

Medication Administration Record
10/28/2023 11:00 - 10/30/2023 12:37

Name: (b) (6) Sex: M
Location: 4
Physician: Quesada, Anthony

Admit Date: 10/28/2023

D Blood Glucose Monitoring NOW	<u>Start:</u> 11:42 10/28 <u>Stop:</u> 12:07 10/28	Admin 10/28 12:07	Sched 11:42	Not Administered/Not Other - See Notes n/a	agarin
D Care Profile and Crisis Plan EVERY 4 HOURS - UNTIL COMPLETE	<u>Start:</u> 11:42 10/28 <u>Stop:</u> 12:04 10/28	Admin 10/28 12:04	Sched 11:42	Complete	agarin
D CBC W/O DIFFERENTIAL EVERY MORNING UNTIL COMPLETE	<u>Start:</u> 10:00 10/29 <u>Stop:</u> 0:47 10/30	Admin 10/29 16:01	Sched 10:00	Not Administered/Not Other - See Notes	kslupek
D COMPREHENSIVE METABOLIC EVERY MORNING UNTIL COMPLETE	<u>Start:</u> 10:00 10/29 <u>Stop:</u> 0:47 10/30	Admin 10/29 16:01	Sched 10:00	Not Administered/Not Other - See Notes	kslupek
D Consent and Declination of Seasonal Influenza Vaccine EVERY 12 HOURS UNTIL COMPLETE	<u>Start:</u> 11:42 10/28 <u>Stop:</u> 12:01 10/28	Admin 10/28 12:01	Sched 11:42	Complete	agarin
A COWS Scale Every 4 hours - COWS If initial score >10 assess vitals per protocol/Verify with MD the initiation of the medical detox protocol.	<u>Start:</u> 17:00 10/28 <u>Stop:</u> 23:59 12/31	Admin 10/28 17:03 10/28 21:10 10/29 9:56 10/29 12:56 10/29 16:02 10/29 21:14 10/30 8:15	Sched 17:00 21:00 9:00 13:00 17:00 21:00 9:00	Complete Complete Complete Complete Complete Complete Complete	kslupek mebreo kslupek kslupek kslupek sjohn rsoriano
A Daily Nursing Progress Note Twice a Day Assessments	<u>Start:</u> 16:00 10/28 <u>Stop:</u> 23:59 12/31	Admin 10/28 12:07	Sched 16:00	Not Administered/Not Other - See Notes see admission assessment	agarin
		10/29 1:32 10/29 14:55 10/29 23:22 10/30 10:30	4:00 16:00 4:00 16:00	Complete Complete Complete Complete	mebreo kslupek sjohn jhundang
A Environment Patient Safety Checklist Twice a Day Assessments	<u>Start:</u> 16:00 10/28 <u>Stop:</u> 23:59 12/31	Admin 10/28 12:07 10/28 21:08 10/29 14:55 10/29 23:18	Sched 16:00 4:00 16:00 4:00	Complete Complete Complete Complete	agarin mebreo kslupek sjohn
D Initial Nursing Assessment EVERY 4 HOURS - UNTIL COMPLETE	<u>Start:</u> 11:42 10/28 <u>Stop:</u> 12:37 10/28	Admin 10/28 12:36	Sched 11:42	Complete	agarin
D Initial Treatment Plan EVERY 4 HOURS - UNTIL COMPLETE	<u>Start:</u> 11:42 10/28 <u>Stop:</u> 12:10 10/28	Admin 10/28 12:10	Sched 11:42	Complete	agarin
D Initiate Treatment Plan for Patient EVERY 4 HOURS - UNTIL COMPLETE	<u>Start:</u> 11:42 10/28 <u>Stop:</u> 13:52 10/28	Admin 10/28 13:52	Sched 11:42	Complete	agarin
D LIPID PANEL W/HDL EVERY MORNING UNTIL COMPLETE	<u>Start:</u> 10:00 10/29 <u>Stop:</u> 10:19 10/30	Admin 10/29 16:01	Sched 10:00	Not Administered/Not Other - See Notes	kslupek
		10/30 10:19	10:00	Complete	rsoriano
D Patient Unit Orientation Checklist EVERY 4 HOURS - UNTIL COMPLETE	<u>Start:</u> 11:42 10/28 <u>Stop:</u> 12:02 10/28	Admin 10/28 12:02	Sched 11:42	Complete	agarin
D Safety and Health Evaluation One time for ancillary orders	<u>Start:</u> 11:42 10/28 <u>Stop:</u> 12:09 10/28	Admin 10/28 12:09	Sched 11:42	Complete	agarin
A buprenorphine TABLET 2 mg (*Subutex) Sublingual TWICE DAILY 0900 & 1700 for Maintenance	<u>Start:</u> 10:00 10/30 <u>Stop:</u> 23:59 12/31	Admin 10/30 10:12	Sched 10:00	Complete	rsoriano

Medication Administration Record
10/28/2023 11:00 - 10/30/2023 12:37

Name: ON

Hospital Num

Location:

Admit Date: 10/28/2023

Physician: Quesada, Anthony

D	buprenorphine TABLET (*Subutex) Sublingual DAILY AT 1700 (1 Day) for Maintenance	8 mg	<u>Start:</u> 17:00 10/28 <u>Stop:</u> 23:59 10/28	Admin 10/28 17:32	Sched 17:00	Complete	kslupek
D	buprenorphine TABLET (*Subutex) Sublingual NOW for Maintenance	8 mg	<u>Start:</u> 12:20 10/29 <u>Stop:</u> 12:56 10/29	Admin 10/29 12:56	Sched 12:20	Complete	kslupek
A	gabapentin TABLET (Neurontin) Oral THREE TIMES DAILY 0900 1300 2100 To give 1,200 mg use 2 of 600 mg for Anxiety	1,200 mg	<u>Start:</u> 17:00 10/28 <u>Stop:</u> 23:59 12/31	Admin 10/28 17:32 10/28 20:44 10/29 9:21 10/29 12:55 10/29 20:36 10/30 8:14	Sched 17:00 21:00 9:00 13:00 21:00 9:00	Complete Complete Complete Complete Complete Complete	kslupek mebreo kslupek kslupek sjohn rsoriano
A	mirtazapine TABLET (Remeron) Oral AT BEDTIME for Sleep	15 mg	<u>Start:</u> 21:00 10/28 <u>Stop:</u> 23:59 12/31	Admin 10/28 20:44 10/29 20:37	Sched 21:00 21:00	Complete Complete	mebreo sjohn
A	multivitamin TABLET (Daily Multiple Vitamins) Oral ONCE A DAY for Nutritional Support	1 tab	<u>Start:</u> 9:00 10/29 <u>Stop:</u> 23:59 12/31	Admin 10/29 9:21 10/30 8:14	Sched 9:00 9:00	Complete Complete	kslupek rsoriano
A	omeprazole DR CAP (PriLOSEC) Oral ONCE A DAY for GERD	20 mg	<u>Start:</u> 9:00 10/29 <u>Stop:</u> 23:59 12/31	Admin 10/29 9:20 10/30 8:14	Sched 9:00 9:00	Complete Complete	kslupek rsoriano
A	prazosin CAPSULE (Minipress) Oral AT BEDTIME for nightmares	1 mg	<u>Start:</u> 21:00 10/28 <u>Stop:</u> 23:59 12/31	Admin 10/28 20:45 10/29 20:37	Sched 21:00 21:00	Complete Complete	mebreo sjohn
D	QUetiapine TABLET (SEROquel) Oral AT BEDTIME for Mood	300 mg	<u>Start:</u> 21:00 10/28 <u>Stop:</u> 16:56 10/29	Admin 10/28 20:45	Sched 21:00	Complete	mebreo
A	QUetiapine TABLET (SEROquel) Oral AT BEDTIME To give 600 mg use 2 of 300 mg for Mood	600 mg	<u>Start:</u> 21:00 10/29 <u>Stop:</u> 23:59 12/31	Admin 10/29 20:37	Sched 21:00	Complete	sjohn
A	Suicidal Ideation Severity Assessment DAILY AT 1600		<u>Start:</u> 16:00 10/28 <u>Stop:</u> 23:59 12/31	Admin 10/28 12:06 10/29 14:55 10/30 10:14	Sched 16:00 16:00 16:00	Complete Complete Complete	agarin kslupek jhundang
D	TSH ONLY, ULTRA SENSITIVE 3RD GEN EVERY MORNING UNTIL COMPLETE		<u>Start:</u> 10:00 10/29 <u>Stop:</u> 10:19 10/30	Admin 10/29 16:01 Other - See Notes 10/30 10:19	Sched 10:00 Not Administered/Not 10:00	Complete Not Administered/Not Complete	kslupek rsoriano
D	Urine Drug Screen EVERY MORNING UNTIL COMPLETE Nurse Collect		<u>Start:</u> 10:00 10/29 <u>Stop:</u> 0:47 10/30	Admin 10/29 16:01 Other - See Notes	Sched 10:00 Not Administered/Not	Complete Not Administered/Not Complete	kslupek
A	Vital Signs TWICE A DAY		<u>Start:</u> 21:00 10/28 <u>Stop:</u> 23:59 12/31	Admin 10/28 21:09 10/29 8:37 10/29 19:57 10/30 10:19	Sched 21:00 9:00 21:00 9:00	Complete Complete Complete Complete	mebreo agarin sjohn rsoriano

Medication Administration Record
10/28/2023 11:00 - 10/30/2023 12:37

Name: [REDACTED]
Location: [REDACTED]
Physician: Quesada, Anthony

Hospital Num: [REDACTED]
Admit Date: 10/28/2023

D	Weight NOW		<u>Start:</u> 11:42 10/28 <u>Stop:</u> 12:08 10/28	<u>Admin</u> 10/28 12:08	<u>Sched</u> 11:42	Complete	agarin
A	rivaroxaban TABLET 10 mg (*Xarelto) Oral ONCE A DAY for dvt		<u>Start:</u> 9:00 10/29 <u>Stop:</u> 23:59 12/31	<u>Admin</u> 10/29 9:21 10/30 8:14	<u>Sched</u> 9:00	Complete Complete	kslupek rsoriano
A	sertraline TABLET (Zoloft) 50 mg Oral ONCE A DAY for Mood Simultaneous with sertraline TABLET (Zoloft) 25 mg		<u>Start:</u> 9:00 10/29 <u>Stop:</u> 23:59 12/31	<u>Admin</u> 10/29 9:20 10/30 8:14	<u>Sched</u> 9:00	Complete Complete	kslupek rsoriano
A	sertraline TABLET (Zoloft) 25 mg Oral ONCE A DAY for Depression take with 50mg (total 75mg) Simultaneous with sertraline TABLET (Zoloft) 50 mg		<u>Start:</u> 9:00 10/31 <u>Stop:</u> 23:59 12/31	<u>Admin</u>	<u>Sched</u>		
P	buprenorphine TABLET 8 mg (*Subutex) PRN Sublingual TWICE DAILY 0900 & 2100 PRN for Maintenance Max Daily Doses: 2		<u>Start:</u> 18:47 10/29 <u>Stop:</u> 9:55 10/30	<u>Admin</u>	<u>Sched</u>		
A	dicyclomine TABLET 20 mg (Bentyl) PRN Oral THREE TIMES DAILY 0900 1300 1700 PRN for Stomach Cramps Max Daily Doses: 3		<u>Start:</u> 13:59 10/28 <u>Stop:</u> 23:59 12/31	<u>Admin</u>	<u>Sched</u>		
A	LORazepam TABLET (*Ativan) 1 mg PRN Oral EVERY 6 HOURS PRN for Anxiety Max Daily Doses: 4		<u>Start:</u> 14:29 10/28 <u>Stop:</u> 23:59 12/31	<u>Admin</u> 10/28 14:56 10/29 1:24 10/29 9:20 10/29 17:46 10/30 0:12 10/30 8:16	<u>Sched</u>	Complete Complete Complete Complete Complete	kslupek mebreo kslupek kslupek sjohn rsoriano
A	melatonin TABLET 5 mg PRN Oral AT BEDTIME PRN for Insomnia Max Daily Doses: 1		<u>Start:</u> 13:59 10/28 <u>Stop:</u> 23:59 12/31	<u>Admin</u> 10/28 20:49	<u>Sched</u>	Complete	mebreo
A	methocarbamol TABLET 500 mg (Robaxin) PRN Oral THREE TIMES DAILY 0900 1300 2100 PRN for muscle spasm		<u>Start:</u> 21:00 10/28 <u>Stop:</u> 23:59 12/31	<u>Admin</u> 10/29 5:57 10/29 20:38 10/30 11:08	<u>Sched</u>	Complete Complete Complete	mebreo sjohn rsoriano
A	nicotine GUM (Nicorette) 2 mg PRN Oral Transmucosal EVERY 2 HOURS PRN for Smoking Cessation Max Daily Doses: 12		<u>Start:</u> 14:11 10/28 <u>Stop:</u> 23:59 12/31	<u>Admin</u> 10/28 16:17 10/28 19:58 10/29 7:26 10/29 9:22 10/29 13:04	<u>Sched</u>	Complete Complete Complete Complete Complete	agarin mebreo mebreo kslupek kslupek
A	traMADol TABLET (Ultram) 100 mg PRN Oral THREE TIMES DAILY 0900 1300 2100 PRN To give 100 mg use 2 of 50 mg for Pain		<u>Start:</u> 21:00 10/28 <u>Stop:</u> 23:59 12/31	<u>Admin</u> 10/28 21:08 10/29 10:34 10/29 16:50 10/30 2:54 10/30 11:08	<u>Sched</u>	Complete Complete Complete Complete Complete	mebreo kslupek kslupek sjohn rsoriano



