073049

RidgeView INSTITUTE

INITIAL CLINICAL ASSESSMENT: ACCESS CENTER

INITIAL MEDICAL SCREENING EXAM

ASSESSMENT DATE: 8/12/11 START TIME: 910 am/(pm)

IDENTIFYING / INITIAL DATA:

Patient: Robert G. Ottley JR DOB 5/18/90 Age: 21 Race C Sex M

Employer: UGA Position/Title: JR. Hx Length of Employment 2

Marital Status: Single Years/Months: ______ # of Children: 0 Ages: 0

Patient lives with: UGA Roommates. Referred by: HOSE - Piedmont Hospital

Person/s accompanying patient for assessment (name/s, relationship) Parents, Rob, Cathy

YES / (NO) **Do you have anything with you that you could use to harm yourself or someone else? (i.e., weapons, sharp objects, medications or drugs, alcohol)**
If so, specify items & location: ______

(YES) NO **Are you willing to give this to a staff member while you are being assessed?**
Items removed: ______

BRIEF MEDICAL SCREENING:

YES / (NO) Are you **currently** experiencing any physical problems that are causing you distress? (describe)

YES / (NO) Do you feel you need medical attention for any of these problems **at this time**? (describe)

YES / (NO) Have you recently received any medical attention for any of these or other problems? (specify)

YES / (NO) Are you taking any medications? (list) Ativan @ hospital

YES / (NO) Are you taking these as prescribed? (explain)

YES / (NO) Do you have any history of seizures or strokes? (give date of most recent)

YES / (NO) Have you recently had a significant weight loss? Amount: NA When: ______

VITAL SIGNS: BP: 130/80 Pulse: 90 Resp: 18 Temp: 98 - Breathalyzer: 0

Height: 5'11" Weight: 125

Does patient present as medically unstable? ☐ Yes ☑ No

If so: ☐ Nurse: ______ consulted ☐ MD: ______ consulted

☐ Patient sent to emergency room ☐ Nurse determined not medically compromised ☐ MD determined not medically compromised

WHY IS TREATMENT NECESSARY AT THIS TIME?

CHIEF COMPLAINT (What is the main reason the patient is here/seeking treatment?) Direct Quote:

"Checked into piedmont hospital today 4 help"

☒ SUICIDAL/ SELF-INJURIOUS - Made suicidal statements to (M)

(YES) / NO 1. Are you currently having thoughts or urges to harm or kill yourself? **(If no, proceed to # 5)**
What specific thoughts are you having and how often are you having them? "theme of whether I could" This is the end

YES / (NO) 2. Do you have a current **plan** to harm or kill yourself? (specify plan) Jump off cliff less afraid of dying

YES / (NO) 3. Do you have the **means** available to carry out your plan? (specify location of means)

YES / (NO) 4. Do you **intend** to follow through with your plan? When?
If so, what do you expect will happen if you do carry out your plan?

YES / (NO) 5. Have you **ever** made an attempt to harm yourself?
Most recent attempt: (Give detailed description including date, method used, intended outcome, medical treatment required after attempt)
High School - never harmed self physically

Other past attempt/s: (Give detailed description including date/s, method/s, medical treatment received, etc.)

INITIAL MEDICAL SCREENING EXAM, page 2

☐ HOMICIDAL / VIOLENT / THREATENING BEHAVIOR

YES / NO 6. Are you currently having thoughts or urges to harm or kill someone else? **(If no, proceed to # 10)** What specific thoughts are you having?

YES / NO 7. Do you have a current **plan** to harm someone else? If so, what is the name of the person you wish to harm and what is his/her relationship to you?

YES / NO 8. Do you have the **means** available to carry out your plan? (Specify location of means)

YES / NO 9. Do you **intend** to carry out your plan? When?

YES / NO 10. Have you **ever** made an attempt to harm someone else? When? Describe briefly:

☐ **If homicidal intent is disclosed and a victim is identified:** ☐ Duty to warn deferred to MD; homicidal patient being admitted -or- ☐ Duty to warn completed by Access Center clinician: ________________ Date: ________ Time: ________ am / pm

Report made to: ☐ Identified victim ☐ Law enforcement authorities (if appropriate) ☐ School Officials (if appropriate)

☐ THREAT TO PERSONAL SAFETY "I've been acting a little weird for the last week"

YES / NO 11. Has anyone harmed you recently? (Describe)

YES / NO 12. Are you **currently** afraid for your own safety? (Specify why)

☐ CHILD ABUSE/ OLDER ADULT ABUSE

YES / NO 13. **Is physical/sexual/emotional abuse of a child or older adult disclosed?**

If so: Mandated report to DFCS/APS

☐ Report to DFCS/APS made by Access Center clinician: ________________ Date: ______ Time: ______ am / pm

Spoke to: ________________________ at ________________ County DFCS/APS, Phone: ____________

☒ SAFETY CONCERNS OF PARENTS / SIGNIFICANT OTHERS

YES / NO 14. Are parents/others afraid for patient's safety **currently**? (Explain)

YES / NO 15. Are they afraid for their or anyone else's safety during assessment? (Explain)

YES / NO 16. Are they afraid patient will try to leave during assessment?

☒ PSYCHOSIS "My opion - my op ed pieces were

YES / NO 17. Are you having any thoughts that are currently causing you distress or feel out of control to you? (Describe)

Paranoia - reports - twitters

YES / NO 18. Are you having fears that other people are out to get you in any way? - Brian Williams

YES / NO 19. Have you been hearing voices or having any kind of hallucinations? (Describe)

☐ EATING DISORDER SYMPTOMS Made several calls to the NY Times

YES / NO 20. Restricting/Binge Eating/ Purging? (Describe)

- Wash Post

☐ SUBSTANCE ABUSE / DEPENDENCE / WITHDRAWAL

- Emailing reporter

YES / NO 21. Do you believe you are having any problems with substance abuse?

YES / NO 22. Do you use any substances or medications? (specify)

When did you last use this/these substance/s?

drink @ school. denies problem.

