# Psychiatry Initial Intake and Progress Note

**CLIENT NAME**: Bo Shang **DATE OF BIRTH**: 06/06/88 **DATE OF SERVICE**: 10/25/2017

**PROVIDER:** Kate Fogarty, PMHNP-BC

**START TIME**:10:30 **STOP TIME**:11:00 **TIME IN COUNSELING/THERAPY:** 20 MIN.

**CPT CODE:** 99214 Office Visit - RN 90833 Office Visit - Secondary Code - RN

If **+90785** used, please indicate criteria related to complexity and elaborate (Manage maladaptive communication that makes tx difficult (High anxiety, N/V sxs, High reactivity), Constricted affect, Tx resistance/non-compliance, Substance use, Caregiver's emotions interfere with implementation of tx, Reporting to 3rd party mandated, Use of play equipment, physical device, interpreter:

**PCP**: Timothy Eddy, DO

**DIAGNOSES**: F41.9 F90.9 **PROVISIONAL DIAGNOSIS**: F84.5

☐ **CHECKING THIS BOX INDICATES A CHANGE IN THE PREVIOUSLY BILLED DIAGNOSIS**

**CHIEF COMPLAINT/REASON For visit:** Pt presents for psychopharm f/u for ADHD.

**HISTORY OF PRESENT SYMPTOMS/ILLNESS**: Pt reports no response with dextroamphetamine ER 15mg QD. Tried 30mg QAM and 15mg BID and found 30mg QAM to be more beneficial. Was better able to focus and sustain attention. Memory improved. On the whole feels more benefit and fewer side effects with Dexedrine as compared to Adderall. No change in sleep or appetite. No headache, GI upset, tics. No change in mood and feels anxiety "almost non-existent." Denies elated mood, racing thoughts, irritability, impulsive behavior. Has been monitoring BP/HR. Believes he needs to a total of 45-60mg QAM with augmentation with armodafinil and addition of short-term Sonata for sleep. Reports he discussed this treatment strategy with Dr. Surmon at MGH and has been in touch with Dr. Furmin as well. Has not receive results of genetic testing yet because Dr. Furmin sent sample in later than planned but should have these in a couple of weeks. Pt has upcoming appt at the Bresslar Center at MGH. Given complexity of case and current fragmentation of care, recommend pt transfer all psychopharm services to MGH which he agrees is the best plan. Will provided dextroamphetamine ER 30mg QAM to cover until appt at Bresslar center.

From initial eval 10/20/17: Pt reports experiencing significant anxiety with panic attacks from March-July 2017 in the context of academic pressure of post-graduate program in computer science at Tufts University. Started program in January 2017 and after a couple of months started to notice he was not able to keep up with the work, sleep was poor, couldn't sustain focus or concentration, was putting off assignments to the last minute and then needing to stay up all night finishing them. Went to ER with panic attack in July and was given lorazepam which he didn't feel was effective and PCP started fluoxetine. Took fluoxetine for a couple weeks. Noticed a beneficial effect the first 2 days and then no effect whatsoever so he now attributes brief improvement to placebo effect. Was started on Adderall by PCP (currently reports he is prescribed 20mg TID although pharmacy reports he had 7 days of 20mg TID in August and then dose returned to 15mg TID). Has noticed considerable benefit with Adderall but after researching different stimulant options is interested in trial of Dexedrine. Reports since he started Adderall his focus and concentration have been better, sleep improved, anxiety reduced and mood stable. Denies side effects or concerns. PCP is retiring in November so pt has attempted to establish care with an BH prescriber. Saw Dr. Melissa Frumin, a psychiatrist in private practice Boston, last month and she ordered genetic testing but pt is unable to continue care with her because she doesn't accept insurance and is too expensive. Will have results of genetic testing next week, however. Also has an initial evaluation at the Bresslar Center at MGH next week and is slated for genetic testing for autism in Feb 2018.