Facesheet (Scanned)



Admit Date: 10/28/2023

Observation Date/Time: 10/28/23 12:32

Facesheet

pdf

CHICAGO BEHAVIORAL HOSPITAL
555 Wilson Lane • Des Plaines, Illinois 60016
Telephone Number: (844) 756-8600

ADMISSION / DISCHARGE RECORD

MEDICAL RECORD NO.		FINANCIAL CLASS		ROOM / BED		HSV	
001026567		DM		419 /B		IAD INPATIENT ADULT DUAL DIAGNOSIS	
PATIENT (Name, Address, Phone)		BIRTH DATE		AGE	SEX	RACE	LANGUAGE
[REDACTED]		12/11/1979		43	M	X	[REDACTED]
CHICAGO IL 60645		MARITAL STATUS		RELIGION		LEGAL STATUS	
		S		UNKNOWN		V	
SSN:		ADMISSION DATE & TIME		DISCHARGE DATE & TIME			
PHONE: 000-0000		10/28/23 11:00					
CELL:		EMPLOYER / SCHOOL		REFERRAL SOURCE			
				ILLINOIS MASONIC			
EMERGENCY CONTACT 1 (Name, Address, Phone, Rel)				EMERGENCY CONTACT 2 (Name, Address, Phone, Rel)			
NONE							
PHONE: 000-0000 REL: UNKNOWN WRK: (000)000-0000 CELL:				PHONE: REL: WRK: (000) - CELL:			
GUARANTOR (Name, Address, Phone, Rel)				ADMITTING PHYSICIAN (Name, Number)			
[REDACTED]				NADKARNI NISHAD 50			
CHICAGO IL 60645				ATTENDING PHYSICIAN (Name, Number)			
PHONE: REL: SELF WRK:				QUESADA ANTHONY 52			
				ADMITTED BY			
				CBH			
PRIMARY INSURANCE		SECONDARY INSURANCE		TERTIARY INSURANCE			
MERIDIAN 222 N LASALLE ST CHICAGO IL 999990000 PHONE: (866)606-3700 POLICY#: [REDACTED] GROUP #: [REDACTED] GRP NAME: [REDACTED] AUTH#: [REDACTED] SEX: M DOB: [REDACTED] REL: SELF		PHONE: POLICY#: [REDACTED] GROUP #: [REDACTED] GRP NAME: [REDACTED] AUTH#: [REDACTED] SEX: DOB: REL:		PHONE: POLICY#: [REDACTED] GROUP #: [REDACTED] GRP NAME: [REDACTED] AUTH#: [REDACTED] SEX: DOB: REL:			
DIAGNOSIS CODES				LAST INPATIENT DATE			
MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED				F339			

10/28/23 11:01

CB1000/011916





**Medical History and Physical
Examination (H&P)**



Admit Date: 10/28/2023

Observation Date/Time: 10/29/23 18:53

Date/Time

10/29/2023 10:21

Medical Diagnosis

Diagnosis Code	System	Class	Type	Priority	Date
-----	-----	----	----	-----	----
Acute embolism and thrombosis I82.401 ICD-10 of unspecified deep veins of right lower extremity		Medical	Working	Secondary Diagnosis	10/29/2023
Alcoholic hepatitis without K70.10 ICD-10 ascites		Medical	Working	Secondary Diagnosis	10/29/2023
Gastro-esophageal reflux K21.00 ICD-10 disease with esophagitis, without bleeding		Medical	Working	Secondary Diagnosis	10/29/2023
Other pulmonary embolism I26.99 ICD-10 without acute cor pulmonale		Medical	Working	Secondary Diagnosis	10/29/2023
Unspecified convulsions R56.9 ICD-10		Medical	Working	Secondary Diagnosis	10/29/2023
		Medical	Working		

Psychiatric Diagnoses

Diagnosis Code	System	Class	Type	Priority	Date
-----	-----	----	----	-----	----
MAJOR DEPRESSIVE DISORDER, F33.9 ICD10 RECURRENT, UNSPECIFIED		Psychiatric	Admitting	Primary Diagnosis	10/28/2023

Reason for admission

SI with plan to OD on prescription meds

Gender

Male

Preferred Pronouns

He/Him/His

Informant

Patient.chart

Reliable

Yes

Past Medical History

LLE DVT, PE, GERD, Congenital spondylosethesis, left hip
acascular necrosis. hx hip replacement, hx back surgery,
hx seizures from withdrawal,

HOME MED LIST AND ADMISSION MED REC



**Medical History and Physical
Examination (H&P)**

MR. [REDACTED]
Hosp # [REDACTED]
DOB: [REDACTED]
Admit Date: 10/28/2023

Observation Date/Time: 10/29/23 18:53

Home Meds:

Description Indication	Brand	Dose	Route	Frequency	PRN
-----	-----	-----	-----	-----	---
clindamycin Oral 300 mg capsule	Cleocin HCl				
gabapentin Oral 300 mg capsule	Neurontin				
gabapentin Oral 400 mg capsule	Neurontin	1,200 mg	PO	TID91317	Anxiety
gabapentin Oral 800 mg TAB 1 ea	Neurontin				
hydroxyzine hydrochloride Oral 50 mg TAB 1 ea	Atarax				
lamotrigine Oral 25 mg tablet	LaMictal	25 mg	PO	DAILY	
Seizures					
methocarbamol Oral 500 mg tablet	Robaxin	500 mg	PO	TID91321	P muscle
spasm					
mirtazapine Oral 15 mg tablet	Remeron	15 mg	PO	HS	Sleep
nicotine 21 mg/24 hr TERF	Habitrol				
omeprazole Oral 20 mg delayed release capsule	PriLOSEC	20 mg	PO	DAILY	GERD
prazosin Oral 1 mg capsule	Minipress	1 mg	PO	HS	
nightmares					
QUetiapine Oral 100 mg tablet	SEROquel				
QUetiapine Oral 300 mg tablet	SEROquel	300 mg	PO	HS	Mood
sertraline Oral 50 mg tablet	Zoloft	50 mg	PO	DAILY	Mood
tramadol 50 mg TAB	Ultram	100 mg	PO	TID91321	P Pain

Admission Meds:

Description Indication	Brand	Dose	Route	Frequency	PRN
-----	-----	-----	-----	-----	---
gabapentin Oral 400 mg capsule	Neurontin	1,200 mg	PO	TID91317	Anxiety
methocarbamol Oral 500 mg tablet	Robaxin	500 mg	PO	TID91321	P muscle
spasm					
mirtazapine Oral 15 mg tablet	Remeron	15 mg	PO	HS	Sleep
omeprazole Oral 20 mg delayed release capsule	PriLOSEC	20 mg	PO	DAILY	GERD
prazosin Oral 1 mg capsule	Minipress	1 mg	PO	HS	
nightmares					
QUetiapine Oral 300 mg tablet	SEROquel	300 mg	PO	HS	Mood
sertraline Oral 50 mg tablet	Zoloft	50 mg	PO	DAILY	Mood
tramadol Oral 50 mg tablet	Ultram	100 mg	PO	TID91321	P Pain

Allergy Comments	Type	Reaction	Severity	Date	Code	System
-----	----	-----	-----	----	----	-----



**Medical History and Physical
Examination (H&P)**

MR#:
Hosp:
DOB:
Admit Date: 10/28/2023

Observation Date/Time: 10/29/23 18:53

ARIPRAZOLE	Drug Allergy		Severe	7704567	RB Alg ID
blurred vision					
BEE STING	Drug Allergy	Swelling	Severe	7708918	RB Alg ID
DUST MITE	Drug Allergy		Mild	7708910	RB Alg ID
KETOROLAC	Drug Allergy	Swelling	Mild	7700739	RB Alg ID
PENICILLIN	Drug Allergy	Hives	Severe	7702923	RB Alg ID
Dietary Restrictions			No		
Activity Restrictions			No		
Height			67 in		
Weight			151 lb		
Body Mass Index			23.6		
Systolic			106 mmHg		
Diastolic			66 mmHg		
Blood Pressure			119 / 70		
Heart Rate			82 beats/min		
Temperature			97.6 °F		
Respirations			20 Resp/Min		
SPO2			99 %		

Past Medical History

Last Dental Exam	2 yrs ago
Last Eye Exam	2 yrs ago
Immunizations	UTD
Last PPD	Neg
Recent Illnesses/Injuries	pt denies
Past Hospitalizations/Psych	Yes

Substance Use

Does patient admit to Substance Use?	Yes and Positive Drug Screen
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SUBSTANCE USE.

Row	Substance	Does pt have Rx?	Route	Amount/Freq uency	Age of 1st Use	Last Used	Current/His torical
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Medical History and Physical Examination (H&P)

DOB: 12/1/1997
Admit Date: 10/28/2023

Observation Date/Time: 10/29/23 18:53

1	Alcohol	No	Oral	1/2 gallon of alcohol / daily	teen	10/26/2023	Current
2	Cannabis	No	Smoke/Vap	sporadicall y	teen	10/26/2023	Current
3	Cocaine/Crack	No	Snort/Inhal e	\$40 / daily	20's	10/26/2023	Current
4	Opiates (heroin/Oxy etc.)	No	Injects	\$80 / heroin	18	10/26/2023	Current

Substance Use

Does patient admit to Tobacco Use? **Yes**

TOBACCO USE

Row	Type	Amount/Frequency
1	Cigarettes	1 ppd

Substance Use

Other Addictive Behaviors **No**

Education

Currently in School? **No**
Highest level of Education? **Some College**

Social/Family History

Family/Living Situation

Current living situation? **Pt reported that he is currently homeless.**
Can patient return? **Yes**
Patient raised by? **adopted parents**
Number of Siblings? **2**
Describe Relationship **1 twin brother, only close with twin brother**
Number of Children? **0**
Describe Relationship **N/a**



**Medical History and Physical
Examination (H&P)**



Admit Date: 10/28/2023

Observation Date/Time: 10/29/23 18:53

Social/Family History

FAMILY PSYCH/SUBSTANCE ABUSE HISTORY

Row	Relationship	History of mental health/chemical dependency issues
1	Sibling	depression, drug addiction

Social/Family History

Family Medical History	pt denies

Legal History

Any Legal Issues?	Yes
Number of arrests	multiple
Current/Pending Charges	No
Arrest Details	drug possession
Time incarcerated	1 month in jail
Probation/Parole	No

Social/Family History

Military Service

Military Service?	No
History of Service?	No

Review of Systems

RESPIRATORY	No History of Problems
Have you been vaccinated for COVID-19? (Corona)	No
Do you want to be vaccinated?	No
Date of last TB Test	UNK
SKIN	No History of Problems



Medical History and Physical Examination (H&P)



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CENTRAL NERVOUS SYSTEM

Tics

No History of Problems

No

GENITOURINARY

No History of Problems

GASTROINTESTINAL

GERD

CARDIOVASCULAR:

"history of DVT and PE"