YES / NO 23. Are you currently intoxicated? If yes, did you drive yourself here? YES / NO If so, are you willing to allow staff to hold your keys for you while you are being assessed? YES / NO

YES / NO 24. Do you believe you are currently experiencing physical withdrawal symptoms from a substance? If so, briefly describe:

"Watching debate on Twitter and live blogs"

INITIAL MEDICAL SCREENING EXAM, page 3

HISTORY OF PRESENT ILLNESS/PRESENTING PROBLEM "18 y/o WM c Money"

PRECIPITATING EVENT (What has motivated the patient/family to seek treatment at this time?)
"news cycle yesterday was directed toward emerging stories - target demographic - I influenced the media more than any other person"

INITIAL SUMMARY STATEMENT (Brief Narrative Format. Include how patient was transported to RVI and who accompanied. For updates see Update Pages.)

Pt presents to RVI on 1013 c parents arriving shortly thereafter. Pt was interviewed while he was laying on the assessment room couch. He was alert, oriented x 4, cooperative eye contact was good. Pt recently in the last week has been increasingly bizarre, feeling that he is "influencing the national media" Pt spent the summer in Washington DC as an intern. Pt grandious, reported to his (M) that he is suicidal. Pt denied current SI, HI, Told his (M) last night that the media would be coming to their house. Pt denies substance abuse, drinks occasionally as a college student. Pt combative (verbally) c (M) last night and told his (M) ~~last nite~~ y today that he would kill himself. Pt cooperative, Parents are divorcing after 26 yrs. Tangential speech grandious ideas

CLINICAL PROVIDED BY REFERRAL SOURCE: (please identify the referral source and document any clinical information you received directly from him/her, as well as any information noted on the callsheet.)

Hospital paperwork
Pt provided info
(M) provided some info

PERPETUATING FACTORS (Ongoing patient/family issues that perpetuate the patient's pathology/dysfunction: e.g., chronic medical/physical/mental health problems, untreated medical/mental illness, enmeshment, absent parent, abuse/domestic violence, denial/misperception of problem, substance abuse in home.)

Student @ UGA.
Recent Stressors - Parents divorce, school starting

INITIAL MEDICAL SCREENING EXAM, page 4

OTHER CLINICAL INFORMATION (include info from persons accompanying patient, clinical from referral source, or info from CallSheet.)

YES / NO Did family/persons accompanying patient provide any information about suicidal/homicidal ideation? List if so.

YES / NO Did Referral Source/s provide any information (written/verbal) about suicidal/homicidal ideation? List if so.

YES / NO Did CallSheet or CallSheet Notes provide any information about suicidal/homicidal ideation? List if so.

Physician Contact

Name of the physician consulted: Weiss Did physician accept the patient? ☒ YES ☐ NO

Was physician advised of patient's SI/HI anc history of thoughts/attempts? ☐ YES ☒ NO ☐ N/A

Was physician advised of SI/HI related clinical obtained from family/persons accompanying patient? ☐ YES ☒ NO ☐ N/A

Was physician advised of any SI/HI related clinical obtained from Referral Source/s? ☐ YES ☒ NO ☐ N/A

Was physician advised of any SI/HI related information from CallSheet & CallSheet Notes? ☐ YES ☒ NO ☐ N/A

Please note the physician's instructions below:

IAAIPPS

Patient and family's response to physician's instructions:

1013 - parents supportive

If inpatient treatment initially indicated due to patient's report of suicidal/homicidal ideation during screening, and patient then refuses inpatient recommendation—stating he/she is not currently suicidal/homicidal:

MD: ____________________ consulted and advised: ☐ Patient needs commitment evaluation ☐ Patient is not committable

☐ Patient able to contract for safety; MD clears patient to leave; patient is not committable

If inpatient treatment initially indicated due to patient's report of SI/HI during screening, and patient then refuses inpatient recommendation—stating he/she is not currently suicidal—was <u>referring clinician</u> contacted about this? ☐ YES ☐ NO ☐ N/A

Comments:

Exit Plan:

If patient who initially presented with SI/HI—and later denied SI/HI— is cleared to leave by MD, the Exit Plan was completed, discussed and signed by patient/guardian.

8/12/11	10:00 pm	[signature]	Tonya Roberts
Date	Time	Clinician Signature	Print Name

ACCESS CENTER CLINICAL IMPRESSIONS: AXIS I-V (Based on DSM IV clinical criteria)

AXIS I: Delusional d/o 297.1

AXIS II: deferred

AXIS III: denied issues

AXIS IV: severe - familial (family breakup)

AXIS V: Current GAF Score: 25-30

Signature: 8/12/11 (Date) 10:00 (Time) am/pm [signature] Roberts, LPC (Qualified Mental Health Professional)

Reviewed by: ______________________________ MD Date: ____________

INITIAL MEDICAL SCREENING EXAM, page 5

POST-SCREENING DISPOSITION

- [x] Inpatient/Observation admission to Ridgeview Institute on: ☐ Voluntary Status or ☒ Involuntary Status.
- ☐ Partial Hospitalization Program admission to Ridgeview Institute.
- ☐ Intensive Outpatient Program admission to Ridgeview Institute.
- ☐ Recovery Residence admission with admission to a Partial or Intensive Outpatient Program.
- ☐ Return to current Outpatient Treatment Provider: ____________________
- ☐ Outpatient referral to: ____________________
- ☐ Outpatient program (PHP/IOP/Group) referral to: ____________________
- ☐ Transferred to other treatment facility for Inpt treatment; Referral/Transfer Form completed: ____________________
- ☐ Refused Inpatient Addiction treatment. MD cleared patient to leave. Pt Signed Refusal of Treatment
- ☐ Refused Inpatient Eating Disorder treatment. MD cleared patient to leave. Pt signed Refusal of Treatment
- ☐ Refused Inpatient Psychiatric treatment. Refusal of Treatment & Exit Plan completed and signed by patient/guardian.
- ☐ Refused PHP/IOP recommendation. Patient Signed Refusal of Treatment
- ☐ Pending Partial admission to Ridgeview Institute, explain: ____________________
- ☐ Pending Intensive Outpatient admission to Ridgeview Institute, explain: ____________________
- ☐ Sent to EAH for Medical Clearance: ____________________
- ☐ Phone Assessment. Disposition/LOC Recommendation: ____________________

