

## ## 4. HIGH SEVERITY CASE

**\*\*MH-29845-DOC\*\***

# MAX SUPER SPECIALITY HOSPITAL

Department of Psychiatry and Mental Health

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**\*\*Patient ID:\*\* MH-29845**

**\*\*Name:\*\* Sonalika Rawat**

**\*\*DOB:\*\* 15/09/1988 (36 years)**

**\*\*Gender:\*\* Female**

**\*\*Contact:\*\* +91 9876543210**

## ## ASSESSMENT SUMMARY

**\*\*Emergency Contact:\*\* Armaan Rawat - +91 9876123456**

**\*\*Primary Care Physician:\*\* Dr. Anil Sharma**

**\*\*Insurance:\*\* ICICI Prudential, #HP78392015**

**\*\*Date of Assessment:\*\* 8 April, 2025**

**\*\*Clinician:\*\* Dr. Priya Malhotra, MD, Psychiatry**

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Sonalika presented for her scheduled follow-up appointment reporting significant deterioration in mood and anxiety symptoms. She describes severe sleep disturbance with frequent middle-of-night awakening and early morning insomnia. Energy levels are severely depleted, impacting all areas of functioning. Her self-reported questionnaire data indicates severe anxiety with persistent depressed mood. Patient reluctantly acknowledges passive suicidal ideation with occasional thoughts of "not waking up" but denies specific plan or intent.

## ## KEY MENTAL HEALTH PARAMETERS

### ### MENTAL HEALTH INDICATORS

Parameter	Score/Rating	Clinical Notes
Mood	2/10	Persistent severe depression with minimal variation
Anxiety	Severe	Near-constant worry, panic attacks 2-3× weekly
Sleep Quality	2/10	Significant disruption, averaging 3-4 hours nightly
Energy Levels	2/10	Severe fatigue impacting all daily functions
Physical Symptoms	Significant	Daily headaches, GI distress, muscle tension
Concentration	2/10	Unable to maintain focus, impacting work performance
Self-Care	3/10	Significant decline in hygiene and self-care
Interests	2/10	Complete withdrawal from almost all activities
Intrusive Thoughts	4/10	Frequent ruminations about failure and worthlessness
Optimism	2/10	Very limited positive future outlook
Social Support	4/10	Relying exclusively on immediate family
Self-Harm Risk	Passive-Moderate	Frequent thoughts without specific plan

### ### ADDITIONAL CLINICAL DATA

#### \*\*Stress Factors:\*\*

Patient reports severe workplace stressors including performance review concerns and possible demotion. Financial stress significant due to decreased work hours. Home environment supportive but strained by patient's worsening condition.

#### \*\*Coping Strategies:\*\*

Patient has abandoned most structured coping mechanisms. Reports daily alcohol consumption to "manage anxiety" (2-3 drinks nightly). Physical activity nearly absent. Social withdrawal nearly complete.

#### \*\*Discussion About Professional Support:\*\*

Patient expresses limited hope in treatment efficacy but acknowledges need for intervention. Agrees to medication adjustment and increased therapy frequency. Willing to consider short-term medical leave but concerned about workplace stigma and financial impact.

## ## ASSESSMENT & RECOMMENDATIONS

### **\*\*Clinical Impression\*\***

Patient presents with symptoms consistent with Severe Major Depressive Disorder (F33.2) with anxiety features. Current PHQ-9 score of 22 indicates severe depression. GAD-7 score of 18 indicates severe anxiety. Significant functional impairment evident across multiple domains.

### **\*\*Treatment Recommendations\*\***

- Increase Escitalopram to 20mg daily
- Add Mirtazapine 15mg at bedtime for sleep and augmentation
- Increase therapy to twice weekly sessions initially
- Medical leave recommendation for 3 weeks
- Alcohol cessation plan with monitoring
- Consider partial hospitalization program if no improvement within 1 week
- Family therapy session to address support needs
- Specific safety planning

### **\*\*Safety Plan\*\***

Comprehensive safety plan developed with patient and spouse. Removal of all potential means of self-harm. 24-hour support person schedule established. Crisis contact information reviewed and programmed into phone. Agreement to contact emergency services if thoughts intensify.

## ## FOLLOW-UP PLAN

**\*\*Next Appointment:\*\*** 15 April, 2025 at 10:30 AM (1 week)

**\*\*Medication Review:\*\*** At next appointment with possible phone check in 3 days

**\*\*PHQ-9/GAD-7 Reassessment:\*\*** Weekly

**\*\*Care Coordination:\*\*** Immediate communication with PCP regarding condition and medication changes

\*Electronically Signed:\*

Dr. Priya Malhotra, MD

Senior Consultant Psychiatrist

License #: DMC/R/12345

Digitally signed on 08/04/2025 11:32 AM IST

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