Pt presents with a constricted affect and rather intense focus on subject of phamacokinetics of stimulant medication. Believes he is a rapid metabolizers and therefore has required higher doses of Adderall to achieve response. Has found Adderall IR "very effective" but effect short-lived and he has tended to take more than prescribed on some days and no medication at all on other days based on "what level of functioning I need." With Adderall feels his inattentive sx are well-controlled, he is able to stay focused on work, seems to retain more information, memory is better, anxiety reduced and sleep improved. Reports on days he takes Adderall he sleeps well (8 hrs uninterrupted) but on days when he doesn't take stimulant he has significant trouble falling asleep and resorts to drinking 3-4 mixed drinks in 30 minutes in order to fall asleep. Pt denies current anxiety. Last panic attack was in July. Mood euthymic. Energy is good even on

# Psychiatry Initial Intake and Progress Note

days when he doesn't sleep well (of note, reports he drank 10 cups of coffee prior to appt with this provider even though he reports sleeping well last night) but denies racing thoughts, elated mood, irritability, increased spending, big ideas. Thinking appears black and white but no evidence of paranoia or delusional thinking. Denies AH/VH.

**PAST, FAMILY, SOCIAL HISTORY (PFSH)** ☐Check if no change ***(1 history area – Pertinent; 2-3 history areas – Complete)***

☒ **Past Medical History:** Denies any significant med hx. EKG in July WNL. No dizziness, syncope. No hx of lead poisoning, head injury.

☒ **Past Psychiatric History:** Pt reports hx of ADHD sx, both inattentive and hypractive as early as elementary school but was not formally diagnosed until testing last month and did not receive special education services. Recalls he would stay up all night playing video games and then sleep through his classes waking up just long enough to get the minimum amount of work done to earn Bs. Pt also reports some hx of OCD sx in early childhood including counting behaviors and "needing to walk in a certain way" with a specified number of steps but states, "OCD isn't logical. It doesn't make sense so I was just able to stop doing it." Denies hx of panic or mood disturbance prior to this year. From April-July 2017 believes he met criteria for MDD but denies he had any SI, SIB, AH/VH. Recalls appetite was lower, energy lower, motivation lower. Was unable to enjoy himself, rarely left the house, was more irritable. Reports a significant improvement in mood with start of Adderall and further improvement when he had neuropsych testing which put helped to explain what he was feeling. States, "I am logical so when the symptoms made sense, they no longer existed for me."

☒ **History of Prior Hospitalization:** Denies

☒ **Safety Risks:** Denies

☒ **Trauma History:** Denies

☒ **Legal History:** Denies

☒ **Substance Use History:** 3-4 mixed drinks about 4 nights a week to fall asleep. Identifies alcohol use as a means to an end and is does not find it pleasurable, doesn't drink socially and doesn't have urges, cravings, or any withdrawal sx.

☒ **Family History of Mental Illness**: ? ADHD in father, OCD in mother and anxiety and poor social functioning in both parents

☒ **Social History**: Pt born in China and moved to US with parents when he was 8 yrs old. Is an only child and reports parents were quiet, focused on work, and did very little parenting when he was younger. Reports he could do whatever h wanted, didn't have specified sleep schedule or evening routine. Didn't engage in social or extracurricular activities. Recalls he did not make social connections in China and didn't really think about making friends when he came to US. Does not feel he was fluent in English until high school but pt doesn't feel language barrier was really a factor on his lack of social connectedness. States, "Having friends was never a priority." Attended Tufts undergrad majoring in engineering after college worked briefly in finance in China and then started an MBA program in Sydney, Australia. Didn't feel the program was a good fit so he returned home and enrolled in a post-graduate program in computer science at Tufts. Is currently living at home in Burlington, MA with his parents. Is not in a relationship. Is not employed outside of school.

**PSYCHOTHERAPY TYPE**: ☐None ☐Dynamic ☐Supportive ☐CBT ☐DBT ☒Other: Psychoeducation

**PSYCHOTHERAPY CONTENT**: Provided psychoeducation ADHD, overlap with anxiety and poor sleep, and treatment options including risks, benefits and potential side effects of various stimulant and non-stimulant options.