MUSCULOSKELETAL

No History of Problems

ADDITIONAL

seizures

SURGICAL HISTORY

Yes

Lumbar fusion, back surgery and total left hip arthroplasty

Sexual History

Sexual History

N/A

Recent contraception

N/A

STI

None

Sexual activity in last five days

No

Assessment

Reviewed Lab Results

Yes

UDS-Benzos/cocaine/fentanyl-+

Physical Assessment

General/Mental Status

WNL

Skin

WNL

Head

WNL

Eyes

WNL

ENT

WNL

Neck

WNL

Lungs

WNL

Heart

WNL

Abdomen

WNL

Extremities

WNL



**Medical History and Physical
Examination (H&P)**

[REDACTED] H
M 1567
[REDACTED]
Admit Date: 10/28/2023

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Back	WNL
Neuro	WNL
GU	Deferred
Tanner stage	WNL

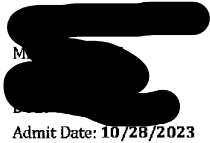
Cranial Nerves

CN I:	WNL
How was CN I tested?	"Sniff and Identify"
CN II:	WNL
How was CN II tested?	Confrontation Test
CN III, IV, VI:	WNL
How was CN III, IV, VI tested?	Finger Tracking
CN V:	WNL
How was CN V tested?	Light touch forehead
CN VII:	WNL
How was this CN VII tested?	Eyebrow raise
CN VIII:	WNL
How was this CN VIII tested?	Finger rub near ear
CN IX, X:	WNL
How was CN IX, X tested?	Palate elevation
CN X:	WNL
How was CN X tested?	Palate elevation
CN XI:	WNL
How was this CN XI tested?	Shoulder Shrug
CN XII:	WNL
How was CN XII tested?	Extend tongue side to side

Plan Of Care



Medical History and Physical
Examination (H&P)



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Impression

- 1. Major depression
- 2. SI w/plan to OD
- 3. Polysubstance abuse
- 4. Seizure-d/t alcohol withdrawal
- 5. LLE DVT/PE-Xarelto
- 6. GERD-omeprazole
- 7. Alcoholic hepatitis
- 8. left hip avascular necrosis/pain- Tramadol
- 9. Nicotine dependence-patch
- 10. Medical consultation-pmh, labs & meds reviewed

Inpatient Meds:

Description	Brand	Dose	Route	Frequency	PRN
Indication					
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**Medical History and Physical
Examination (H&P)**



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acetaminophen Oral 325 mg tablet	APAP	650 mg	PO	Q4H	P	Pain
LORazepam Oral 1 mg tablet	*Ativan	1 mg	PO	Q6H	P	Anxiety
dicyclomine Oral 20 mg tablet	Bentyl	20 mg	PO	TID91317	P	Stomach
Cramps						
gabapentin Oral 600 mg tablet	Neurontin	1,200 mg	PO	TID91321		Anxiety
loperamide Oral 2 mg capsule	Imodium	2 mg	PO	Q2H	P	
Diarrhea						
Notes:Not more than 16mg per day						
LORazepam Injectable 2 mg/mL	Ativan	2 mg	IM	Q4H	P	FOR
SEIZURE ONLY						
solution						
melatonin Oral 5 mg TAB 1 ea		5 mg	PO	HS	P	
Insomnia						
methocarbamol Oral 500 mg tablet	Robaxin	500 mg	PO	TID91321	P	muscle
spasm						
mirtazapine Oral 15 mg tablet	Remeron	15 mg	PO	HS		Sleep
multivitamin Oral tablet	Daily	1 tab	PO	DAILY		
Nutritional Support	Multiple Vitamins					
nicotine Oral Transmucosal 2 mg	Nicorette	2 mg	OM	Q2H	P	Smoking
Cessation						
gum						
omeprazole Oral 20 mg delayed	PriLOSEC	20 mg	PO	DAILY		GERD
release capsule						
ondansetron Oral 4 mg tablet,	Zofran	4 mg	PO	Q6H	P	
Nausea/Vomiting						
disintegrating	ODT					
Patient Own Medication - Stored in	POM	1 ea	NA	UD	P	Patient
Own Med						
Notes:Patient Own Medications						
"Stored in the Pharmacy"						
Pharmacy						
prazosin Oral 1 mg capsule	Minipress	1 mg	PO	HS		
nightmares						
QUETiapine Oral 300 mg tablet	SEROquel	600 mg	PO	HS		Mood
sertraline Oral 50 mg tablet	Zoloft	50 mg	PO	DAILY		Mood
buprenorphine Sublingual 8 mg	*Subutex	8 mg	SL	BID921	P	
Maintenance						
tablet						
tramADol Oral 50 mg tablet	Ultram	100 mg	PO	TID91321	P	Pain
rivaroxaban Oral 10 mg tablet	*Xarelto	10 mg	PO	DAILY		dvt

Ancillary Orders:

Description

-Admit to: 4N, Dual Diagnosis - Substance Abuse and Detox
-Environment Patient Safety Checklist

-Patient/Family Education
-Daily Nursing Progress Note

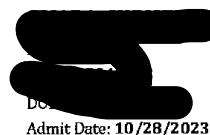
-Psychotropic Medication Notice and Consent Form
-LIPID PANEL W/HDL

Frequency PRN

BID -
Assessmen
ts
Q4H P
BID -
Assessmen
ts
Q4H P
IN AM-UC



Medical History and Physical Examination (H&P)



Admit Date: 10/28/2023

Observation Date/Time: 10/29/23 18:53

-Suicidal Ideation Severity Assessment 1600
 -TSH ONLY, ULTRA SENSITIVE 3RD GEN IN AM-UC
 -COMPREHENSIVE METABOLIC IN AM-UC
 -CBC W/O DIFFERENTIAL IN AM-UC
 -Special Diet Heart Healthy: Finger Foods: No Consult Needed?
 Yes Reason: VS_BID
 -Vital Signs
 -Level Of Observation: Q10 minutes (Q10) Reason: SI with plan
 to OD on prescription meds LOS Rational;
 -Precautions SUICIDAL Precaution, HIGH RISK Precaution and DETOX
 -Provisional Diagnosis SI with plan to OD on prescription meds
 -Legal Status Voluntary
 -Urine Drug Screen IN AM-UC
 Notes:Nurse Collect
 -COWS Scale Q4H-COWS
 Notes:If initial score >10 assess vitals per protocolVerify with MD the initiation of the
 medical detox protocol.

