-Being (Resolved)
Description: Negative Impact On Physical or Psychosocial Well-Being

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU		JB 08/21/16 0950	Done
	Acceptance	E	NR		SE 08/22/16 1128	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Signs/Symptoms Unresolved or Worsening (Resolved)
Description: Signs/Symptoms Unresolved or Worsening

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU		JB 08/21/16 0950	Done
	Acceptance	E	NR		SE 08/22/16 1128	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Title: Constipation (Adult) (Resolved)

Topic: Constipation: Personal Risk Factors and Signs/Symptoms (Resolved)

Point: Personal Risk Factors (Resolved)
Description: Personal Risk Factors

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	VU		SH 08/26/16 1004	Done

Point: Signs and Symptoms of Constipation (Resolved)
Description: Signs and Symptoms of Constipation

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		EM 08/16/16 2231	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active

Topic: Treatment Plan (Resolved)

Immunizations (continued)

Education (continued)

Point: Medication: Laxatives (Resolved)
Description: Medication: Laxatives

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Medication: Meds Causing Constipation (Resolved)
Description: Medication: Meds Causing Constipation

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Diet: Advance As Tolerated (Resolved)
Description: Diet: Advance As Tolerated

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Diet: Adequate Hydration (Resolved)
Description: Diet: Adequate Hydration

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Diet: Dietary Fiber (Resolved)
Description: Diet: Dietary Fiber

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		SE 08/22/16 1128	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	VU		SH 08/26/16 1004	Done

Point: Activity: Increase As Tolerated (Resolved)
Description: Activity: Increase As Tolerated

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Treatment: Diagnostic Tests (Resolved)
Description: Treatment: Diagnostic Tests

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Treatment: Disimpaction Process (Resolved)
Description: Treatment: Disimpaction Process

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Topic: Self-Management (Resolved)

Point: Regular Elimination Time (Resolved)
Description: Regular Elimination Time

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		EM 08/17/16 2326	Done
	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	VU,NR		EM 08/25/16 1639	Done

Immunizations (continued)

Education (continued)

Point: Attention to Urge (Resolved)
Description: Attention to Urge

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Diet Modification (Resolved)
Description: Diet Modification

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Medication (Resolved)
Description: Medication

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		LM 08/18/16 1424	Done
	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		SE 08/22/16 1037	Active
	Acceptance	E	NR		SE 08/22/16 1128	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	VU,NR		LM 08/23/16 1238	Done

Point: Behavior Modification (Resolved)
Description: Behavior Modification

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Activity (Resolved)
Description: Activity

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		LM 08/19/16 0955	Done
	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	VU,NR		EM 08/25/16 1639	Done

Topic: When to Seek Medical Attention (Resolved)

Point: Unresolved Symptoms (Resolved)
Description: Unresolved Symptoms

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		EM 08/19/16 1849	Done
	Acceptance	E	VU		JB 08/21/16 0950	Done
	Acceptance	E	NR		SE 08/22/16 1128	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Worsening Symptoms (Resolved)
Description: Worsening Symptoms

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU		JB 08/21/16 0950	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Negative Impact On Well-Being (Resolved)
Description: Negative Impact On Well-Being

Learning Progress Summary

Immunizations (continued)

Education (continued)

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU		JB 08/21/16 0950	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active

Title: Suicide Risk (Adult,Obstetrics,Pediatric) (Resolved)

Topic: Suicide Risk: Personal Risk Factors and Signs/Symptoms (Resolved)

Point: Personal Risk Factors (Resolved)
Description: Personal Risk Factors

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		KR 08/21/16 1650	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Signs/Symptoms Related to Suicide Risk (Resolved)
Description: Signs/Symptoms Related to Suicide Risk

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Topic: Treatment Plan (Resolved)

Point: Treatment: Counseling Participation (Resolved)
Description: Treatment: Counseling Participation

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	VU,NR		LM 08/23/16 1238	Done