**REVIEW OF SYSTEMS & ACTIVE MEDICAL PROBLEMS**
***(1 system - Problem Pertinent; 2-9 systems – Extended; 10 or more systems or some systems noted as "all others negative"- Complete)***

| | | | | |
|---|---|---|---|---|
| 1. | Constitutional | WNL☒ | ABN☐ | |
| 2. | Eyes | WNL ☒ | ABN☐ | |
| 3. | Ears/Nose/Mouth/Throat | WNL ☒ | ABN☐ | |
| 4. | Cardiovascular | WNL ☒ | ABN☐ | Last EKG: |
| 5. | Respiratory | WNL ☒ | ABN☐ | |
| 6. | Gastrointestinal | WNL ☒ | ABN☐ | |
| 7. | Genitourinary | WNL ☒ | ABN☐ | |
| 8. | Muscular | WNL ☒ | ABN☐ | |

# Psychiatry Initial Intake and Progress Note

| | | |
|---|---|---|
| 9. Integumentary | WNL ☒ | ABN ☐ |
| 10. Neurological | WNL ☒ | ABN ☐ |
| 11. Endocrine | WNL ☒ | ABN ☐ |
| 12. Hemotologic/Lymphatic | WNL ☒ | ABN ☐ |
| 13. Immune | WNL ☒ | ABN ☐ |

**ROS**: ☐ No Changes Since Last Visit ☐

**VITAL SIGNS: BP:**140/101 **HR:**91 **RR**:16 **TEMP**: afeb **WEIGHT:**140 **HEIGHT:** 5'9" **BMI**: 20.7

---

**MENTAL STATUS EXAM (CURRENT)** 10/25/2017 **:**
**ORIENTATION**: ALERT AND ORIENTED TO TIME, PERSON, AND PLACE
**APPEARANCE/ BEHAVIOR/ATTITUDE**: APPEARS IN GOOD HEALTH.
**MOVEMENT, GAIT AND STATION**: OBSERVED GAIT AND STATION WITHIN THE NORMAL LIMITS
**SPEECH/LANGUAGE**: Normal rate, rhythm, volume, and prosody.
**APPETITE:** INCREASED
**ENERGY LEVEL:** wnl
**LIBIDO:** no change
**SLEEP:** DIFFICULTIES INITIATING SLEEP
**MOOD**: "OK"
**AFFECT**: Constricted.
**THOUGHT PROCESS**: Logical. Coherent.
**THOUGHT CONTENT**: DENIES SI. DENIES HI. NO PROMINENT DELUSIONS.
**PERCEPTIONS:** No auditory hallucinations. No visual hallucinations. No gustatory hallucinations.
**COGNITION/MEMORY**: Cognitively intact.
**INSIGHT**: Intact.
**JUDGMENT**: Intact.
**RISK:** NO REPORTED RISK.

---

**LABORATORY and DIAGNOSTIC TESTS ORDERED/REVIEWED:** Records requested from PCP

☒ BDI-II 3 ☒ BAI/AMAS 1 ☐ MDQ ☐ ADHD rating scales ☐ Other Notes:

**LAST PHYSICAL EXAM:** Within past 3 months
**COLLATERALS:**

☒ **NKDA** **ALLERGIES:**

| Current Medication | Dose/Frequency | Comments/Rx Info |
|---|---|---|
| Dexedrine spansules | 30mg QAM | |
| | | |
| | | |
| | | |
| | | |

**PREVIOUS MEDICATIONS:** trazodone (up to 100mg, ineffective), diphenhydramine 50mg QHS (worked once for sleep and then ineffective), fluoxetine (20mg QD x 2 wks, ineffective), lorazepam (ineffective), Adderall IR (effective), melatonin (ineffective)
**ADVERSE MEDICATION EFFECTS**: ☒ None ☐