Telehealth

This visit was conducted with the use of interactive audio and video telecommunication that permits real time communication between the patient and the provider. No

The patient consent for virtual visit obtained on

Originating Site: Chicago Behavioral Hospital

Distant Site: Provider Home

Plan Of Care

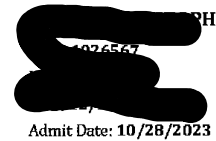
Documented by Scribe No

APN Signature e-Signed by Ethakattu, Sosimol, NP at 10/29/2023 10:22

Medical Provider Signature e-Signed by Papanos, Nicholas, MD at 10/30/2023 00:28



Psychiatric Evaluation



Admit Date: 10/28/2023

Observation Date/Time: 10/29/23 16:56

Date/Time	10/29/2023 10:43
Legal status	Voluntary
Gender	Male
Reason for Admission from Intake	SI with plan to OD on prescription meds
Identifying Data	43-year-old male with past psychiatric history of bipolar disorder, PTSD, and polysubstance abuse
Chief complaint from Intake	"Im depressed"
Chief Complaint in patient's own words	"I'm dealing with a lot of trauma"
History of Present Illness	Patient is a 43-year-old male with past psychiatric history of bipolar disorder, PTSD, and polysubstance abuse who presents as a transfer from Illinois Masonic for suicidal ideation with plan to overdose. Reports he has been feeling increasingly depressed and hopeless since his fiancé passed away in June. Prior to presentation to the ED, he reports taking "a bunch of pills" combined with cocaine and alcohol to try to end life. In addition he feels like he has poor support system and is homeless. He states he is "dealing with a lot of trauma" and that he has been coping with heroin, reports using \$80-100 worth daily. He states he is currently on quetiapine 600mg and suboxone 8mg twice daily. Utox +benzos, cocaine, fentanyl. Patient presents depressed, anxious, hopeless, helpless, with avolition, anhedonia, racing ruminating thought process, poor sleep, poor insight and poor self care. Patient is unable to contract for safety and requires immediate hospitalization for safety and stabilization.
Detox Status	Detox Monitoring
COWS Total	2.00000

Risk of Harm to self and others

Risk of harm to SELF	Inability to care for self, Thoughts to harm self, Active suicidal ideation/intention, Active suicide plan and Unable to contract for safety
	SI with plan to OD
C-SSRS Score from Intake	18
Note: A score of 15 or more indicates "high risk".	
Recent suicidal Intent Notes	plan to OD
Risk of Harm to OTHERS	"Denies thought, plan or ideation to harm others"
History of assaultive thoughts or behaviors?	No



Psychiatric Evaluation



Admit Date: 10/28/2023

Observation Date/Time:

IF ANY ABOVE ARE AFFIRMATIVE, RN MUST BE INFORMED
TO INITIATE ASSESSMENT

Evidence of failure at, or inability to benefit from a less intensive
outpatient setting

yes

Medical History (current, recent, chronic, disabilities)

**hx blood clot disorder, hx hip replacement, hx back
surgery, hx seizures from withdrawal, sciatica, hx bipolar**

Surgical History

Yes

Lumbar fusion, back surgery and total left hip arthroplasty

Does any of the patient's medical or surgical history contribute
to current psychiatric presentation?

No

Allergies and Home Meds

Allergies reviewed in banner

Yes

Home Meds:

Description
Indication

Brand

Dose

Route

Frequency

PRN



Psychiatric Evaluation



Admit Date: 10/28/2023

Observation Date/Time: 10/29/23 16:56

clindamycin Oral 300 mg capsule	Cleocin HCl					
gabapentin Oral 300 mg capsule	Neurontin					
gabapentin Oral 400 mg capsule	Neurontin	1,200 mg	PO	TID91317		Anxiety
gabapentin Oral 800 mg TAB 1 ea	Neurontin					
hydroxyzine hydrochloride Oral 50 mg TAB 1 ea	Atarax					
lamotrigine Oral 25 mg tablet	LaMictal	25 mg	PO	DAILY		
Seizures						
methocarbamol Oral 500 mg tablet	Robaxin	500 mg	PO	TID91321	P	muscle
spasm						
mirtazapine Oral 15 mg tablet	Remeron	15 mg	PO	HS		Sleep
nicotine 21 mg/24 hr TERF	Habitrol					
omeprazole Oral 20 mg delayed release capsule	PriLOSEC	20 mg	PO	DAILY		GERD
prazosin Oral 1 mg capsule	Minipress	1 mg	PO	HS		
nightmares						
quetiapine Oral 100 mg tablet	SEROquel					
quetiapine Oral 300 mg tablet	SEROquel	300 mg	PO	HS		Mood
sertraline Oral 50 mg tablet	Zoloft	50 mg	PO	DAILY		Mood
tramadol 50 mg TAB	Ultram	100 mg	PO	TID91321	P	Pain

Admission Meds:

Description	Brand	Dose	Route	Frequency	PRN	
Indication						
-----	-----	-----	-----	-----	---	

gabapentin Oral 400 mg capsule	Neurontin	1,200 mg	PO	TID91317		Anxiety
methocarbamol Oral 500 mg tablet	Robaxin	500 mg	PO	TID91321	P	muscle
spasm						
mirtazapine Oral 15 mg tablet	Remeron	15 mg	PO	HS		Sleep
omeprazole Oral 20 mg delayed release capsule	PriLOSEC	20 mg	PO	DAILY		GERD
prazosin Oral 1 mg capsule	Minipress	1 mg	PO	HS		
nightmares						
QUETiapine Oral 300 mg tablet	SEROquel	300 mg	PO	HS		Mood
sertraline Oral 50 mg tablet	Zoloft	50 mg	PO	DAILY		Mood
tramadol Oral 50 mg tablet	Ultram	100 mg	PO	TID91321	P	Pain

Treatment History

History of Inpatient Treatment	Yes
Number of hospitalizations	16+
Most recent admission: date and location	Swedish Covenant 2 weeks ago
Age of first hospitalization	20
Reason for admission	suicidal ideation, detox

TRAUMA AND ABUSE

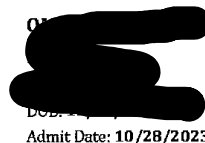
Row	Type of abuse	Age of abuse	By whom	Details	DCFS/APS Involvement	DCFS/APS Report Filed
-----	---------------	--------------	---------	---------	----------------------	-----------------------

Printed On: 10/30/2023 @ 12:37

Page 3 of 11



Psychiatric Evaluation



Admit Date: 10/28/2023

Observation Date/Time: 10/29/23 16:56

1	Sexual Assault	18	stranger	pt reported was raped and drugged by a man as a teenager. Pt denies legal action.	N/A	N/A
2	Neglect	childhood	biological parents	pt reported was adopted when he was very young and was neglected by his biological parents.	N/A	N/A

Substance Use

Does patient admit to Substance Use?