NOTES: ____________________

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ADDITIONAL CLINICAL INFORMATION Page 1 (to be completed on individuals admitted to RVI)

RN REVIEW	SYMPTOMS	SPECIFY: behavioral indicators, severity, date of onset, frequency, and whether currently experiencing and/or history of experiencing.
OK	1. ☐ ANHEDONIA	Stressful day today
	2. ☑ HOPELESS FEELINGS (Specify current degree of hopelessness)	a little bit today. ✓
	3. ☑ AGITATION/RESTLESSNESS (Specify current level of agitation)	Very hyper last week
	4. ☐ SUICIDAL IDEATION: HISTORY (Specify frequency & duration of SI)	
	5. ☐ CRYING SPELLS	
	6. ☐ ISOLATION/WITHDRAWAL	
	7. ☐ NEGLECTS PERSONAL HYGIENE	
	8. ☑ SLEEP PROBLEMS/NIGHTMARES	hyperactive – 6 or less. last week
	9. ☑ APPETITE DISTURBANCE	Small tummy
	10. ☐ WEIGHT LOSS:______ GAIN:______	Over what period of time? 120 lbs.
	11. ☐ RESTRICTING/BINGE EATING / PURGING	If #11 is yes: Complete Addendum B for eating disorder symptoms.
	12. ☐ ANXIETY/PANIC ATTACKS	"I am the story"
	13. ☑ OBSESSIVE THOUGHTS	Paranoia – Media
	14. ☐ COMPULSIVE BEHAVIORS	President / Democrats.
	15. ☐ PARAPHILIAS/GENDER IDENTITY ISSUES (Specify type)	Republicans think the story
Anger Mgmt	16. ☑ MOOD SWINGS/MANIC EPISODES	is some terrible thing the left
	17. ☐ IMPULSIVE BEHAVIORS (Spending, Gambling, Sexual, etc.) If yes for Gambling or Sexual behaviors, complete appropriate Addendum	is keeping from them (16) "Hyper"
	18. ☑ RAGE EPISODES	Intern for Tom Price
	19. ☐ HOMICIDAL IDEATION: HISTORY (Specify frequency & duration of HI)	Chair of convention @ UGA
	20. ☑ PARANOIA	Influencing media yesterday
	21. ☐ HALLUCINATIONS (Specify Type)	Reporting of the debate.
	22. ☑ DELUSIONS (Specify Type)	Paranoid – Media

Twitter handle

Parents getting divorced

my name has been floating around Washington.

ADDITIONAL CLINICAL INFORMATION, page 2

RN REVIEW	SYMPTOMS	SPECIFY: behavioral indicators, severity, date of onset, frequency, and whether currently experiencing and/or history of experiencing.
a/	23. ☐ SELF-INJURIOUS BEHAVIOR	denies
	24. ☐ TIME DISTORTION / LOSS OF TIME / AMNESTIC EPISODES	denies
	25. ☐ OTHER DISTINCT IDENTITIES / PERSONALITY STATES	
	FAMILY PSYCHIATRIC HISTORY	
	26. ☑ FAMILY HISTORY OF PSYCHIATRIC ILLNESS / TREATMENT	all immediate family needs therapy
	27. ☑ FAMILY/FRIEND HISTORY OF SUICIDES/HOMICIDES	girl in H.S. killed self
	ABUSE / TRAUMA HISTORY	INCLUDE: age of patient at time of abuse/trauma, and specifics of the abuse/trauma.
	28. ☐ EMOTIONAL	denies
	29. ☐ PHYSICAL	
	30. ☐ SEXUAL	
	31. ☐ UNRESOLVED TRAUMA HISTORY (Specify – ie rape, abortion, violent crime, fire, natural disaster, war, etc.)	

RN REVIEW	CURRENT STRESSORS	SPECIFY DETAILS
	32. ☐ SEPARATION / DIVORCE / RELATIONSHIP PROBLEMS	Parents divorcing after 26 yrs "dont agree c it"
	33. ☐ SEXUAL DYSFUNCTION OR CHANGE IN DESIRE	
	34. ☐ PROBLEMS WITH CHILDREN/ CUSTODY ISSUES	
	35. ☑ GRIEF / LOSS ISSUES (Life partner/family/friend/pet)	React strongly when people die & most recent - girl who killed self my SR yr high school
	36. ☑ SEXUAL ORIENTATION ISSUES	down on my luck c ladies decided I'm not really gay - Im comfortable
	37. ☐ SPIRITUAL / RELIGIOUS / CULTURAL ISSUES	
	38. ☑ WORK / SCHOOL PROBLEMS (Deterioration of work performance, Absences, At risk of losing job, Job loss) (36)	
	39. ☐ FINANCIAL PROBLEMS (Overwhelming debt, Bankruptcy, Credit problems, etc.)	
	40. ☐ LEGAL PROBLEMS / PRISON HISTORY (Current/pending charges, Probation/parole status)	Just learned that his Parents are getting divorce
	41. ☑ RECENT SIGNIFICANT EVENTS / LIFE CHANGES (New job, Career change, Promotion, Retirement, New home, Marriage, Birth of children, etc.)	UGA Im a reporter for college news paper. Intern in Washington.