**THERAPEUTIC PROCESS AND PROGRESS TOWARD TREATMENT PLAN:**

| Problem /Symptom | Intervention | Progress/Response/ Outcome |
|---|---|---|

# Psychiatry Initial Intake and Progress Note

| | | |
|---|---|---|
| Inattention, poor executive functioning | Medication, supportive therapy, psychoeducation | ☐ New ☒ Improved ☐ Stable ☐ No Change ☐ Worsened |
| Anxiety, stable currently | Supportive therapy, psychoeducation, will continue to monitor | ☐ New ☐ Improved ☒ Stable ☐ No Change ☐ Worsened |
| Depresion, stable currently | Supportive therapy, psychoeducation, will continue to monitor | ☐ New ☐ Improved ☒ Stable ☐ No Change ☐ Worsened |
| Social impairments | Will continue to monitor | ☐ New ☐ Improved ☐ Stable ☒ No Change ☐ Worsened |
| | | ☐ New ☐ Improved ☐ Stable ☐ No Change ☐ Worsened |
| | | ☐ New ☐ Improved ☐ Stable ☐ No Change ☐ Worsened |
| | | ☐ New ☐ Improved ☐ Stable ☐ No Change ☐ Worsened |
| | | ☐ New ☐ Improved ☐ Stable ☐ No Change ☐ Worsened |
| | | ☐ New ☐ Improved ☐ Stable ☐ No Change ☐ Worsened |
| | | ☐ New ☐ Improved ☐ Stable ☐ No Change ☐ Worsened |

**ASSESSMENT AND TREATMENT PLAN**:
Pt reports some improvement in ADHD sx with Dexedrine 30mg QAM but feels higher dose is needed and has thoughts of augmentation strategies as well. Denies side effects and feels that while dose of Dexedrine is too low, it is more effective than Adderall. Recommend transfer to MGH for psychopharm to avoid the current fragmentation of care. Pt agrees. Will provider Dexedrine 30mg QAM to cover until appt at Bresslar Center at MGH.

1. Continue Dexedrine 30mg QAM. Reviewed r/b and side effects including, but not limited to, insomnia, decreased appetite, increased HR/BP, tics, mood changes, increased anxiety.
2. Pt has upcoming appt at MGH for tx of ADHD and exploration of ASD and plans to transfer psychopharm services to there while continuing therapy with Dr Crowe at CPA.
3.
4.
5.
6.
7.

**CONSULTS AND REFERRALS:**

☐ Client to be seen in weeks.

☒ I reviewed the rationale for and risks & benefits of the recommended treatment with the client or legal guardian who is competent and agreed with the recommendations.

☐ The client/legal guardian declined the recommended treatment.

☒ I reviewed my office availability, limits of confidentiality, emergency policy and need to take care of all medication changes in the office (not over the phone)

*Electronically signed on 10/27/2017 at 9:40 AM by Kate Fogarty*, PMHNP-BC

☐ Click here to spell check this document

# Psychiatry Initial Intake and Progress Note

**CLIENT NAME**: Bo Shang **DATE OF BIRTH**: 06/06/88 **DATE OF SERVICE**: 10/20/2017

**PROVIDER:** Kate Fogarty, PMHNP-BC

**START TIME**:11:30 **STOP TIME**:12:30 **TIME IN COUNSELING/THERAPY:** 20 MIN.

**CPT CODE:** 99204 Office Visit - New Client - RN

If **+90785** used, please indicate criteria related to complexity and elaborate (Manage maladaptive communication that makes tx difficult (High anxiety, N/V sxs, High reactivity), Constricted affect, Tx resistance/non-compliance, Substance use, Caregiver's emotions interfere with implementation of tx, Reporting to 3rd party mandated, Use of play equipment, physical device, interpreter**:**

**PCP**: Timothy Eddy, DO _____

**DIAGNOSES**: F41.9 F90.9 _____ _____ _____ **PROVISIONAL DIAGNOSIS**: F84.5

☐ **CHECKING THIS BOX INDICATES A CHANGE IN THE PREVIOUSLY BILLED DIAGNOSIS**

**CHIEF COMPLAINT/REASON For visit:** Pt presents for initial psychopharm eval w/ c.c of recent diagnoses of ADHD and possible autism spectrum.

