



Patient : Kane Williams
Date of Birth : Jan 01, 2010
Provider : Dr. Angela Smith
Visit Type : New Patient Visit

Record Id : CHARM0030
Age / Gender : 13 / unknown
Date of Visit : Jul 31, 2023

History of Present Illness

Reason for visit: Medication Management

Reviewed limits of confidentiality. Patient/parent/legal guardian expressed understanding and voluntarily agreed to proceed with the visit.

This visit is conducted in
office. The visit was attended
alone Referral source:
Google search

History of present illness

Patient reports

Problematic symptoms:

Associated symptoms:

Duration:

Progression:

Precipitating factors/stressors:

Alleviating factors:

Symptoms cause impairments in:

Suicidal or homicidal ideations, plan or intent:

Further details of symptoms below in psychiatric review of systems.

Past Medical History

Any past Hospitalizations? No

Past Psychiatric History

Diagnoses:

Depression

- Major depressive disorder



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History of:

None of the following
Self-injurious
behaviors

Medical History

Current Active Medical Issues:

\${Patient.Diagnoses}

Serious illnesses (eg. cancer, blood clot, stroke, heart attack, autoimmune disease, organ failure/damage): None

Traumatic brain injuries or concussions:

No Seizures: No

Medical Hospitalizations/Surgeries/Procedures/Blood transfusions:

test est

Active Medications:

◉desvenlafaxine 25 mg oral tablet, extended release - 1 tablet(s) once a day before a meal for 30 , oral route.

Recommended times 8am, 2pm , 6pm.

◉escitalopram 10 mg oral tablet - Start with half tab daily for 7 days, then increase to 1 tablet(s) once a day in the morning

◉ibuprofen 800 mg oral tablet - 800 mg every 6 to 8 hours before a meal , oral

◉route propranolol 10 mg oral tablet - 1 tablet(s) 3 times a day as needed for anxiety/panic

◉dicyclomine 10 mg/mL intramuscular solution - 10 mg 4 times a day before a meal , intramuscular

◉route ibuprofen 100 mg/5 mL oral suspension - 1 once a day before a meal for 1 Day(s), oral route

◉Ibuprphone - 1 tablet(s) once a day before a meal for 10 Day(s), compounding route

◉ibuprofen 200 mg oral tablet - 1 tablet(s) once a day before a meal for 10 Day(s), oral route

Supplements

Active Supplements:

◉Complete Vitamin C CTW - 1 application Once a day(After Meals for 10 Day(s))

◉Aminolase TPA 90 caps - 1 application Once a day(After Meals for 10 Day(s))

◉120/80 Blood Pressure 60 caps - 1 gram/m2 ()

◉Vitamin - 1 capsule(s) Once(With Breakfast)- Comments about the supp



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oAnanda Professional Topical Salve - 1 application Once a day(Before Meals for 10 Day(s))



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◉Calcium 500 mg tablet - 1 application Once a day(Before Meals for 10 Day(s))

Allergies:

Specific diet or nutrition plan: None

Family and Social History

Developmental History

Delivery/Birth:

Full term
Vaginal

Complications: None

Milestones met by expected age for:

Talking
Walking
Eating
Toilet Training
Reading
Writing

Academic performance: Average

Housing/living situation: Stable housing

Military: None

Legal (list year(s) and reason(s)): None

Trauma history: No history of significant

trauma. Support system:

Good
Family
Friends

Alcohol/substance use (include amount, frequency, age of onset, last

use): No current daily or problematic use of alcohol

No current daily or problematic use of

substance(s) No current daily or problematic use

of nicotine

Other addictions: None

Review of Systems

A complete review of systems is performed and is negative except where documented.

Metabolic risk factors (select all that apply): None reported

Psychiatric: Per HPI and as detailed below.



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Bipolar Disorder

No symptoms of mania or hypomania in the
past No symptoms of mania or hypomania
currently

Schizophrenia No signs or symptoms of psychosis

Post Traumatic Stress Disorder No history of traumatic
experience(s) Attention-Deficit/Hyperactivity Disorder Not
assessed today Obsessive Compulsive Disorder Not assessed
today

Eating Disorders No restricting, bingeing or purging

Oppositional Defiant Disorder Not assessed today

Health Vitals

Height: 5 ft 9 ins

Physical Examination

Vitals

Obtained at this visit: No

Physical Exam

Constitutional: Well-developed. Well-nourished. Active. No acute
distress. HEENT:

Head: Atraumatic.

Eyes: Extraocular movements intact. Pupils are equal, round. Palpebral fissures symmetrical. Lids have normal
size, position and motility. No lid lag. Lashes and eyebrows show normal texture, amount and distribution. Sclera
white, no icterus.

Conjunctiva clear without discharge.

Ears: Auricle and tragus have normal size, shape, symmetry and
location. Nose: No nasal discharge. Airways patent.

Neck/Throat: Symmetrical. Normal range of motion. Trachea midline and freely moveable. No jugular venous
distension while patient seated upright.

Cardiovascular: No extremity edema. No cyanosis.

Pulmonary/Chest: No respiratory distress. Breathing room air. Respirations even and
unlabored.. Abdominal: No distension.

Musculoskeletal:

Normal range of
motion. No muscle
atrophy.

Normal gait.



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No joint swelling or
erythema. Neurological:



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Patient is awake and alert.

Is not lethargic, confused, stuporous, drowsy, asleep, vigilant. Is not exhibiting fluctuations in level of consciousness.

No tremors, fasciculations or involuntary movements noted. Cranial nerves II-IX and XI-XII grossly intact bilaterally.

Facial function

symmetric. Skin:

Not diaphoretic.

No rashes, lesions, bruising, masses, excoriations or lichenification.