ADDITIONAL CLINICAL INFORMATION page 3

SUBSTANCE ABUSE HISTORY

Student @ UofA

RN REVIEW	SUBSTANCE	LAST USE	CURRENT USE Quantity (ex: 8-10, 16oz beers) Frequency (ex: 5-7 days per week) Duration (ex. 2 years)	HISTORY OF USE (Not in Past Year)
ok	☒ ALCOHOL	Date: Tues. Time: am/pm night Amt: 2 shots of vodka	Q= 3 beers F= 1x2x week D=	Age of 1st Use: Pattern: 21yo May 2011
	☐ SEDATIVES, HYPNOTICS, & ANXIOLYTICS (Valium, Xanax, Ativan, Serax, Tranxene, Halcion, Restoril, Seconal, Klonopin, Librium, Dalmane, Centrax, Surital, Soma, Fiorinal, Fioncet, Blue Nitro, GHB)	Date: Time: am/pm Amt:	Q= F= D=	Age of 1st Use: Pattern:
	☐ OPIOIDS (Morphine, Heroin, Codeine, Darvon, Methadone, Hydrocodone, Dilaudid, Demerol, Darvocet, Lomotil, Talwin, Oxycodone, Percocet, Lorcet, Lortab, Vicodin, Tylox, Fentanyl, Stadol, Nubain, Ultram, Tylenol #3)	Date: Time: am/pm Amt:	Q= F= D=	Age of 1st Use: Pattern:
	☐ AMPHETAMINES (Crystal Meth, Crank, Ice, Speed, Prescription Diet Pills)	Date: Time: am/pm Amt:	Q= F= D=	Age of 1st Use: Pattern:
	☐ COCAINE (Powder, Crack, Rock, Freebase, Blunt laced marijuana cigar)	Date: Time: am/pm Amt:	Q= F= D=	Age of 1st Use: Pattern:
	☐ HALLUCINOGENS (LSD, Acid, Blotter, Microdot, XTC, Ecstasy, Mescaline, Peyote, Special "K"etamine, MDA, MDMA)	Date: Time: am/pm Amt:	Q= F= D= Denied	Age of 1st Use: Pattern:
	☐ PHENCYCLIDINES (PCP, Angel Dust)	Date: Time: am/pm Amt:	Q= F= D=	Age of 1st Use: Pattern:
	☐ STEROIDS	Date: Time: am/pm Amt:	Q= F= D=	Age of 1st Use: Pattern:
	☐ INHALANTS (Gasoline, Freon, Glue, Paint, Butane, Paint Thinner, Scotchguard, Glade, White Out, Amyl & Butyl Nitrate, Nitrous Oxide)	Date: Time: am/pm Amt:	Q= F= D=	Age of 1st Use: Pattern:

ADDITIONAL CLINICAL INFORMATION, page 4

SUBSTANCE ABUSE HISTORY, continued

RN REVIEW	SUBSTANCE	LAST USE	CURRENT USE Quantity (ex: 8-10, 16oz beers) Frequency (ex: 5-7 days per week) Duration (ex: 2 years)	HISTORY OF USE (Not in Past Year)
a	☐ CANNABIS (THC, Marijuana, Hashish, Joint, Bong, Bowl, Reefer, Blunt: laced)	Date: Time: am/pm Amt:	Q= F= Denies D=	Age of 1st Use: Pattern:
	☐ NICOTINE (Cigarette, Cigar, Pipe Tobacco, Chewing Tobacco, Snuff)	Date: Time: am/pm Amt:	Q= F= D=	Age of 1st Use: Pattern:
	☐ OVER THE COUNTER MEDICATIONS (Sleeping Pills, Diet Pills, Alert Pills, Decongestants, Antihistamines, Cough Syrup)	Date: Time: am/pm Amt:	Q= F= D=	Age of 1st Use: Pattern:
	☐ CAFFEINE (coffee, sodas, tea)	Date: Time: am/pm Amt:	Q= F= D=	Age of 1st Use: Pattern:
	☐ ______ (Other)	Date: Time: am/pm Amt:	Q= F= D=	Age of 1st Use: Pattern:
	☐ ______ (Other)	Date: Time: am/pm Amt:	Q= F= D=	Age of 1st Use: Pattern:
	☐ ______ (Other)	Date: Time: am/pm Amt:	Q= F= D=	Age of 1st Use: Pattern:
	☐ ______ (Other)	Date: Time: am/pm Amt:	Q= F= D=	Age of 1st Use: Pattern:
	☐ ______ (Other)	Date: Time: am/pm Amt:	Q= F= D=	Age of 1st Use: Pattern:

ADDITIONAL CLINICAL INFORMATION, page 5

SUBSTANCE ABUSE HISTORY, continued

FAMILY HISTORY: denies

HEALTH PROBLEMS RELATED TO SUBSTANCE ABUSE

LEGAL CHARGES RELATED TO SUBSTANCE ABUSE – Include current charges and history (DUI's, possession, etc.)

RELATIONSHIP PROBLEMS DUE TO SUBSTANCE ABUSE

EMPLOYMENT/ CAREER PROBLEMS DUE TO SUBSTANCE ABUSE

MOST RECENT PERIOD OF TOTAL ABSTINENCE FROM **ALL** MOOD-ALTERING SUBSTANCES:

LONGEST PERIOD OF TOTAL ABSTINENCE FROM **ALL** MOOD-ALTERING SUBSTANCES IN LIFETIME:

WHAT HELPED YOU REMAIN SOBER DURING THIS TIME?

WITHDRAWAL SYMPTOMS

RN REVIEW	WITHDRAWAL SYMPTOMS	CURRENTLY EXPERIENCING	FREQUENTLY EXPERIENCES	RN REVIEW	WITHDRAWAL SYMPTOMS	CURRENTLY EXPERIENCING	FREQUENTLY EXPERIENCES
	Nausea	☐ Yes ☐ No	☐ Yes ☐ No		Loss of Sleep	☐ Yes ☐ No	☐ Yes ☐ No
	Vomiting	☐ Yes ☐ No	☐ Yes ☐ No		Loss of Appetite	☐ Yes ☐ No	☐ Yes ☐ No
	Diarrhea	☐ Yes ☐ No	☐ Yes ☐ No		Weakness	☐ Yes ☐ No	☐ Yes ☐ No
	Tremors	☐ Yes ☐ No	☐ Yes ☐ No		Irritability	☐ Yes ☐ No	☐ Yes ☐ No
	Racing Heart Rate	☐ Yes ☐ No	☐ Yes ☐ No		Aggressive, Assaultive	☐ Yes ☐ No	☐ Yes ☐ No
	Visibly Sweating	☐ Yes ☐ No	☐ Yes ☐ No		Headaches, Migraines	☐ Yes ☐ No	☐ Yes ☐ No
	Flushed Face	☐ Yes ☐ No	☐ Yes ☐ No		High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No
	Fever, Chills	☐ Yes ☐ No	☐ Yes ☐ No		Seizures	☐ Yes ☐ No	☐ Yes ☐ No
	Tingling, Numbness	☐ Yes ☐ No	☐ Yes ☐ No		Blackouts	☐ Yes ☐ No	☐ Yes ☐ No
	Cramping	☐ Yes ☐ No	☐ Yes ☐ No		Hallucinations	☐ Yes ☐ No	☐ Yes ☐ No
	Extreme Agitation	☐ Yes ☐ No	☐ Yes ☐ No		Delirium	☐ Yes ☐ No	☐ Yes ☐ No