**HISTORY OF PRESENT SYMPTOMS/ILLNESS**: Pt reports experiencing significant anxiety with panic attacks from March-July 2017 in the context of academic pressure of post-graduate program in computer science at Tufts University. Started program in January 2017 and after a couple of months started to notice he was not able to keep up with the work, sleep was poor, couldn't sustain focus or concentration, was putting off assignments to the last minute and then needing to stay up all night finishing them. Went to ER with panic attack in July and was given lorazepam which he didn't feel was effective and PCP started fluoxetine. Took fluoxetine for a couple weeks. Noticed a beneficial effect the first 2 days and then no effect whatsoever so he now attributes brief improvement to placebo effect. Was started on Adderall by PCP (currently reports he is prescribed 20mg TID although pharmacy reports he had 7 days of 20mg TID in August and then dose returned to 15mg TID). Has noticed considerable benefit with Adderall but after researching different stimulant options is interested in trial of Dexedrine. Reports since he started Adderall his focus and concentration have been better, sleep improved, anxiety reduced and mood stable. Denies side effects or concerns. PCP is retiring in November so pt has attempted to establish care with an BH prescriber. Saw Dr. Melissa Frumin, a psychiatrist in private practice Boston, last month and she ordered genetic testing but pt is unable to continue care with her because she doesn't accept insurance and is too expensive. Will have results of genetic testing next week, however. Also has an initial evaluation at the Bresslar Center at MGH next week and is slated for genetic testing for autism in Feb 2018.

Pt presents with a constricted affect and rather intense focus on subject of phamacokinetics of stimulant medication. Believes he is a rapid metabolizers and therefore has required higher doses of Adderall to achieve response. Has found Adderall IR "very effective" but effect short-lived and he has tended to take more than prescribed on some days and no medication at all on other days based on "what level of functioning I need." With Adderall feels his inattentive sx are well-controlled, he is able to stay focused on work, seems to retain more information, memory is better, anxiety reduced and sleep improved. Reports on days he takes Adderall he sleeps well (8 hrs uninterrupted) but on days when he doesn't take stimulant he has significant trouble falling asleep and resorts to drinking 3-4 mixed drinks in 30 minutes in order to fall asleep. Pt denies current anxiety. Last panic attack was in July. Mood euthymic. Energy is good even on days when he doesn't sleep well (of note, reports he drank 10 cups of coffee prior to appt with this provider even though he reports sleeping well last night) but denies racing thoughts, elated mood, irritability, increased spending, big ideas. Thinking appears black and white but no evidence of paranoia or delusional thinking. Denies AH/VH.

**PAST, FAMILY, SOCIAL HISTORY (PFSH)** ☐Check if no change ***(1 history area – Pertinent; 2-3 history areas – Complete)***

☒ **Past Medical History:** Denies any significant med hx. EKG in July WNL. No dizziness, syncope. No hx of lead poisoning, head injury.

☒ **Past Psychiatric History:** Pt reports hx of ADHD sx, both inattentive and hypractive as early as elementary school but was not formally diagnosed until testing last month and did not receive special education services. Recalls he would stay

# Psychiatry Initial Intake and Progress Note

up all night playing video games and then sleep through his classes waking up just long enough to get the minimum amount of work done to earn Bs. Pt also reports some hx of OCD sx in early childhood including counting behaviors and "needing to walk in a certain way" with a specified number of steps but states, "OCD isn't logical. It doesn't make sense so I was just able to stop doing it." Denies hx of panic or mood disturbance prior to this year. From April-July 2017 believes he met criteria for MDD but denies he had any SI, SIB, AH/VH. Recalls appetite was lower, energy lower, motivation lower. Was unable to enjoy himself, rarely left the house, was more irritable. Reports a significant improvement in mood with start of Adderall and further improvement when he had neuropsych testing which put helped to explain what he was feeling. States, "I am logical so when the symptoms made sense, they no longer existed for me."

☒ **History of Prior Hospitalization:** Denies

☒ **Safety Risks:** Denies

☒ **Trauma History:** Denies

☒ **Legal History:** Denies

☒ **Substance Use History:** 3-4 mixed drinks about 4 nights a week to fall asleep. Identifies alcohol use as a means to an end and is does not find it pleasurable, doesn't drink socially and doesn't have urges, cravings, or any withdrawal sx.

☒ **Family History of Mental Illness**: ? ADHD in father, OCD in mother and anxiety and poor social functioning in both parents

☒ **Social History**: Pt born in China and moved to US with parents when he was 8 yrs old. Is an only child and reports parents were quiet, focused on work, and did very little parenting when he was younger. Reports he could do whatever h wanted, didn't have specified sleep schedule or evening routine. Didn't engage in social or extracurricular activities. Recalls he did not make social connections in China and didn't really think about making friends when he came to US. Does not feel he was fluent in English until high school but pt doesn't feel language barrier was really a factor on his lack of social connectedness. States, "Having friends was never a priority." Attended Tufts undergrad majoring in engineering after college worked briefly in finance in China and then started an MBA program in Sydney, Australia. Didn't feel the program was a good fit so he returned home and enrolled in a post-graduate program in computer science at Tufts. Is currently living at home in Burlington, MA with his parents. Is not in a relationship. Is not employed outside of school.