Yes and Positive Drug Screen

SUBSTANCE USE.

Row	Substance	Does pt have Rx?	Route	Amount/Freq uency	Age of 1st Use	Last Used	Current/His torical
1	Alcohol	No	Oral	1/2 gallon of alcohol / daily	teen	10/26/2023	Current
2	Cannabis	No	Smoke/Vap	sporadicall y	teen	10/26/2023	Current
3	Cocaine/Cra ck	No	Snort/Inhal e	\$40 / daily	20's	10/26/2023	Current
4	Opiates (heroin/Oxy etc.)	No	Injects	\$80 / heroin	18	10/26/2023	Current

Substance Use

Does patient admit to Tobacco Use?

Yes

TOBACCO USE

Row	Type	Amount/Frequency
1	Cigarettes	1 ppd

Substance Use

Other Addictive Behaviors

No



Psychiatric Evaluation



Admit Date: 10/28/2023

Observation Date/Time: 10/29/23 16:56

SUBSTANCE ABUSE TREATMENT

Row	Type of Treatment	Location of Treatment	Dates of Treatment
1	RTC	LSSI	2020
2	RTC	ECS - Joliet, IL	"a few months ago"
3	dual diagnosis	CBH - Des Plaines, IL	2018

Family/Living Situation

Current living situation?	Pt reported that he is currently homeless.
Can patient return?	Yes
Patient raised by?	adopted parents
Number of Siblings?	2
Describe Relationship	1 twin brother, only close with twin brother
Number of Children?	0
Describe Relationship	N/a

Legal History

Any Legal Issues?	Yes
Number of arrests	multiple
Current/Pending Charges	No
Arrest Details	drug possession
Time incarcerated	1 month in jail
Probation/Parole	No

Military Service

Military Service?	No
History of Service?	No

ADL's

Sleep disturbance(s)	Yes
	"I get about 4 hours a night."
Sleep disturbance type	difficulty falling asleep and frequent awakening
Normal hours of sleep	8



Psychiatric Evaluation



Admit Date: 10/28/2023

Observation Date/Time: 10/29/23 16:56

Activities of Daily Living Comments none

Family History

Known Family History Yes

FAMILY PSYCH/SUBSTANCE ABUSE HISTORY

Row	Relationship	History of mental health/chemical dependency issues
1	Sibling	depression, drug addiction

Education

Currently in School? No

Highest level of Education? Some College

Employment

Currently employed? No

Receives Disability? No

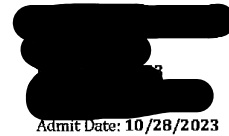
Mental Status Exam

Orientation:	Place, Person and Situation
Appearance:	Disheveled, Malodorous and Poor hygiene
Behavior:	Anxious, Isolated and Withdrawn
Eye Contact	Avoidant
Speech:	Slow and Soft
Psychomotor:	Sedated
Mood:	Anxious, Depressed, Dysphoric and Sad
Affect	Dysphoric and Restricted
Thought Process:	Perseveration and Ruminating
Thought Content	Anhedonia, Avolition and Hopelessness
What is the year, date, day, month, and season?	assessed
What is the name of the hospital, city, and state?	assessed
Perceptual Disturbance	Denies
Hallucinations	None

JUDGEMENT



Psychiatric Evaluation



Admit Date: 10/28/2023

Observation Date/Time: 10/29/23 16:56

Judgement abilities

Difficulty predicting results of choices, Inability to maintain safety of self/others and "Inability to utilize food, shelter and/or clothing"

Overall estimate of Judgement from patient response

Poor

INSIGHT

Insight ability

Patient inability to understand: Nature of illness, Patient inability to understand: Need for medication and Patient inability to understand: Need for treatment

Overall estimate of Insight from patient response

Poor

GENERAL INTELLECTUAL FUNCTIONING

ATTENTION SPAN

Intact

How tested?

Spelling backwards

RECENT MEMORY

Not Impaired

How tested?

Current Medications

REMOTE MEMORY

Not Impaired

How tested?

Recollection of childhood history

ABSTRACT REASONING

Not Impaired

How tested?

Perceptiveness

INTELLIGENCE

Average

How tested?

Fund of knowledge

Is there a need for further testing?

No

Plan Of Care

Problem: Danger to Self (SI with plan to OD on prescription meds)

Problem: High Risk (SI with plan to OD on prescription meds)

Special Program Services

Individual Therapy, Group Therapy and Expressive Therapy

Indications for Inpatient Hospitalization

Severity of Illness Criteria

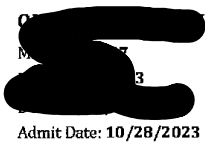
"a) Suicidal, self-injurious threats, gestures or behaviors", e) Marked regression or intensification of significant symptoms and f) Severe impairment in ability to perform ADLs

Intensity of Service Criteria

a) Failure to respond to treatment in an outpatient or other less restrictive milieu such that symptoms are worsened or course of illness has deteriorated



Psychiatric Evaluation



Admit Date: 10/28/2023

Observation Date/Time:

Communication

Is there a reasonable expectation that this patient will make timely and significant practical improvement in the presenting acute symptoms as a result of inpatient hospitalization services? **Yes**

MEDICATION AND ANCILLARY ORDERS

Inpatient Meds:					
Description	Brand	Dose	Route	Frequency	PRN
Indication					
-----	-----	-----	-----	-----	---



