Chaya Newfield
History and Physical 1 psychiatry

Identification:
Name: WW
DOB: 3/4/1972
Date and Time: 3/17/21 2:00 PM
Location: Queens Hospital Center Medical ER- Comprehensive Psychiatric Emergency Program (CPEP) consult
Source of Information: Self, unreliable
Source of Referral: Self
Mode of Transport: EMS

WW is a 49 year old African American male who is 6 feet tall and weighs 200 pounds. WW is currently homeless and living in the Fortune Hotel.

Chief Complaint:
"I felt like I wanted to kill myself today"

History of Present Illness:
Patient is a 49 year old African American male, single, undomiciled, unemployed, with past medical history of HIV (not on any medication as per patient and electronic medical records) and hypertension, and past psychiatric history of schizoaffective disorder and substance abuse (alcohol, marijuana, K2, cocaine.) Patient was brought in by EMS activated by self for suicidal thoughts. The patient states that he has been using cannabis for the past few weeks and soon after began feeling depressed and having thoughts of hurting himself. Patient states, "I just wanted to end things. There are so many people after me, I can't handle it." Patient admits to noncompliance with medications. Patient reports he uses alcohol quite frequently (more than two beers three times a week) and denies having withdrawal symptoms when he stops alcohol use. Patient admits to feeling helpless and hopeless because he is living on the street where it is dangerous, he does not have anyone that can help him escape from "the agencies that are after me".

As per electronic medical records, patient has had multiple inpatient admissions in the past, most recently in Jamaica Hospital from 7/24/20-8/12/20 and was discharged on Zyprexa 30 mg by mouth every night at bedtime and Depakote ER 1500 mg by mouth every night at bedtime and has received Invega Sustenna long acting injectable in February of 2020. Patient also has a history of Jewish Board ACT team involvement that was discontinued because of non-compliance.
Patient appears disheveled, is malodorous, poorly groomed and often is incoherent during the interview. Patient appears to be responding to internal stimuli and has poor eye contact throughout the interview. Patient admits to current auditory hallucinations, including "voices telling me that I'm under attack and should give up." Patient admits to passive suicidal ideations but denies suicidal or homicidal intent or plan. Patient states he feels anxious and upset, and appears to have a labile affect, at times sad and tearful alternating with anger and paranoia. Patient denies having an outpatient psychiatrist and refuses to provide collateral contact information. Patient is currently exhibiting erratic behavior with acute psychotic features and is a risk to self and others and thus

warrants admission to CPEP for observation and stabilization after medical clearance from the MER.

Past Medical History:
HIV
Hypertension
Past Psychiatric History:
Schizoaffective disorder
Substance-induced disorder

Allergies:
No Known Allergies to medications, foods or environmental factors
Medications:
Zyprexa 30 mg by mouth once daily at bedtime (noncompliant, last dose over 6 months ago)
Depakote ER 1500 mg mouth once daily at bedtime (noncompliant, last dose over 6 months ago)

Family History:
Denies family history of any psychiatric disorders

Social and Occupational History:
WW is an African American male, single, heterosexual, unemployed, undomiciled living in Fortune Hotel homeless shelter. Patient states he has not had gainful employment since 2004 when he did odd-jobs for a mechanic in his neighborhood. Patient admits to collecting cans and empty plastic bottles from trash cans to get 5 cents for each from recycling. Patient states he did not complete high school and dropped out in ninth grade. When asked what he enjoys doing patient states, "I like drinking beer and smoking with my friends." Patient does not have any relatives that he is in contact with. Patient reports poor sleep, less than three hours a night. Admits to using alcohol, marijuana, K2 and cocaine. Admits history of arrest and incarceration and past inpatient psychiatric hospitalization.

Review of Systems:
General – Patient denies loss of appetite, weight loss or gain, fever, and fatigue

- Skin – No evidence of self-inflicted wounds, intravenous drug use, or skin picking
- Neurology – Patient denies headache, loss of consciousness, history of head trauma, unsteady gait, and unintentional body movements
- Psychiatric – Patient admits to feeling down and loss of interest in usual activities for the past month. Admits to passive suicidal ideations but denies homicidal ideations, plan or intent. Admits auditory hallucinations, denies visual hallucinations.

Physical Exam:
General Survey: 49-year-old African American male, alert and oriented to person, place and time, disheveled appearance, malodorous, overweight, hyperverbal and anxious, with a labile affect and occasional crying and angry outbursts. Appears older than stated age.
Vital Signs: BP:143/90 Pulse:88 Respirations:18, Temp:97.4°F (36.3°C) oral O2 saturation: 100%
Height:6 feet Weight:200 pounds BMI: 27.1
Mental Status Exam:

General

- Appearance – WW is a tall, overweight, black male with long uncombed hair. He is disheveled, malodorous, rips and stains on clothing. He appears older than his stated age. He does not appear to have any acute wounds or injuries.
- Behavior – Upon initial evaluation in Comprehensive Psychiatric Emergency Program triage, the patient is seated looking around the room in a paranoid manner, and appears to be responding to internal stimuli. Patient appears restless as noted shifting in his seat and shaking his legs. He does not appear to have any tics, tremors, or psychomotor agitation or retardation.
- Attitude Towards Examiner – WW is superficially cooperative and does not respond to some questions. He appears guarded during the interview and maintained poor eye contact. He does not display any hostility or aggression towards the examiner or other unit staff. He remains paranoid throughout the interview and asks "why do you want to know all this about me, this is private information."