Point: Treatment: Implement Safety Recovery Plan (Resolved)
Description: Treatment: Implement Safety Recovery Plan

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		EM 08/16/16 2231	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active

Topic: Self-Management (Resolved)

Point: Effective Coping Strategies (Resolved)
Description: Effective Coping Strategies

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		EM 08/16/16 2231	Done
	Acceptance	E	VU,NR		EM 08/17/16 2326	Done
	Acceptance	E	VU,NR		EM 08/19/16 1849	Done
	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Eliminate Self-Defeating Behaviors (Resolved)
Description: Eliminate Self-Defeating Behaviors

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		EM 08/16/16 2231	Done
	Acceptance	E	VU,NR		EM 08/19/16 1849	Done
	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Enhance Assertive Communication Skills (Resolved)
Description: Enhance Assertive Communication Skills

Learning Progress Summary

Immunizations (continued)

Education (continued)

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		LM 08/18/16 1424	Done
	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Personal Safety Plan (Resolved)
Description: Personal Safety Plan

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		EM 08/16/16 2231	Done
	Acceptance	E	VU,NR		EM 08/17/16 2326	Done
	Acceptance	E	VU,NR		EM 08/19/16 1849	Done
	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		SE 08/22/16 1037	Active
	Acceptance	E	NR		SE 08/22/16 1128	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	NR		SE 08/24/16 1039	Active

Point: Provider Follow-Up (Resolved)
Description: Provider Follow-Up

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Recognize Suicidal Signs/Symptoms/Factors (Resolved)
Description: Recognize Suicidal Signs/Symptoms/Factors

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		LM 08/19/16 0955	Done
	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Utilize Community Resources (Resolved)
Description: Utilize Community Resources

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Utilize Support System (Resolved)
Description: Utilize Support System

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Topic: When to Seek Medical Attention (Resolved)

Point: Negative Impact On Physical or Psychosocial Well-Being (Resolved)
Description: Negative Impact On Physical or Psychosocial Well-Being

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU		JB 08/21/16 0950	Done
	Acceptance	E	NR		SE 08/22/16 1037	Active
	Acceptance	E	NR		SE 08/22/16 1128	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	NR		SE 08/24/16 1039	Active

Point: Signs/Symptoms Unresolved or Worsening (Resolved)
Description: Signs/Symptoms Unresolved or Worsening

Learning Progress Summary

Immunizations (continued)

Education (continued)

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU		JB 08/21/16 0950	Done
	Acceptance	E	NR		SE 08/22/16 1037	Active
	Acceptance	E	NR		SE 08/22/16 1128	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	NR		SE 08/24/16 1039	Active

Title: Fall Risk (Adult) (Resolved)

Topic: Personal Risk Factors & Signs/Symptoms (Resolved)

Point: Personal Risk Factors (Resolved)
Description: Personal Risk Factors

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Signs and Symptoms Related to Fall Risk (Resolved)
Description: Signs and Symptoms Related to Fall Risk

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Topic: Treatment Plan (Resolved)

Point: Awareness of Meds Increasing Fall Risk (Resolved)
Description: Awareness of Meds Increasing Fall Risk

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		EM 08/16/16 2231	Done
	Acceptance	E	VU,NR		EM 08/17/16 2326	Done
	Acceptance	E	VU,NR		EM 08/19/16 1849	Done
	Acceptance	E	VU		JB 08/21/16 0950	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	VU,NR		EM 08/25/16 1639	Done

Point: Diet: Adequate Fluids/Nutrition (Resolved)
Description: Diet: Adequate Fluids/Nutrition

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		EM 08/16/16 2231	Done
	Acceptance	E	VU,NR		EM 08/17/16 2326	Done
	Acceptance	E	VU,NR		EM 08/19/16 1849	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	VU,NR		EM 08/25/16 1639	Done

Point: Assistance With Out of Bed Activities (Resolved)
Description: Assistance With Out of Bed Activities

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Environmental Risk Reduction (Resolved)
Description: Environmental Risk Reduction