Psychiatric Evaluation



Admit Date: 10/28/2023

Observation Date/Time: 10/29/23 16:56

acetaminophen Oral 325 mg tablet	APAP	650 mg	PO	Q4H	P	Pain
LORazepam Oral 1 mg tablet	*Ativan	1 mg	PO	Q6H	P	Anxiety
dicyclomine Oral 20 mg tablet	Bentyl	20 mg	PO	TID91317	P	Stomach
Cramps						
gabapentin Oral 600 mg tablet	Neurontin	1,200 mg	PO	TID91321		Anxiety
loperamide Oral 2 mg capsule	Imodium	2 mg	PO	Q2H	P	
Diarrhea						
Notes: Not more than 16mg per day						
LORazepam Injectable 2 mg/mL	Ativan	2 mg	IM	Q4H	P	FOR
SEIZURE ONLY						
solution						
melatonin Oral 5 mg TAB 1 ea		5 mg	PO	HS	P	
Insomnia						
methocarbamol Oral 500 mg tablet	Robaxin	500 mg	PO	TID91321	P	muscle
spasm						
mirtazapine Oral 15 mg tablet	Remeron	15 mg	PO	HS		Sleep
multivitamin Oral tablet	Daily	1 tab	PO	DAILY		
Nutritional Support	Multiple Vitamins					
nicotine Oral Transmucosal 2 mg	Nicorette	2 mg	OM	Q2H	P	Smoking
Cessation						
gum						
omeprazole Oral 20 mg delayed	PriLOSEC	20 mg	PO	DAILY		GERD
release capsule						
ondansetron Oral 4 mg tablet,	Zofran	4 mg	PO	Q6H	P	
Nausea/Vomiting						
disintegrating	ODT					
Patient Own Medication - Stored in	PCM	1 ea	NA	UD	P	Patient
Own Med						
Notes: Patient Own Medications						
"Stored in the Pharmacy"						
Pharmacy						
prazosin Oral 1 mg capsule	Minipress	1 mg	PO	HS		
nightmares						
QUetiapine Oral 300 mg tablet	SEROquel	300 mg	PO	HS		Mood
sertraline Oral 50 mg tablet	Zoloft	50 mg	PO	DAILY		Mood
tramADol Oral 50 mg tablet	Ultram	100 mg	PO	TID91321	P	Pain
rivaroxaban Oral 10 mg tablet	*Xarelto	10 mg	PO	DAILY		dvt

Ancillary Orders:

Description

-Admit to: 4N, Dual Diagnosis - Substance Abuse and Detox

-Environment Patient Safety Checklist

-Patient/Family Education

-Daily Nursing Progress Note

-Psychotropic Medication Notice and Consent Form

-LIPID PANEL W/HDL

-Suicidal Ideation Severity Assessment

-TSH ONLY, ULTRA SENSITIVE 3RD GEN

-COMPREHENSIVE METABOLIC

Frequency PRN

BID -
Assessmen
ts

Q4H P

BID -
Assessmen
ts

Q4H P

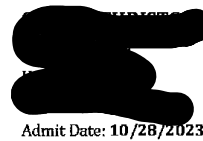
IN AM-UC

1600
IN AM-UC

IN AM-UC



Psychiatric Evaluation



Admit Date: 10/28/2023

Observation Date/Time: 10/29/23 16:56

-CBC W/O DIFFERENTIAL
 -Special Diet Heart Healthy: Finger Foods: No Consult Needed?
 Yes Reason:
 -Vital Signs
 -Level Of Observation: Q10 minutes (Q10) Reason: SI with plan
 to OD on prescription meds LOS Rational;
 -Precautions SUICIDAL Precaution, HIGH RISK Precaution and DETOX
 -Provisional Diagnosis SI with plan to OD on prescription meds
 -Legal Status Voluntary
 -Urine Drug Screen
 Notes:Nurse Collect
 -COWS Scale
 Notes:If initial score >10 assess vitals per protocolVerify with MD the initiation of the
 medical detox protocol.

IN AM-UC

VS_BID

IN AM-UC

Q4H-COWS

Estimated Length of Stay

8 Days

Strengths

Who do you call for when you when need support? **Yes**

Pt reported that his brother, mother, and "NA people" are supportive of him.

Do you have an outpatient treatment team that supports you? **Yes**

Dr. Dalawari - Christ Hospital

Tell me one goal you have for yourself for the future. **Yes**

Pt reported that he would like to

Liabilities

How has your living situation changed or impacted your stress levels? **Yes**

Pt is currently homeless.

Patient has been engaging in using the following substances: **Yes**

Pt abuses alcohol, heroin, and cocaine.

Patient is currently involved with the following legal issues: **Yes**

Pt has a history of legal issues.

Discharge

Diagnosis - Must have at least one ACTIVE and one PRIMARY
 Diagnosis

Diagnosis Code	System	Class	Type	Priority	Date
-----	-----	-----	-----	-----	-----
----	-----				



Psychiatric Evaluation



Admit Date: 10/28/2023

Observation Date/Time: 10/29/23 16:56

MAJOR DEPRESSIVE DISORDER, F33.9 ICD10 RECURRENT, UNSPECIFIED Major depressive disorder, F33.2 ICD-10 recurrent severe without psychotic features	Psychiatric	Admitting	Primary Diagnosis	10/28/2023
		Provisiona		
		1		
Initial Aftercare Plan				
Living/Placement			Home/Independent Living, Residential Treatment Center and Halfway House/Shelter	
Programs/Follow-Up			Partial Hospitalization Program and Individual Therapy/Medication Management	
Discharge Goals and Criteria			"Establish and maintain safety (no SI/HI, self harm, aggression)", "Improvement in signs and symptoms of mood disorder and/or psychosis" and Build insight into condition	
Treatment has been explained to			Patient	

Telehealth

This visit was conducted with the use of interactive audio and video telecommunication that permits real time communication between the patient and the provider. No

The patient consent for virtual visit obtained on

Originating Site: Chicago Behavioral Hospital

Distant Site: Provider Home

Discharge

Documented by Scribe No

I have discussed with the patient the use of anti psychotic drugs as part of the treatment plan including the risks and benefits of the medications including but not limited to possible adverse effects such as possible weight gain, increased serum glucose, sedation, movement disorders, and

cardiac reactions; likely symptoms and risk and benefits of the medication not being taking, and alternative treatments along with the risks and benefits of those alternative treatments.

Provider Signature

e-Signed by Silverman, Eric, MD at 10/29/2023 16:58