- Sensorium and Cognition
  - Alertness and Consciousness – WW was conscious and alert consistently throughout the interview
  - Orientation – Patient was oriented to person, place, time, and situation
  - Concentration and Attention – WW was easily distracted throughout the interview and often had to be redirected. Patient was also internally preoccupied and responding to internal stimuli. Patient was not able to answer all questions appropriately, and often tangential and had flight of ideas.
  - Visuospatial Ability – The patient displays normal visual perception as suggested by appropriate balance on her feet, normal gait, and purposeful body movements. He did not maintain consistent eye contact and often looked around the room in a suspicious manner.
  - Capacity to Read and Write – WW displayed average reading and writing ability as shown by his reviewing and signing of admission documents.
  - Abstract Thinking – The patient displays intact abstract thinking by interpretation of commonly used English metaphors
    - Memory – The patient's remote and recent memory appear normal as suggested by his ability to provide history of medications given at Jamaica hospital and recollection of recent events leading up to his presentation to the facility.
  - Fund of Information and Knowledge – AK's intellectual performance was average and consistent with his education level and training.
- Mood and Affect
  - Mood – The patient's mood is labile, patient states feeling anxious and depressed, as well as angry
  - Affect – WW appeared guarded, anxious and paranoid
  - Appropriateness – AK's mood and affect were congruent throughout the interview
- Motor
  - Speech – WW's speech rate was pressured, rhythm was variable, and volume increased as the patient became agitated. His speech was often incoherent and

disorganized. The patient's answer latency was increased. He required redirection to answer questions.
    - Eye Contact – WW maintained poor eye contact and only made contact when he required a question to be repeated or was asked directly to look up.
    - Body Movements – Patient appeared irritated during the exam as shown by shifting in his seat and shaking his legs and gesturing wildly when describing his hallucinations. He does not display any tics or unintentional body movements. All movements were fluid.
- Reasoning and Control
    - Impulse Control – WW displays poor impulse control. Admits passive suicidal ideations, denies homicidal ideations, plan or intent. Patient is compliant with medical requests (urine sample, blood samples, accepting food and drinks etc.)
    - Judgment – WW currently has impaired judgement. Admits current paranoia, delusions, and auditory hallucinations.
    - Insight – WW's insight is poor, he is non compliant with medication and states "I'm not psych, I'm just sad."

Assessment: WW is a 49 year old African American male, single, undomiciled, unemployed, past medical history of HIV and hypertension, past psychiatric history of schizoaffective disorder and substance use disorder. Patient was brought by EMS activated by self-calling 911 because of thought of suicide. Patient admits to auditory hallucinations encouraging him to harm himself and warning him that he is being persecuted. Patient admits to recent marijuana use before feeling suicidal. Patient appears disheveled, paranoid and illogical. Patient is acutely psychotic, disorganized, noncompliant with medication, and may be a danger to self or others. Patient will be admitted for observation and stabilization and re-evaluation for possible inpatient admission.
Differential diagnoses:

1. Schizoaffective Disorder, Bipolar Type (Depressive Episode) – Based on the patient's history of schizoaffective disorder unspecified type, current delusions of persecution and auditory hallucinations, depressive symptoms and passive suicidal ideations in conjunction with noncompliance with medications indicates schizoaffective disorder bipolar type
2. Bipolar Disorder with psychotic features -- Patient does have history of psychosis, is non-compliant with mood stabilizing medication and is currently experiencing symptoms of depression such as depressed mood most of the day, nearly every day for a week, feeling fatigued, worthless and stating passive suicidal ideations and having auditory hallucinations. However, given his past history of schizoaffective diagnosis that seems more likely.
3. Substance (Cannabis) induced psychosis -- Patient admits to recent cannabis use, is experiencing symptoms of anxiety, paranoia, auditory hallucinations, sleep disturbance, depression, and agitation. However, this is less likely than schizoaffective disorder because it cannot be established that the patient's symptoms may not abate/be reduced with drug abstinence and the occurrence of psychotic symptoms on increase of cannabis amount cannot be established.
4. Major depressive disorder with psychotic features -- This patient appears to be having a major depressive episode, and it is unclear from patient and electronic medical records

whether he has had a previous manic or hypomanic episode. The patient admits to feelings of depressed mood, difficulty sleeping, loss of pleasure in regular activities, low energy, and thoughts of suicide for over two weeks. The patient is also having delusions of persecution and auditory hallucinations which indicate psychotic symptoms. However, given the patient's history of schizoaffective disorder and likely, but undocumented, history of manic episodes this diagnosis is less likely.

Diagnosis:
Schizoaffective disorder, bipolar type
Cannabis intoxication

Treatment plan:
PLAN:
1. Admit to Comprehensive Psychiatric Emergency Program (CPEP) under Mental Hygiene Law 9.40 legal status for observation, stabilization and re-evaluation in the morning due to depressed mood, psychotic symptoms
2. Review labs (Complete blood count, comprehensive metabolic panel, Covid-19 PCR test, urine toxicology including THC), and review chart. Pt was provided with a urine specimen container and encouraged to provide specimen for urine toxicology screen and urinalysis. Repeat vital signs in the morning. Consult with medical providers regarding patient's HIV status and possible medication treatment with BIKTARVY.
3. Review medications and encourage patient to provide collateral information.
4. Order stat medication Risperdal mtab 2 mg po, Cogentin 1 mg po and Ativan 1 mg po for stabilization in cpep.
5. Nursing staff should observe patient at every 15 minute observation intervals for patient safety.
6. Notify nursing staff and attending doctor of patient treatment plan.
7. Re-evaluation of patient in morning.