**PSYCHOTHERAPY TYPE**: ☐None ☐Dynamic ☐Supportive ☐CBT ☐DBT ☒Other: Psychoeducation

**PSYCHOTHERAPY CONTENT**: Provided psychoeducation ADHD, overlap with anxiety and poor sleep, and treatment options including risks, benefits and potential side effects of various stimulant and non-stimulant options.

**REVIEW OF SYSTEMS & ACTIVE MEDICAL PROBLEMS**

***(1 system - Problem Pertinent; 2-9 systems – Extended; 10 or more systems or some systems noted as "all others negative"- Complete)***

| | | | |
|---|---|---|---|
| 1. Constitutional | WNL☒ | ABN☐ | |
| 2. Eyes | WNL ☒ | ABN☐ | |
| 3. Ears/Nose/Mouth/Throat | WNL ☒ | ABN☐ | |
| 4. Cardiovascular | WNL ☒ | ABN☐ | Last EKG: |
| 5. Respiratory | WNL ☒ | ABN☐ | |
| 6. Gastrointestinal | WNL ☒ | ABN☐ | |
| 7. Genitourinary | WNL ☒ | ABN☐ | |
| 8. Muscular | WNL ☒ | ABN☐ | |
| 9. Integumentary | WNL ☒ | ABN☐ | |
| 10. Neurological | WNL ☒ | ABN☐ | |
| 11. Endocrine | WNL ☒ | ABN☐ | |
| 12. Hemotologic/Lymphatic | WNL ☒ | ABN☐ | |
| 13. Immune | WNL ☒ | ABN☐ | |

**ROS**: ☐No Changes Since Last Visit ☐

**VITAL SIGNS: BP:**138/110 **HR:**84 **RR**:16 **TEMP**: afeb **WEIGHT:**140 **HEIGHT:** 5'9" **BMI**: 20.7

# Psychiatry Initial Intake and Progress Note

**MENTAL STATUS EXAM (CURRENT)** 10/20/2017 **:**
**ORIENTATION**: ALERT AND ORIENTED TO TIME, PERSON, AND PLACE
**APPEARANCE/ BEHAVIOR/ATTITUDE**: APPEARS IN GOOD HEALTH.
**MOVEMENT, GAIT AND STATION**: OBSERVED GAIT AND STATION WITHIN THE NORMAL LIMITS
**SPEECH/LANGUAGE**: Normal rate, rhythm, volume, and prosody.
**APPETITE:** INCREASED
**ENERGY LEVEL:** wnl
**LIBIDO:** no change
**SLEEP:** DIFFICULTIES INITIATING SLEEP
**MOOD**: "OK"
**AFFECT**: Constricted.
**THOUGHT PROCESS**: Logical. Coherent.
**THOUGHT CONTENT**: DENIES SI. DENIES HI. NO PROMINENT DELUSIONS.
**PERCEPTIONS:** No auditory hallucinations. No visual hallucinations. No gustatory hallucinations.
**COGNITION/MEMORY**: Cognitively intact.
**INSIGHT**: Intact.
**JUDGMENT**: Intact.
**RISK:** NO REPORTED RISK.

---

**LABORATORY and DIAGNOSTIC TESTS ORDERED/REVIEWED:** Records requested from PCP

☒ BDI-II 3 ☒ BAI/AMAS 1 ☐ MDQ ☐ ADHD rating scales ☐ Other Notes:

**LAST PHYSICAL EXAM:** Within past 3 months
**COLLATERALS:**

☒ **NKDA** **ALLERGIES:**

| Current Medication | Dose/Frequency | Comments/Rx Info |
|---|---|---|
| Adderall IR | 15-20mg TID | Discontinued today |
| Dexedrine spansules | 15mg QAM | Started today |
| | | |
| | | |
| | | |