DIAGNOSTIC CRITERIA FOR SUBSTANCE DEPENDENCE (manifested by 3 or more of the following within the same 12 month period):

- ☐ Tolerance: a need for increased amounts to achieve desired effect ~ or ~ diminished effect with continued use of same amount.
- ☐ Withdrawal: the characteristic withdrawal syndrome for the substance ~ or ~ a substance is taken to relieve/avoid symptoms.
- ☐ The substance is often taken in larger amounts or over a longer period than was intended.
- ☐ There is a persistent desire or unsuccessful efforts to cut down or control substance use.
- ☐ A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
- ☐ Important social, occupational, or recreational activities are given up or reduced because of substance use.
- ☐ The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

ADDITIONAL CLINICAL INFORMATION, page 6

ENVIRONMENT

1. Where do you plan to live once you have completed treatment? In Athens 3 Roommates
   Marietta

2. Who currently lives in that home and what is their relationship to you?

Name of Person	Relationship
Rob	Dad
Cathy	Mom
Mary	Sister
Chris	Brother

3. Please describe the positive strengths and characteristics of that home.

   Comment: ______________________

4. Please check all the boxes that apply to that home:

Yes	No	
☒	☐	Alcohol and/or drugs are used in the home. Wine
☒	☐	There are weapons in the home. gun cases. locked - Sportsman
☐	☒	Physical or sexual abuse is occurring in the home.
☐	☒	The police or Department of Family and Children Services have been to the home within the last two years.

   Comment: denies

5. Do you have an alternative place to live if you are not able to return to that home?

   Yes ☒ No ☐ If "yes," where: ______________________

EATING DISORDER RISK ASSESSMENT

The following questions should be asked of all female patients, 13 years old and older.

Small Stomach

YES/NO (circled NO) Is your mood frequently affected by what you weigh or how you feel about your body weight and shape?

YES/NO (circled NO) Are you actively restricting food intake, binge eating, and/or purging? Skip dinner

YES/NO (circled NO) Have you ever been told or worried that you have an eating disorder?
If "yes," when, by whom, and did you seek treatment? ______________________

If the patient answered "yes" to any of the preceding questions please follow the initial clinical assessment with Addendum B and consider a level of care within the Women's Program for disposition

ADDITIONAL CLINICAL INFORMATION, page 7

HISTORY OF PRESENT ILLNESS/PRESENTING PROBLEM, continued

PREVIOUS TREATMENT HISTORY

INPATIENT TREATMENT FACILITY	DATES (Month/Year & # of Days)	DIAGNOSES or PROBLEM	HELPFUL OR NOT HELPFUL	COMPLIANT WITH DISCHARGE PLAN?
denies				

OUTPATIENT PROGRAM / THERAPIST	LAST SEEN	HOW OFTEN	HOW LONG	DIAGNOSIS or PROBLEM	COMPLIANT WITH TREATMENT PLAN?
Current Therapist: Dr. Crawford	1.5 yr. ago.			depression	
Current Psychiatrist:					
Current/Recent 12-Step Involvement					
Past 12-Step Group Involvement:					
Other History (OP, IOP, PHP)					
Other History (OP, IOP, PHP)					
Other History (OP, IOP, PHP)					

Compliant with medications? ☐ Yes ☒ No: explain:

no meds.

Does patient / family expect to return to the current Outpatient therapist?

☐ Yes ☒ No: why not? n/a

ADDITIONAL CLINICAL INFORMATION, page 8

MEDICAL INFORMATION PCP name: Jonathan Schue

CURRENT MEDICAL PROBLEMS/COMPLICATIONS	HISTORY OF MEDICAL PROBLEMS/COMPLICATIONS	CHECK IF PATIENT HAS EVER HAD THE FOLLOWING	MOST RECENT (MONTH & YEAR)
	Asthma	☐ NEUROPSYCHIATRIC EVALUATION	
		☐ PREVIOUS DIAGNOSIS OF DEMENTIA	
		☐ PREVIOUS DIAGNOSIS OF ORGANIC BRAIN SYNDROME	
		☐ HEAD INJURY	
		☐ SEIZURES	
		☐ STROKES	
		☐ EEG	
		☐ MRI	
		☐ EKG	
		☐ ECT	

DATE OF LAST FULL PHYSICAL WITH LABS: in June 2011

SPECIAL EQUIPMENT NEEDS: ______

ALLERGIES (FOOD, MEDICATION, ENVIRONMENT) ☑ NONE KNOWN

LIST	REACTION AND EFFECTIVE TREATMENT	LIST	REACTION AND EFFECTIVE TREATMENT
NKA			

For Current Medications, See **Home Medication List**

Discontinued Psychotropic Medications:

RECENT PSYCHOTROPIC MEDICATIONS	DATE DISCONTINUED	REASON DISCONTINUED
no meds		

ADDITIONAL CLINICAL INFORMATION, page 9

MENTAL STATUS EXAM

APPEARANCE AND GENERAL BEHAVIOR:

Dress: ☐ Provocative (describe briefly) [x] Neat [x] Appropriate ☐ Bizarre ☐ Disheveled

Motor Activity: ☐ Impaired/Unbalanced ☐ Catatonic ☐ Agitated/Fidgety [x] Calm ☐ Motor Retardation

Facial Expression: ☐ Appropriate/Varied [x] Animated ☐ Anxious/Fearful ☐ Angry ☐ Sad ☐ Fixed

Level of Awareness: ☐ Present and Alert ☐ Drowsy [x] Hyper Alert

Posture: [x] Relaxed ☐ Tense

Laying prone on couch

MOOD AND AFFECT:

☐ Appropriate/Varied ☐ Depressed ☐ Anxious ☐ Angry ☐ Euphoric ☐ Labile ☐ Flat [x] Inappropriate/Bizarre

RAPPORT WITH INTERVIEWER:

☐ Friendly [x] Cooperative ☐ Guarded ☐ Hostile ☐ Other:

THOUGHT PROCESSES AND FLOW OF MENTAL ACTIVITY:

Orientation: [x] Circumstance [x] Time [x] Place [x] Person

Speech: ☐ Poverty of Speech ☐ Mute ☐ Normal ☐ Slurred [x] Pressured ☐ Loud ☐ Soft

Thought Processes: ☐ Ability to Stay Focused ☐ Difficulty with Concentration ☐ Confused State ☐ Intoxicated ☐ Good Comprehension ☐ Disorganized Thoughts ☐ Slow Thoughts [x] Racing Thoughts [x] Tangential Thoughts

SUICIDAL, SELF-HARMING AND HOMICIDAL IDEATION:

[x] None ☐ Suicidal ☐ Self-Harming/Mutilating ☐ Homicidal

PSYCHOTIC SIGNS AND SYMPTOMS:

Hallucinations: ☐ None ☐ Auditory ☐ Visual ☐ Tactile ☐ Olfactory ☐ Gustatory

Delusions: ☐ None [x] Paranoid ☐ Persecutory [x] Grandiose ☐ Jealous ☐ Erotomanic ☐ Somatic

Influencing media

INSIGHT/JUDGMENT/IMPULSE CONTROL:

Insight:
- ☐ Can identify problems, contributing factors and role he/she plays in presenting problem.
- ☐ Can identify problems, but not contributing factors.
- ☐ Can identify problems, but denies any self involvement.
- [x] Denies any problems.

Judgment:
- ☐ Good decision making with awareness of consequences.
- ☐ Risky decision making with awareness of consequences.
- [x] Unsafe decision making, lacking awareness of consequences.

Impulse Control:
- ☐ Good - Thinks through decisions before acting.
- ☐ Fair - Sometimes thinks through decisions before acting.
- [x] Poor - Acts before thinking through decisions.

For Disoriented or Geriatric Patients only or when otherwise clinically indicated:

RECENT MEMORY:

"Listen carefully. I am going to say three words. You say them back after I stop. Ready? Here they are: APPLE [pause], PENNY [pause], TABLE [pause]. Now repeat those words back to me." [Repeat up to 5 times, but score only first trial.]

✓ if recalled.

APPLE ____________

PENNY ____________

TABLE ____________

"Now keep those words in mind. I am going to ask you to say them again in a few minutes." Alternative word sets (e.g., PONY, QUARTER, ORANGE) may be substituted and noted when retesting an examinee.

REMOTE MEMORY:

✓ if recalled. (If answer incorrectly write out response)

"Do you know who the current President is?" ____________

"Can you name the previous President?" ____________

"Can you name the President prior to him?" ____________

"Can you name the President prior to him?" ____________

ATTENTION & CALCULATION:

"Now I'd like you to subtract 7 from 100. Then keep subtracting 7 from each answer until I tell you to stop."

✓ if calculated correctly.

"What is 100 take away 7?" [93] ____________

If needed, say: "Keep going." [86] ____________

If needed, say: "Keep going." [79] ____________

If needed, say: "Keep going." [72] ____________

If needed, say: "Keep going." [65] ____________

RECALL:

"What were those three words I asked you to remember?" [Do not offer any hints.]

✓ if recalled.

APPLE ____________

PENNY ____________

TABLE ____________

ADDITIONAL CLINICAL INFORMATION, page 11

ACCESS CENTER LEVEL OF CARE RECOMMENDATION

INPATIENT ACUTE CARE

- ☐ Behavior, or clear and immediate threat of behavior, which is life threatening, destructive or disabling to self/others.
- ☐ Symptoms/behaviors indicative of need for 24 hour continued monitoring and assessment of the patient's condition (circle all that apply): vegetative signs/symptoms, significant weight loss/gain, significant inability to sleep, significant inability to care for self/family, self-mutilation, endangerment to health due to eating disorder, disabling depression, command hallucinations, disabling psychomotor agitation/retardation, acute onset of confusion/memory loss, active psychiatric disorder with potential to interfere with treatment of serious medical condition.
- ☐ Emergence of worsening symptomatology in a toxic environment (ex: suicidal depression in an abusive home, etc.).
- ☐ Failure of outpatient/partial hospital treatment evidenced by clinical instability, or a physician consult indicates a condition which precludes safe treatment at a lesser level care.
- ☐ Condition requires detoxification in a medically monitored setting.
- ☐ Severe deterioration of level of functioning. GAF Score: 1 - 40.
- ☐ Treatment Recommendations: ☒ Individual Therapy ☒ Group Therapy ☒ Family Therapy ☒ Support Groups ☒ Discharge Planning

PARTIAL HOSPITALIZATION / ☐ without Halfway House ☐ with Halfway House

- ☐ Behavior indicative of risk to harm self or others within past four to seven days.
- ☐ Symptoms/behaviors indicative of need for increased intensity and frequency of services (circle all that apply): significant depression, intense anxiety/panic attacks, debilitating obsessions/compulsions, maladaptive eating behaviors, isolating, maladaptive behaviors which may be related to a psychiatric disorder, pathological drug/alcohol use.
- ☐ Impaired to the degree that there is moderate to severe disability in interpersonal, occupational, educational functioning.
- ☐ Failure of treatment at a lesser level of care.
- ☐ Moderate to severe deterioration of level of functioning. GAF Score: 41 - 60.
- ☐ Treatment Recommendations: ☐ Individual Therapy ☐ Group Therapy ☐ Family Therapy ☐ Support Groups ☐ Discharge Planning

INTENSIVE OUTPATIENT PROGRAM / OUTPATIENT TREATMENT ☐ without halfway house ☐ with halfway house

- ☐ Minimal risk of behavior which is life threatening, destructive or disabling to self or others.
- ☐ Symptoms/behaviors indicative of need for services (circle all that apply): depressed mood, obsessions causing distress, anxiety, significant use of drugs/alcohol.
- ☐ Impaired to the degree that there is mild disability in interpersonal, occupational, educational functioning.
- ☐ Failure of other treatment programs, aftercare, support groups or outpatient therapy.
- ☐ Presence of social, physical, familial support environment.
- ☐ Minimal to mild deterioration of level of functioning. GAF Score: 61 – 75.
- ☐ Treatment Recommendations: ☐ Individual Therapy ☐ Group Therapy ☐ Family Therapy ☐ Support Groups ☐ Discharge Planning