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		SE 08/22/16 1128	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Orientation/Reorientation Rationale (Resolved)
Description: Orientation/Reorientation Rationale

Immunizations (continued)

Education (continued)

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Behaviors That Increase Risk (Resolved)
Description: Behaviors That Increase Risk

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Topic: Self-Management (Resolved)

Point: Potential Environmental Hazard Identification (Resolved)
Description: Potential Environmental Hazard Identification

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Safety Measures (Resolved)
Description: Safety Measures

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	VU,NR		EM 08/17/16 2326	Done
	Acceptance	E	VU,NR		LM 08/18/16 1424	Done
	Acceptance	E	VU,NR		LM 08/19/16 0955	Done
	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	VU,NR		KR 08/21/16 1650	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	VU,NR		LM 08/23/16 1238	Done
	Acceptance	E	VU,NR		EM 08/25/16 1639	Done
	Acceptance	E	VU		SH 08/26/16 1004	Done

Point: Energy Conservation Techniques (Resolved)
Description: Energy Conservation Techniques

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Safe Timing of Medication (Resolved)
Description: Safe Timing of Medication

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		SE 08/22/16 1037	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	NR		SE 08/25/16 1151	Active

Topic: When to Seek Medical Attention (Resolved)

Point: Actual Fall (Resolved)
Description: Actual Fall

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Increase In Risk Factors (Resolved)
Description: Increase In Risk Factors

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		SE 08/22/16 1128	Active

Immunizations (continued)

Education (continued)

Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Inadequate Caregiver Support (Resolved)
Description: Inadequate Caregiver Support

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		SE 08/22/16 1128	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Title: Depression (Adult,Obstetrics,Pediatric) (Resolved)

Topic: Depression: Personal Risk Factors and Signs/Symptoms (Resolved)

Point: Personal Risk Factors (Resolved)
Description: Personal Risk Factors

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	VU		JB 08/21/16 0950	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Signs/Symptoms of Depression (Resolved)
Description: Signs/Symptoms of Depression

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	VU		JB 08/21/16 0950	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active

Topic: Treatment Plan (Resolved)

Point: Diet: Adequate Fluid/Nutrition (Resolved)
Description: Diet: Adequate Fluid/Nutrition

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	VU,NR		EM 08/16/16 2231	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Activity: Counseling/Therapeutic Play (Resolved)
Description: Activity: Counseling/Therapeutic Play

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	VU,NR		LM 08/23/16 1238	Done

Point: Treatment: Development of Safety Plan (Resolved)
Description: Treatment: Development of Safety Plan

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	VU,NR		EM 08/16/16 2231	Done
	Acceptance	E	VU,NR		EM 08/17/16 2326	Done
	Acceptance	E	VU,NR		EM 08/19/16 1849	Done
	Acceptance	E	NR		SE 08/22/16 1128	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	VU		SH 08/26/16 1004	Done

Point: Treatment: Identification of Safety Risk Factors (Resolved)
Description: Treatment: Identification of Safety Risk Factors

Immunizations (continued)

Education (continued)

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	VU,NR		EM 08/16/16 2231	Done
	Acceptance	E	VU,NR		EM 08/19/16 1849	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	VU		AS1 08/23/16 2017	Done
	Acceptance	E	VU,NR		EM 08/25/16 1639	Done

Point: Treatment: Identification Personal Strengths (Resolved)
Description: Treatment: Identification Personal Strengths

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Treatment: Psychiatry Consult, If Indicated (Resolved)
Description: Treatment: Psychiatry Consult, If Indicated

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Topic: Self-Management (Resolved)

Point: Develop Coping Strategies (Resolved)
Description: Develop Coping Strategies

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	VU,NR		EM 08/17/16 2326	Done
	Acceptance	E	VU,NR		LM 08/19/16 0955	Done
	Acceptance	E	VU,NR		EM 08/19/16 1849	Done
	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	VU,NR		EM 08/25/16 1639	Done