**PREVIOUS MEDICATIONS:** trazodone (up to 100mg, ineffective), diphenhydramine 50mg QHS (worked once for sleep and then ineffective), fluoxetine (20mg QD x 2 wks, ineffective), lorazepam (ineffective), Adderall IR (effective), melatonin (ineffective)
**ADVERSE MEDICATION EFFECTS**: ☒None ☐

**THERAPEUTIC PROCESS AND PROGRESS TOWARD TREATMENT PLAN:**

| Problem /Symptom | Intervention | Progress/Response/ Outcome |
|---|---|---|
| Inattention, poor executive functioning | Medication, supportive therapy, psychoeducation | ☒ New ☐ Improved ☐ Stable ☐ No Change ☐ Worsened |
| Anxiety, stable currently | Supportive therapy, psychoeducation, will continue to monitor | ☒ New ☐ Improved ☐ Stable ☐ No Change ☐ Worsened |
| Depresion, stable currently | Supportive therapy, psychoeducation, will continue to monitor | ☒ New ☐ Improved ☐ Stable ☐ No Change ☐ Worsened |
| Social impairments | Will continue to monitor | ☒ New ☐ Improved ☐ Stable ☐ No Change ☐ Worsened |
| | | ☐ New ☐ Improved ☐ Stable ☐ No Change ☐ Worsened |

# Psychiatry Initial Intake and Progress Note

| | | |
|---|---|---|
| | | ☐ New ☐ Improved ☐ Stable ☐ No Change ☐ Worsened |
| | | ☐ New ☐ Improved ☐ Stable ☐ No Change ☐ Worsened |
| | | ☐ New ☐ Improved ☐ Stable ☐ No Change ☐ Worsened |
| | | ☐ New ☐ Improved ☐ Stable ☐ No Change ☐ Worsened |
| | | ☐ New ☐ Improved ☐ Stable ☐ No Change ☐ Worsened |

**ASSESSMENT AND TREATMENT PLAN**:
Pt is a 29 yo graduate student who presents with anxiety over the past 10 months in the context of the demands of graduate school and feeling unsettled and unfocused in his career and academic pursuits since college. Did not response to medication trials for anxiety but PCP diagnosed him with ADHD in July and this was confirmed through neuropsych testing in Sept and pt reports good response with Adderall IR. Pt reports focus, attention, mood, sleep and anxiety are all improved with Adderall but is concerned that he may be a fast metabolizer since he has seemed to needed higher doses of medication to achieved a response. Had genetic testing a couple weeks ago to assses for any metabolic concerned and reports he will likely have results next week. Pt presents with a rather intense focus on how stimulants work and appears to have done extensive research into different formulations. Chronic poor sleep and anxiety may be responsible, at leaast in part, for some of his ADHD sx and discussed importance of focusing on these issues while also targeting ADHD. Pt is interested in trial of dexedrine. Reviewed r/b and side effects and off-label use in adult ADHD. Recommend ER formulation and once daily use. Of note, pt seems to have multiple providers including Dr. Crowe at CPA for therapy, PCP who was prescribing previously but is retiring, outpatient psychiatrist whom he met with once and had genetic testing, and a scheduled appt at the Bresslar Center next week. Discussed importance of centralized care and using only one pharmacy. Will start dexedrine spansules 15mg QAM with plan to meet in 2 wks to discuss response and review results of genetic testing.

1. Start dexedrine 15mg QAM. Reviewed r/b and side effects including, but not limited to, insomnia, decreased appetite, increased HR/BP, tics, mood changes, increased anxiety.
2. Will f/u in 2 wks or sooner as needed.
3.
4.
5.
6.
7.

**CONSULTS AND REFERRALS:**

☒ Client to be seen in 2 weeks.

☒ I reviewed the rationale for and risks & benefits of the recommended treatment with the client or legal guardian who is competent and agreed with the recommendations.

☐ The client/legal guardian declined the recommended treatment.

☒ I reviewed my office availability, limits of confidentiality, emergency policy and need to take care of all medication changes in the office (not over the phone)

*Electronically signed on 10/23/2017 at 1:46 PM by Kate Fogarty*, PMHNP-BC

☐ Click here to spell check this document