ADDITIONAL CLINICAL INFORMATION, page 12

DISPOSITION

PATIENT/FAMILY RESPONSE TO TREATMENT RECOMMENDATIONS AND OBSERVED FAMILY DYNAMICS

1013 - Parents supportive

SUPPORT SYSTEMS AVAILABLE TO PATIENT UPON DISCHARGE

- ☐ SPOUSE/LIFE PARTNER
- ☒ PARENTS
- ☒ FAMILY
- ☐ FRIENDS
- ☐ WORK
- ☐ CHURCH
- ☐ EAP
- ☐ THERAPIST
- ☐ PSYCHIATRIST/ADDICTIONOLOGIST
- ☐ PRIMARY CARE PHYSICIAN
- ☐ SCHOOL COUNSELOR
- ☐ SUPPORT GROUPS/12-STEP GROUPS

PATIENT'S STRENGTHS/POSITIVE COPING SKILLS

Smart.

BARRIERS TO TREATMENT

☐ FINANCES ☐ LACK OF FAMILY SUPPORT ☐ TRANSPORTATION ☐ LACK OF COMMITMENT TO TREATMENT

☐ PHYSICAL DISABILITIES: ______

☐ LEARNING DISABILITIES: ______

☐ OTHER: denies

Violence Risk Assessment

History of violent/angry outbursts ☐ Yes ☐ No (If no, skip this "Violence Risk Assessment")

Comments: "Freaked out in the room @ hospital"

Precipitating factors to past violent outbursts:

Comments: Hyper

Previous techniques, methods or tools used to help prevent violent outbursts in the past:

☐ None ☐ Verbal De-escalation ☒ Medication ☐ Time Out ☐ Other (indicate in Comments section)

Comments: Today Hospital gave pt ativan

Patient's response to **past** violence prevention techniques as described above:

☐ Poor ☐ Positive/Beneficial ☒ N/A

Comments:

How would you like us to assist **you** with de-escalation when you are angry? (use quotes)

Is there a way your family could help with de-escalation when you are angry? (use quotes)

Clinician Signature:

8/12/11 Date 10:00 Time am/pm (pm circled) [signature] LPC Qualified Mental Health Professional

Reviewed by: [signature] R.N. Date: 8/13/11

Comments: Reviewed 8/24/11 @ 0900 T. Brantley [signature]

Physician Progress Note

Date: 8/13/11 **Time:** 2eo

☒ Inpatient ☐ PHP ☐ IOP ☐ Rec. Residence

073049 - 01
OTTLEY, ROBERT G.
05/18/90 M
ADULT PSYCHIATRIC/ADDICTION
INP PSYCH ADULT
DR WEISS, LEONARD
08/12/11

PATIENT IDENTIFICATION

NOTES (include patient quotes and behaviors indicating acuity): IN + OUT OF ROOM, DISORGANIZED, [illegible]

MENTAL STATUS:

Oriented To: ☒ Person ☒ Place ☒ Time ☒ Circumstance ☐ None ☐ N / A

Current Mood: SUBDUED Affect: [illegible]

Appearance / ADLs: UNKEMPT

Eye Contact: ☒ Poor ☐ Fair ☐ Good

Hallucinations: ☒ Yes ☐ No If Yes, describe: ?

Delusions: ☒ Yes ☐ No If Yes, describe: ?

Current Thoughts: ☐ Racing ☒ Tangential ☒ Circumstantial ☐ Loose ☒ Disorganized ☐ Obsessive ☒ Paranoid ☒ Confused ☐ Clear ☐ Goal Directed

Sleep: ☐ Poor ☒ Interrupted ☐ Early Awakening ☐ Difficulty Going to Sleep ☐ Fair ☐ Good

Number of Hours: ____

Appetite: ☐ Poor ☒ Fair ☐ Improved ☐ Good Number of meals/day: ____ % consumed: ____

Insight: ☐ Poor ☒ Fair ☐ Limited ☐ Improved ☐ Good

Judgment: ☐ Poor ☒ Fair ☐ Improved ☐ Good

Patient Reports **Suicidal Ideation:** ☐ Yes ☐ No Patient Reports **Homicidal Ideation:** ☐ Yes ☐ No

Self Harming Thoughts / Behaviors: ☐ Yes ☒ No

Patient is still considered a risk, even if not reporting: ☐ Yes ☒ No

Rationale: ____

PRECAUTIONS / RESTRICTIONS: ☒ N / A

☐ TSP/SP ☐ Fall ☐ High Risk Fall ☐ Elopement ☐ Seizure ☐ Exercise ☐ 1:1 ☐ AC

☐ AC/SB ☐ CR ☐ SE ☐ Room ☐ Gender ☐ Other: ____

WITHDRAWAL SYMPTOMS / POST ACUTE WITHDRAWAL SYMPTOMS: ☒ N / A

☐ Continues on Detox regimen ☐ Nausea ☐ Vomiting ☐ Tremors ☐ Chills

☐ Elevated VS ☐ Sweating ☐ Blackouts ☐ Seizures ☐ Flushed Face ☐ DTs

☐ Numbness ☐ Unsteady Gait ☐ Cramping ☐ Craving ☐ Dysphoria ☐ Anxious

☐ Diarrhea ☐ Restless/disturbed sleep ☐ Poor concentration/memory ☐ None

(OVER)

Physician Progress Note

Describe patient's relapse risk: ______ ☐ N/A

Recovery environment: ______ ☐ N/A

Readiness to change: ______

EATING DISORDERS: ☐ N / A

Eating 100%: ☐ Yes ☐ No If No, describe: ______

☐ Purging ☐ Weight increasing due to laxative withdrawal ☐ NG Tube

Using: ☐ Diuretics ☐ Laxatives ☐ Stimulants ☐ Compulsive exercise

Compliant with meetings: ☐ Yes ☐ No ______

MEDICATIONS: ***DANGEROUS ABBREVIATIONS:*** **D / C, Q, HS, S.Q., U, u, I.U.**

Medication Compliant: ☐ Yes ☒ No **If new med started, response to 1st Dose:** ______