Point: Follow-Up Care Plan (Resolved)
Description: Follow-Up Care Plan

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		SE 08/22/16 1037	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	NR		SE 08/24/16 1039	Active
	Acceptance	E	VU		SH 08/26/16 1004	Done

Point: Identify/Develop Supportive Relationships (Resolved)
Description: Identify/Develop Supportive Relationships

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	VU,NR		EM 08/25/16 1639	Done
	Acceptance	E	VU		SH 08/26/16 1004	Done

Point: Identify/Utilize Available Resources (Resolved)
Description: Identify/Utilize Available Resources

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active

Immunizations (continued)

Education (continued)

Acceptance	E	NR		DY 08/20/16 1121	Active
Acceptance	E	NR		MA 08/22/16 2156	Active

Point: Self-Care Promotion (Resolved)
Description: Self-Care Promotion

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	VU,NR		EM 08/16/16 2231	Done
	Acceptance	E	VU,NR		EM 08/17/16 2326	Done
	Acceptance	E	VU,NR		LM 08/18/16 1424	Done
	Acceptance	E	VU,NR		EM 08/19/16 1849	Done
	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	VU,NR		KR 08/21/16 1650	Done
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	NR		SE 08/24/16 1039	Active
	Acceptance	E	NR		SE 08/25/16 1151	Active
	Acceptance	E	VU,NR		EM 08/25/16 1639	Done

Point: Stressors/Triggers Management (Resolved)
Description: Stressors/Triggers Management

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	VU,NR		EM 08/19/16 1849	Done
	Acceptance	E	NR		DY 08/20/16 1121	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active

Topic: When to Seek Medical Attention (Resolved)

Point: Negative Impact On Physical or Psychosocial Well-Being (Resolved)
Description: Negative Impact On Physical or Psychosocial Well-Being

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	NR		SE 08/22/16 1037	Active
	Acceptance	E	NR		SE 08/22/16 1128	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	NR		SE 08/24/16 1039	Active
	Acceptance	E	NR		SE 08/25/16 1151	Active

Point: Signs/Symptoms Unresolved or Worsening (Resolved)
Description: Signs/Symptoms Unresolved or Worsening

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Patient	Acceptance	E	NR		WH 08/10/16 1836	Active
	Acceptance	E	NR		SE 08/22/16 1037	Active
	Acceptance	E	NR		SE 08/22/16 1128	Active
	Acceptance	E	NR		MA 08/22/16 2156	Active
	Acceptance	E	NR		SE 08/24/16 1039	Active
	Acceptance	E	NR		SE 08/25/16 1151	Active

User Key

Initials	Effective Dates	Name	Provider Type	Discipline
JB	03/12/15 -	Britt, Julia Anna, RN	Registered Nurse	Nursing
HE	03/13/15 -	Elliott, Harold Edward, OT	Occupational Therapist	Occupat. Therapy
LM	05/20/15 -	Marin, Lisa Nicole, RN	Registered Nurse	Nursing
EM	04/15/15 -	McCullough, Elizabeth Ann, RN	Registered Nurse	Nursing
PB	06/24/16 -	Bailey, Peter Julian, OT	Occupational Therapist	Occupat. Therapy
MA	11/10/15 -	Abend, Marquel Marie, RN	Registered Nurse	Nursing
WH	03/11/16 -	Hudson II, William Howard, RN	Registered Nurse	Nursing
SE	02/05/15 -	Edwards, Sarah C, RN	Registered Nurse	Nursing

Immunizations (continued)

Education (continued)

AS1	02/05/15 -	Senior, Adolfo A, RN	Registered Nurse	Nursing
AS	02/05/15 -	Silver, Amy E, RN	Registered Nurse	Nursing
DY	04/22/16 -	Yerby, Derrick J, RN	Registered Nurse	Nursing
SH	07/02/15 -	Harris, Stephanie, RN	Registered Nurse	Nursing
KR	04/09/15 -	Rowny, Katharine Lynne, RN	Registered Nurse	Nursing

END OF REPORT