Mental Status Exam

General:

Casually

dressed

Well-nourished

Well-developed

Dressed appropriately for weather

Appears stated age

Gait/Station: Normal,
unassisted Psychomotor
activity: Normal Muscle

Tone/Strength: Good

Behavior:

Good eye

contact Calm

Cooperative

Speech:

Normal rate and

rhythm Normal

volume

Affect:

Constricted

Mood

congruent

Dysphoric

Anxious



Thought Process:

Clear, logical,
linear
Coherent and goal directed

Thought Content: No abnormal or psychotic thoughts



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Suicidal/Homicidal Ideation: Absent

Orientation Alert and oriented to person, place, time,
situation Attention Span and Concentration Intact during
interview Fund of Knowledge Adequate

Memory

Recent

- Intact by history and

interview Remote

- Intact by history and interview

Judgment and Insight Judgement and Insight Intact

Assessment Notes

The diagnosis of psychiatric illness is a complex integration of history, psychiatric, medical and physical findings, social and developmental history, history of substance abuse as well as MSE. Considerations include mood disorders, psychotic disorders, substance induced disorders, anxiety and trauma disorders, and many others. These have all been considered in formulating the diagnoses/diagnosis below. This may change as more information arises and further diagnostic clarification is performed.

Diagnoses



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Diagnosis	Code	Comments
Other obesity	E66.8	
Post-traumatic stress disorder, unspecified	F43.10	
Post-traumatic stress disorder, chronic	F43.12	
Major depressive disorder, single episode, mild	F32.0	
Major depressive disorder, single episode, moderate	F32.1	
Major depressive disorder, single episode, severe without psychotic features	F32.2	
Major depressive disorder, single episode, in partial remission	F32.4	
Dysthymic disorder	F34.1	
Adjustment disorder with depressed mood	F43.21	
Adjustment disorder with anxiety	F43.22	
Adjustment disorder with mixed anxiety and depressed mood	F43.23	
Other situational type phobia	F40.248	
Other specified phobia	F40.298	
Panic disorder [episodic paroxysmal anxiety]	F41.0	
Social phobia, unspecified	F40.10	
Generalized anxiety disorder	F41.1	
Epilepsy, unspecified, not intractable, without status epilepticus	G40.909	--

Rx



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Prescription	Directions	Details
desvenlafaxine 25 mg oral tablet, extended release [Desvenlafaxine]	1 tablet(s) once a day before a meal for 30 , oral route. Recommended times 8am, 2pm , 6pm.	Dispense :30 Tablet, Refill :0,Generic Allowed,I gave it at 2 pm
ibuprofen 800 mg oral tablet [Ibuprofen]	800 mg every 6 to 8 hours before a meal , oral route	Dispense :1 Capsule, Refill :21, Manufactured,Generic Allowed

Lab Tests

Lab Name	Test Name
General	BASIC METABOLIC PANEL
General	CBC w/diff
General	Hepatic (Liver) Panel
General	Blood cultures
General	Sputum Culture
General	Procalcitonin
General	Rapid flu/RSV
General	RVP

Treatment Notes

Safety

Patient denies any suicidal or homicidal ideations, plan or intent at this time.
Patient is future-oriented and treatment seeking.
Patient has support system in place.
Patient denies access to firearms or lethal weapons.

Plan:

Advised patient/parent/legal guardian to sign ROI for the following to assist with coordination of care:
- PCP

Informed Consent:

Diagnoses, medication allergy and medication reconciliation completed.



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Discussed:

- Interpretation of psychiatric evaluation with patient/parent/legal guardian/family, including diagnosis, differential diagnosis and prognosis.
- Management and treatment options with patient/parent/guardian/significant other/family member.
- Risks, benefits, side effects, and alternatives to these treatments with patient/parent/legal guardian.
- Risks of nonadherence to treatment recommendations and medications, including but not limited to, exacerbation of psychiatric symptoms, decompensation in mood and discontinuation symptoms.
- Importance of taking medication(s) as prescribed and importance of notifying the Physician prior to stopping medication(s) abruptly.

Informed consent given for medication regimen.

Answered all questions that the patient/parent/legal guardian asked. - Psychoeducation discussed with patient/parent/legal guardian. Patient /parent/legal guaridan verbally acknowledged understanding of psychoeducation, treatment plan rationale, treatment options, and expressed verbal agreement with plan.

Patient/parent/legal guardian agree to call office or send message via the secure CHARM EHR patient portal for any questions or concerns.

Potential drug-to-drug interactions accounted for. Benefits outweigh risk.

Potential medication side effects General medication side effects reviewed including risk of Steven Johnson Syndrome (including warning signs and to go to the ED if rash develops), risk of harm to fetus if pregnant, importance of use of birth control emphasized, and FDA off-label use of medication.

Medical Follow-up by PCP/Specialists/Other

referrals: Will coordinate care as needed.

Routine follow up with PCP.

Follow up planning

Follow up
scheduled.

Patient is aware follow-up can be moved to closer need as clinically indicated.

Patient/parent encouraged to reach out to me if any questions/concerns arise after this visit.

If symptoms worsen, or there is no improvement, call office for follow-up or seek emergency care. If any crisis or emergency: call 911 or go to the emergency room.

Return to clinic 4 weeks

Linh Phuong (Trish) Dinh, MD

General Psychiatry

Beacon Psychiatry, LLC

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Handouts & Educational Resources



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Resources	Link
Drug/ibuprofen	https://medlineplus.gov/druginfo/meds/a682159.html?utm_source=mplusconnect&utm_medium=service

Follow up

Type	Notes	Date
Lab Tests	Please schedule appointment with the office coordinator to review your labs.	in 1 weeks

Dr. Angela Smith

Electronically Signed By Dr. Angela Smith on Aug 01, 2023 01:20 PM