Medication Changes Today: ☐ Yes ☐ No Rationale: ______

Pertinent Medical Issues / Side Effects: ______

PATIENT / FAMILY EDUCATION (INCLUDING MEDS): ______

Family Contacted: ☐ Yes ☒ No Describe: ______

Outpatient Provider contacted: ☐ Yes ☒ No ☐ PCP ☐ Therapist ☐ Psychiatrist

Describe Contact: ______

TREATMENT GOALS:

Patient needs to stay in current level of care: ☒ Yes ☐ No If Yes, specify concerning behaviors, impairment and / or medical issues: ______

ELOS at this Level of Care: ______

Treatment Plan reviewed with patient: ☐ Yes ☐ No If Yes, comments: ______

DISPOSITION PLAN: if plan is transition to another LOC, specify program:

☒ PHP: ______ ☐ IOP (day): ______ ☐ IOP (eve): ______ ☐ Rec. Residence

☐ Home ☐ Nursing Home / Assisted Living ☐ Outpatient Counseling ☐ Other: ______

ADDITIONAL COMMENTS:

______

Physician Signature

073049 - 01
OTTLEY, ROBERT G.
05/18/90 M
ADULT PSYCHIATRIC/ADDICTION
INP PSYCH ADULT
DR WEISS, LEONARD
08/12/11

PATIENT IDENTIFICATION

Physician Progress Note

Date: 8.15.11 Time: 4

☑ Inpatient ☐ PHP ☐ IOP ☐ Rec. Residence

NOTES (include patient quotes and behaviors indicating acuity): Pt not respond to high dose Ceroton ... will Δ to Haldol. Either extremely agitated or psychotic; now sleeping & verbally unresponsive

MENTAL STATUS:

Oriented To: ☑ Person ☑ Place ☑ Time ☑ Circumstance ☐ None ☐ N / A

Current Mood: anxious Affect: agitated

Appearance / ADLs: somnolent

Eye Contact: ☑ Poor ☐ Fair ☐ Good

Hallucinations: ☑ Yes ☐ No If Yes, describe:

Delusions: ☑ Yes ☐ No If Yes, describe:

Current Thoughts: ☐ Racing ☐ Tangential ☐ Circumstantial ☐ Loose ☑ Disorganized ☐ Obsessive ☐ Paranoid ☐ Confused ☐ Clear ☐ Goal Directed

Sleep: ☑ Poor ☐ Interrupted ☐ Early Awakening ☐ Difficulty Going to Sleep ☐ Fair ☐ Good

Number of Hours:

Appetite: ☑ Poor ☐ Fair ☐ Improved ☐ Good Number of meals/day: ______ % consumed: ______

Insight: ☑ Poor ☐ Fair ☐ Limited ☐ Improved ☐ Good

Judgment: ☑ Poor ☐ Fair ☐ Improved ☐ Good

Patient Reports **Suicidal Ideation:** ☑ Yes ☐ No Patient Reports **Homicidal Ideation:** ☑ Yes ☐ No

Self Harming Thoughts / Behaviors: ☑ Yes ☐ No

Patient is still considered a risk, even if not reporting: ☑ Yes ☐ No

Rationale: Extremely agitated & psychotic. Was not protecting meds, side-effect

PRECAUTIONS / RESTRICTIONS: ☑ N / A

☐ TSP/SP ☐ Fall ☐ High Risk Fall ☐ Elopement ☐ Seizure ☐ Exercise ☐ 1:1 ☐ AC

☐ AC/SB ☐ CR ☐ SE ☐ Room ☐ Gender ☐ Other:

WITHDRAWAL SYMPTOMS / POST ACUTE WITHDRAWAL SYMPTOMS: ☑ N / A

☐ Continues on Detox regimen ☐ Nausea ☐ Vomiting ☐ Tremors ☐ Chills

☐ Elevated VS ☐ Sweating ☐ Blackouts ☐ Seizures ☐ Flushed Face ☐ DTs

☐ Numbness ☐ Unsteady Gait ☐ Cramping ☐ Craving ☐ Dysphoria ☐ Anxious

☐ Diarrhea ☐ Restless/disturbed sleep ☐ Poor concentration/memory ☐ None

(OVER)

Physician Progress Note

Describe patient's relapse risk: ______ ☐ N/A

Recovery environment: ______ ☐ N/A

Readiness to change: ______

EATING DISORDERS: ☐ N/A

Eating 100%: ☐ Yes ☐ No If No, describe: ______

☐ Purging ☐ Weight increasing due to laxative withdrawal ☐ NG Tube

Using: ☐ Diuretics ☐ Laxatives ☐ Stimulants ☐ Compulsive exercise

Compliant with meetings: ☐ Yes ☐ No ______

MEDICATIONS: ***DANGEROUS ABBREVIATIONS:*** **D / C, Q, HS, S.Q., U, u, I.U.**

Medication Compliant: ☑ Yes ☐ No **If new med started,** response to 1st Dose: ______

Medication Changes Today: ☑ Yes ☐ No Rationale: ______

Pertinent Medical Issues / Side Effects: see above

PATIENT / FAMILY EDUCATION (INCLUDING MEDS): ______

Family Contacted: ☐ Yes ☑ No Describe: ______

Outpatient Provider contacted: ☐ Yes ☑ No ☐ PCP ☐ Therapist ☐ Psychiatrist

Describe Contact: ______

TREATMENT GOALS:

Patient needs to stay in current level of care: ☑ Yes ☐ No If Yes, specify concerning behaviors, impairment and / or medical issues: see above – very far from stability

ELOS at this Level of Care: ______

Treatment Plan reviewed with patient: ☑ Yes ☐ No If Yes, comments: ______

DISPOSITION PLAN: If plan is transition to another LOC, specify **program:**

☐ PHP: ______ ☐ IOP (day): ______ ☐ IOP (eve): ______ ☐ Rec. Residence

☐ Home ☐ Nursing Home / Assisted Living ☐ Outpatient Counseling ☐ Other: ______

ADDITIONAL COMMENTS:

[signature]

Physician Signature